NEW YORK LIFE INSURANCE COMPANY

Group Plan for New York Life Employees

- **Employee Life Insurance Coverage**
- **Dependent Life Insurance Coverage**
- **Long-Term Disability Coverage**
- **Accidental Death and Dismemberment Coverage**
- **Short-Term Disability Benefits**

January 1, 2024

Summary Plan Description for Eligible Active Employees of New York Life Insurance Company ("Company") and Participating Employers

The Group Plan for New York Life Employees (the "Plan") contains the various components under New York Life's Employees Flexible Benefits Program. This document (together with the attached Exhibits) summarizes the important features of the following components:

- Employee Life Insurance Coverage
- Dependent Life Insurance Coverage
- Long-Term Disability ("LTD") Coverage
- Accidental Death and Dismemberment ("AD&D") Coverage
- Short-Term Disability ("STD") Benefits

This document is not a contract of insurance. The Employee Life, Dependent Life, LTD and AD&D Coverages are fully insured under group policies (each, a "Policy" or collectively " Policies") issued by New York Life Group Insurance Company of NY ("NYLGICNY"). STD benefits are paid from the general assets of the Company.

A summary of each of the Employee Life, Dependent Life, LTD and AD&D benefits is set forth in the attached certificates of insurance issued by NYLGICNY (each a "Certificate" or collectively, "Certificates"). Please read each Certificate carefully. STD Benefits are described in the "Short-Term Disability Benefits" section of this SPD.

This document also contains information regarding the Employee Life, Dependent Life, LTD and AD&D coverages that may not be addressed in the Certificates (e.g., enrollment, adding or changing Beneficiaries, and imputed income). The Certificates address, among other things:

- Eligibility
- Benefits
- When coverage begins and ends
- Continuation Provisions
- Conversion Privileges
- Supplemental Information as required under the Employee Retirement Income Security Act of 1974, as amended ("ERISA")
- Statement of ERISA Rights
- Claims Procedures

This document, together with the Certificates, is the Summary Plan Description ("SPD") for the Employee Life, Dependent Life, LTD and AD&D Coverages, and the STD Benefits under the Plan for active Eligible Employees of an Employer. In general, the term "Employer" means New York Life Insurance Company and any other entity that is a member of the same "controlled group" as the Company, and which has adopted the Plan with the approval of the Company. A list of "Employers" as of January 1, 2024 is set forth in the "Important Information" section on the last page of this SPD. An Employer may terminate its participation in the Plan at any time.

This SPD summarizes Employee Life, Dependent Life, LTD, AD&D and STD Benefits for active Eligible Employees only. Life coverage for eligible retirees is provided under the separate Group Plan for Retired Agents and Employees ("Retiree Group Plan"). You should refer to the SPD for the Retiree Group Plan for further information regarding retiree life coverage (including, eligibility and benefits).

Other components available under the Plan, besides Employee Life, Dependent Life, LTD and AD&D Coverages, and STD Benefits are described in separate SPDs.

The Company reserves the right to amend, suspend, change, eliminate or terminate all or any part of the Plan (including without limitation, the Employee Life, Dependent Life, LTD and AD&D Coverages, and STD Benefits) at any time, including without limitation, the right to terminate or modify any coverage or benefits (or costs thereof) under the Plan for any and all Eligible Employees of an Employer, including those not yet covered or receiving benefits, and those already covered or receiving benefits. Your eligibility for, or your right to benefits described in this SPD is not a guarantee of employment.

If there is a conflict between this SPD and the official Plan Document, or any written or oral communication by a representative of the Plan, then the Plan Document prevails. The Plan Document is available upon request. Employee Life, Dependent Life, LTD and AD&D will be paid only if NYLGICNY, as Claims Administrator, decides in its discretion that the participant is entitled to them. STD Benefits will only be paid if Life Insurance Company of North America ("LINA"), as Claims Administrator, decides in its discretion that the participant is entitled to them. New York Life cannot independently review or reverse claim decisions by NYLGICNY or LINA. Eligibility decisions are the responsibility of the Plan Administrator.

All Eligible Employees are provided with a copy of this SPD. All Eligible Employees and their Dependents may obtain an additional paper copy of this SPD on the Company's Intranet site or the Your Benefits Resources website at http://digital.alight.com/newyorklife, or by calling the New York Life Info Line at 1-888-513-4636. Updated SPDs will be sent to Eligible Employees.

This SPD describes Life, LTD and AD&D Coverages as of January 1, 2024, and STD benefits as of April 1, 2024.

For More Information

If you need additional information regarding the Employee Life, Dependent Life, LTD, AD&D or the STD Benefits, access the Your Benefits Resources™ website via the New York Life Intranet at http://digital.alight.com/newyorklife, or call the New York Life InfoLine at 1-888-513-4636.

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Enrollment Process

Enrollment and Effective Date of Coverage for Eligible Employees

Annual Enrollment Period

If you enroll during the Annual Enrollment Period and agree to pay the required contributions, the Employee Life, Dependent Life, LTD and AD&D Coverages you elect will begin on the January 1 following the Annual Enrollment Period. Coverage cannot begin before the date that you enroll.

Eligible Employees are automatically enrolled in the Employee Life coverage of one (1) times your Benefits Salary, up to a maximum of $1,000,000, and the 50% LTD coverage option. If you would like Dependent Life Coverage, AD&D Coverage, additional Employee Life Coverage or the 60% LTD Coverage, you need to make an affirmative election during enrollment. Eligible Employees do not need to enroll for Short-Term Disability.

New Eligible Employee

If you are a newly hired Eligible Employee, the Employee Life, Dependent Life, LTD and AD&D Coverages you elect will take effect on your date of hire, but only if the Company receives your completed enrollment (including your agreement to pay the required contribution) within 31 days of your date of hire. If you do not enroll within 31 days of your hire date, (i) you will be automatically enrolled in the Employee Life coverage of one (1) times your Benefits Salary, up to a maximum of $1,000,000, and the 50% LTD coverage option, and (ii) you will have no coverage for Dependent Life or AD&D. New Eligible Employees do not need to enroll for Short-Term Disability.

Failure to Enroll

If you are a new Employee, and you do not enroll for coverage during the initial 31-day period – that is, if you fail to timely submit your completed enrollment – you will not be able to enroll in the Dependent Life and AD&D coverage or change your Employee Life or LTD Coverage until New York Life's next Annual Enrollment Period (usually in October, effective for the following January 1), unless you have a qualified family status change, which may allow you to change your Employee Life or Dependent Life coverage under the Plan if you have certain changes in your family status (See "Qualified Family Status Change" below).

Reemployment

If your employment with the Company or an Employer terminates and then you are reemployed by the Company or Employer in the same Calendar Year as your termination date, your previous coverage elections for Employee Life, Dependent Life, LTD and AD&D will be reinstated. If you are reemployed by the Company or an Employer in a later Calendar Year, you will be required to make new enrollment decisions.

Contributions

Your contributions for the Employee Life and AD&D Coverages will be deducted from your pay on a pre-tax basis and are subject to change each year. Your contributions for Dependent Life and LTD Coverages will be deducted from your pay on a post-tax basis and are subject to change each year. The Company will notify you of the contribution rate at the time of enrollment and in advance of each Annual Enrollment Period. The rate of any required contributions will be determined by the Company and will not be based

upon your health factors. No contributions are required for Short-Term Disability. Short-Term Disability benefits are paid by the Company.

Special Enrollment for a Status Change

If, after you enroll for coverage, a qualified change in status event occurs, you may be able to adjust your life and/or dependent life coverage under the Plan or elect another available coverage under the Plan. To do so, one of the following "changes in status" must occur:

- Marriage.
- Divorce, Annulment or Legal Separation.
- Birth, adoption of a child or placement of a child for adoption.
- Death of spouse, domestic partner or Dependent Child.
- Domestic partner affidavit accepted by New York Life.
- Dissolution of the domestic partner relationship.
- Termination of your Spouse's employment.
- A change in the benefit plan available to your Spouse
- A change in employment for you or your Spouse that affects your eligibility for benefits.

In addition, the proposed change in Plan coverage must be on account of, and correspond with, that change in status (i.e., the proposed change must bear a logical relationship to the event that has occurred) and the change in status must affect eligibility under the Plan (i.e., there must be a gain or loss of coverage in response to the change in status event). For example, if you get married, you can enroll in Dependent Life Coverage to cover your new spouse if you submit your change in status request within 31 days of your marriage. Certain changes in Employee Life Coverage may require evidence of insurability (referred to in the Group Life Insurance Coverage Certificate attached as Exhibit A as the "Insurability Requirement").

You can make your change on the Your Benefits Resources website at http://digital.alight.com/newyorklife or by calling the New York Life InfoLine at 1-888-513-4636. You must submit your change in status request within 31 days of the status change event to adjust your coverage. If you do not make the change in status within the 31-day period, you must wait until the next Annual Enrollment Period to adjust your coverage.

Verification of Status Change

The Plan reserves the right to require participants to verify the reason for a change in status. In that regard, the Plan may require participants to submit documentation and/or information that the Plan in its discretion determines is necessary to confirm a change in status. Failure to provide requested documentation and/or information on a timely basis may result in a denial of your request to change your coverage due to a change in status (which may result in your eligible Dependents not having coverage).

No Duplicate Coverage

No person may be covered both as an Eligible Employee and Dependent or as a Dependent of more than one Eligible Employee under this Plan, and no person may be covered as a Dependent of an Eligible Employee under this Plan and an eligible Agent or a Dependent of an eligible Agent under the Group Plan for New York Life Agents.

Verification of Dependents

The Plan reserves the right to require Eligible Employees to verify the eligibility of Dependents. In that regard, the Plan may require you to submit documentation and/or other information that the Plan in its discretion determines is necessary to verify the eligibility of your Dependents. Failure to provide requested documentation and/or information on a timely basis may result in your Dependent not having or losing coverage under the Plan.

Domestic Partner Certification

By enrolling your domestic partner for coverage, you are attesting that this person meets the conditions described in the applicable Certificate (attached hereto as Exhibits A through C). The Company reserves the right to request additional information or certifications, as it deems appropriate. You can obtain further information by calling the New York Life InfoLine toll-free at 1-888-513-4636

Adding or Changing Beneficiaries

You should designate a beneficiary(ies) for your Employee Life and AD&D Coverages during the enrollment process.

You can add or change beneficiaries for your Employee Life and/or AD&D Coverages at any time by accessing the Your Benefits Resources™ website via the New York Life Intranet at http://digital.alight.com/newyorklife**,** or calling the New York Life InfoLine at 1-888-513-4636 to speak with a Benefits Center representative.

The change will take effect at the time you submit the request.
If you do not name a beneficiary, or if all named beneficiaries do not survive you, or if the named beneficiary is disqualified, the death benefit will be paid in accordance with the terms of the applicable Policy.

Imputed Income – Employee Life Coverage

Under the Internal Revenue Code, the cost of the first $50,000 of life insurance coverage is tax exempt. The cost of the coverage above this amount is taxable. If your election for life coverage results in an amount over $50,000, the cost to provide the excess must be treated as income to you. Each year, you will be sent a W-2 form which will include the cost of the insurance in excess of the $50,000 base. This adjustment to your taxable wages is called “imputed income.” Your imputed income is calculated from an IRS table which is based on your age and amount of life insurance coverage in excess of $50,000. Keep in mind you pay tax on the value of the coverage, not on the amount of the coverage itself.

Employee, Dependent Life, LTD and AD&D Certificates

The Employee Life, Dependent Life, AD&D and LTD Coverages under the Plan are set forth in the following Certificates describing these benefits, which are attached as Exhibits A through D. STD Benefits are described in the section of this SPD regarding "Short-Term Disability Benefits."

Benefit	**Exhibit**	**Certificate issued by NYLGICNY**
Employee Life Coverage and Dependent Life Coverages	Exhibit A	Group Life Insurance Certificate Policy Number: FLY-980020 Policy Effective Date: January 1, 2022 • Class 1: Employee Life and Dependent Life Coverages for Eligible Employees who do not have life coverage under either the New York Life Executive Officer Life Plan or the New York Life Officer Life Plan
Employee Dependent Life Coverage	Exhibit B	Group Life Insurance Certificate Policy Number: FLY-980020 Policy Effective Date: January 1, 2022 • Class 3: Dependent Life Coverage for Eligible Employees who have life coverage under either the New York Life Executive Officer Life Plan or the New York Life Officer Life Plan
LTD Coverage	Exhibit C	Group Long Term Disability Insurance Certificate Policy Number: NYK-980036 Policy Effective Date: January 1, 2022
AD&D Coverage	Exhibit D	Group Accident (AD&D) Insurance Certificate Policy Number: YOK-980021 Policy Effective Date: January 1, 2022

Short-Term Disability (STD) Benefits

Eligible Employees

Any Employee regularly employed on a salaried basis by an Employer, who is employed and residing in the United States (other than in Puerto Rico), is eligible to apply for Short-Term Disability Benefits.

The following persons are not eligible for STD Benefits under the Plan and are not Eligible Employees:

- Agents of New York Life Insurance Company ("Company"), including (but not limited to) "Training Allowance Subsidy" insurance agents;
- Individuals hired by the Company (or an affiliate) on a temporary basis;
- Any individual who performs services for the Company (or an affiliate) as an independent contractor, including any individual who performs services for the Company (or an affiliate) under an agreement or arrangement (as evidenced by a writing, oral statement or payroll practice) between the Company (or an affiliate) and the individual or another organization that provides the individual services to the Company (or an affiliate) under which the individual is treated as an independent contractor or an employee or agent of an entity other than the Company (or an affiliate), irrespective of whether such individual is treated as an Employee or agent of the Company (or an affiliate) under common-law principles, state insurance law or the provisions of the Code (including sections 414(m), 414(n) or 414(o)) or is later appointed or reclassified by the courts, the Internal Revenue Service ("IRS"), the U.S. Department of Labor ("DOL") or other governmental agency as an Employee of the Company (or an affiliate);
- Individuals who are employees of an affiliate of the Company that does not participate in the Plan and who perform services for the Company or an Employer, without regard to whether such individuals are reclassified by a court, the IRS, the DOL or another governmental agency as an Employee of the Company or an Employer; and
- Individuals who are employees of another entity, even if working on the premises of the Company or an affiliate or otherwise serving the Company or an affiliate.

Applying for Short-Term Disability Benefits

You should apply for STD benefits no later than 15 days after the date your Sickness or Injury begins or occurs, or a soon as reasonably possible. You can apply for STD benefits by using the Company Intranet, logging onto www.mynylgbs.com, or calling the New York Life InfoLine at 1-888-513-4636. On the Intranet, click on Tools & Services -> Human Resources -> Leave & Accommodation -> Initiate a Leave.

Life Insurance Company of North America ("LINA"), the Claims Administrator, will review your individual circumstances based on the information provided by your physician. You will qualify for STD Benefits if LINA determines that you have a "Disability" (as defined below).

If you qualify for STD Benefits, LINA will also determine the duration of your benefit payment period. While STD Benefits can last up to 25 weeks after you complete a five business day (up to seven calendar days) elimination period, the maximum payment period is not automatic. If you are not initially approved for the maximum payment period and you request that your benefit payment period be extended, your physician may be asked to provide additional information.

You should also be aware that the duration of STD Benefits and the duration of a medical leave under the Company's medical leave policy may differ. For information regarding the Company's medical leave policy, please refer to the Employee Handbook that is available on the Intranet.

Claimant Cooperation

Failure to cooperate with the Plan in the administration of your claim may result in the termination of your claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual amount of benefit due.

Proof of Loss

Written proof of loss (proof of your Disability) must be given to the Plan within 45 days of the date of the loss for which a claim is made. If written proof of loss is not given in that time, the claim will not be invalidated nor reduced if it is shown that written proof of loss was given as soon as reasonably possible. If written proof of loss is provided outside of these time limits, the claim will be denied. These time limits will not apply while the person making the claim lacks legal capacity.

Written proof of continued Disability and Appropriate Care by a physician must be given to the Plan within 30 days of a request.

Definition of Disability for Short-Term Disability Benefits

Initial Claims

For purposes of initial claims, Disability means that:

- You are unable to perform the material and substantial duties of your Regular Occupation due to your Sickness or Injury; and
- You are under the regular care of a physician.

Residual (Ongoing) Claims

For purposes of residual claims, Disability means that:

- You are limited from performing the material and substantial duties of your Regular Occupation due to your Sickness or Injury;
- You have a 20% or more loss in Weekly Earnings due to the same Sickness or Injury; and
- You are under the regular care of a physician.

A residual claim occurs when you have already been approved for, and are receiving STD Benefits, and your physician determines that you can only return to work on a reduced schedule. In this case, you may be eligible for a portion of your Weekly Earnings as STD Benefits if, upon your return to service, your Weekly Earnings are at least 20 percent lower than your regular weekly earnings.

For example, suppose you are out of the office receiving STD Benefits for several weeks, and after that time your physician approves your return to work, but only at a 50% schedule for the next two weeks. For those two weeks, subject to approval by LINA, you will be paid a portion of your Weekly Earnings based on your reduced work schedule, and you may qualify for STD Benefits equal to a portion of what would have been your remaining Weekly Earnings if you had returned to work at

100% of your regular work schedule.

If you return to work on a reduced schedule, the portion of your Weekly Earnings you are paid plus your STD Benefit cannot exceed 100% of the Weekly Earnings you would have otherwise been paid if you had returned to your regular work schedule.

Short-Term Disability Benefit Amounts

You can qualify for up to 25 weeks of STD Benefit payments based on your medical needs after a five business day elimination period (up to seven calendar days) in accordance with the chart below, and subject to the "Successive Periods of Disability – Impact on Short Term Disability Benefits" section immediately following the chart.

Period	Short -Term Disability Benefit
Elimination Period	5 consecutive business days (up to 7 calendar days) unpaid; however, you may use accrued vacation, accrued personal holidays or any paid unscheduled absence days available
Benefit Amount – First 6 weeks after the Elimination Period	After the elimination period, 100% of Base Salary* for the first 6 weeks
Benefit Amount – Up to 19 additional weeks	75% of Base Salary* for up to 19 additional weeks

* For this purpose, "Base Salary" refers to the portion of the Base Salary you would have otherwise been paid if you were working your regular schedule (or your "Weekly Earnings" for each week you are approved for STD Benefits). Base Salary is your base salary as of the initial date of your Disability; provided that if your Base Salary increases while on leave, your STD Benefit after the date of the increase will be adjusted prospectively.

Successive Periods of Disability – Impact on Short-Term Disability Benefits

When You Need to Complete a New Elimination Period

- If you are approved for STD Benefits, you do not need to complete a new elimination period if you return to work for less than 30 calendar days, and then are subsequently approved for STD Benefits for the same Sickness or Injury.

- You need to complete a new elimination period if you either (i) return to work for more than 30 calendar days (even if you are approved for STD Benefits for the same Sickness or Injury) or (ii) return to work for at least one day and are subsequently approved for STD Benefits for a different Sickness or Injury.

Limit on 100% Base Salary Replacement in any Rolling 12-Month Period

Income replacement at 100% of Base Salary for the first six weeks applies to a rolling twelve-month period. If you have received STD Benefits in the past twelve months, your benefit will be adjusted so you receive 100% of Base Salary for a combined total of six weeks, then 75% of Base Salary for the balance of your leave.

For example, suppose you are approved for STD Benefits in February of a given year for a period of eight weeks. You subsequently return to work, and are then approved for STD Benefits in November of the same year. After you complete your elimination period, your STD Benefit will start at 75% of Base Salary.

Additional Information regarding Pregnancy Leave

The STD Benefit covers six weeks of pregnancy leave at 100% of Base Salary. If you received STD Benefits in the 12-month period prior to your pregnancy leave, your benefit will be adjusted so you receive 100% of Base Salary for a combined total of six weeks (taking into account your prior leave to determine the 6-week period), then 75% of Base Salary for the balance of your leave. If you continue to be disabled as the result of complications of pregnancy or delivery, you may be eligible to continue your STD Benefit beyond six weeks, up to an additional 19 weeks. The next portion of your benefit will be paid at 75% of Base Salary.

Reductions to Short-Term Disability Benefits

Your STD benefits will be reduced by the amount of any:

- Worker's Compensation
- State Mandated Disability Benefits

you are receiving at the same time you are eligible for STD.

Coordination with State Mandated Disability Benefits

Certain states may require specific state mandated disability benefits. If you work in one of these states, your state or local leave laws will apply. Any state mandated disability benefits will be coordinated with the STD Benefits under the Plan, so that together, you will receive the maximum benefit you would have received from the Company if you did not live in a state with mandated disability benefits.

Exclusions

An Employee is not eligible for STD Benefits if the Employee's Disability is due to:

- Active participation in a riot;
- Self-inflicted injuries;
- War or any act of war, whether or not declared;
- Incarceration;
- Injury or Sickness while the employee is serving on full-time active duty in the armed forces;
- Any cosmetic surgery or surgical procedure that is not medically necessary (as such term is defined under the Company's medical coverage), unless such surgery is necessary due to an accidental Injury;
- Commission of a felony;
- Commission of a crime for which the Employee has been convicted; or
- Attempt to commit a crime.

Termination of Short-Term Disability Benefits

Subject to applicable law, STD Benefits will end on the earliest of the following:

- The date LINA determines the Employee is no longer Disabled;
- The date the Employee returns to work on a full-time basis;

- For a Residual Claim (as defined above), the date the Employee earns more than 80 percent of Weekly Earnings from any occupation;
- The Employee has received STD Benefits for the maximum permitted period;
- The Employee is terminated involuntarily (e.g., for misconduct, poor performance, or the violation of Company policies, rules or procedures) during the period during which the employee is approved for STD benefits, with the exception of involuntary termination related to the exhaustion of a protected medical leave or an "Involuntary Termination due to Job Elimination" under the New York Life Insurance Company Job Elimination Severance Benefit Plan;
- The Employee fails to submit proof of continued Disability;
- The Employee is no longer receiving Appropriate Care;
- The Employee refuses to fully participate, without Good Cause, in all required phases of a Rehabilitation Plan;
- The Employee refuses to participate in a Transitional Work Arrangement;
- The Employee fails to cooperate with the Plan in the administration of the claim; such cooperation includes, but is not limited to, providing any information or documents need to determine whether benefits are payable or the actual amount due; or
- The Employee dies.

Claims Procedures

In General

The claims procedures described below are intended to comply with Department of Labor Regulations at 29 CFR 2560.503-1, and should be construed in accordance with these regulations. In no event shall the claims procedures be interpreted as expanding your rights beyond what is required under these regulations. If you have any questions regarding a claim for STD Benefits, you should call the New York Life InfoLine at 1-888-513-4636.

Claims Administrator

LINA is the Claims Fiduciary, and has the exclusive and final discretionary authority to decide claims and appeals for STD Benefits under the Plan. The Claims Fiduciary shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for STD Benefits under the Plan, and to make any related findings of fact. All decisions made by the Claims Fiduciary shall be final and binding on Participants to the full extent permitted by applicable law. New York Life cannot independently review or reverse claim decisions made by the Claims Administrator.

Eligibility or Other Non-Benefit Claims

Eligibility decisions unrelated to the decision of a pending claim for benefits are the responsibility of the Plan Administrator and will be handled, where required, under procedures similar to those for benefit claims. Please contact the New York Life Info Line at 1-888-513-4636 for more information.

Claims for Short-Term Disability Benefits

A disability "claim" is any claim which requires a determination of Disability by the Claims Fiduciary. A disability claim is "filed" as of the date Claims Fiduciary first receives, in writing (including electronically) or by telephone (through the Claims Fiduciary's intake department), notice that a claimant is seeking disability benefits. The notice of claim received should provide the date of disability/loss, the claimant's name and address, and

the Plan sponsor's name and address. Properly filed claims will be decided with independence and impartiality.

The Claims Fiduciary has 45 days from the date it receives a claim for benefits to determine whether or not benefits are payable in accordance with the terms of the Plan. The Claims Fiduciary may require more time to review the claim if necessary due to matters beyond its control. The review period may be extended for up to two additional 30 day periods. If this should happen, the Claims Fiduciary must provide its extension notice in writing before expiration of the current decision period, explaining the circumstances requiring extension and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Claims Fiduciary's decision shall be tolled (suspended) from the date on which the notification of the extension was sent until the date the Claims Fiduciary receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

During the review period, the Claims Fiduciary may require a medical examination of the claimant, at the Plan's expense, or additional information regarding the claim. If a medical examination is required, the Claims Fiduciary will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Claims Fiduciary will notify the claimant, in writing, stating what information is needed and why it is needed.

If the claim is approved, the Plan will pay the appropriate STD Benefit. If the claim decision is adverse, in whole or in part, the Claims Fiduciary will provide written or electronic notice which will include the following information:

1. The specific reason(s) for the decision;
2. Specific reference to the Plan provision(s) on which the decision was based;
3. A description of any additional information required to perfect the claim, and the reason this information is necessary;
4. A description of the review procedures and the time limits applicable to those procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA after the claimant appeals and after the claimant receives an adverse decision on appeal;
5. A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Claims Fiduciary of the health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Claims Fiduciary in connection with the claimant's adverse benefit decision, without regard to whether the advice was relied upon in making the benefit decision; and (iii) a disability decision regarding the claimant presented by the claimant to the Claims Fiduciary made by the Social Security Administration;
6. Either the specific internal rules, guidelines, protocols, standards or other similar Plan criteria the Claims Fiduciary relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar Plan criteria do not exist;.
7. If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to the

claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

8. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; and
9. A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA.

Appeal of an Adverse Decision

Whenever a claim decision is fully or partially adverse, unless ERISA provides otherwise, the claimant may appeal once to the Claims Fiduciary. As part of the claimant's appeal, the claimant may receive, upon request, free of charge, copies of all documents, records, and other information relevant to the claim for benefits, and the claimant may submit to the Claims Fiduciary, written comments, documents, records, and other information relating to the claim. The review will take into account all comments, documents, records and other information the claimant submits related to the claim, without regard to whether such information was submitted or considered in the initial claim decision. Once an appeal request has been received by the Claims Fiduciary, a full and fair review of the claim appeal will take place.

A written request for appeal must be received by the Claims Fiduciary within 180 days from the date the claimant received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived. The Claims Fiduciary has 45 days from the date it receives a request for appeal to provide its decision. Under special circumstances, the Claims Fiduciary may require more time to review the claim and can extend the time for decision, once, by an additional 45 days. If this should happen, the Claims Fiduciary must provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Claims Fiduciary's decision shall be tolled (suspended) from the date on which the notification of the extension was sent until the date the Claims Fiduciary receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

The review will give no deference to the original claim decision. The review will not be made by the person who made the initial claim decision, or a subordinate of that person. When deciding an appeal based in whole or in part upon medical judgment, the Claims Fiduciary will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment. Any medical or vocational experts consulted by the Claims Fiduciary for the review will be identified and will not be the expert who was consulted during the initial claim decision or a subordinate of that expert.

During the appeal, the Claims Fiduciary may require a medical examination of the claimant, at the Plan's expense, or additional information regarding the claim. If a medical examination is required, the Claims Fiduciary will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Claims Fiduciary will notify the claimant, in writing, stating what information is needed and why it is needed.

Before the Claims Fiduciary issues an adverse benefit decision on appeal, if the Claims Fiduciary considered, relied upon, or generated any new or additional evidence in

connection with the claim, and/or if the Claims Fiduciary intends to rely on any new or additional rationale in connection with that review, then such evidence and/or rationale will be provided to the claimant, free of charge, as soon as possible and sufficiently in advance of the date that the decision on appeal is required to be made, giving the claimant a reasonable opportunity to respond.

If the claim is approved, the Plan will pay the appropriate STD Benefit. If the claim decision on appeal is adverse, in whole or in part, the Claims Fiduciary will provide written or electronic notice that includes:

1. The specific reason(s) for the decision;
2. Specific reference to the Plan provision(s) on which the decision was based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
4. A statement describing any voluntary appeal procedures offered, and the claimant's right to obtain the information about those procedures;
5. A statement of claimant's right to bring a civil action under section 502(a) of ERISA, including a description of any applicable contractual limitations period that applies to the claimant's right to bring such an action, and the calendar date on which the contractual limitations period expires for the claim;
6. A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Claims Fiduciary of the health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Claims Fiduciary in connection with the adverse decision, without regard to whether the advice was relied upon in making the adverse decision; and (iii) a disability decision regarding the claimant presented by the claimant to the Claims Fiduciary made by the Social Security Administration;
7. Either the specific internal rules, guidelines, protocols, standards or other similar plan criteria the Claims Fiduciary relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar plan criteria do not exist;
8. If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
9. A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA.

Legal Actions – Short-Term Disability Benefit Claims

You may not bring a lawsuit to recover STD Benefits under the Plan until you have exhausted the applicable administrative process, as described in this section. No action may be brought at all unless brought no later than one (1) year following a final decision on your claim for STD Benefits. The one-year (1-year) statute of limitations on suits for all benefits shall apply in any forum where you may initiate such suit.

Recovery of Overpayments

The Plan has the right to recover any amounts overpaid to you.

Glossary

"Appropriate Care" means the determination of an accurate and medically supported diagnosis of your Disability by a Physician, or a plan established by a Physician of ongoing medical treatment and care of the Disability that conforms to generally accepted medical standards, including frequency of treatment and care.

"Base Salary" means your annual base salary as determined by the Company. Base Salary does not include incentive payments, overtime pay, supplemental allowances, severance pay, recognition awards and any other additional forms of compensation.

"Good Cause" means a medical reason preventing participation in the Rehabilitation Plan. Satisfactory proof of Good Cause must be provided to the Plan.

"Injury" means any accidental loss or bodily harm that results directly or indirectly of all other causes from an Accident.

"Regular Occupation" means the occupation the Eligible Employee routinely performs at the time the Disability begins. In evaluating Disability, the Claims Administrator will consider the duties of the occupation as it normally performed in the general labor market in the national economy. It is not work tasks that are performed for a specific employer or at a specific location.

"Rehabilitation Plan" means a written plan designed to enable an Employee to return to work. The Rehabilitation Plan will consist of one or more the following phases:

1. Rehabilitation, under which the Plan may provide, arrange or authorize education, vocational or physical rehabilitation or other appropriate services;
2. Work, which may include modified work and work on a part-time basis.

"Sickness" means any physical or mental illness or disease.

"Transitional Work Arrangement" means any work offered to the Employee by an Employer or affiliate while the Employee is Disabled and which may be his or her own occupation, including but not limited to, reassigned duties, work site modification, flexible work arrangements, job adaptation or special equipment.

"Weekly Earnings" means 1/52nd of your Base Salary.

Additional Information regarding Short-Term Disability Benefits provided by New York Life Insurance Company

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA), as amended. Your Plan Administrator has determined that this information, together with the information contained elsewhere herein, is the SPD for STD Benefits as required by ERISA.

Name of Plan
New York Life Insurance Company Group Plan for New York Life Employees

Name and Address of Plan Sponsor
New York Life Insurance Company
51 Madison Avenue
New York, NY 10010

Name and Address of Each Participating Employer

- New York Life Investment Management LLC
- NYL Investors LLC
- Life Insurance Company of North America
- New York Life Group Insurance Company of NY
- Apogem Capital LLC ("Apogem")
- New York Life Enterprises LLC
- IndexIQ LLC
- IndexIQ Advisors LLC
- New York Life Trust Company
- NYLINK Insurance Agency, Incorporated

Address for all Participating Employers other than Apogem:
51 Madison Avenue
New York, NY 10010

Address for Apogem:
299 Park Avenue, 37th Floor
New York, NY 10171

Plan Sponsor Identification Number
13-5582869

Plan Number
501

Type of Plan
Welfare – Short-Term Disability

Type of Administration
Administrative Service Only ("ASO") Agreement with:
Life Insurance Company of North America
51 Madison Avenue
New York, NY 10010

Plan Administrator
The Plan Administrator has the exclusive and final discretionary authority to administer, apply and interpret the Plan and any other Plan documents and to decide all matters arising in connection with the operation or administration of the Plan, including without limitation, the right to determine whether an individual is eligible for coverage and the class of coverage. The Plan Administrator is:

Maria J. Mauceri, Vice President & Actuary
New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
Tel: 1-212-576-7000

Claims Administrator
The Claims Administrator is the fiduciary with exclusive and final discretionary authority to determine whether or not a participant's claim for STD Benefits will be approved.

The Claims Administrator is:
Life Insurance Company of North America
51 Madison Avenue
New York, NY 10010

Agent for Service of Legal Process
Maria J. Mauceri, Vice President & Actuary
New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
Tel: 1-212-576-7000

Plan Year
January 1 through December 31

Source of Contributions
New York Life makes payments from its general assets.

Benefits
The Plan provides, among other benefits, STD Benefits. All Eligible Employees are provided with a copy of this SPD, which includes a description of STD Benefits and the exclusions and limitations that apply to them. All Eligible Employees may obtain an additional paper copy of this SPD on the Company's Intranet site or by calling the New York Life Info Line at 1-888-513-4636. Updated SPDs will be sent to Eligible Employees.

Funding
No Employee contributions are required. STD Benefits and Plan expenses are paid from the general assets of the Company.

Amendment and Termination
The Company reserves the right to amend, suspend, change, eliminate or terminate all or any part of the Plan (including without limitation, the STD Benefits) at any time, including without limitation, the right to terminate or modify any coverage or benefit (or cost thereof) under the Plan for any and all Eligible Employees of an Employer,

including those not yet covered or receiving benefits, and those already covered or receiving benefits. An Employer may terminate its participation in the Plan at any time.

Statement of ERISA Rights

As a participant in the Group Plan for New York Life Employees, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, 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 SPDs. 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 Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including the Company or any other person, may terminate your employment or otherwise discriminate against you in any way to prevent you from obtaining a STD benefit under the Plan or exercising your rights under ERISA.

Enforcing Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you 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 was denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a 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 the court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the

court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the Plan Administrator or the nearest regional 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, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

EXHIBIT A

GROUP LIFE INSURANCE CERTIFICATE – EMPLOYEE LIFE AND DEPENDENT LIFE COVERAGES

(FOR ELIGIBLE EMPLOYEES WHO DO NOT HAVE LIFE COVERAGE UNDER EITHER THE NEW YORK LIFE EXECUTIVE OFFICER LIFE PLAN OR THE NEW YORK LIFE OFFICER LIFE PLAN)

Group Life
Insurance Certificate

New York Life Insurance Company
Class 1

IMPORTANT NOTICES

If you reside in one of the following states, please read the important notices below:

Arizona, Florida and Maryland residents:

The group policy is issued in the state of New York and will be governed by its laws. If you reside in a state other than New York, this certificate of insurance may not provide all of the benefits and protections provided by the laws of your state. PLEASE READ YOUR CERTIFICATE CAREFULLY.

Washington Residents:

(In Accordance With WAC 284-23-610, 620, 650, 730)

The accelerated life benefit in this policy does not and is not intended to qualify as long-term care under Washington state law. Washington state law prevents this accelerated life benefit from being marketed or sold as long-term care.

If an Insured receives payment of accelerated benefits from a life insurance policy, he or she may lose the right to receive certain public funds, such as Medicare, Medicaid, Social Security, Supplemental Security, Supplemental Security Income (SSI), and possibly others. Also, receiving accelerated benefits from a life insurance policy may have tax consequences for the Insured. We cannot give advice about this. The Insured may wish to obtain advice from a tax professional or an attorney before he or she decides to receive accelerated benefits under a life policy.

NOTICE

BENEFITS PAID UNDER THE TERMINAL ILLNESS BENEFIT PROVISION WILL REDUCE THE DEATH BENEFIT PAYABLE FOR LIFE INSURANCE.

BENEFITS PAYABLE UNDER THE TERMINAL ILLNESS BENEFIT PROVISION MAY BE TAXABLE. IF SO, THE INSURED OR THE INSURED'S BENEFICIARY MAY INCUR A TAX OBLIGATION. AS WITH ALL TAX MATTERS, AN INSURED SHOULD CONSULT WITH A PERSONAL TAX ADVISOR TO ASSESS THE IMPACT OF THIS BENEFIT.

RECEIPT OF ACCELERATED BENEFITS MAY AFFECT ELIGIBILITY FOR PUBLIC ASSISTANCE PROGRAMS.

TERMINAL ILLNESS BENEFITS ARE NOT PAYABLE IF LIFE INSURANCE COVERAGE UNDER THIS POLICY IS NOT IN FORCE.

TY-005198

CLAIM PAYMENT NOTICE

MANNER OF PAYMENTS OF CLAIMS

THE POLICYHOLDER AUTHORIZES THAT ANY BENEFIT PAYMENT DUE AS A LUMP SUM OF $5,000 OR MORE SHALL BE CREDITED TO A DRAFT ACCOUNT WITH THE INSURANCE COMPANY, IN THE NAME OF THE CLAIMANT. THE CLAIMANT MAY WITHDRAW THE ENTIRE PROCEEDS AT ANY TIME BY ISSUING ONE OR MORE DRAFTS, OR MAY WITHDRAW LESSER AMOUNTS, SUBJECT TO A MINIMUM ACCOUNT BALANCE SET BY THE INSURANCE COMPANY FROM TIME TO TIME. INTEREST SHALL BE CREDITED TO SUCH ACCOUNT AT RATES AS DETERMINED FROM TIME TO TIME BY THE INSURANCE COMPANY.

DRAFT ACCOUNTS

THE INSURANCE COMPANY SHALL BE ENTITLED TO RETAIN, AS PART OF ITS COMPENSATION, ANY EARNINGS ON DRAFT ACCOUNTS CREATED IN CONNECTION WITH BENEFIT CLAIMS, IN EXCESS OF INTEREST CREDITED UNDER THE TERMS OF THE POLICY.

FOREWORD

Life insurance provides individuals and their families with financial protection. The Life Insurance Benefit described in this booklet will help secure your family's financial security in the event of your death.

The need for life insurance protection depends on individual circumstances and financial situations. A portion of the cost of this coverage is provided by your Employer. You may need to contribute to the remaining cost of coverage through payroll deduction so that your benefit program is more comprehensive and responsive to your needs.

The following pages describe the main provisions of the life insurance plan available to you.

Insurance benefits described in the following pages will apply to you if your Employer has made this coverage available to you at no cost or you have elected the benefit and authorized payroll deduction for the required premium.

CIGNA LIFE INSURANCE COMPANY OF NEW YORK
51 MADISON AVENUE
NEW YORK, NY 10010
(800) 732-1603 TDD (800) 336-2485
A STOCK INSURANCE COMPANY

GROUP INSURANCE
CERTIFICATE

We, the CIGNA LIFE INSURANCE COMPANY OF NEW YORK, certify that we have issued a Group Policy, FLY-980020, to New York Life Insurance Company.

We certify that we insure all eligible persons, who are enrolled according to the terms of the Policy. Your coverage will begin and end according to the terms set forth in this certificate.

This certificate describes the benefits and basic provisions of your coverage. You should read it with care so you will understand your coverage.

This is not the insurance contract. It does not waive or alter any of the terms of the Policy. If questions arise, the Policy will govern. You may examine the Policy at the office of the Policyholder or the Administrator.

This certificate replaces any and all certificates which may have been issued to you in the past under the Policy.

Nothing in this group policy will invalidate or impair the rights granted to holders of any certificates issued under this policy, under the terms of the certificate or by law.

Scott Berlin, President

TY-005151

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SCHEDULE OF BENEFITS

Policy Effective Date: January 1, 2022

Certificate Effective Date: January 1, 2024

Policy Anniversary Date: January 1

Policy Number: FLY-980020

Class Definition

You are eligible for insurance if you are a member of the class defined below.

All active Employees of the Employer who are (i) classified as either full-time by the Employer at the location at which the Employee is employed, or part-time regularly scheduled to work a minimum of 20 hours per week, and are (ii) citizens or permanent resident aliens of the United States employed and residing in the United States (other than Puerto Rico) in one of the following categories:

- All Non-officer Employees of all Employers;
- Any Appointive Officers of an Employer other than an Investment Boutique hired, or rehired as, or promoted to, Appointive Officer on or after January 1, 2017;
- All Appointive Officers of the Investment Boutiques, regardless of their date of hire, and
- Prior to January 1, 2023, Executive Officers of the Investment Boutiques.

The following Employees who have active life coverage under either the New York Life Insurance Company Executive Officer Life Plan or the New York Life Insurance Company Officer Life Plan are excluded:

- Executive Officers (including, but not limited to, Executive Officers of the Investment Boutiques as of January 1, 2023);
- Managing Partners;
- Zone Vice Presidents; and
- Appointive Officers prior to January 1, 2017 (other than (i) Appointive Officers of the Investment Boutiques or (ii) individuals who were Appointive Officers of an Employer other than an Investment Boutique prior to January 1, 2017, and who terminated employment and were subsequently rehired by an Employer on or after January 1, 2017).

For this purpose, the Investment Boutiques include the following Employers: IndexIQ LLC, IndexIQ Advisors LLC, Apogem Capital LLC (effective April 1, 2022), and prior to April 1, 2022, Madison Capital Funding LLC and GoldPoint Partners LLC.

Your Eligibility Waiting Period

The Eligibility Waiting Period is the period of time you must be in Active Service to be eligible for coverage. It will be extended by the number of days you are not in Active Service.

If you were hired on or before the Policy Effective Date: No Waiting Period

If you were hired after the Policy Effective Date: No Waiting Period

LIFE INSURANCE BENEFITS

If an Insured is eligible under one Class of Eligible Employees and later becomes eligible under a different Class of Eligible Employees, changes in his or her insurance due to the class change will be effective on the first date the Insured is in Active Service on or after the date of the change in class.

Employee Benefits

Basic Benefit	
Option 1:	$50,000
Option 2:	1 times your Annual Compensation
Guaranteed Issue Amount:	the greater of $50,000 or the lesser of 1 times Annual Compensation or $1,000,000
Maximum Benefit:	the greater of $50,000 or the lesser of 1 times Annual Compensation or $1,000,000

The Benefit Amount, Guaranteed Issue Amount and Maximum Benefit will be rounded to the next higher $1,000, if not already a multiple thereof.

*Option 1 benefit is not eligible to select Supplemental life coverage

Basic Terminal Illness Benefit	You can elect up to 75% of Basic Life Insurance Benefits in force on the date you are determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $750,000.
Supplemental Benefit	Your Annual Compensation rounded to the next higher $1,000, if not already a multiple thereof, times 1, 2, 3, 4, 5 or 6 times
Guaranteed Issue Amount:	the greater of a), b) or c) below: a) the lesser of 3 times Annual Compensation or $650,000 or b) an amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan c) an amount equal to the employee's prior coverage amount under the NYL Executive Officer Life plan
Maximum Benefit:	the lesser of 6 times your Annual Compensation or $3,000,000
Benefit Level:	An amount equal to the difference between your current benefit option and the next higher benefit option.
Supplemental Terminal Illness Benefit	You can elect up to 75% of Supplemental Life Insurance Benefits in force on the date you are determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $1,000,000.

Automatic Increase Feature for Life Insurance

An increase in your Life Insurance resulting from an increase in Annual Compensation will not be subject to the Insurability Requirement, even if the increase causes the Life Insurance to exceed the Guaranteed Issue Amount.

If you are not in Active Service on the date the increase would go into effect, your benefit will not increase until you return to Active Service.

Premiums must be paid on the basis of any increased amount of Life Insurance resulting from increases in Annual Compensation.

Spouse or Domestic Partner Benefits

Supplemental Benefit	
Option 1	$20,000
Option 2	$30,000
Option 3	$50,000
Guaranteed Issue Amount:	the greater of a) or b) below: a) $50,000, or b) an amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan
Supplemental Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Dependent Child Benefits

Supplemental Benefit	
Option 1	$3,000
Option 2	$5,000

All Dependent Child benefits are Guaranteed Issue.

Increases and Decreases in Coverage

If you, your Spouse and Dependent Children are currently insured under the Supplemental Life Insurance portion of this Policy, coverage may be increased or decreased, or if a person is eligible but has not previously enrolled, he or she may become insured for coverage under this Policy during an Annual Enrollment Period or within 31 days after a Life Status Change only. See *Annual Enrollment Period and Life Status Change* provision(s).

Annual Enrollment Period

For Employees
During an Annual Enrollment Period, if you are currently insured under the Supplemental Life Insurance portion of this Policy, you may increase your Supplemental Life Insurance Benefit by one benefit Salary increment not to exceed a total volume of coverage of $650,000, without satisfying the Insurability Requirement. If you are eligible for the Supplemental Life Insurance portion of this Policy but have not previously enrolled, you may become insured under the Policy lowest Benefit Salary Increment to a maximum of $650,000, without satisfying the Insurability Requirement. Guaranteed Issue Amounts and Benefit Levels are shown above. Insurance will be effective on January 1 following the Annual Enrollment Period.

You may increase coverage or become insured for a Benefit in excess of amounts described above, only if you satisfy the Insurability Requirement. Any excess amounts will be effective on the later of January 1 following the Annual Enrollment Period or the date the Insurance Company agrees in writing to insure you.

For Spouses
During an Annual Enrollment Period, if you are an eligible Employee, you may elect coverage for your eligible Spouse. If your Spouse is currently insured under the Supplemental Life Insurance portion of this Policy, his or her Supplemental Life Insurance Benefit may be increased, or if your Spouse is eligible for the Supplemental Life Insurance portion of this Policy but has not previously enrolled, he or she may become insured under the Policy, as long as the total Benefit does not exceed the Maximum Benefit, by satisfying the Insurability Requirement. Insurance will be effective on the later of the first of the month following the Annual Enrollment Period or the date the Insurance Company agrees in writing to insure him or her.

A request for a Benefit reduction received during an Annual Enrollment Period will become effective on January 1 following the Annual Enrollment Period.

TY-008025-1

Life Status Change

For Spouses
Within 31 days after a Life Status Change, if your Spouse is currently insured under the Supplemental Life Insurance portion of this Policy, you may increase his or her Supplemental Life Insurance Benefit, or if your Spouse is eligible for the Supplemental Life Insurance portion of this Policy but has not previously enrolled, he or she may become insured under the Policy, as long as the total Benefit does not exceed the Maximum Benefit by satisfying the Insurability Requirement. Insurance will be effective on the first of the month following the Life Status Change.

Insurance Benefits may be reduced at any time. The reduced amount will be effective on the date the Insurance Company receives the completed change form.

TY-008030-1

Former Employee Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Life Insurance Benefits allowable to you, less any amount of conversion insurance issued under the Conversion Privilege for Life Insurance. Any amount elected in excess of the Life Insurance Benefits in effect on the date you no longer qualify as an Employee will be effective on the date the Insurance Company agrees in writing to insure you.
Maximum Benefit Period	To Age 70
Terminal Illness Benefit	You can elect up to 75% of Life Insurance Benefits in force on the date you are determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $1,000,000.

Spouse or Domestic Partner of Former Employee Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Supplemental Life Insurance Benefits available to a Spouse or Domestic Partner. Any amount elected in excess of the Supplemental Life Insurance Benefits in effect on the date your employment with the Employer ends will be effective on the date we agree in writing to insure him or her.
Maximum Benefit Period	To Age 70
Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Former Spouse or Domestic Partner Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Supplemental Life Insurance Benefits available to a Spouse or Domestic Partner. Any amount elected in excess of the Supplemental Life Insurance Benefits in effect on the date he or she no longer qualifies as a Spouse or Domestic Partner will be effective on the date we agree in writing to insure him or her.
Maximum Benefit Period	To Age 70
Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Former Dependent Child Benefits

Amount of Insurance	Units of $25,000
Guaranteed Issue Amount:	$25,000
Maximum Benefit:	$50,000
Maximum Benefit Period	To Age 70

TY-005159

WHO IS ELIGIBLE

Classes of Eligible Persons
A person may be insured only once under the Basic Life portion of the Policy even though he or she may be eligible under more than one class. A person may also be insured only once under the Supplemental Life portion of the Policy as an Employee, Spouse or Dependent Child, even though he or she may be eligible under more than one class.

An Employee who is the Spouse of another Employee may not be insured for Supplemental Life Insurance as both an Employee and as a Spouse at the same time.

Any Employee, who is eligible for Supplemental Life Insurance, will not be eligible to be insured as a Dependent Child of another Employee.

If an Employee is eligible and has enrolled as the Spouse of another Employee, but ceases to be eligible to maintain the amount of insurance for which he or she has enrolled as a Spouse, that Employee may, within 31 days, enroll for coverage as an Employee, in an amount equal to the lesser of (1) the amount of Spouse Supplemental Life Insurance terminating, or (2) the maximum amount of Employee Supplemental Life Insurance for which the Employee is eligible. The Insurability Requirement does not apply. If this amount is not equal to a Supplemental Life Insurance coverage option, it will be adjusted to the next higher available Supplemental Life Insurance coverage option. This provision shall be in lieu of the Policy's provisions, if any, regarding coverage changes following Life Status Changes.

If a Spouse is eligible and has enrolled for Supplemental Life Insurance as an Employee, but ceases to be eligible to maintain the amount of insurance for which he or she has enrolled as an Employee, the Spouse may, within 31 days, instead become enrolled as a Spouse of another Employee, in an amount equal to the lesser of (1) the amount of Employee Supplemental Life Insurance terminating, or (2) the Maximum Benefit Amount of Spouse Supplemental Life Insurance for which the Spouse is eligible. The Insurability Requirement does not apply. If this amount is not equal to a Supplemental Life Insurance coverage option, it will be adjusted to the next higher available Supplemental Life Insurance coverage option.

A Dependent Child of two or more Employees may only be insured once under the Policy. If an Employee who has elected to insure Dependent Children ceases to be eligible to do so, then the Employee's Spouse may, within 31 days, elect to insure Dependent Children, provided he or she is insured as an Employee. In all cases, "Dependent Child" shall be defined with respect to the Employee who has enrolled dependent children.

In all cases, amounts of insurance referred to in these provisions shall be determined before the application of any reductions in benefits due to age.

Any amount of Supplemental Life Insurance Coverage which cannot be continued under the above provisions may be subject to the Conversion Privilege.

Employee
If you qualify under the Class Definition shown in the Schedule of Benefits, you are eligible to be insured under the Policy on the Policy Effective Date, or the day after you complete the applicable Eligibility Waiting Period, if later.

If you have previously converted your insurance under the Policy, you will not become eligible until your converted policy is surrendered. This does not apply to any amount of insurance that was previously converted under the Policy due to a reduction in your Life Insurance Benefits based on age or a change in class unless those conditions no longer affect the amount of insurance available to you.

Except as noted in the Reinstatement Provision, if you terminate coverage and later wish to reapply, or if you are a former Employee who is rehired, a new Eligibility Waiting Period must be satisfied. You are not required to satisfy a new Eligibility Waiting Period, if insurance ends because you are no longer in a Class of Eligible Employees, but continue to be employed by the Employer, and within one year you become a member of an eligible class.

Spouse
Your Spouse is eligible to be insured on the date you are eligible or the date he or she becomes your Spouse, if later.

For eligibility purposes, your Spouse must be a lawful Spouse and not legally separated from, divorced from, or widowed by you.

Dependent Child
Your Dependent Child is eligible to be insured on the date you are eligible or the date the child becomes a Dependent Child, if later.

In no event will a Dependent Child be eligible to be insured more than once under the Policy.

TY-005154-2

WHEN COVERAGE BEGINS

You, your Spouse and Dependent Children will be insured for an amount not to exceed the Guaranteed Issue Amount on the date you become eligible, if you are not required to contribute to the cost of this insurance.

You and your Spouse will be insured for an amount that exceeds the Guaranteed Issue Amount on the date we agree in writing to provide this coverage. We will require an eligible person to satisfy the Insurability Requirement before we agree to insure him or her.

If you are required to contribute to the cost of this insurance, you may elect insurance for yourself, your Spouse and Dependent Children only by authorizing payroll deduction in a form approved by the Employer and us. The effective date of this insurance depends on the date and amount of insurance elected.

If you or your Spouse elect insurance in an amount that exceeds the Guaranteed Issue Amount or if your enrollment form is received more than 31 days after you become eligible to elect coverage, this insurance is effective on the date we agree in writing to provide this coverage. We will require an eligible person to satisfy the Insurability Requirement before we agree to insure him or her.

If coverage for a Dependent Child is in force and another Dependent Child becomes eligible, coverage for that child is effective on the date he or she qualifies as a Dependent Child.

If you are not in Active Service on the date insurance would otherwise go into effect, it will be effective on the date you return to Active Service.

If an eligible Spouse or Dependent Child is:

1. an inpatient in a hospital, hospice, rehabilitation or convalescence center, or custodial care facility; or
2. confined to his or her home under the care of a Physician on the date insurance would otherwise be effective, it will be effective on the date he or she is no longer an inpatient in these facilities or confined at home. If such Spouse or Dependent Child was covered by the Prior Plan immediately prior to the Policy Effective Date, this provision will not apply to the amount of coverage in effect as of the Policy Effective Date, but will apply to any increase in coverage. This does not apply to a Dependent Child who is age 6 months or less.

TY-005155-2

Takeover Provision

Special Terms Applicable to Previously Insured Employees Not in Active Service and Their Dependents

Coverage will not go into effect for you, or your Spouse and Dependent Children unless you are in Active Service on the date you would have first become eligible to be insured under this Policy.

However:

1. if you, and your Spouse or Dependent Children were insured under a Prior Plan on the date immediately prior to the date you would have first become eligible to be insured under this Policy and had satisfied the Active Service requirement, and
2. if you, your Spouse or Dependent Child die, we agree to provide a Death Benefit only equal to the lesser of:

a. the amount due under this Policy (had you satisfied the Active Service requirement), or
b. the amount that would have been due under the Prior Plan had it remained in force.

The benefit amount will be reduced by any amount paid by the Prior Plan, or that would have been paid had this Policy not been issued and had timely filing of the claim been made under the Prior Plan.

These special terms will end on the earliest of the following dates:

1. the date you meet the Active Service requirements;
2. the date insurance terminates for one of the reasons stated in the Termination of Insurance provision;
3. 12 months after the date you first become eligible under this Policy; or
4. the last day you, your Spouse or Dependent Children would have been covered under the Prior Plan if coverage under that plan for you, your Spouse or Dependent Children was still in force.

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WHEN COVERAGE ENDS

Coverage will end on the earliest of the following dates:

1. the date you are eligible for coverage under a plan intended to replace this coverage;
2. the date we terminate the Policy;
3. the date you, your Spouse or Dependent Children are no longer in an eligible class;
4. the date coinciding with the end of the last period for which required premiums are paid;
5. the date you are no longer in Active Service;
6. for an Employee, Spouse or Dependent Child, the date the Employer cancels participation under the Policy; and
7. the date your coverage ends, for any insured Spouse or Dependent Child.

TY-005156-1

CONTINUATION OF INSURANCE

Continuation for Temporary Leave of Absence, Non-Medical Leave of Absence, Military Leave of Absence or Family Medical Leave If you are an Employee and your Active Service ends due to an Employer approved leave of absence, non-medical leave of absence, military leave of absence or family medical leave of absence, your insurance will continue if the required premium is paid.

In these circumstances, your insurance may continue as follows.
1. For an Employer approved leave of absence, up to up to 26 weeks.
2. For an Employer approved non-medical leave of absence, up to up to 90 days.
3. For an Employer approved military leave of absence, up to up to 90 days.
4. For an Employer approved family medical leave, up to the later of the period of the approved FMLA leave or the leave period required by the laws of the state in which the Employee is employed.

Portability Options
Continuation of Life Insurance for Employees

If your employment ends prior to age 70, you may continue Life Insurance Benefits. Benefits will continue in an amount elected, subject to the Maximum Benefit allowable for Life Insurance Benefits in effect on the date you no longer qualify as an Employee. Any amount elected in excess of the Life Insurance Benefits in effect on the date you no longer qualify as an Employee will be effective on the date we agree in writing to insure you. In lieu of continuation, the Conversion Privilege is available to the Employee on the date employment ends and at any time during the period his or her Life Insurance Benefits under the Policy continue under this option.

To continue insurance, you must submit an application to us and pay the required premium. If you continue insurance, you may also continue insurance for a Spouse or Dependent Child if they are covered under the Policy on the date insurance would otherwise end. If you do not elect to continue insurance within 62 days after your employment ends, you may not elect this insurance at a later date.

If you continue insurance in this manner you will become a Former Employee. A Spouse whose insurance is continued will become a Spouse of a Former Employee. Insurance under this provision will be effective on the first of the month following the date your insurance as an Employee ends, provided we receive your completed application and the required premium is paid.

If, as a Former Employee, you later acquire a Spouse or Dependent Child, you may elect insurance for them by submitting an application to us and paying the required premium. Insurance for a Spouse or Dependent Child of a Former Employee not in effect on the date your employment with the Employer ends, will be effective on the date we agree in writing to insure them. We may require your Spouse or Dependent Child to satisfy the Insurability Requirement before we agree to insure him or her.

Continuation of Life Insurance for Spouses

If a Spouse is legally divorced from, or widowed by, an insured Employee or Former Employee prior to age 70, he or she may continue Life Insurance Benefits. Benefits will continue in an amount elected, subject to the Maximum Benefit allowable for Life Insurance Benefits. Any amount elected in excess of the Life Insurance Benefits in effect on the date he or she no longer qualifies as a Spouse will be effective on the date we agree in writing to insure him or her. In lieu of continuation, the Conversion Privilege is available to the Spouse on the date the event occurs, and at any time during the period his or her Life Insurance Benefits under the Policy continue under this option.

To continue insurance, the Spouse must submit an application to us and pay the required premium. If a Spouse continues insurance, he or she may also continue insurance for a Dependent Child if the child is covered under the Policy on the date insurance would otherwise end. If a Spouse does not elect to continue insurance within 62 days after insurance ends, he or she may not elect this insurance at a later date.

A Spouse who continues insurance in this manner will become a Former Spouse and will be issued a separate certificate of insurance. Insurance will be effective on the first of the month following the date the Spouse's insurance otherwise ends, provided the Insurance Company receives the completed application and the required premium is paid.

Continuation of Life Insurance for Dependent Children

If a Dependent Child is insured under the Policy and is at least 19 years of age, he or she may continue Life Insurance Benefits by electing an amount of insurance in units of $25,000 up to a maximum benefit of $50,000. In lieu of continuation, the Conversion Privilege is available to the Dependent Child at attainment of the limiting age and at any time during the period his or her Life Insurance Benefits under the Policy continue under this option.

To continue insurance, the Dependent Child must submit an application to us and pay the required premium. If the Dependent Child does not elect to continue coverage within 62 days after insurance ends, he or she may not elect this insurance at a later date.

A Dependent Child who continues insurance in this manner will become a Former Dependent Child and will be issued a separate certificate of insurance. Insurance under this provision will be effective on the following dates.

1. For any Guaranteed Issue Amount, the first of the month following the date the Dependent Child's insurance otherwise ends, provided we receive the completed application and required premium.
2. For any amount of insurance that exceeds the Guaranteed Issue Amount, the date we agree in writing to insure him or her. We will require the Dependent Child to satisfy the Insurability Requirement before we agree to insure him or her.

Notice of Continuation Right

The Insured must be notified of his or her right to continue this insurance within 31 days before or after an event that would otherwise result in termination or reduction in his or her group life insurance, but if notice is given more than 31 days but less than 105 days after the event, the time period allowed for the exercise of the continuation right shall be extended to 45 days after giving notice. If such notice is not given within 105 days after the event, the time allowed for the exercise of the continuation right expires at the end of 105 days. Notice, for the purpose of this section, means written notice presented to the Insured by the Policyholder or mailed to the Insured's last known address as reported by the Policyholder.

Termination of Continued Insurance

Insurance will end on the earliest of the following dates.

1. The date the Policy is terminated.
2. The date the Insurance Company cancels insurance for all members of the Insured's class.
3. The day after the end of the period for which premiums are paid.
4. For a Former Employee, or for the Spouse or Dependent Child of a Former Employee, the date he or she is age 70.

Also, insurance for any Dependent Child will end on any of the dates listed above or when he or she no longer qualifies as a Dependent Child, if earlier.

On the date continued insurance ends, the Conversion Privilege for Life Insurance is available.

WHAT IS COVERED

LIFE INSURANCE BENEFITS

Death Benefit
If an Insured dies, we will pay the Life Insurance Benefit in force for that Insured on the date of his or her death. The Amount of Life Insurance is shown in the Schedule of Benefits.

TY-005164

CONVERSION PRIVILEGE

Who May Convert

An Insured Employee may apply for a conversion policy of life insurance for him or herself and for such spouse and children of such Employee as are then insured by the Policy if his or/her term life insurance ends for any reason, except loss of insurance for non-payment of premium. An Insured Employee may also apply if his or her life insurance benefit is reduced due to a change in age, class or the Policy. An Insured Employee may not apply for a conversion policy for amounts reduced due to payment of an Accelerated Benefit. Conversion life insurance will not provide accident, disability or other benefits. If the Employee's life insurance is continued under a Life Insurance Portability Option of the Policy, he or she may apply for a life insurance conversion at any time while coverage is continued. Insurance continued under a Life Insurance Portability Option of the Policy will end when the life insurance conversion becomes effective.

An Insured Spouse may apply for a conversion policy of life insurance for him or herself and for such children of such Employee as are then insured by the Policy if either of the following occurs.

1. His or her term life insurance under the Policy ends or reduces at the death of the Insured Employee.
2. His or her term life insurance under the Policy ends due to the divorce from, or annulment of, his or her marriage to the Employee.

An Insured Dependent Child may apply for a conversion policy of life insurance if:

1. His/her life insurance under the Policy ends or reduces due to his or her attainment of the limiting age.
2. His or her coverage ends due to the divorce of, or annulment of, the marriage of the Employee and the Employee's Spouse, or former Spouse. This item does not apply if the Employee's Spouse or former Spouse, converts the Dependent Child's coverage.

Any such conversion is subject to the provisions that follow.

Availability: The conversion insurance may be a type of life insurance currently being offered by the Insurance Company at the Insured's age. It may not be term insurance with the exceptions that follow.

Exceptions for Conversion to Term Life

1. life insurance ends for loss of employment due to the person's total and permanent disability.
2. the first year after his or her insurance under the Policy ends, or if. For that year, he or she may elect term insurance to precede the permanent plan.

If the Insurance Company does not have an individual life insurance form which meets the requirements of this privilege, it will offer an individual life insurance policy of Connecticut General Life Insurance Company that does meet such requirements.

The amount that may be converted may not be greater than the amount determined by the following:

For conversion due to a change in age, in class or in the Policy: the amount by which the Insured Person's Life Insurance Benefits under the Policy is most recently reduced.

For conversion due to loss of life insurance due to amendment of the Policy, or to the end of the Policy: the amount of such person's life insurance protection in effect immediately before the date the Policy is amended or ends, less the amount of any group life insurance that is replaced by the same or another insurer within forty-five days after group life insurance protection under the Policy ends.

For conversion for all other reasons: an amount equal to the amount of the person's protection under such group insurance policy at the time of such termination. This amount may be reduced by the amount of any life insurance which is replaced with the same or another insurer within forty-five days after group life insurance protection under the Policy ends due to the employee's loss of employment due to his or her total and permanent disability.

The converted insurance will be issued only if it is applied for and the premium paid within 62-days after insurance ends or is reduced. Conversion life insurance will not provide accident, disability or other benefits. Evidence of Insurability is not required. Premium for the conversion insurance will be based on the age and class of risk of the Insured and the type and amount of coverage issued.

The conversion coverage will not exclude suicide occurring more than two years after the effective date of the person's coverage under this group policy.

Effective Date of Conversion Policy

Conversion insurance will become effective on the 31st day after the date coverage under the Policy is reduced or ends if, by that 31st day, the application has been received by the Insurance Company and the required premium is paid. If the Insured dies during this 31 day period, the amount of life insurance which could have been converted will be paid under the Policy regardless of whether the person applied for a conversion insurance. If a conversion policy is issued, it will be in exchange for any benefits payable for that amount of insurance under the Policy.

Extension of Conversion Period

If an Insured is eligible for conversion insurance and is not notified of this right within 31 days before or after an event that results in the end or reduction of his or her group life insurance, the conversion period will be extended. The Insured will have 45 days from the date notice is given to apply for conversion insurance. In no event will the conversion period be extended beyond 105 days. Notice, for the purpose of this section, means written notice presented to the Insured by the Employer or mailed to the Insured's last known address as reported by the Employer.

If the Insured dies during the extended conversion period, the amount of life insurance which could have been converted will be paid under the Policy regardless of whether he or she applied for the conversion insurance. If the Insured's application for conversion insurance is received by the Insurance Company and the required premium is paid during the extended conversion period, Life Insurance Benefits will be payable under the conversion insurance.

CLAIM PROVISIONS

Notice of Claim
Written notice or notice by any other electronic or telephonic means authorized by us, must be given to us after a covered loss occurs or begins, or as soon as reasonably possible. If this notice is not given within a reasonable amount of time, the claim will not be invalidated or reduced if it is shown that such notice was given as soon as was reasonably possible. Written notice can be given at our home office in New York, New York or to our agent. Notice should include the Policyholder's name and policy number and the Insured's name and address.

Written notice of a diagnosis of a Terminal Illness on which claim is based must be given to us within 60 days after the diagnosis. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as reasonably possible.

Claim Forms
When we receive the notice of claim, we will send claim forms for filing proof of loss. If claim forms are not sent within 15 days after notice is received by us, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof or proof by any other electronic or telephonic means authorized by us, of the nature and extent of the loss.

Claimant Cooperation Provision
If you fail to cooperate with us in our administration of your claim, we may terminate the claim. A claimant will be required to provide any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Insurance Data
The Employer is required to cooperate with us in the review of claims and applications for coverage. Any information we provide to the Employer in these areas is confidential and may not be used or released by the Employer if not permitted by applicable privacy laws.

Proof of Loss
Written proof of loss, or proof by any other electronic/telephonic means authorized by us, for Accelerated Benefits must be furnished as soon as reasonably possible after the date of diagnosis. This proof must describe the occurrence, character and extent of the diagnosis for which claim is made.

In case of claim for any other loss, written proof or notice by any other electronic or telephonic means authorized by us, of loss must be given to us as soon as reasonably possible after the date of the loss for which a claim is made.

We will not deny or reduce any claim if it: 1) is not reasonably possible to furnish the required proof within that period; and 2) is shown that such proof of loss was given as soon as was reasonably possible.

Time of Payment
Any benefits due under the Policy for a loss, other than a loss for which the Policy provides installments, will be paid immediately upon receipt of due written proof of loss or proof by any other electronic/telephonic means authorized by us.

To Whom Payable
Death benefits for you will be paid to the beneficiary named in our records, if any, at the time of payment. If there is no named beneficiary or surviving beneficiary, or if you die while Disability Benefits are payable to you, we may, at our option, make direct payment to any of the following:

1. spouse of the Insured;
2. child or children of the Insured;
3. parents of the Insured;
4. sisters or brothers of the Insured; or
5. the estate of the Insured.

All benefits payable under the Accelerated Benefits section are payable to the Insured, if living. If the Insured dies prior to the payment of an eligible claim for an Accelerated Benefit, benefits will be paid in accordance with the provisions applicable to the payment of Life Insurance Benefits, unless the Insured has directed us otherwise in writing. However, any payment made by us prior to notice of the Insured's death shall discharge us of any benefit that was paid.

If we are to pay benefits to the estate or to a person who is incapable of giving a valid release, we may pay up to $500 at the Insured's death to a person appearing to us to be equitably entitled by reason of having incurred expenses on behalf of the Insured for his or her burial. This good faith payment satisfies our legal duty to the extent of that payment. Any other accrued benefits which are unpaid at the Insured's death may, at our option, be paid either to the Insured's beneficiary or to the Insured's estate. We may reduce the amount payable by any indebtedness due.

All other proceeds payable under the Policy, unless otherwise stated in the Policy, will be payable to the Insured.

Change of Beneficiary
You may change your beneficiary at any time by giving us written notice or notice by any other electronic or telephonic means authorized by us. The beneficiary's consent is not required for this or any other change which you may make unless the designation of beneficiary is irrevocable.

No change in beneficiary will take effect until the request form is received by us. When the request form is received, it will take effect as of the date of the form. If you die before the request form is received, we will not be liable for any payment that was made before receipt of the request form.

Physical Examination and Autopsy
We may, at our expense, exercise the right to examine any person for whom a claim is pending as often as we may reasonably require. Also, we may, at our expense, require an autopsy unless prohibited by law.

Legal Actions
No action at law or in equity may be brought to recover benefits under the Policy less than 60 days after written proof of loss, or proof by any other electronic or telephonic means authorized by us, has been furnished as required by the Policy. No such action shall be brought more than 3 years after the time written proof of loss is required to be furnished.

Time Limitations
If any time limit stated in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity, is less than that permitted by the law of the state in which you live when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that state.

Physician/Patient Relationship
You have the right to choose any Physician who is practicing legally. We will in no way disturb the Physician/patient relationship.

ADMINISTRATIVE PROVISIONS

Premiums
The premiums for this Policy will be based on the rates currently in force, the plan and the amount of insurance in effect.

If an Insured's coverage amount is reduced due to acceleration of a Death Benefit, premium will be based on the amount of coverage in force on the day before the reduction took place.

Your Grace Period
If your required premium is not paid on the Premium Due Date, there is a 60 day grace period after each premium due date after the first. If the required premium is not paid during the grace period, insurance will end on the last day for which premium was paid.

Reinstatement of Insurance
Your insurance may be reinstated if your insurance ends because you are on an unpaid leave of absence.

Your insurance may be reinstated only if reinstatement occurs within five years from the date your insurance ends. For your insurance to be reinstated all of the following conditions must be met.

1. You must be in a Class of Eligible Employees.
2. The required premium must be paid.
3. A written request, or a request by any other telephonic or electronic means authorized by the Employer and the Insurance Company, for reinstatement must be received by us within 31 days from the date you return to Active Service.
4. The Insurability Requirement, if any, is satisfied.

Your reinstated insurance is effective on the date you return to Active Service if the required premium is paid. If you did not fully satisfy your Eligibility Waiting Period before your insurance ended, you will receive credit for any time that was satisfied.

GENERAL PROVISIONS

Entire Contract
The Policy, the application of the Policyholder (a copy of which is attached at issue), the Policyholder endorsements, riders, certificate and attached papers constitute the entire contract between the parties. If an application of any Employee is required, it may also be made a part of this contract, at our option. Nothing in this Policy will invalidate or impair the rights granted to any certificate holders by their certificates or by law.

Incontestability
All statements made by the Policyholder, or by an Employee are deemed representations and not warranties. No statement will cause us to deny or reduce benefits or be used as a defense to a claim, unless a copy of the written instrument, signed by the claimant, containing the statement is, or has been, furnished to such person while such person is still living. In the event of his death or legal incapacity, the beneficiary or representative must receive a copy. After two years from the Employee's effective date of insurance, no such statement will cause insurance to be contested except for non-payment of premium. This also applies to any added or increased benefits, from the effective date of the addition or increase in benefits.

Misstatement of Age
If your age has been misstated, we will adjust all benefits to the amounts that would have been purchased for the correct age.

Misstatement of Smoker Status
SMOKER STATEMENT: If an Insured misstates his or her status as a non-Smoker an adjustment in premium will be made to reflect a Smoker's rate. If an Insured has misstated his or her status as a non-Smoker and he or she dies, the Life Insurance Benefit will be reduced to the amount of insurance, which the premium would have purchased had the Insured correctly stated his or her status.

Workers' Compensation Insurance
The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance.

Assignment
The Insurance Company will not be affected by any assignment of your certificate until the original assignment or a certified copy of the assignment is filed with the Insurance Company. We do not assume responsibility for the validity or sufficiency of an assignment. An assignment of the certificate will operate so long as the assignment remains in force. To the extent provided under the terms of the assignment, an assignment will transfer all rights and obligations of the Insured, or of the owner if other than the Employee.

This insurance may not be levied on, attached, garnisheed, or otherwise taken for a person's debts. This prohibition does not apply where it is contrary to law.

Conformity with State Statutes
Any provision of the Policy in conflict on the Policy Effective Date with the laws of the state where the Policy is delivered is amended to conform to the minimum requirements of such laws.

Male Pronoun
The male pronoun as used herein will be deemed to include the female.

Clerical Error
Your coverage will not be affected by error or delay in keeping records of insurance under the Policy. If such an error or delay is found, the premium will be adjusted fairly.

Agency
The Policyholder, Employer and plan administrator are agents of the Employee for transactions relating to insurance under the Policy. The Insurance Company is not liable for any of their acts or omissions.

Ownership of Records
All records maintained by the Insurance Company are, and shall remain, the property of the Insurance Company.

TY-005182-1

DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout this document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

Active Service
If you are an Employee, you are in Active Service with the Employer on a day which is one of the Employer's scheduled work days if either of the following conditions are met.

1. You are actively at work. This means you are performing your regular occupation for the Employer on a Full-time basis or a part-time basis regularly scheduled to work a minimum of 20 hours per week, either at one of the Employer's usual places of business or at some location to which the Employer's business requires you to travel.
2. The day is a scheduled holiday, vacation day or period of Employer approved paid leave of absence, other than disability or sick leave after 7 days.

You are considered in Active Service on a day which is not one of the Employer's scheduled work days only if you were in Active Service on the preceding scheduled work day.

Annual Compensation
An Employee's "Benefits Salary" as of December 31 of the prior calendar year, which is an Employee's base salary (including pay for hours worked beyond an individual's regularly scheduled hours but no more than 40 hours in a week), plus any short term incentive payments received during the year under a plan or arrangement that provides for such payment to be taken into account for benefit purposes, and any contribution by the Employer on the Employee's behalf under a salary reduction agreement pursuant to Internal Revenue Code 125 (such as any flexible benefits), Internal Revenue Code Section 132(f) (i.e., a qualified transportation benefit arrangement) or 401(k) (i.e., contributions to the 401(k) Savings Plan). It does not include amounts received as overtime pay, severance pay, any employee recognition award, recruiting and development credits, New York State Paid Family Leave (NYSPFL) benefits (unless the Employee is on a leave under the Parental Leave Program concurrent with NYSPFL and is eligible for a Paid New Parent Benefit), or any other additional forms of compensation. Annual Compensation in the year of hire is annualized base salary.

Annual Enrollment Period
The period in each calendar year agreed upon by your Employer and us when you may enroll for, or change benefit elections, under the Policy.

Dependent Child
A child who meets the following requirements.

1. A child from live birth but less than 19 years old and primarily supported by you;
2. A child who is 19 or more years old but less than 26 years old and primarily supported by you;
3. A child who is 19 or more years old, primarily supported by you and incapable of self-sustaining employment by reason of mental or physical incapacity.

The term "child" means:

a. your natural child;
b. your legally adopted child, beginning with any waiting period pending finalization of the child's adoption. It also means the legally adopted child of your Spouse provided the child is living with, and is financially dependent upon you;
c. a stepchild born to your Spouse and who is living with and financially dependent upon you;
d. a child for whom you are the court-appointed legal guardian and who resides with, and is financially dependent upon you.

Employee
For eligibility purposes, you are an Employee if you work for the Employer and are in one of the "Classes of Eligible Employees." Otherwise, you are an Employee if you are an employee of the Employer who is insured under the Policy.

Employer
The Policyholder and any affiliates or subsidiaries covered under the Policy. The Employer is acting as your agent for transactions relating to this insurance. You shall not consider any actions of the Employer as actions of the Insurance Company.

Insurability Requirement
You will be considered to have satisfied the Insurability Requirement on the day we agree in writing to accept you as covered under the Policy. To determine a person's acceptability for insurance, we will require evidence of good health and may require it be provided at your own expense.

Insurance Company
The Insurance Company underwriting the Policy is CIGNA Life Insurance Company of New York. References to the Insurance Company have been changed to "we", "our", "ours", and "us" throughout the certificate.

Insured
You are an Insured if you are eligible for insurance under the Policy, insurance is elected for you, any applicable Insurability Requirement is met, the required premium is paid and your insurance is in force under the Policy.

Life Status Change
The following events are Life Status Changes.
1. Marriage
2. Divorce, annulment or legal separation
3. Birth or adoption of a child
4. Death of your spouse
5. Termination of your spouse's employment
6. A change in the benefit plan available to your spouse
7. A change in employment status for you or your spouse that affects your eligibility for benefits

Physician
Physician means a licensed doctor practicing within the scope of his or her license and rendering care and treatment to an Insured that is appropriate for the condition and locality. The term does not include you, your spouse, the immediate family (including parents, children, siblings, or spouses of any of the foregoing, whether the relationship derives from blood or marriage), of you or your spouse, or a person living in your household.

Policy Anniversary
A Policy Anniversary is the date stated on the policy cover and the same date that follows every 12 months for as long the Policy is in effect.

Policy Effective Date
The Policy Effective Date is the date stated on the policy cover.

Policyholder
A Policyholder is an Employer who has applied for coverage under the policy for his eligible Employees and their Dependents.

Prior Plan
The Prior Plan refers to the plan of insurance providing similar benefits to you, sponsored by the Employer and in effect directly prior to the Policy Effective Date. A Prior Plan will include the plan of an employer in effect on the day prior to that employer's addition to this policy.

To be covered under the Policy, required premium must be paid for all covered Employees.

Sickness
The term Sickness means a physical or mental illness. It also includes pregnancy.

Smoker
Smoker means a person who has smoked cigarettes, cigars or used a pipe or chewing tobacco, nicotine chewing gum or snuff during the twelve months prior to the date he or she applied for coverage.

Spouse
Your current lawful spouse.

TY-005153-2

AMENDATORY RIDER
DOMESTIC PARTNER/CIVIL UNION PARTNER COVERAGE

Policy No. FLY-980020
Effective Date: January 1, 2022

This rider amends the Policy and Certificate to which it is attached. It is effective on the Effective Date shown above, and expires when the Policy expires.

Domestic Partner/Civil Union Partner means any of the following:

1. A person with whom the Employee has a registered civil union or domestic partnership under state law which imposes legal obligations on the parties substantially similar to marriage. Such person will continue to be recognized as a Domestic Partner or Civil Union Partner unless and until: (1) the civil union or domestic partnership is dissolved under applicable law; or (2) either the Employee or the Domestic Partner/Civil Union Partner marries another person.

2. A person meeting all of the following requirements, with respect to an Employee:
   a. Shares a permanent residence with the Employee;
   b. Has resided with the Employee for at least 6 months and is expected to continue to reside with the Employee indefinitely;
   c. Has not been legally married to any other person within the previous six months, and has no Domestic Partner other than the Employee during the previous six months, and is the Employee's or Former Employee's sole Domestic Partner;
   d. Has signed a Domestic Partner declaration with the Employee, if the Employee resides in a jurisdiction which provides for Domestic Partner declarations;
   e. Has not signed a Domestic Partner declaration with any other person within the last 6 months;
   f. Is interdependent with the Employee in three or more of the following ways:
      1. Both partners are registered under any municipal ordinance as domestic partners.
      2. Both partners are jointly parties to a lease, mortgage or deed.
      3. Both partners jointly own one or more motor vehicles.
      4. Both partners jointly own one or more bank or credit accounts.
      5. The Employee has named the Domestic Partner as attorney-in-fact under a durable power of attorney with authority over health care decisions.
      6. The Employee has designated the Domestic Partner as beneficiary under a retirement plan or a life insurance policy.
      7. The Employee has designated the Domestic Partner as beneficiary of the Employee's or Former Employee's will.
      8. Each partner has agreed in writing to assume the financial responsibility for the welfare of the other.
   g. Is not so closely related by blood to the Employee as to prohibit legal marriage in their state of residence;
   h. Is no less than 18 years of age.

The Employee and Domestic Partner must furnish the Employer and Insurance Company with a signed declaration that the above requirements are met, at the time of enrollment.

All references in the policy to "Spouse" shall be changed to read "Spouse, Domestic Partner, and Civil Union Partner except as follows:

1. The definition of "Spouse" remains unchanged.

2. For purposes of any provision of the policy providing for payment of benefits to relatives of the Employee, a Domestic Partner/Civil Union Partner shall be included only if:
   a. the Domestic Partner/Civil Union Partner meets the requirements of the definition of Domestic Partner/Civil Union Partner referenced in item 1; or
   b. the Employee and Domestic Partner have furnished the Employer or the Insurance Company with a signed statement affirming that the requirements referenced in item 2 within the definition of Domestic Partner are met.

3. A Domestic Partner/Civil Union Partner shall be deemed eligible to be enrolled for insurance on the latest of:
   a. the date of registration under Item 1 of the definition of Domestic Partner/Civil Union Partner;
   b. the date that the Employee is eligible for insurance under the Policy;
   c. the effective date of this Amendment to the Policy.

4. A child of a Domestic Partner/Civil Union Partner may only be eligible to be insured if:
   a. the child is primarily dependent on the Employee for financial support; or
   b. the Employee has a legal obligation of support of the child; or
   c. the Employee is the child's legal guardian.

Except for the above this rider does not change the Policy or Certificate to which it is attached.

CIGNA LIFE INSURANCE COMPANY OF NEW YORK

Scott Berlin, President

TY-008930

CIGNA LIFE INSURANCE COMPANY OF NEW YORK
51 MADISON AVENUE
NEW YORK, NY 10010

STATE MODIFYING PROVISIONS AMENDMENT RIDER

Policyholder: New York Life Insurance Company
Policy No. FLY-980020
Amendment Effective Date: January 1, 2022

This amendment is attached to and made part of the Policy/Certificate specified above. Its provisions are intended to conform this Policy/Certificate to the laws of the state in which the insured resides.

The Policy delivered under the Group Policy are amended as follows:

APPLICABLE TO CALIFORNIA RESIDENTS:

1. **Conversion Privilege for Life Insurance**
   Insured Employees and Insured Spouses may convert to an individual policy of life insurance for an amount not greater than the Conversion Amount shown below when the Policy ends, without regard to any requirement that the person be insured under the policy for a specified period of time, if all of the following apply.

   a. The Insured became Totally Disabled while covered for the Life Benefit of the Policy. Totally Disabled means the person is unable to perform all the material duties of any occupation for which he or she may reasonably be qualified based on training, education and experience.
   b. The Insured remained Totally Disabled until the Policy ended while covered for the Life Benefit of this Policy.
   c. The Policy does not provide a Waiver of Premium, Extended Death Benefit Provision or monthly payments to Totally Disabled Insureds for the Life Benefit.
   d. The person meets all other conditions for converting the insurance.

   Conversion Amount - Insured's life insurance amount under the Policy on the date the Policy ends minus the amount for which the Insured is insured under a group policy that provides life coverage to employees of the Insured Employee's Employer covered under this Policy. The dollar limit that applies to the amount for conversion at Policy termination does not apply.

   The requirement that the Insured be covered under the Policy for the stated number of years in order to convert life insurance does not apply.

APPLICABLE TO FLORIDA RESIDENTS:

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

APPLICABLE TO MARYLAND RESIDENTS:

The Group Insurance Policy was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

TL-01-3000

APPLICABLE TO MISSOURI RESIDENTS:

Applicable to Supplemental Life Insurance Benefits
If an Insured commits suicide, while sane or insane, within 1 year from the date his or her insurance under the Policy becomes effective, Supplemental Life Insurance Benefits will be limited to a refund of the premiums paid on the Insured's behalf. The suicide exclusion applies from the effective date of any additional benefits or increases in Life Insurance Benefits.

Except for any amount of benefits in excess of the Prior Plan's benefits, this exclusion will not apply to any person covered under the Prior Plan for more than one year. If a person was not insured for one year under the Prior Plan, credit will be given for the time he or she was insured.

If a Dependent Child commits suicide and is survived by other Dependent Children covered under the same certificate, no refund of premiums will be paid.

APPLICABLE TO NORTH DAKOTA RESIDENTS:

The Suicide exclusion, if any, is limited to one year from the effective date of insurance. The suicide exclusion with respect to any increase in death benefits which results from an application of the insured subsequent to the effective date, if any, is limited to one year from the effective date of the increase.

APPLICABLE TO OREGON RESIDENTS:

NOTICE: MUST PROVIDE DOMESTIC PARTNER COVERAGE FOR OREGON RESIDENTS

APPLICABLE TO VERMONT RESIDENTS:

To the extent the Policy provides insurance coverage to a spouse, the identical consideration must be applied to same sex marriages and civil unions. The language is as follows:

1. Civil Union Partner means:
   a. A person with whom the Employee has a registered civil union under Vermont law which imposes obligations on the parties substantially similar to marriage. Such person will continue to be recognized as a Civil Union Partner unless and until:
      (1) the civil union is dissolved under applicable law; or
      (2) either the Employee or the Civil Union Partner marries another person.

2. Spouse means:
   a. "Lawful spouse" and includes a lawful spouse of the same sex.
   b. This also includes a partner to a civil union recognized under Vermont Law.

APPLICABLE TO WASHINGTON RESIDENTS:

1. The following *Continuation of Insurance* provision is added to the Policy:

   Continuation of Life Coverage During Labor Disputes
   If an Employee's Active Service ends because of a Labor Dispute and his or her premium for Life Insurance Benefits under the Policy is paid either by the Employer, in whole or in part, or by the Employee through payroll deductions, then the Employee may continue his or her Life Insurance Benefits. The Employer will send written notice of the right to continue coverage to each insured Employee at his or her most recent address as on file with the Employer.

   To continue coverage, the Employee must pay premiums directly to the Employer, who will remit the premiums to the Insurance Company. Premiums must be paid by the date they are due, subject to the 31 day grace period. Policy coverages and premiums will stay the same during a Labor Dispute; however, the Insurance Company may make normal changes in premium rates when the Policy is renewed, under the terms set forth in the Policy.

   Coverage continued in this manner will end on the earliest of the following dates.
   a. The date the Labor Dispute has ended.
   b. The date coverage has been continued for 6 months.

   If the Labor Dispute continues beyond 6 months, the Employee may apply for an individual insurance policy, as set forth in detail under "Conversion Privilege for Life Insurance."

   "Labor Dispute," as used here, means a strike, lockout, or other labor dispute between the Employer and its Employees, during which time the Employee is not paid by the Employer.

2. If the Policy provides coverage to dependents, benefits for a Spouse or Dependent Child are limited to 100% of the insured Employee's coverage amount. Stand-alone Spouse and Dependent Child coverage (when Employee is not insured) is not permitted.

3. The *Suicide* Exclusion, if any, does not apply.

4. To the extent the policy includes *Accelerated Benefits*, the following resolution of disputes requirements are added to the Policy.

   - For Terminal Illness – *Determination of Terminal Illness*

     In the event the Physician representing the Insurance Company disputes the existence of a Terminal Illness, and the dispute cannot be resolved, the Insured has the right to mediation and binding arbitration in accordance with Washington Administrative Code 284-23-730.

5. The *Incontestability Provision* is replaced as follows:

   Incontestability
   All statements made by the Employer or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement has been furnished to the claimant. In the event of death or legal incapacity, the beneficiary or representative must receive the copy.

   After two years from an Insured's effective date of insurance, or from the effective date of any added or increased benefits, no such statement will cause insurance to be contested.

6. Any Domestic Partner of an Employee who is registered as a Domestic Partner under Washington state law will be deemed to be eligible on the same basis as a Spouse.

   Please refer to your certificate of insurance which describes the benefit provisions and limitations applicable to you as a resident of this state.

Signed for the
CIGNA Life Insurance Company of New York

Scott Berlin, President

TY-00-3000.00

SUPPLEMENTAL INFORMATION
for

Group Plan for New York Life Employees ("Plan")
required by the Employee Retirement
Income Security Act of 1974

As a Plan participant in New York Life Insurance Company's Plan, you are entitled to certain information, rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

The benefits described in your Certificate are provided under a group insurance Policy issued by the Insurance Company. The Policy is incorporated into the Plan. The Certificate, along with the following Supplemental Information, makes up the Summary Plan Description as required by ERISA.

IMPORTANT INFORMATION ABOUT THE PLAN

- The Plan is established and maintained by New York Life Insurance Company, the Plan Sponsor.
- The Employer Identification Number (EIN) is 13-5582869.
- The Plan Number is 501.
- The Insurance Plan is administered directly by the Plan Administrator with benefits provided, in accordance with the provisions of the group insurance contract, FLY-980020 ("Policy"), issued by CIGNA LIFE INSURANCE COMPANY OF NEW YORK ("Insurance Company").
- The Plan Administrator is: Maria Mauceri, VP and Actuary
  51 Madison Avenue, Room 513
  New York, NY 10010
  212-576-5707
- The Plan Administrator has authority to control and manage the operation and administration of the Plan.
- The Plan Sponsor may terminate, suspend, withdraw or amend the Plan, in whole or in part, at any time, subject to the applicable provisions of the Policy. (Your rights upon termination or amendment of the Plan are set forth in your Certificate.)
- The agent for service of legal process is the Plan Administrator.
- The Plan of benefits is financed by the Employer and Employees.
- The date of the end of the Plan Year is December 31.

YOUR RIGHTS AS SET FORTH BY 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, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit 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 Benefit Security Administration.

WHAT YOU SHOULD DO AND EXPECT IF YOU HAVE A CLAIM

The Plan Administrator designates and names the Insurance Company the named fiduciary for deciding claims and appeals for benefits under the Plan. The Insurance Company shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Insurance Company shall be final and binding on Participants and Beneficiaries to the full extent permitted by applicable law.

Claims for Disability Benefits (applies to all claims filed on or after April 1, 2018)

A disability "claim" is any claim which requires a determination of disability by the Insurance Company regardless of the type of policy under which it arises (for example, short/long term disability, waiver of premium, etc.). A disability claim is "filed" as of the date the Insurance Company first receives, in writing (including electronically) or by telephone (through the Insurance Company's intake department), notice that a claimant is seeking disability benefits under the Policy. The notice of claim received should provide the date of disability/loss, the claimant's name and address, and the group Policy holder's name and address. Properly filed claims will be decided with independence and impartiality.

The Insurance Company has 45 days from the date it receives a claim for disability benefits to determine whether or not benefits are payable in accordance with the terms of the Policy. The Insurance Company may require more time to review the claim if necessary due to matters beyond its control. The review period may be extended for up to two additional 30 day periods. If this should happen, the Insurance Company must provide its extension notice in writing before expiration of the current decision period, explaining the circumstances requiring extension and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Insurance Company's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Insurance Company receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

During the review period, the Insurance Company may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company will notify the claimant, in writing, stating what information is needed and why it is needed.

If the claim is approved, the Insurance Company will pay the appropriate benefit. If the claim decision is adverse, in whole or in part, the Insurance Company will provide written or electronic notice which will include the following information:

1. The specific reason(s) for the decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A description of any additional information required to perfect the claim, and the reason this information is necessary;
4. A description of the review procedures and the time limits applicable to those procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA after the claimant appeals and after the claimant receives an adverse decision on appeal;
5. A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Insurance Company of the health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the claimant's adverse benefit decision, without regard to whether the advice was relied upon in making the benefit decision; and (iii) a disability decision regarding the claimant presented by the claimant to the Insurance Company made by the Social Security Administration;
6. Either the specific internal rules, guidelines, protocols, standards or other similar plan criteria the Insurance Company relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar plan criteria do not exist;.
7. If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Policy to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
8. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; and
9. A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA.

Appeal of Denied Disability Claims (applies to all claims filed on or after April 1, 2018)

Whenever a claim decision is fully or partially adverse, unless ERISA provides otherwise, the claimant must appeal once to the Insurance Company. As part of the claimant's appeal, the claimant may receive, upon request, free of charge, copies of all documents, records, and other information relevant to the claim for benefits, and the claimant may submit to the Insurance Company, written comments, documents, records, and other information relating to the claim. The review will take into account all comments, documents, records and other information the claimant submits related to the claim, without regard to whether such information was submitted or considered in the initial claim decision. Once an appeal request has been received by the Insurance Company, a full and fair review of the claim appeal will take place.

A written request for appeal must be received by the Insurance Company within 180 days from the date the claimant received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived. The Insurance Company has 45 days from the date it receives a request for appeal to provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim and can extend the time for decision, once, by an additional 45 days. If this should happen, the Insurance Company must provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Insurance Company's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Insurance Company receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

The review will give no deference to the original claim decision. The review will not be made by the person who made the initial claim decision, or a subordinate of that person. When deciding an appeal based in whole or in part upon medical judgment, the Insurance Company will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment. Any medical or vocational experts consulted by the Insurance Company for the review will be identified and will not be the expert who was consulted during the initial claim decision or a subordinate of that expert.

During the appeal, the Insurance Company may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company will notify the claimant, in writing, stating what information is needed and why it is needed.

Before the Insurance Company issues an adverse benefit decision on appeal, if the Insurance Company considered, relied upon, or generated any new or additional evidence in connection with the claim, and/or if the Insurance Company intends to rely on any new or additional rationale in connection with that review, then such evidence and/or rationale will be provided to the claimant, free of charge, as soon as possible and sufficiently in advance of the date that the decision on appeal is required to be made, giving the claimant a reasonable opportunity to respond.

If the claim is approved, the Insurance Company will pay the appropriate benefit. If the claim decision on appeal is adverse, in whole or in part, the Insurance Company will provide written or electronic notice that includes:

1. The specific reason(s) for the decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
4. A statement describing any Supplemental appeal procedures offered, and the claimant's right to obtain the information about those procedures;
5. A statement of claimant's right to bring a civil action under section 502(a) of ERISA, including a description of any applicable contractual limitations period that applies to the claimant's right to bring such an action, and the calendar date on which the contractual limitations period expires for the claim;
6. A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Insurance Company of the health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse decision, without regard to whether the advice was relied upon in making the adverse decision; and (iii) a disability decision regarding the claimant presented by the claimant to the Insurance Company made by the Social Security Administration;
7. Either the specific internal rules, guidelines, protocols, standards or other similar plan criteria the Insurance Company relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar plan criteria do not exist;
8. If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Policy to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
9. A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA.

Claims for Non-Disability Benefits (applies to all claims filed on or after April 1, 2018)

A non-disability "claim" is any claim which does not require a determination of disability by the Insurance Company regardless of the type of policy under which it arises (for example, a death claim, an accident claim, etc.). A non-disability claim is "filed" as of the date the Insurance Company first receives, in writing or by telephone (through the Insurance Company's intake department), notice that a claimant is seeking benefits under the Policy. The notice of claim should include the group Policy holder's name, the Policy and Certificate number and the claimant's name and address.

The Insurance Company has 90 days from the date the claim is filed to determine whether or not benefits are payable in accordance with the terms of the Policy. The Insurance Company may require more time to review the claim if special circumstances exist. The review period may be extended for up to one additional 90 day period. If this should happen, the Insurance Company will provide the extension notice in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected.

During the review period, the Insurance Company may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company must notify the claimant, in writing, stating what information is needed and why it is needed.

If the claim is approved, the Insurance Company will pay the appropriate benefit. If the claim decision is adverse, in whole or in part, the Insurance Company will provide written or electronic notice which will include the following information:

1. The specific reason(s) for the claim decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A description of any additional information required to perfect the claim, and the reason this information is necessary; and
4. A description of the review procedures and the time limits applicable to those procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA after the claimant appeals and after the claimant receives an adverse decision on appeal.

Appeal of Denied Non-Disability Claims (applies to all claims filed on or after April 1, 2018)

Whenever a claim decision is fully or partially adverse, the claimant must appeal once to the Insurance Company. As part of the claimant's appeal, the claimant may receive, upon request, free of charge, copies of all documents, records, and other information relevant to the claim for benefits, and the claimant may submit to the Insurance Company, written comments, documents, records, and other information relating to the claim. The review will take into account all comments, documents, records and other information the claimant submits related to the claim, without regard to whether such information was submitted or considered in the initial claim decision. Once an appeal request has been received by the Insurance Company, a full and fair review of the claim appeal will take place.

A written request for appeal must be received by the Insurance Company within 60 days from the date the claimant received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived. The Insurance Company has 60 days from the date it receives a request for appeal to provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim and extend the time for decision, once, by an additional 60 days. If this should happen, the Insurance Company will provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected.

If the appeal decision is adverse, in whole or in part, the Insurance Company will provide written or electronic notice that includes:

1. The specific reason(s) for the claim decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
4. A statement describing any Supplemental appeal procedures offered, and the claimant's right to obtain the information about those procedures, and
5. A statement of the claimant's right to bring a civil action under section 502(a) of ERISA.

ER-03-2

UNDERWRITTEN BY:
CIGNA LIFE INSURANCE COMPANY OF NEW YORK
a New York Life Insurance company

Class 1
12/2023

EXHIBIT B

GROUP LIFE INSURANCE CERTIFICATE – EMPLOYEE DEPENDENT LIFE COVERAGE

(FOR ELIGIBLE EMPLOYEES WHO HAVE LIFE COVERAGE UNDER EITHER THE NEW YORK LIFE EXECUTIVE OFFICER LIFE PLAN OR THE NEW YORK LIFE OFFICER LIFE PLAN)

Group Life
Insurance Certificate

New York Life Insurance Company
Class 3

IMPORTANT NOTICES

If you reside in one of the following states, please read the important notices below:

Arizona, Florida and Maryland residents:

The group policy is issued in the state of New York and will be governed by its laws. If you reside in a state other than New York, this certificate of insurance may not provide all of the benefits and protections provided by the laws of your state. PLEASE READ YOUR CERTIFICATE CAREFULLY.

Washington Residents:

(In Accordance With WAC 284-23-610, 620, 650, 730)

The accelerated life benefit in this policy does not and is not intended to qualify as long-term care under Washington state law. Washington state law prevents this accelerated life benefit from being marketed or sold as long-term care.

If an Insured receives payment of accelerated benefits from a life insurance policy, he or she may lose the right to receive certain public funds, such as Medicare, Medicaid, Social Security, Supplemental Security, Supplemental Security Income (SSI), and possibly others. Also, receiving accelerated benefits from a life insurance policy may have tax consequences for the Insured. We cannot give advice about this. The Insured may wish to obtain advice from a tax professional or an attorney before he or she decides to receive accelerated benefits under a life policy.

NOTICE

BENEFITS PAID UNDER THE TERMINAL ILLNESS BENEFIT PROVISION WILL REDUCE THE DEATH BENEFIT PAYABLE FOR LIFE INSURANCE.

BENEFITS PAYABLE UNDER THE TERMINAL ILLNESS BENEFIT PROVISION MAY BE TAXABLE. IF SO, THE INSURED OR THE INSURED'S BENEFICIARY MAY INCUR A TAX OBLIGATION. AS WITH ALL TAX MATTERS, AN INSURED SHOULD CONSULT WITH A PERSONAL TAX ADVISOR TO ASSESS THE IMPACT OF THIS BENEFIT.

RECEIPT OF ACCELERATED BENEFITS MAY AFFECT ELIGIBILITY FOR PUBLIC ASSISTANCE PROGRAMS.

TERMINAL ILLNESS BENEFITS ARE NOT PAYABLE IF LIFE INSURANCE COVERAGE UNDER THIS POLICY IS NOT IN FORCE.

TY-005198

CLAIM PAYMENT NOTICE

MANNER OF PAYMENTS OF CLAIMS

THE POLICYHOLDER AUTHORIZES THAT ANY BENEFIT PAYMENT DUE AS A LUMP SUM OF $5,000 OR MORE SHALL BE CREDITED TO A DRAFT ACCOUNT WITH THE INSURANCE COMPANY, IN THE NAME OF THE CLAIMANT. THE CLAIMANT MAY WITHDRAW THE ENTIRE PROCEEDS AT ANY TIME BY ISSUING ONE OR MORE DRAFTS, OR MAY WITHDRAW LESSER AMOUNTS, SUBJECT TO A MINIMUM ACCOUNT BALANCE SET BY THE INSURANCE COMPANY FROM TIME TO TIME. INTEREST SHALL BE CREDITED TO SUCH ACCOUNT AT RATES AS DETERMINED FROM TIME TO TIME BY THE INSURANCE COMPANY.

DRAFT ACCOUNTS

THE INSURANCE COMPANY SHALL BE ENTITLED TO RETAIN, AS PART OF ITS COMPENSATION, ANY EARNINGS ON DRAFT ACCOUNTS CREATED IN CONNECTION WITH BENEFIT CLAIMS, IN EXCESS OF INTEREST CREDITED UNDER THE TERMS OF THE POLICY.

FOREWORD

Life insurance provides individuals and their families with financial protection. The Life Insurance Benefit described in this booklet will help secure your family's financial security in the event of your death.

The need for life insurance protection depends on individual circumstances and financial situations. A portion of the cost of this coverage is provided by your Employer. You may need to contribute to the remaining cost of coverage through payroll deduction so that your benefit program is more comprehensive and responsive to your needs.

The following pages describe the main provisions of the life insurance plan available to you.

Insurance benefits described in the following pages will apply to you if your Employer has made this coverage available to you at no cost or you have elected the benefit and authorized payroll deduction for the required premium.

CIGNA LIFE INSURANCE COMPANY OF NEW YORK
51 MADISON AVENUE
NEW YORK, NY 10010
(800) 732-1603 TDD (800) 336-2485
A STOCK INSURANCE COMPANY

GROUP INSURANCE
CERTIFICATE

We, the CIGNA LIFE INSURANCE COMPANY OF NEW YORK, certify that we have issued a Group Policy, FLY-980020, to New York Life Insurance Company.

We certify that we insure all eligible persons, who are enrolled according to the terms of the Policy. Your coverage will begin and end according to the terms set forth in this certificate.

This certificate describes the benefits and basic provisions of your coverage. You should read it with care so you will understand your coverage.

This is not the insurance contract. It does not waive or alter any of the terms of the Policy. If questions arise, the Policy will govern. You may examine the Policy at the office of the Policyholder or the Administrator.

This certificate replaces any and all certificates which may have been issued to you in the past under the Policy.

Nothing in this group policy will invalidate or impair the rights granted to holders of any certificates issued under this policy, under the terms of the certificate or by law.

Scott Berlin, President

TY-005151

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SCHEDULE OF BENEFITS

Policy Effective Date: January 1, 2022

Certificate Effective Date: January 1, 2023

Policy Anniversary Date: January 1

Policy Number: FLY-980020

Class Definition

You are eligible for insurance if you are a member of the class defined below.

All active Employees classified as Appointive Officers prior to January 1, 2017, Executive Officers, Managing Partners and Zone Vice Presidents regularly working a minimum of 20 hours per week who are citizens or permanent resident aliens of the United States.

Your Eligibility Waiting Period

The Eligibility Waiting Period is the period of time you must be in Active Service to be eligible for coverage. It will be extended by the number of days you are not in Active Service.

If you were hired on or before the Policy Effective Date:
No Waiting Period

If you were hired after the Policy Effective Date:
No Waiting Period

LIFE INSURANCE BENEFITS

If an Insured is eligible under one Class of Eligible Employees and later becomes eligible under a different Class of Eligible Employees, changes in his or her insurance due to the class change will be effective on the first date the Insured is in Active Service on or after the date of the change in class.

Spouse or Domestic Partner Benefits

Amount of Insurance	
Option 1	$20,000
Option 2	$30,000
Option 3	$50,000

Dependent Child Benefits

Amount of Insurance	
Option 1	$3,000
Option 2	$5,000

All Dependent Child benefits are Guaranteed Issue.

Spouse or Domestic Partner of Former Employee Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Life Insurance Benefits available to a Spouse or Domestic Partner. Any amount elected in excess of the Life Insurance Benefits in effect on the date your employment with the Employer ends will be effective on the date we agree in writing to insure him or her.
Maximum Benefit Period	To Age 70

Former Spouse or Domestic Partner Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Life Insurance Benefits available to a Spouse or Domestic Partner. Any amount elected in excess of the Life Insurance Benefits in effect on the date he or she no longer qualifies as a Spouse or Domestic Partner will be effective on the date we agree in writing to insure him or her.
Maximum Benefit Period	To Age 70

Former Dependent Child Benefits

Amount of Insurance	Units of $25,000
Guaranteed Issue Amount:	$25,000
Maximum Benefit:	$50,000
Maximum Benefit Period	To Age 70

TY-005159

WHO IS ELIGIBLE

Classes of Eligible Persons
A person may be insured only once under the Basic Life portion of the Policy even though he or she may be eligible under more than one class. A person may also be insured only once under the Supplemental Life portion of the Policy as an Employee, Spouse or Dependent Child, even though he or she may be eligible under more than one class.

An Employee who is the Spouse of another Employee may not be insured for Supplemental Life Insurance as both an Employee and as a Spouse at the same time.

Any Employee, who is eligible for Supplemental Life Insurance, will not be eligible to be insured as a Dependent Child of another Employee.

If an Employee is eligible and has enrolled as the Spouse of another Employee, but ceases to be eligible to maintain the amount of insurance for which he or she has enrolled as a Spouse, that Employee may, within 31 days, enroll for coverage as an Employee, in an amount equal to the lesser of (1) the amount of Spouse Supplemental Life Insurance terminating, or (2) the maximum amount of Employee Supplemental Life Insurance for which the Employee is eligible. The Insurability Requirement does not apply. If this amount is not equal to a Supplemental Life Insurance coverage option, it will be adjusted to the next higher available Supplemental Life Insurance coverage option. This provision shall be in lieu of the Policy's provisions, if any, regarding coverage changes following Life Status Changes.

If a Spouse is eligible and has enrolled for Supplemental Life Insurance as an Employee, but ceases to be eligible to maintain the amount of insurance for which he or she has enrolled as an Employee, the Spouse may, within 31 days, instead become enrolled as a Spouse of another Employee, in an amount equal to the lesser of (1) the amount of Employee Supplemental Life Insurance terminating, or (2) the Maximum Benefit Amount of Spouse Supplemental Life Insurance for which the Spouse is eligible. The Insurability Requirement does not apply. If this amount is not equal to a Supplemental Life Insurance coverage option, it will be adjusted to the next higher available Supplemental Life Insurance coverage option.

A Dependent Child of two or more Employees may only be insured once under the Policy. If an Employee who has elected to insure Dependent Children ceases to be eligible to do so, then the Employee's Spouse may, within 31 days, elect to insure Dependent Children, provided he or she is insured as an Employee. In all cases, "Dependent Child" shall be defined with respect to the Employee who has enrolled dependent children.

In all cases, amounts of insurance referred to in these provisions shall be determined before the application of any reductions in benefits due to age.

Any amount of Supplemental Life Insurance Coverage which cannot be continued under the above provisions may be subject to the Conversion Privilege.

Employee
If you qualify under the Class Definition shown in the Schedule of Benefits, you are eligible to be insured under the Policy on the Policy Effective Date, or the day after you complete the applicable Eligibility Waiting Period, if later.

If you have previously converted your insurance under the Policy, you will not become eligible until your converted policy is surrendered. This does not apply to any amount of insurance that was previously converted under the Policy due to a reduction in your Life Insurance Benefits based on age or a change in class unless those conditions no longer affect the amount of insurance available to you.

Except as noted in the Reinstatement Provision, if you terminate coverage and later wish to reapply, or if you are a former Employee who is rehired, a new Eligibility Waiting Period must be satisfied. You are not required to satisfy a new Eligibility Waiting Period, if insurance ends because you are no longer in a Class of Eligible Employees, but continue to be employed by the Employer, and within one year you become a member of an eligible class.

Spouse
Your Spouse is eligible to be insured on the date you are eligible or the date he or she becomes your Spouse, if later.

For eligibility purposes, your Spouse must be a lawful Spouse and not legally separated from, divorced from, or widowed by you.

Dependent Child
Your Dependent Child is eligible to be insured on the date you are eligible or the date the child becomes a Dependent Child, if later.

In no event will a Dependent Child be eligible to be insured more than once under the Policy.

TY-005154-2

WHEN COVERAGE BEGINS

If you are required to contribute to the cost of this insurance, you may elect insurance for yourself, your Spouse and Dependent Children only by authorizing payroll deduction in a form approved by the Employer and us. The effective date of this insurance depends on the date and amount of insurance elected.

If you or your Spouse elect insurance in an amount that exceeds the Guaranteed Issue Amount or if your enrollment form is received more than 31 days after you become eligible to elect coverage, this insurance is effective on the date we agree in writing to provide this coverage. We will require an eligible person to satisfy the Insurability Requirement before we agree to insure him or her.

If coverage for a Dependent Child is in force and another Dependent Child becomes eligible, coverage for that child is effective on the date he or she qualifies as a Dependent Child.

If you are not in Active Service on the date insurance would otherwise go into effect, it will be effective on the date you return to Active Service.

If an eligible Spouse or Dependent Child is:
1. an inpatient in a hospital, hospice, rehabilitation or convalescence center, or custodial care facility; or
2. confined to his or her home under the care of a Physician on the date insurance would otherwise be effective, it will be effective on the date he or she is no longer an inpatient in these facilities or confined at home. If such Spouse or Dependent Child was covered by the Prior Plan immediately prior to the Policy Effective Date, this provision will not apply to the amount of coverage in effect as of the Policy Effective Date, but will apply to any increase in coverage. This does not apply to a Dependent Child who is age 6 months or less.

TY-005155-2

Takeover Provision
Special Terms Applicable to Previously Insured Employees Not in Active Service and Their Dependents

Coverage will not go into effect for you, or your Spouse and Dependent Children unless you are in Active Service on the date you would have first become eligible to be insured under this Policy.

However:
1. if you, and your Spouse or Dependent Children were insured under a Prior Plan on the date immediately prior to the date you would have first become eligible to be insured under this Policy and had satisfied the Active Service requirement, and
2. if you, your Spouse or Dependent Child die, we agree to provide a Death Benefit only equal to the lesser of:

a. the amount due under this Policy (had you satisfied the Active Service requirement), or
b. the amount that would have been due under the Prior Plan had it remained in force.

The benefit amount will be reduced by any amount paid by the Prior Plan, or that would have been paid had this Policy not been issued and had timely filing of the claim been made under the Prior Plan.

These special terms will end on the earliest of the following dates:
1. the date you meet the Active Service requirements;
2. the date insurance terminates for one of the reasons stated in the Termination of Insurance provision;
3. 12 months after the date you first become eligible under this Policy; or
4. the last day you, your Spouse or Dependent Children would have been covered under the Prior Plan if coverage under that plan for you, your Spouse or Dependent Children was still in force.

TL-009020-1

WHEN COVERAGE ENDS

Coverage will end on the earliest of the following dates:
1. the date you are eligible for coverage under a plan intended to replace this coverage;
2. the date we terminate the Policy;
3. the date you, your Spouse or Dependent Children are no longer in an eligible class;
4. the date coinciding with the end of the last period for which required premiums are paid;
5. the date you are no longer in Active Service;
6. for an Employee, Spouse or Dependent Child, the date the Employer cancels participation under the Policy; and
7. the date your coverage ends, for any insured Spouse or Dependent Child.

TY-005156-1

CONTINUATION OF INSURANCE

Continuation for Temporary Leave of Absence, Non-Medical Leave of Absence, Military Leave of Absence or Family Medical Leave If you are an Employee and your Active Service ends due to an Employer approved leave of absence, non-medical leave of absence, military leave of absence or family medical leave of absence, your insurance will continue if the required premium is paid.

In these circumstances, your insurance may continue as follows.
1. For an Employer approved leave of absence, up to up to 26 weeks.
2. For an Employer approved non-medical leave of absence, up to up to 90 days.
3. For an Employer approved military leave of absence, up to up to 90 days.
4. For an Employer approved family medical leave, up to the later of the period of the approved FMLA leave or the leave period required by the laws of the state in which the Employee is employed.

Portability Options

Continuation of Life Insurance for Employees

If your employment ends prior to age 70, you may continue Life Insurance Benefits. Benefits will continue in an amount elected, subject to the Maximum Benefit allowable for Life Insurance Benefits in effect on the date you no longer qualify as an Employee. Any amount elected in excess of the Life Insurance Benefits in effect on the date you no longer qualify as an Employee will be effective on the date we agree in writing to insure you. In lieu of continuation, the Conversion Privilege is available to the Employee on the date employment ends and at any time during the period his or her Life Insurance Benefits under the Policy continue under this option.

To continue insurance, you must submit an application to us and pay the required premium. If you continue insurance, you may also continue insurance for a Spouse or Dependent Child if they are covered under the Policy on the date insurance would otherwise end. If you do not elect to continue insurance within 62 days after your employment ends, you may not elect this insurance at a later date.

If you continue insurance in this manner you will become a Former Employee. A Spouse whose insurance is continued will become a Spouse of a Former Employee. Insurance under this provision will be effective on the first of the month following the date your insurance as an Employee ends, provided we receive your completed application and the required premium is paid.

If, as a Former Employee, you later acquire a Spouse or Dependent Child, you may elect insurance for them by submitting an application to us and paying the required premium. Insurance for a Spouse or Dependent Child of a Former Employee not in effect on the date your employment with the Employer ends, will be effective on the date we agree in writing to insure them. We may require your Spouse or Dependent Child to satisfy the Insurability Requirement before we agree to insure him or her.

Continuation of Life Insurance for Spouses

If a Spouse is legally divorced from, or widowed by, an insured Employee or Former Employee prior to age 70, he or she may continue Life Insurance Benefits. Benefits will continue in an amount elected, subject to the Maximum Benefit allowable for Life Insurance Benefits. Any amount elected in excess of the Life Insurance Benefits in effect on the date he or she no longer qualifies as a Spouse will be effective on the date we agree in writing to insure him or her. In lieu of continuation, the Conversion Privilege is available to the Spouse on the date the event occurs, and at any time during the period his or her Life Insurance Benefits under the Policy continue under this option.

To continue insurance, the Spouse must submit an application to us and pay the required premium. If a Spouse continues insurance, he or she may also continue insurance for a Dependent Child if the child is covered under the Policy on the date insurance would otherwise end. If a Spouse does not elect to continue insurance within 62 days after insurance ends, he or she may not elect this insurance at a later date.

A Spouse who continues insurance in this manner will become a Former Spouse and will be issued a separate certificate of insurance. Insurance will be effective on the first of the month following the date the Spouse's insurance otherwise ends, provided the Insurance Company receives the completed application and the required premium is paid.

Continuation of Life Insurance for Dependent Children

If a Dependent Child is insured under the Policy and is at least 19 years of age, he or she may continue Life Insurance Benefits by electing an amount of insurance in units of $25,000 up to a maximum benefit of $50,000. In lieu of continuation, the Conversion Privilege is available to the Dependent Child at attainment of the limiting age and at any time during the period his or her Life Insurance Benefits under the Policy continue under this option.

To continue insurance, the Dependent Child must submit an application to us and pay the required premium. If the Dependent Child does not elect to continue coverage within 62 days after insurance ends, he or she may not elect this insurance at a later date.

A Dependent Child who continues insurance in this manner will become a Former Dependent Child and will be issued a separate certificate of insurance. Insurance under this provision will be effective on the following dates.

1. For any Guaranteed Issue Amount, the first of the month following the date the Dependent Child's insurance otherwise ends, provided we receive the completed application and required premium.
2. For any amount of insurance that exceeds the Guaranteed Issue Amount, the date we agree in writing to insure him or her. We will require the Dependent Child to satisfy the Insurability Requirement before we agree to insure him or her.

Notice of Continuation Right

The Insured must be notified of his or her right to continue this insurance within 31 days before or after an event that would otherwise result in termination or reduction in his or her group life insurance, but if notice is given more than 31 days but less than 105 days after the event, the time period allowed for the exercise of the continuation right shall be extended to 45 days after giving notice. If such notice is not given within 105 days after the event, the time allowed for the exercise of the continuation right expires at the end of 105 days. Notice, for the purpose of this section, means written notice presented to the Insured by the Policyholder or mailed to the Insured's last known address as reported by the Policyholder.

Termination of Continued Insurance

Insurance will end on the earliest of the following dates.

1. The date the Policy is terminated.
2. The date the Insurance Company cancels insurance for all members of the Insured's class.
3. The day after the end of the period for which premiums are paid.
4. For a Former Employee, or for the Spouse or Dependent Child of a Former Employee, the date he or she is age 70.

Also, insurance for any Dependent Child will end on any of the dates listed above or when he or she no longer qualifies as a Dependent Child, if earlier.

On the date continued insurance ends, the Conversion Privilege for Life Insurance is available.

TY-005157-1

WHAT IS COVERED

LIFE INSURANCE BENEFITS

Death Benefit

If an Insured dies, we will pay the Life Insurance Benefit in force for that Insured on the date of his or her death. The Amount of Life Insurance is shown in the Schedule of Benefits.

TY-005164

CONVERSION PRIVILEGE

Who May Convert

An Insured Employee may apply for a conversion policy of life insurance for him or herself and for such spouse and children of such Employee as are then insured by the Policy if his or/her term life insurance ends for any reason, except loss of insurance for non-payment of premium. An Insured Employee may also apply if his or her life insurance benefit is reduced due to a change in age, class or the Policy. An Insured Employee may not apply for a conversion policy for amounts reduced due to payment of an Accelerated Benefit. Conversion life insurance will not provide accident, disability or other benefits. If the Employee's life insurance is continued under a Life Insurance Portability Option of the Policy, he or she may apply for a life insurance conversion at any time while coverage is continued. Insurance continued under a Life Insurance Portability Option of the Policy will end when the life insurance conversion becomes effective.

An Insured Spouse may apply for a conversion policy of life insurance for him or herself and for such children of such Employee as are then insured by the Policy if either of the following occurs.

1. His or her term life insurance under the Policy ends or reduces at the death of the Insured Employee.
2. His or her term life insurance under the Policy ends due to the divorce from, or annulment of, his or her marriage to the Employee.

An Insured Dependent Child may apply for a conversion policy of life insurance if:

1. His/her life insurance under the Policy ends or reduces due to his or her attainment of the limiting age.
2. His or her coverage ends due to the divorce of, or annulment of, the marriage of the Employee and the Employee's Spouse, or former Spouse. This item does not apply if the Employee's Spouse or former Spouse, converts the Dependent Child's coverage.

Any such conversion is subject to the provisions that follow.

Availability: The conversion insurance may be a type of life insurance currently being offered by the Insurance Company at the Insured's age. It may not be term insurance with the exceptions that follow.

Exceptions for Conversion to Term Life

1. life insurance ends for loss of employment due to the person's total and permanent disability.
2. the first year after his or her insurance under the Policy ends, or if. For that year, he or she may elect term insurance to precede the permanent plan.

If the Insurance Company does not have an individual life insurance form which meets the requirements of this privilege, it will offer an individual life insurance policy of Connecticut General Life Insurance Company that does meet such requirements.

The amount that may be converted may not be greater than the amount determined by the following:

For conversion due to a change in age, in class or in the Policy: the amount by which the Insured Person's Life Insurance Benefits under the Policy is most recently reduced.

For conversion due to loss of life insurance due to amendment of the Policy, or to the end of the Policy: the amount of such person's life insurance protection in effect immediately before the date the Policy is amended or ends, less the amount of any group life insurance that is replaced by the same or another insurer within forty-five days after group life insurance protection under the Policy ends.

For conversion for all other reasons: an amount equal to the amount of the person's protection under such group insurance policy at the time of such termination. This amount may be reduced by the amount of any life insurance which is replaced with the same or another insurer within forty-five days after group life insurance protection under the Policy ends due to the employee's loss of employment due to his or her total and permanent disability.

The converted insurance will be issued only if it is applied for and the premium paid within 62-days after insurance ends or is reduced. Conversion life insurance will not provide accident, disability or other benefits. Evidence of Insurability is not required. Premium for the conversion insurance will be based on the age and class of risk of the Insured and the type and amount of coverage issued.

The conversion coverage will not exclude suicide occurring more than two years after the effective date of the person's coverage under this group policy.

Effective Date of Conversion Policy

Conversion insurance will become effective on the 31st day after the date coverage under the Policy is reduced or ends if, by that 31st day, the application has been received by the Insurance Company and the required premium is paid. If the Insured dies during this 31 day period, the amount of life insurance which could have been converted will be paid under the Policy regardless of whether the person applied for a conversion insurance. If a conversion policy is issued, it will be in exchange for any benefits payable for that amount of insurance under the Policy.

Extension of Conversion Period

If an Insured is eligible for conversion insurance and is not notified of this right within 31 days before or after an event that results in the end or reduction of his or her group life insurance, the conversion period will be extended. The Insured will have 45 days from the date notice is given to apply for conversion insurance. In no event will the conversion period be extended beyond 105 days. Notice, for the purpose of this section, means written notice presented to the Insured by the Employer or mailed to the Insured's last known address as reported by the Employer.

If the Insured dies during the extended conversion period, the amount of life insurance which could have been converted will be paid under the Policy regardless of whether he or she applied for the conversion insurance. If the Insured's application for conversion insurance is received by the Insurance Company and the required premium is paid during the extended conversion period, Life Insurance Benefits will be payable under the conversion insurance.

CLAIM PROVISIONS

Notice of Claim

Written notice or notice by any other electronic or telephonic means authorized by us, must be given to us after a covered loss occurs or begins, or as soon as reasonably possible. If this notice is not given within a reasonable amount of time, the claim will not be invalidated or reduced if it is shown that such notice was given as soon as was reasonably possible. Written notice can be given at our home office in New York, New York or to our agent. Notice should include the Policyholder's name and policy number and the Insured's name and address.

Written notice of a diagnosis of a Terminal Illness on which claim is based must be given to us within 60 days after the diagnosis. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as reasonably possible.

Claim Forms
When we receive the notice of claim, we will send claim forms for filing proof of loss. If claim forms are not sent within 15 days after notice is received by us, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof or proof by any other electronic or telephonic means authorized by us, of the nature and extent of the loss.

Claimant Cooperation Provision
If you fail to cooperate with us in our administration of your claim, we may terminate the claim. A claimant will be required to provide any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Insurance Data
The Employer is required to cooperate with us in the review of claims and applications for coverage. Any information we provide to the Employer in these areas is confidential and may not be used or released by the Employer if not permitted by applicable privacy laws.

Proof of Loss
Written proof of loss, or proof by any other electronic/telephonic means authorized by us, for Accelerated Benefits must be furnished as soon as reasonably possible after the date of diagnosis. This proof must describe the occurrence, character and extent of the diagnosis for which claim is made.

In case of claim for any other loss, written proof or notice by any other electronic or telephonic means authorized by us, of loss must be given to us as soon as reasonably possible after the date of the loss for which a claim is made.

We will not deny or reduce any claim if it: 1) is not reasonably possible to furnish the required proof within that period; and 2) is shown that such proof of loss was given as soon as was reasonably possible.

Time of Payment
Any benefits due under the Policy for a loss, other than a loss for which the Policy provides installments, will be paid immediately upon receipt of due written proof of loss or proof by any other electronic/telephonic means authorized by us.

To Whom Payable
Death benefits for you will be paid to the beneficiary named in our records, if any, at the time of payment. If there is no named beneficiary or surviving beneficiary, or if you die while Disability Benefits are payable to you, we may, at our option, make direct payment to any of the following:
1. spouse of the Insured;
2. child or children of the Insured;
3. parents of the Insured;
4. sisters or brothers of the Insured; or
5. the estate of the Insured.

All benefits payable under the Accelerated Benefits section are payable to the Insured, if living. If the Insured dies prior to the payment of an eligible claim for an Accelerated Benefit, benefits will be paid in accordance with the provisions applicable to the payment of Life Insurance Benefits, unless the Insured has directed us otherwise in writing. However, any payment made by us prior to notice of the Insured's death shall discharge us of any benefit that was paid.

If we are to pay benefits to the estate or to a person who is incapable of giving a valid release, we may pay up to $500 at the Insured’s death to a person appearing to us to be equitably entitled by reason of having incurred expenses on behalf of the Insured for his or her burial. This good faith payment satisfies our legal duty to the extent of that payment. Any other accrued benefits which are unpaid at the Insured's death may, at our option, be paid either to the Insured's beneficiary or to the Insured's estate. We may reduce the amount payable by any indebtedness due.

All other proceeds payable under the Policy, unless otherwise stated in the Policy, will be payable to the Insured.

Change of Beneficiary
You may change your beneficiary at any time by giving us written notice or notice by any other electronic or telephonic means authorized by us. The beneficiary's consent is not required for this or any other change which you may make unless the designation of beneficiary is irrevocable.

No change in beneficiary will take effect until the request form is received by us. When the request form is received, it will take effect as of the date of the form. If you die before the request form is received, we will not be liable for any payment that was made before receipt of the request form.

Physical Examination and Autopsy
We may, at our expense, exercise the right to examine any person for whom a claim is pending as often as we may reasonably require. Also, we may, at our expense, require an autopsy unless prohibited by law.

Legal Actions
No action at law or in equity may be brought to recover benefits under the Policy less than 60 days after written proof of loss, or proof by any other electronic or telephonic means authorized by us, has been furnished as required by the Policy. No such action shall be brought more than 3 years after the time written proof of loss is required to be furnished.

Time Limitations
If any time limit stated in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity, is less than that permitted by the law of the state in which you live when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that state.

Physician/Patient Relationship
You have the right to choose any Physician who is practicing legally. We will in no way disturb the Physician/patient relationship.

ADMINISTRATIVE PROVISIONS

Premiums
The premiums for this Policy will be based on the rates currently in force, the plan and the amount of insurance in effect.

If an Insured's coverage amount is reduced due to acceleration of a Death Benefit, premium will be based on the amount of coverage in force on the day before the reduction took place.

Your Grace Period
If your required premium is not paid on the Premium Due Date, there is a 60 day grace period after each premium due date after the first. If the required premium is not paid during the grace period, insurance will end on the last day for which premium was paid.

Reinstatement of Insurance
Your insurance may be reinstated if your insurance ends because you are on an unpaid leave of absence.

Your insurance may be reinstated only if reinstatement occurs within five years from the date your insurance ends. For your insurance to be reinstated all of the following conditions must be met.
1. You must be in a Class of Eligible Employees.
2. The required premium must be paid.

3. A written request, or a request by any other telephonic or electronic means authorized by the Employer and the Insurance Company, for reinstatement must be received by us within 31 days from the date you return to Active Service.
4. The Insurability Requirement, if any, is satisfied.

Your reinstated insurance is effective on the date you return to Active Service if the required premium is paid. If you did not fully satisfy your Eligibility Waiting Period before your insurance ended, you will receive credit for any time that was satisfied.

TY-005180-1

GENERAL PROVISIONS

Entire Contract
The Policy, the application of the Policyholder (a copy of which is attached at issue), the Policyholder endorsements, riders, certificate and attached papers constitute the entire contract between the parties. If an application of any Employee is required, it may also be made a part of this contract, at our option. Nothing in this Policy will invalidate or impair the rights granted to any certificate holders by their certificates or by law.

Incontestability
All statements made by the Policyholder, or by an Employee are deemed representations and not warranties. No statement will cause us to deny or reduce benefits or be used as a defense to a claim, unless a copy of the written instrument, signed by the claimant, containing the statement is, or has been, furnished to such person while such person is still living. In the event of his death or legal incapacity, the beneficiary or representative must receive a copy. After two years from the Employee's effective date of insurance, no such statement will cause insurance to be contested except for non-payment of premium. This also applies to any added or increased benefits, from the effective date of the addition or increase in benefits.

Misstatement of Age
If your age has been misstated, we will adjust all benefits to the amounts that would have been purchased for the correct age.

Misstatement of Smoker Status
SMOKER STATEMENT: If an Insured misstates his or her status as a non-Smoker an adjustment in premium will be made to reflect a Smoker’s rate. If an Insured has misstated his or her status as a non-Smoker and he or she dies, the Life Insurance Benefit will be reduced to the amount of insurance, which the premium would have purchased had the Insured correctly stated his or her status.

Workers' Compensation Insurance
The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance.

Assignment
The Insurance Company will not be affected by any assignment of your certificate until the original assignment or a certified copy of the assignment is filed with the Insurance Company. We do not assume responsibility for the validity or sufficiency of an assignment. An assignment of the certificate will operate so long as the assignment remains in force. To the extent provided under the terms of the assignment, an assignment will transfer all rights and obligations of the Insured, or of the owner if other than the Employee.

This insurance may not be levied on, attached, garnisheed, or otherwise taken for a person's debts. This prohibition does not apply where it is contrary to law.

Conformity with State Statutes
Any provision of the Policy in conflict on the Policy Effective Date with the laws of the state where the Policy is delivered is amended to conform to the minimum requirements of such laws.

Male Pronoun
The male pronoun as used herein will be deemed to include the female.

Clerical Error
Your coverage will not be affected by error or delay in keeping records of insurance under the Policy. If such an error or delay is found, the premium will be adjusted fairly.

Agency
The Policyholder, Employer and plan administrator are agents of the Employee for transactions relating to insurance under the Policy. The Insurance Company is not liable for any of their acts or omissions.

Ownership of Records
All records maintained by the Insurance Company are, and shall remain, the property of the Insurance Company.

DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout this document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

Active Service
If you are an Employee, you are in Active Service with the Employer on a day which is one of the Employer's scheduled work days if either of the following conditions are met.

1. You are actively at work. This means you are performing your regular occupation for the Employer on a Full-time basis or a part-time basis regularly scheduled to work a minimum of 20 hours per week, either at one of the Employer's usual places of business or at some location to which the Employer's business requires you to travel.
2. The day is a scheduled holiday, vacation day or period of Employer approved paid leave of absence, other than disability or sick leave after 7 days.

You are considered in Active Service on a day which is not one of the Employer's scheduled work days only if you were in Active Service on the preceding scheduled work day.

Annual Compensation
An Employee's "Benefits Salary" as of December 31 of the prior calendar year, which is an Employee's base salary (including pay for hours worked beyond an individual's regularly scheduled hours but no more than 40 hours in a week), plus any short term incentive payments received during the year under a plan or arrangement that provides for such payment to be taken into account for benefit purposes, and any contribution by the Employer on the Employee's behalf under a salary reduction agreement pursuant to Internal Revenue Code 125 (such as any flexible benefits), Internal Revenue Code Section 132(f) (i.e., a qualified transportation benefit arrangement) or 401(k) (i.e., contributions to the 401(k) Savings Plan). It does not include amounts received as overtime pay, severance pay, any employee recognition award, recruiting and development credits, New York State Paid Family Leave (NYSPFL) benefits (unless the Employee is on a leave under the Parental Leave Program concurrent with NYSPFL and is eligible for a Paid New Parent Benefit), or any other additional forms of compensation. Annual Compensation in the year of hire is annualized base salary.

Annual Enrollment Period
The period in each calendar year agreed upon by your Employer and us when you may enroll for, or change benefit elections, under the Policy.

Dependent Child
A child who meets the following requirements.
1. A child from live birth but less than 19 years old and primarily supported by you;
2. A child who is 19 or more years old but less than 26 years old and primarily supported by you;
3. A child who is 19 or more years old, primarily supported by you and incapable of self-sustaining employment by reason of mental or physical incapacity.

The term "child" means:
a. your natural child;
b. your legally adopted child, beginning with any waiting period pending finalization of the child's adoption. It also means the legally adopted child of your Spouse provided the child is living with, and is financially dependent upon you;
c. a stepchild born to your Spouse and who is living with and financially dependent upon you;
d. a child for whom you are the court-appointed legal guardian and who resides with, and is financially dependent upon you.

Employee
For eligibility purposes, you are an Employee if you work for the Employer and are in one of the "Classes of Eligible Employees." Otherwise, you are an Employee if you are an employee of the Employer who is insured under the Policy.

Employer
The Policyholder and any affiliates or subsidiaries covered under the Policy. The Employer is acting as your agent for transactions relating to this insurance. You shall not consider any actions of the Employer as actions of the Insurance Company.

Insurability Requirement
You will be considered to have satisfied the Insurability Requirement on the day we agree in writing to accept you as covered under the Policy. To determine a person's acceptability for insurance, we will require evidence of good health and may require it be provided at your own expense.

Insurance Company
The Insurance Company underwriting the Policy is CIGNA Life Insurance Company of New York. References to the Insurance Company have been changed to "we", "our", "ours", and "us" throughout the certificate.

Insured
You are an Insured if you are eligible for insurance under the Policy, insurance is elected for you, any applicable Insurability Requirement is met, the required premium is paid and your insurance is in force under the Policy.

Life Status Change
The following events are Life Status Changes.
1. Marriage
2. Divorce, annulment or legal separation
3. Birth or adoption of a child
4. Death of your spouse
5. Termination of your spouse's employment
6. A change in the benefit plan available to your spouse
7. A change in employment status for you or your spouse that affects your eligibility for benefits

Physician
Physician means a licensed doctor practicing within the scope of his or her license and rendering care and treatment to an Insured that is appropriate for the condition and locality. The term does not include you, your spouse, the immediate family (including parents, children, siblings, or spouses of any of the foregoing, whether the relationship derives from blood or marriage), of you or your spouse, or a person living in your household.

Policy Anniversary
A Policy Anniversary is the date stated on the policy cover and the same date that follows every 12 months for as long the Policy is in effect.

Policy Effective Date
The Policy Effective Date is the date stated on the policy cover.

Policyholder
A Policyholder is an Employer who has applied for coverage under the policy for his eligible Employees and their Dependents.

Prior Plan
The Prior Plan refers to the plan of insurance providing similar benefits to you, sponsored by the Employer and in effect directly prior to the Policy Effective Date. A Prior Plan will include the plan of an employer in effect on the day prior to that employer's addition to this policy.

To be covered under the Policy, required premium must be paid for all covered Employees.

Sickness
The term Sickness means a physical or mental illness. It also includes pregnancy.

Smoker
Smoker means a person who has smoked cigarettes, cigars or used a pipe or chewing tobacco, nicotine chewing gum or snuff during the twelve months prior to the date he or she applied for coverage.

Spouse
Your current lawful spouse.

TY-005153-2

AMENDATORY RIDER
DOMESTIC PARTNER/CIVIL UNION PARTNER COVERAGE

Policy No. FLY-980020
Effective Date: January 1, 2022

This rider amends the Policy and Certificate to which it is attached. It is effective on the Effective Date shown above, and expires when the Policy expires.

Domestic Partner/Civil Union Partner means any of the following:

1. A person with whom the Employee has a registered civil union or domestic partnership under state law which imposes legal obligations on the parties substantially similar to marriage. Such person will continue to be recognized as a Domestic Partner or Civil Union Partner unless and until: (1) the civil union or domestic partnership is dissolved under applicable law; or (2) either the Employee or the Domestic Partner/Civil Union Partner marries another person.

2. A person meeting all of the following requirements, with respect to an Employee:
   a. Shares a permanent residence with the Employee;
   b. Has resided with the Employee for at least 6 months and is expected to continue to reside with the Employee indefinitely;
   c. Has not been legally married to any other person within the previous six months, and has no Domestic Partner other than the Employee during the previous six months, and is the Employee's or Former Employee's sole Domestic Partner;
   d. Has signed a Domestic Partner declaration with the Employee, if the Employee resides in a jurisdiction which provides for Domestic Partner declarations;
   e. Has not signed a Domestic Partner declaration with any other person within the last 6 months;
   f. Is interdependent with the Employee in three or more of the following ways:
      1. Both partners are registered under any municipal ordinance as domestic partners.
      2. Both partners are jointly parties to a lease, mortgage or deed.
      3. Both partners jointly own one or more motor vehicles.
      4. Both partners jointly own one or more bank or credit accounts.
      5. The Employee has named the Domestic Partner as attorney-in-fact under a durable power of attorney with authority over health care decisions.
      6. The Employee has designated the Domestic Partner as beneficiary under a retirement plan or a life insurance policy.
      7. The Employee has designated the Domestic Partner as beneficiary of the Employee's or Former Employee's will.
      8. Each partner has agreed in writing to assume the financial responsibility for the welfare of the other.
   g. Is not so closely related by blood to the Employee as to prohibit legal marriage in their state of residence;
   h. Is no less than 18 years of age.

The Employee and Domestic Partner must furnish the Employer and Insurance Company with a signed declaration that the above requirements are met, at the time of enrollment.

All references in the policy to "Spouse" shall be changed to read "Spouse, Domestic Partner, and Civil Union Partner except as follows:

1. The definition of "Spouse" remains unchanged.

2. For purposes of any provision of the policy providing for payment of benefits to relatives of the Employee, a Domestic Partner/Civil Union Partner shall be included only if:
   a. the Domestic Partner/Civil Union Partner meets the requirements of the definition of Domestic Partner/Civil Union Partner referenced in item 1; or
   b. the Employee and Domestic Partner have furnished the Employer or the Insurance Company with a signed statement affirming that the requirements referenced in item 2 within the definition of Domestic Partner are met.

3. A Domestic Partner/Civil Union Partner shall be deemed eligible to be enrolled for insurance on the latest of:
   a. the date of registration under Item 1 of the definition of Domestic Partner/Civil Union Partner;
   b. the date that the Employee is eligible for insurance under the Policy;
   c. the effective date of this Amendment to the Policy.

4. A child of a Domestic Partner/Civil Union Partner may only be eligible to be insured if:
   a. the child is primarily dependent on the Employee for financial support; or
   b. the Employee has a legal obligation of support of the child; or
   c. the Employee is the child's legal guardian.

Except for the above this rider does not change the Policy or Certificate to which it is attached.

CIGNA LIFE INSURANCE COMPANY OF NEW YORK

Scott Berlin, President

TY-008930

CIGNA LIFE INSURANCE COMPANY OF NEW YORK
51 MADISON AVENUE
NEW YORK, NY 10010

STATE MODIFYING PROVISIONS AMENDMENT RIDER

Policyholder: New York Life Insurance Company
Policy No. FLY-980020
Amendment Effective Date: January 1, 2022

This amendment is attached to and made part of the Policy/Certificate specified above. Its provisions are intended to conform this Policy/Certificate to the laws of the state in which the insured resides.

The Policy delivered under the Group Policy are amended as follows:

APPLICABLE TO CALIFORNIA RESIDENTS:

1. **Conversion Privilege for Life Insurance**
   Insured Employees and Insured Spouses may convert to an individual policy of life insurance for an amount not greater than the Conversion Amount shown below when the Policy ends, without regard to any requirement that the person be insured under the policy for a specified period of time, if all of the following apply.

   a. The Insured became Totally Disabled while covered for the Life Benefit of the Policy. Totally Disabled means the person is unable to perform all the material duties of any occupation for which he or she may reasonably be qualified based on training, education and experience.
   b. The Insured remained Totally Disabled until the Policy ended while covered for the Life Benefit of this Policy.
   c. The Policy does not provide a Waiver of Premium, Extended Death Benefit Provision or monthly payments to Totally Disabled Insureds for the Life Benefit.
   d. The person meets all other conditions for converting the insurance.

   Conversion Amount - Insured's life insurance amount under the Policy on the date the Policy ends minus the amount for which the Insured is insured under a group policy that provides life coverage to employees of the Insured Employee's Employer covered under this Policy. The dollar limit that applies to the amount for conversion at Policy termination does not apply.

   The requirement that the Insured be covered under the Policy for the stated number of years in order to convert life insurance does not apply.

APPLICABLE TO FLORIDA RESIDENTS:

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

APPLICABLE TO MARYLAND RESIDENTS:

The Group Insurance Policy was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

TL-01-3000

APPLICABLE TO MISSOURI RESIDENTS:

Applicable to Supplemental Life Insurance Benefits
If an Insured commits suicide, while sane or insane, within 1 year from the date his or her insurance under the Policy becomes effective, Supplemental Life Insurance Benefits will be limited to a refund of the premiums paid on the Insured's behalf. The suicide exclusion applies from the effective date of any additional benefits or increases in Life Insurance Benefits.

Except for any amount of benefits in excess of the Prior Plan's benefits, this exclusion will not apply to any person covered under the Prior Plan for more than one year. If a person was not insured for one year under the Prior Plan, credit will be given for the time he or she was insured.

If a Dependent Child commits suicide and is survived by other Dependent Children covered under the same certificate, no refund of premiums will be paid.

APPLICABLE TO NORTH DAKOTA RESIDENTS:

The Suicide exclusion, if any, is limited to one year from the effective date of insurance. The suicide exclusion with respect to any increase in death benefits which results from an application of the insured subsequent to the effective date, if any, is limited to one year from the effective date of the increase.

APPLICABLE TO OREGON RESIDENTS:

NOTICE: MUST PROVIDE DOMESTIC PARTNER COVERAGE FOR OREGON RESIDENTS

APPLICABLE TO VERMONT RESIDENTS:

To the extent the Policy provides insurance coverage to a spouse, the identical consideration must be applied to same sex marriages and civil unions. The language is as follows:

1. Civil Union Partner means:
   a. A person with whom the Employee has a registered civil union under Vermont law which imposes obligations on the parties substantially similar to marriage. Such person will continue to be recognized as a Civil Union Partner unless and until:
      (1) the civil union is dissolved under applicable law; or
      (2) either the Employee or the Civil Union Partner marries another person.

2. Spouse means:
   a. "Lawful spouse" and includes a lawful spouse of the same sex.
   b. This also includes a partner to a civil union recognized under Vermont Law.

APPLICABLE TO WASHINGTON RESIDENTS:

1. The following *Continuation of Insurance* provision is added to the Policy:

   Continuation of Life Coverage During Labor Disputes
   If an Employee's Active Service ends because of a Labor Dispute and his or her premium for Life Insurance Benefits under the Policy is paid either by the Employer, in whole or in part, or by the Employee through payroll deductions, then the Employee may continue his or her Life Insurance Benefits. The Employer will send written notice of the right to continue coverage to each insured Employee at his or her most recent address as on file with the Employer.

   To continue coverage, the Employee must pay premiums directly to the Employer, who will remit the premiums to the Insurance Company. Premiums must be paid by the date they are due, subject to the 31 day grace period. Policy coverages and premiums will stay the same during a Labor Dispute; however, the Insurance Company may make normal changes in premium rates when the Policy is renewed, under the terms set forth in the Policy.

   Coverage continued in this manner will end on the earliest of the following dates.
   a. The date the Labor Dispute has ended.
   b. The date coverage has been continued for 6 months.

   If the Labor Dispute continues beyond 6 months, the Employee may apply for an individual insurance policy, as set forth in detail under "Conversion Privilege for Life Insurance."

   "Labor Dispute," as used here, means a strike, lockout, or other labor dispute between the Employer and its Employees, during which time the Employee is not paid by the Employer.

2. If the Policy provides coverage to dependents, benefits for a Spouse or Dependent Child are limited to 100% of the insured Employee's coverage amount. Stand-alone Spouse and Dependent Child coverage (when Employee is not insured) is not permitted.

3. The *Suicide* Exclusion, if any, does not apply.

4. To the extent the policy includes *Accelerated Benefits,* the following resolution of disputes requirements are added to the Policy.

   - For Terminal Illness – *Determination of Terminal Illness*

     In the event the Physician representing the Insurance Company disputes the existence of a Terminal Illness, and the dispute cannot be resolved, the Insured has the right to mediation and binding arbitration in accordance with Washington Administrative Code 284-23-730.

5. The *Incontestability Provision* is replaced as follows:

   Incontestability
   All statements made by the Employer or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement has been furnished to the claimant. In the event of death or legal incapacity, the beneficiary or representative must receive the copy.

   After two years from an Insured's effective date of insurance, or from the effective date of any added or increased benefits, no such statement will cause insurance to be contested.

6. Any Domestic Partner of an Employee who is registered as a Domestic Partner under Washington state law will be deemed to be eligible on the same basis as a Spouse.

   Please refer to your certificate of insurance which describes the benefit provisions and limitations applicable to you as a resident of this state.

Signed for the
CIGNA Life Insurance Company of New York

Scott Berlin, President

TY-00-3000.00

SUPPLEMENTAL INFORMATION
for

Group Plan for New York Life Employees ("Plan")
required by the Employee Retirement
Income Security Act of 1974

As a Plan participant in New York Life Insurance Company's Plan, you are entitled to certain information, rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

The benefits described in your Certificate are provided under a group insurance Policy issued by the Insurance Company. The Policy is incorporated into the Plan. The Certificate, along with the following Supplemental Information, makes up the Summary Plan Description as required by ERISA.

IMPORTANT INFORMATION ABOUT THE PLAN

- The Plan is established and maintained by New York Life Insurance Company, the Plan Sponsor.
- The Employer Identification Number (EIN) is 13-5582869.
- The Plan Number is 501.
- The Insurance Plan is administered directly by the Plan Administrator with benefits provided, in accordance with the provisions of the group insurance contract, FLY-980020 ("Policy"), issued by CIGNA LIFE INSURANCE COMPANY OF NEW YORK ("Insurance Company").
- The Plan Administrator is: Maria Mauceri, VP and Actuary
  51 Madison Avenue, Room 513
  New York, NY 10010
  212-576-5707
- The Plan Administrator has authority to control and manage the operation and administration of the Plan.
- The Plan Sponsor may terminate, suspend, withdraw or amend the Plan, in whole or in part, at any time, subject to the applicable provisions of the Policy. (Your rights upon termination or amendment of the Plan are set forth in your Certificate.)
- The agent for service of legal process is the Plan Administrator.
- The Plan of benefits is financed by the Employees.
- The date of the end of the Plan Year is December 31.

YOUR RIGHTS AS SET FORTH BY 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, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit 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 Benefit Security Administration.

WHAT YOU SHOULD DO AND EXPECT IF YOU HAVE A CLAIM

The Plan Administrator designates and names the Insurance Company the named fiduciary for deciding claims and appeals for benefits under the Plan. The Insurance Company shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Insurance Company shall be final and binding on Participants and Beneficiaries to the full extent permitted by applicable law.

Claims for Disability Benefits (applies to all claims filed on or after April 1, 2018)

A disability "claim" is any claim which requires a determination of disability by the Insurance Company regardless of the type of policy under which it arises (for example, short/long term disability, waiver of premium, etc.). A disability claim is "filed" as of the date the Insurance Company first receives, in writing (including electronically) or by telephone (through the Insurance Company's intake department), notice that a claimant is seeking disability benefits under the Policy. The notice of claim received should provide the date of disability/loss, the claimant's name and address, and the group Policy holder's name and address. Properly filed claims will be decided with independence and impartiality.

The Insurance Company has 45 days from the date it receives a claim for disability benefits to determine whether or not benefits are payable in accordance with the terms of the Policy. The Insurance Company may require more time to review the claim if necessary due to matters beyond its control. The review period may be extended for up to two additional 30 day periods. If this should happen, the Insurance Company must provide its extension notice in writing before expiration of the current decision period, explaining the circumstances requiring extension and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Insurance Company's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Insurance Company receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

During the review period, the Insurance Company may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company will notify the claimant, in writing, stating what information is needed and why it is needed.

If the claim is approved, the Insurance Company will pay the appropriate benefit. If the claim decision is adverse, in whole or in part, the Insurance Company will provide written or electronic notice which will include the following information:

1. The specific reason(s) for the decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A description of any additional information required to perfect the claim, and the reason this information is necessary;
4. A description of the review procedures and the time limits applicable to those procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA after the claimant appeals and after the claimant receives an adverse decision on appeal;
5. A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Insurance Company of the health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the claimant's adverse benefit decision, without regard to whether the advice was relied upon in making the benefit decision; and (iii) a disability decision regarding the claimant presented by the claimant to the Insurance Company made by the Social Security Administration;
6. Either the specific internal rules, guidelines, protocols, standards or other similar plan criteria the Insurance Company relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar plan criteria do not exist;.
7. If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Policy to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
8. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; and
9. A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA.

Appeal of Denied Disability Claims (applies to all claims filed on or after April 1, 2018)

Whenever a claim decision is fully or partially adverse, unless ERISA provides otherwise, the claimant must appeal once to the Insurance Company. As part of the claimant's appeal, the claimant may receive, upon request, free of charge, copies of all documents, records, and other information relevant to the claim for benefits, and the claimant may submit to the Insurance Company, written comments, documents, records, and other information relating to the claim. The review will take into account all comments, documents, records and other information the claimant submits related to the claim, without regard to whether such information was submitted or considered in the initial claim decision. Once an appeal request has been received by the Insurance Company, a full and fair review of the claim appeal will take place.

A written request for appeal must be received by the Insurance Company within 180 days from the date the claimant received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived. The Insurance Company has 45 days from the date it receives a request for appeal to provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim and can extend the time for decision, once, by an additional 45 days. If this should happen, the Insurance Company must provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Insurance Company's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Insurance Company receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

The review will give no deference to the original claim decision. The review will not be made by the person who made the initial claim decision, or a subordinate of that person. When deciding an appeal based in whole or in part upon medical judgment, the Insurance Company will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment. Any medical or vocational experts consulted by the Insurance Company for the review will be identified and will not be the expert who was consulted during the initial claim decision or a subordinate of that expert.

During the appeal, the Insurance Company may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company will notify the claimant, in writing, stating what information is needed and why it is needed.

Before the Insurance Company issues an adverse benefit decision on appeal, if the Insurance Company considered, relied upon, or generated any new or additional evidence in connection with the claim, and/or if the Insurance Company intends to rely on any new or additional rationale in connection with that review, then such evidence and/or rationale will be provided to the claimant, free of charge, as soon as possible and sufficiently in advance of the date that the decision on appeal is required to be made, giving the claimant a reasonable opportunity to respond.

If the claim is approved, the Insurance Company will pay the appropriate benefit. If the claim decision on appeal is adverse, in whole or in part, the Insurance Company will provide written or electronic notice that includes:

1. The specific reason(s) for the decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
4. A statement describing any Supplemental appeal procedures offered, and the claimant’s right to obtain the information about those procedures;
5. A statement of claimant’s right to bring a civil action under section 502(a) of ERISA, including a description of any applicable contractual limitations period that applies to the claimant’s right to bring such an action, and the calendar date on which the contractual limitations period expires for the claim;
6. A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Insurance Company of the health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse decision, without regard to whether the advice was relied upon in making the adverse decision; and (iii) a disability decision regarding the claimant presented by the claimant to the Insurance Company made by the Social Security Administration;
7. Either the specific internal rules, guidelines, protocols, standards or other similar plan criteria the Insurance Company relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar plan criteria do not exist;
8. If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Policy to the claimant’s medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
9. A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA.

Claims for Non-Disability Benefits (applies to all claims filed on or after April 1, 2018)

A non-disability "claim" is any claim which does not require a determination of disability by the Insurance Company regardless of the type of policy under which it arises (for example, a death claim, an accident claim, etc.). A non-disability claim is "filed" as of the date the Insurance Company first receives, in writing or by telephone (through the Insurance Company's intake department), notice that a claimant is seeking benefits under the Policy. The notice of claim should include the group Policy holder's name, the Policy and Certificate number and the claimant's name and address.

The Insurance Company has 90 days from the date the claim is filed to determine whether or not benefits are payable in accordance with the terms of the Policy. The Insurance Company may require more time to review the claim if special circumstances exist. The review period may be extended for up to one additional 90 day period. If this should happen, the Insurance Company will provide the extension notice in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected.

During the review period, the Insurance Company may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company must notify the claimant, in writing, stating what information is needed and why it is needed.

If the claim is approved, the Insurance Company will pay the appropriate benefit. If the claim decision is adverse, in whole or in part, the Insurance Company will provide written or electronic notice which will include the following information:

1. The specific reason(s) for the claim decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A description of any additional information required to perfect the claim, and the reason this information is necessary; and
4. A description of the review procedures and the time limits applicable to those procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA after the claimant appeals and after the claimant receives an adverse decision on appeal.

Appeal of Denied Non-Disability Claims (applies to all claims filed on or after April 1, 2018)

Whenever a claim decision is fully or partially adverse, the claimant must appeal once to the Insurance Company. As part of the claimant's appeal, the claimant may receive, upon request, free of charge, copies of all documents, records, and other information relevant to the claim for benefits, and the claimant may submit to the Insurance Company, written comments, documents, records, and other information relating to the claim. The review will take into account all comments, documents, records and other information the claimant submits related to the claim, without regard to whether such information was submitted or considered in the initial claim decision. Once an appeal request has been received by the Insurance Company, a full and fair review of the claim appeal will take place.

A written request for appeal must be received by the Insurance Company within 60 days from the date the claimant received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived. The Insurance Company has 60 days from the date it receives a request for appeal to provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim and extend the time for decision, once, by an additional 60 days. If this should happen, the Insurance Company will provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected.

If the appeal decision is adverse, in whole or in part, the Insurance Company will provide written or electronic notice that includes:

1. The specific reason(s) for the claim decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
4. A statement describing any Supplemental appeal procedures offered, and the claimant's right to obtain the information about those procedures, and
5. A statement of the claimant's right to bring a civil action under section 502(a) of ERISA.

ER-03-2

UNDERWRITTEN BY:
CIGNA LIFE INSURANCE COMPANY OF NEW YORK
a New York Life Insurance company

Class 3
08/2023

EXHIBIT C

GROUP LONG-TERM DISABILITY (LTD)
INSURANCE CERTIFICATE

Group Long Term Disability
Insurance Certificate

New York Life Insurance Company

IMPORTANT NOTICES

If you reside in one of the following states, please read the important notices below:

Arizona, Florida and Maryland residents:

The group policy is issued in the state of New York and will be governed by its laws. If you reside in a state other than New York, this certificate of insurance may not provide all of the benefits and protections provided by the laws of your state. PLEASE READ YOUR CERTIFICATE CAREFULLY.

FOREWORD

Disability insurance provides individuals and their families with financial protection. The Disability Insurance Benefit described in this booklet will help secure your family's financial security in the event of your disability.

The need for disability insurance protection depends on individual circumstances and financial situations. A portion of the cost of this coverage is provided by your Employer. You may need to contribute to the remaining cost of coverage through payroll deduction so that your benefit program is more comprehensive and responsive to your needs.

The following pages describe the main provisions of the disability insurance plan available to you.

Insurance benefits described in the following pages will apply to you if your Employer has made this coverage available to you at no cost or you have elected the benefit and authorized payroll deduction for the required premium.

CIGNA LIFE INSURANCE COMPANY OF NEW YORK
51 MADISON AVENUE
NEW YORK, NY 10010
(800) 732-1603 TDD (800) 336-2485
A STOCK INSURANCE COMPANY

GROUP INSURANCE CERTIFICATE

We, the CIGNA LIFE INSURANCE COMPANY OF NEW YORK, certify that we have issued a Group Policy, NYK-980036, to New York Life Insurance Company.

We certify that we insure all eligible persons, who are enrolled according to the terms of the Policy. Your coverage will begin and end according to the terms set forth in this certificate.

This certificate describes the benefits and basic provisions of your coverage. You should read it with care so you will understand your coverage.

This is not the insurance contract. It does not waive or alter any of the terms of the Policy. If questions arise, the Policy will govern. You may examine the Policy at the office of the Policyholder or the Administrator.

This certificate replaces any and all certificates which may have been issued to you in the past under the Policy.

Nothing in this group policy will invalidate or impair the rights granted to holders of any certificates issued under this policy, under the terms of the certificate or by law.

Scott Berlin, President

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SCHEDULE OF BENEFITS

Policy Effective Date: January 1, 2022

Certificate Effective Date: January 1, 2024

Policy Anniversary Date: January 1

Policy Number: NYK-980036

Eligible Class Definition:
All active Employees of the Employer who are (i) classified as either full-time by the Employer at the location at which the Employee is employed or part-time regularly scheduled to work a minimum of 20 hours per week and (ii) who are citizens or permanent residents of the United States employed and residing in the United States (other than Puerto Rico).

The following persons are not eligible for coverage and are not eligible Employees:

- Agents of New York Life Insurance Company ("Company"), including (but not limited to) "Training Allowance Subsidy" insurance agents;
- Individuals hired by the Company (or an affiliate) on a temporary basis;
- Any individual who performs services for the Company (or an affiliate) as an independent contractor, including any individual who performs services for the Company (or an affiliate) under an agreement or arrangement (as evidenced by a writing, oral statement or payroll practice) between the Company (or an affiliate) and the individual or another organization that provides the individual services to the Company (or an affiliate) under which the individual is treated as an independent contractor or an employee or agent of an entity other than the Company (or an affiliate), irrespective of whether such individual is treated as an Employee or agent of the Company (or an affiliate) under common-law principles, state insurance law or the provisions of the Code (including sections 414(m), 414(n) or 414(o)) or is later appointed or reclassified by the courts, the Internal Revenue Service ("IRS"), the U.S. Department of Labor ("DOL") or other governmental agency as an Employee of the Company (or an affiliate);
- Individuals who are employees of an affiliate of the Company that does not participate in the Group Plan for New York Life Employees and who perform services for the Company or an Employer, without regard to whether such individuals are reclassified by a court, the IRS, the DOL or another governmental agency as an Employee of the Company or an Employer; and
- Individuals who are employees of another entity, even if working on the premises of the Company or an affiliate or otherwise serving the Company or an affiliate.

Eligibility Waiting Period

If you were hired on or before the Policy Effective Date: No Waiting Period

If you were hired after the Policy Effective Date: No Waiting Period

Benefit Waiting Period

Core Benefit: 6 months
Optional Benefit: 6 months

Disability Benefit

Core Benefit:	50%
Optional Benefit:	60%

The lesser of the percent of your monthly Covered Earnings listed above, rounded to the nearest dollar, or the Maximum Disability Benefit, reduced by any Other Income Benefits.

"Other Income Benefits" means any benefits listed in the Other Income Benefits provision that you receive on your own behalf or for your dependents, or which your dependents receive because of your entitlement to Other Income Benefits.

Maximum Disability Benefit

Core Benefit:	$10,000 per month
Optional Benefit:	$15,000 per month

Minimum Disability Benefit

Core Benefit:	The lesser of $100 or 10% of your Monthly Benefit prior to any reductions for Other Income Benefits.
Optional Benefit:	The lesser of $100 or 10% of your Monthly Benefit prior to any reductions for Other Income Benefits.

Maximum Benefit Period

Age When Disability Begins	Maximum Benefit Period
Under Age 60	To age 65, but not less than 5 years.
Age 60 - 64	5 years.
Age 65 - 69	To age 70, but not less than 5 years.
Age 70 or older	1 year.

TY-005159

WHO IS ELIGIBLE

Employee Eligibility
If you qualify under the Class Definition shown in the Schedule of Benefits you are eligible for coverage under the Policy on the Policy Effective Date, or the day after you complete the Eligibility Waiting Period, if later.

If you have previously converted your insurance under the Policy, you will not become eligible until the converted policy is surrendered. This does not apply to any amount of insurance that was previously converted under the Policy due to a reduction in your Disability Insurance benefits based on age or a change in class unless those conditions no longer affect the amount of coverage available to you.

Except as noted in the Reinstatement Provision, if you terminate your coverage and later wish to reapply, or if you are a former Employee who is rehired, you must satisfy a new Eligibility Waiting Period. You are not required to satisfy a new Eligibility Waiting Period if your insurance ends because you are no longer in an eligible class, but you continue to be employed by the Employer and within one year you become a member of an eligible class.

You must be in Active Service throughout the Eligibility Waiting Period to be eligible for coverage. The Eligibility Waiting Period will be extended by the number of days you are not in Active Service.

TY-005154-1

TL-004710

WHEN COVERAGE BEGINS

You will be insured on the date you become eligible, if you are not required to contribute to the cost of this insurance.

If you are required to contribute to the cost of your insurance you may elect to be insured only by authorizing payroll deduction in a form approved by the Employer and us. The effective date of your insurance depends on the date coverage is elected.

If you elect coverage within 31 days after you become eligible, your insurance is effective on the latest of the following dates.
1. The Policy Effective Date.
2. The date you authorized payroll deduction for this insurance.
3. The date the completed enrollment request is received by the Employer or us.

If your enrollment request is received more than 31 days after you are eligible to elect coverage, insurance is effective on the date we agree in writing to insure you. We will require you to satisfy the Insurability Requirement before we agree to insure you.

If you are not in Active Service on the date your insurance would otherwise be effective, it will be effective on the date you return to Active Service.

TY-005155-1

TL-004712

WHEN COVERAGE ENDS

Your insurance ends on the earliest of the dates below.

1. The date you are eligible for coverage under a plan intended to replace this coverage.
2. The date the Policy is terminated.
3. The date you no longer qualify under your Class Definition.
4. The day after the period for which premiums are paid.
5. The date you are no longer in Active Service.

TY-005156

CONTINUATION OF INSURANCE

This provision modifies the When Coverage Ends provision to allow insurance to continue under certain circumstances if you are no longer in Active Service. Insurance that is continued under this provision is subject to all other terms of the When Coverage Ends provisions.

Your Disability Insurance will continue if your Active Service ends because of a Disability for which benefits under the Policy are or may become payable. Your premiums will be waived while Disability Benefits are payable. If you do not return to Active Service, this insurance ends when your Disability ends or when benefits are no longer payable, whichever occurs first.

If your Active Service ends due to an approved leave pursuant to the Family and Medical Leave Act (FMLA), insurance will continue up to the later of the period of your approved FMLA leave or the leave period required by law in the state in which you are employed. Premiums are required for this coverage.

If your Active Service ends due to any other leave of absence approved in writing by the Employer prior to the date you cease work, insurance will continue for you until the end of the month following the month in which the leave begins. Premiums are required for this coverage. An approved leave of absence does not include Furlough, Temporary Layoff or termination of employment.

If your Active Service ends due to Temporary Layoff, insurance will continue for you until the end of the month following the month in which the Temporary Layoff begins. Premiums are required for this coverage.

If your Active Service ends due to any other excused short term absence from work that is reported to the Employer timely in accordance with the Employer's reporting requirements for such short term absence, your insurance will continue until the earlier of:

a. the date your employment relationship with the Employer terminates;
b. the date premiums are not paid when due;
c. the end of the 30 day period that begins with the first day of such excused absence;
d. the end of the period for which such short term absence is excused by the Employer.

Notwithstanding any other provision of this policy, if your Active Service ends due to termination of employment or any other termination of the employment relationship, insurance will terminate and continuation of insurance under this provision will not apply.

If your insurance is continued pursuant to this When Coverage Continues provision, and you become Disabled during such period of continuation, Disability Benefits will not begin until the later of the date the Benefit Waiting Period is satisfied or the date you are scheduled to return to Active Service.

TY-010040

TAKEOVER PROVISION

This provision applies to you only if you are eligible under this Policy and were covered for long term disability coverage on the day prior to the effective date of this Policy under the Prior Plan provided by the Policyholder or by an entity that has been acquired by the Policyholder.

A. This section A applies to you if you are not in Active Service on the day prior to the effective date of this Policy due to a reason for which the Prior Plan and this Policy both provide for continuation of insurance. If required premium is paid when due, we will insure an Employee to which this section applies against a disability that occurs after the effective date of this Policy for the affected employee group. This coverage will be provided until the earlier of the date: (a) you return to Active Service, (b) continuation of insurance under the Prior Plan would end but for termination of that plan; or (c) the date continuation of insurance under this Policy would end if computed from the first day you were not in Active Service. The Policy will provide this coverage as follows:

    1. If benefits for a disability are covered under the Prior Plan, no benefits are payable under this Plan.
    2. If the disability is not a covered disability under the Prior Plan solely because the plan terminated, benefits payable under this Policy for that disability will be the lesser of: (a) the disability benefits that would have been payable under the Prior Plan; and (b) those provided by this Policy. Credit will be given for partial completion under the Prior Plan of Benefit Waiting Periods and partial satisfaction of pre-existing condition limitations.

B. The Benefit Waiting Period under this Policy will be waived for a Disability which begins while you are insured under this Policy if all of the following conditions are met:

    1. The Disability results from the same or related causes as a Disability for which monthly benefits were payable under the Prior Plan;
    2. Benefits are not payable for the Disability under the Prior Plan solely because it is not in effect;
    3. The Benefit Waiting Period would not apply to the Disability if the Prior Plan had not ended;
    4. The Disability begins within 6 months of your return to Active Service and your insurance under this Policy is continuous from this Policy's Effective Date.

C. Except for any amount of benefit in excess of a Prior Plan's benefits, the Pre-existing Condition Limitation will not apply if you were covered under a Prior Plan and satisfied the pre-existing condition limitation, if any, under that plan. If you did not fully satisfy the pre-existing condition limitation of that plan, credit will be given for any time that was satisfied under the Prior Plan's pre-existing condition limitation.

    Benefits will be determined based on the lesser of: (1) the amount of the gross disability benefit under the Prior Plan and any applicable maximums; and (2) those provided by this Policy.

    If benefits are payable under the Prior Plan for the Disability, no benefits are payable under this Policy.

TY-005108

DESCRIPTION OF BENEFITS
WHAT IS COVERED

Disability Benefits
If you become Disabled, as we define the term in the Definitions section, while you are covered under the Policy, we will pay you Disability Benefits. After you are Disabled, you must satisfy the Benefit Waiting Period and be under the care and treatment of a Physician. Also, we ask you to provide us with satisfactory proof of your Disability, at your expense, before benefits will be paid.

We will require continued proof of your Disability for benefits to continue.

Benefit Waiting Period
The Benefit Waiting Period is the period of time you must be continuously Disabled before Disability Benefits may be payable. Your Benefit Waiting Period is shown in the Schedule of Benefits.

We will not require you to satisfy the Benefit Waiting Period if benefits were payable to you under a Prior Plan on the Policy Effective Date and you return to Active Service within 6 months after this Effective Date and are Disabled again within 14 days. Your later period of Disability must be caused by the same or related causes for your Benefit Waiting Period to be waived.

Termination of Your Disability Benefits
Your Disability Benefits will end on the earliest of the dates listed below.
1. The date we determine you are no longer Disabled
2. The date the Maximum Benefit Period ends
3. The date you die

Successive Periods of Disability
Once you are eligible to receive Disability Benefits under the Policy, separate periods of Disability resulting from the same or related causes are a continuous period of Disability unless you return to Active Service for more than 6 months.

A period of Disability is not continuous if separate periods of Disability result from unrelated causes, or your later Disability occurs after your coverage under the Policy ends.

The Successive Periods of Disability provision will not apply if you are eligible for coverage under a plan that replaces the Policy.

Mental Illness Limitation
We will pay Disability Benefits on a limited basis for a Disability caused by, or contributed to by, any one or more of the following conditions. Once 24 monthly Disability Benefits have been paid during your lifetime, no further benefits will be payable for any of the following conditions.
1) Anxiety disorders
2) Delusional (paranoid) disorders
3) Depressive disorders
4) Eating disorders
5) Mental illness

If, before reaching the lifetime maximum benefit, you are confined in a hospital for more than 14 consecutive days, that period of confinement will not count against the lifetime limit. The confinement must be for the Appropriate Care of any of the conditions listed above.

Alcoholism and Drug Abuse Limitation
We will pay Disability Benefits on a limited basis for a Disability caused by, or contributed to by, any one or more of the following conditions. Once 24 monthly Disability Benefits have been paid during your lifetime, no further benefits will be payable for any of the following conditions.

1) Alcoholism
2) Drug addiction

If, before reaching your lifetime maximum benefit, you are confined in a hospital for more than 14 consecutive days, that period of confinement will not count against your lifetime limit. The confinement must be for the Appropriate Care of any of the conditions listed above.

Pre-Existing Condition Limitation
We will not pay benefits on account of any Disability which is caused or contributed to by, or results from, a Pre-Existing Condition, until 12 months after your most recent effective date of insurance. The Pre-Existing Condition Limitation will apply to any added benefits or increases in benefits.

A "Pre-existing Condition" means any Injury or Sickness for which you incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 6 months before his or her most recent effective date of insurance.

The Pre-existing Condition Limitation will not apply if you were covered under your Employer's Prior Plan and satisfied the Pre-existing Condition limitation, if any, under that Plan. It will, however, apply to any amount of benefit in excess of a Prior Plan's benefits. If you were covered under your Employer's Prior Plan, but did not fully satisfy the Pre-existing Condition Limitation of that plan, credit will be given for any time you did satisfy.

In addition, if you provide satisfactory evidence that you were provided substantially similar coverage under another disability benefit plan through a date not more than 60 days prior to the effective date of your insurance under this Policy, then we will credit the period of time you were covered under the plan against the period of time during which coverage of pre-existing conditions is not provided under this Policy.

Disability Benefit Calculation
Your Disability Benefit for any month Disability Benefits are payable to you is shown in the Schedule of Benefits. We base our calculation of Disability Benefits on a 30 day period. Benefits will be prorated if payable for any period less than a month.

Work Incentive Benefit
For the first 24 months you are eligible for a Disability Benefit, your Disability Benefit is as defined in the Schedule of Benefits. If, for any month during this period, the sum of your Disability Benefit, your current earnings and any additional Other Income Benefits exceed 100% of your Indexed Covered Earnings, your Disability Benefit will be reduced by the excess amount.

After 24 months, your Disability Benefit is as shown in the Schedule of Benefits, reduced by 50% of your current earnings received during any month you return to work. If the sum of your Disability Benefit, your current earnings and any additional Other Income Benefits exceed 80% of your monthly Indexed Covered Earnings, your Disability Benefit will be reduced by the excess amount.

No Disability Benefits will be paid if we determine you are able to work under a Transitional Work Arrangement or other modified work arrangement, and you refuse to do so.

If you are working for another employer on a regular basis when Disability begins, your earnings will include the amount of any increase in the amount you are earning from this work while you are Disabled.

We will, from time to time, review your status and will require satisfactory proof of earnings and continued Disability.

Other Income Benefits
While you are Disabled, you may be eligible for benefits from other income sources. If so, we reduce the Disability Benefits payable by the amount of such Other Income Benefits payable due to the same disability.

Other Income Benefits include:

1. any amounts you or your dependents, if applicable, receive (or are assumed to receive*) under:
   a. the Canada and Quebec Pension Plans;
   b. any local, state, provincial or federal government disability or retirement plan or law as it pertains to your Employer;
   c. any sick leave or salary continuation plan of your Employer;
   d. any work loss provision in any mandatory "No-Fault" auto insurance.
2. any Social Security disability or retirement benefits you or any third party receive (or are assumed to receive*) either on your behalf or for your dependents; or, if applicable, which your dependents receive (or are assumed to receive*) because of your entitlement to such benefits.
3. any retirement plan benefits funded by your Employer. "Retirement plan" means any defined benefit or defined contribution plan sponsored or funded by your Employer. It does not include an individual deferred compensation agreement; a profit sharing or any other retirement or savings plan maintained in addition to a defined benefit or other defined contribution pension plan, or any Employee savings plan including a thrift, stock option or stock bonus plan, individual retirement account or 40l(k) plan.
4. any proceeds payable under any franchise or group insurance or similar plan. If there is other insurance that applies to the same claim for Disability, and contains the same or similar provision for reduction because of other insurance, we will pay our pro rata share of the total claim. "Pro rata share" means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies.
5. any amounts you or your dependents, if applicable, receive (or are assumed to receive*) under any Workers' Compensation, occupational disease, unemployment compensation law or similar state or federal law, including all permanent as well as temporary disability benefits.
6. any amounts paid on account of loss of earnings or earning capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined.
7. any wage or salary for work performed while Disability Benefits are payable, to the extent they exceed the amount allowed under the Work Incentive Benefit.

Dependents include your spouse and children or step-children.

*See the Assumed Receipt of Benefits provision.

Increases in Other Income Benefits

After we make the first deduction for any Other Income Benefits, any cost of living increases for Other Income Benefits, except for wage or salary, will not further reduce your Disability Benefit during a period of Disability.

Lump Sum Payments

Other Income Benefits or earnings that are paid in a lump sum will be prorated over the period for which the sum is given. If no time is stated, the lump sum will be prorated monthly over a five-year period.

If no specific allocation of a lump sum payment is made, we will assume the total payment is an Other Income Benefit.

Assumed Receipt of Benefits

We will assume you or your dependents, if applicable, are receiving Other Income Benefits if you are eligible to receive them. We will estimate the amount of these assumed benefits on the basis of what you may be eligible to receive.

We will not assume your receipt of Other Income Benefits if you give us proof of the following events.

1. Application was made for these benefits.
2. Reimbursement Agreement is signed by you.
3. Any and all appeals were made for these benefits, or we have determined further appeals will not be successful.
4. Payments were denied.

We will not assume you have received, nor will we reduce your Disability Benefits by, any elective, actuarially reduced, or early retirement benefits under such laws until you actually receive them.

Social Security Assistance

We will, at our own discretion, assist you in applying for Social Security Disability Income (SSDI) benefits. Disability Benefits will not be reduced by your assumed receipt of SSDI benefits while you participate in the Social Security Assistance Program.

We may require you to file an appeal if we believe a reversal of a prior decision is possible. If you refuse to participate in, or cooperate with, the Social Security Assistance Program, we will assume receipt of SSDI benefits until you give us proof that you have exhausted all the administrative remedies available to you.

Minimum Benefit

We will pay the Minimum Benefit regardless of any reductions made for Other Income Benefits. However, if there is an overpayment due, this benefit may be reduced to recover the overpayment.

Recovery of Overpayment

If we overpay your benefits, we have the right to recover the amount overpaid by either requesting you to pay the overpaid amount in a lump sum or by reducing any amounts payable to you by the amount due. If there is an overpayment due when you die, we will reduce any benefits payable under the Policy to recover the overpayment.

ADDITIONAL BENEFITS

Rehabilitation During A Period of Disability

If you are Disabled and we determine that you are a suitable candidate for rehabilitation, you may participate in a Rehabilitation Plan. We must agree on the terms and conditions of the Rehabilitation Plan.

The Rehabilitation Plan may, at our discretion, allow for payment of your medical expense, education expense, moving expense, accommodation expense or family care expense while you participate in the program.

A "Rehabilitation Plan" is a written agreement between you and us in which we agree to provide, arrange or authorize vocational or physical rehabilitation services.

TY-005189-1

Conversion Privilege for Disability Insurance Benefits

If an Employee's insurance ends because employment with the Employer ends, or an Employee is laid off or on an uninsured leave of absence, he or she may be eligible for conversion insurance.

To be eligible, an Employee must have been insured for Disability Benefits and actively at work for at least 12 straight months. An Employee must apply for conversion insurance within 62 days after insurance under this Policy ends or within 31 days of the date notice is given to apply for a converted policy or certificate, whichever is later. In no event will the conversion period be extended beyond 105 days from the date insurance ends.

The benefits of the conversion plan will be those benefits offered at the time the Employee applies. The premium will be based on the rates in effect for conversion plans at that time.

Conversion insurance is not available if any of the following conditions apply:

1. the Employee is retired or age 70 or older;
2. the Employee is not in Active Service because of Disability;
3. the Policy is canceled for any reason;
4. the Employee is no longer in a Class of Eligible Employees, but is still employed by the Employer.

TY-010035

Survivor Benefit

We will pay a Survivor Benefit if you die while Disability Benefits are payable and at least 6 Monthly Benefits have been payable to you for a continuous period of Disability. The Survivor Benefit will equal 100% of the sum of the last full Disability Benefit payable to you plus any current earnings by which the Disability Benefit was reduced for that month. A single lump sum payment equal to 3 monthly Survivor Benefits will be payable.

Benefits will be paid according to the *To Whom Payable* section of the *Claim Provisions.*

TY-005191

WHAT IS NOT COVERED

We will not pay any Disability Benefits for a Disability that results, indirectly or directly, from:

1. suicide, attempted suicide, or self-inflicted injury.
2. war or any act of war, whether or not declared.
3. an Injury or Sickness that occurs while engaged in the activities of active duty service in the military, navy or air force of any country or international organization. An Injury or Sickness that occurs while engaged in Reserve or National Guard training is not excluded until training extends beyond 31 days.

We will not pay Disability Benefits for a Disability that results directly from the commission of a felony or attempted felony.

We will not pay Disability Benefits for any period of Disability during which you:

4. are incarcerated in a penal or corrections institution.
5. are not receiving Appropriate Care.
6. fail to cooperate with us in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit due.
7. refuse to participate in rehabilitation efforts as required by us.
8. refuses to participate in a Transitional Work Arrangement or other modified work arrangement. These work arrangements mean any work offered to you by the Policyholder, Employer, or an affiliated company while you are Disabled and which you are capable of performing as determined by us and your Physician. The work may be your own occupation or any occupation. The work arrangements include, but are not limited to: reassigned duties, work site modifications, flexible work arrangements, job adaptations, and special equipment. If benefits are not payable to you under this exclusion, and if at a later time your Disability prevents you from participating in such work arrangement, benefits will become payable according to the terms of the Policy.

CLAIM PROVISIONS

Notice of Claim
Written notice or notice by any other electronic or telephonic means authorized by us, must be given to us after a covered loss occurs or begins, or as soon as reasonably possible. If this notice is not given within a reasonable amount of time, the claim will not be invalidated or reduced if it is shown that such notice was given as soon as was reasonably possible. Written notice can be given at our home office in New York, New York or to our agent. Notice should include the Policyholder's name and policy number and the Insured's name and address.

Claim Forms
When we receive the notice of claim, we will send claim forms for filing proof of loss. If claim forms are not sent within 15 days after notice is received by us, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof or proof by any other electronic or telephonic means authorized by us, of the nature and extent of the loss.

Claimant Cooperation Provision
If you fail to cooperate with us in our administration of your claim, we may terminate the claim. A claimant will be required to provide any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Insurance Data
The Employer is required to cooperate with us in the review of claims and applications for coverage. Any information we provide to the Employer in these areas is confidential and may not be used or released by the Employer if not permitted by applicable privacy laws.

Proof of Loss
Written proof, or proof by any other electronic/telephonic means authorized by us, that Disability continues and of Appropriate Care by, or regular attendance by a Physician must be given to us at intervals required by us. Within 30 days of a request, such proof of continued Disability must be furnished to us.

We will not deny or reduce any claim if it: 1) is not reasonably possible to furnish the required proof within that period; and 2) is shown that such proof of loss was given as soon as was reasonably possible.

Time of Payment
Disability Benefits will be paid at regular intervals of not less frequently than once a month. Any balance, unpaid at the end of any period for which we are liable, will be paid at that time.

To Whom Payable
Any benefits that are payable for Disability will be paid to you. If any person to whom benefits are payable is a minor or, in our opinion, is not able to give a valid receipt, such payment will be made to their legal guardian.

If you die while any Disability Benefits remain unpaid, we may, at our option, make direct payment to the first surviving class of the following living relatives: spouse, children, parents, brothers and sisters; or to the executors or administrators of your estate. We may reduce the amount payable by any indebtedness due.

Payment in the manner described above will release us from all liability for any payment made.

Physical Examination and Autopsy
We may, at our expense, exercise the right to examine any person for whom a claim is pending as often as we may reasonably require. Also, we may, at our expense, require an autopsy unless prohibited by law.

Legal Actions
No action at law or in equity may be brought to recover benefits under the Policy less than 60 days after written proof of loss, or proof by any other electronic or telephonic means authorized by us, has been furnished as required by the Policy. No such action shall be brought more than 3 years after the time written proof of loss is required to be furnished.

Time Limitations
If any time limit stated in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity, is less than that permitted by the law of the state in which you live when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that state.

Physician/Patient Relationship
You have the right to choose any Physician who is practicing legally. We will in no way disturb the Physician/patient relationship.

ADMINISTRATIVE PROVISIONS

Premiums
The premiums for this Policy will be based on the rates currently in force, the plan and the amount of insurance in effect.

Your Grace Period
If your required premium is not paid on the Premium Due Date, there is a 31 day grace period after each premium due date after the first. If the required premium is not paid during the grace period, insurance will end on the last day for which premium was paid.

Reinstatement of Insurance
Your insurance may be reinstated if it ends because you are on an unpaid leave of absence. If your Active Service ended due to an approved leave pursuant to the Family and Medical Leave Act (FMLA) and Continuation of Insurance is not applicable, your insurance may be reinstated at the conclusion of the FMLA leave.

If your Active Service ends due to an Employer approved unpaid leave of absence, other than an approved FMLA leave, insurance may be reinstated only:
1. If the reinstatement occurs within 6 months from the date insurance ends, or
2. When returning from military service pursuant to the Uniformed Services Employment Act of 1994 (USERRA).

For insurance to be reinstated the following conditions must be met:
1. You must be in a Class of Eligible Employees.
2. The required premium must be paid.
3. We must receive a written request for reinstatement within 31 days from the date you return to Active Service.

Reinstated insurance will be effective on the date you return to Active Service. If you did not fully satisfy the Eligibility Waiting Period or the Pre-Existing Condition Limitation (if any) before insurance ended due to an unpaid leave of absence or Temporary Layoff, credit will be given for any time that was satisfied.

GENERAL PROVISIONS

Entire Contract
The Policy, the application of the Policyholder (a copy of which is attached at issue), the Policyholder endorsements, riders, certificate and attached papers constitute the entire contract between the parties. If an application of any Employee is required, it may also be made a part of this contract, at our option. Nothing in this Policy will invalidate or impair the rights granted to any certificateholders by their certificates or by law.

Incontestability
All statements made by the Policyholder, or by an Employee are deemed representations and not warranties. No statement will cause us to deny or reduce benefits or be used as a defense to a claim, unless a copy of the written instrument, signed by the claimant, containing the statement is, or has been, furnished to such person while such person is still living. In the event of his death or legal incapacity, the beneficiary or representative must receive a copy. After two years from the Employee's effective date of insurance, no such statement will cause insurance to be contested except for non-payment of premium. This also applies to any added or increased benefits, from the effective date of the addition or increase in benefits.

Misstatement of Age
If your age has been misstated, we will adjust all benefits to the amounts that would have been purchased for the correct age.

Workers' Compensation Insurance
The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance.

Assignment
The Insurance Company will not be affected by any assignment of your certificate until the original assignment or a certified copy of the assignment is filed with the Insurance Company. We do no assume responsibility for the validity or sufficiency of an assignment. An assignment of the certificate will operate so long as the assignment remains in force. To the extent provided under the terms of the assignment, an assignment will transfer all rights and obligations of the Insured, or of the owner if other than the Employee.

This insurance may not be levied on, attached, garnisheed, or otherwise taken for a person's debts. This prohibition does not apply where it is contrary to law.

Conformity with State Statutes
Any provision of the Policy in conflict on the Policy Effective Date with the laws of the state where the Policy is delivered is amended to conform to the minimum requirements of such laws.

Male Pronoun
The male pronoun as used herein will be deemed to include the female.

Clerical Error
Your coverage will not be affected by error or delay in keeping records of insurance under the Policy. If such an error or delay is found, the premium will be adjusted fairly.

Agency
The Policyholder, Employer and plan administrator are agents of the Employee for transactions relating to insurance under the Policy. The Insurance Company is not liable for any of their acts or omissions.

DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout this document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

Active Service
If you are an Employee, you are in Active Service on a day which is one of your Employer's scheduled work days if either of the following conditions are met.

1. You are actively at work. This means you are performing your regular occupation for the Employer on a Full-time basis or a part-time basis regularly scheduled to work a minimum of 20 hours per week, either at one of the Employer's usual places of business or at some location to which the Employer's business requires you to travel.
2. The day is a scheduled holiday, vacation day or period of Employer approved paid leave of absence.

You are in Active Service on a day which is not one of the Employer's scheduled work days only if you were in Active Service on the preceding scheduled work day.

Appropriate Care
Appropriate Care means you:

1. Have received treatment, care and advice from a Physician who is qualified and experienced in the diagnosis and treatment of the conditions causing Disability. If the condition is of a nature or severity that it is customarily treated by a recognized medical specialty, the Physician is a practitioner in that specialty.
2. Continue to receive such treatment, care or advice as often as is required for treatment of the conditions causing Disability.
3. Adhere to the treatment plan prescribed by the Physician, including the taking of medications.

Consumer Price Index (CPI-W)
The Consumer Price Index for Urban Wage Earners and Clerical Workers published by the U.S. Department of Labor.

Covered Earnings
An Employee's "Benefits Salary" as of December 31 of the prior calendar year, which is an Employee's base salary (including pay for hours worked beyond an individual's regularly scheduled hours but no more than 40 hours in a week), plus any short term incentive payments received during the year under a plan or arrangement that provides for such payment to be taken into account for benefit purposes, and any contribution by the Employer on the Employee's behalf under a salary reduction agreement pursuant to Internal Revenue Code 125 (such as any flexible benefits), Internal Revenue Code Section 132(f) (i.e., a qualified transportation benefit arrangement) or 401(k) (i.e., contributions to the 401(k) Savings Plan). It does not include amounts received as overtime pay, severance pay, any employee recognition award, recruiting and development credits, New York State Paid Family Leave (NYSPFL) benefits (unless the Employee is on a leave under the Parental Leave Program concurrent with NYSPFL and is eligible for a Paid New Parent Benefit), or any other additional forms of compensation. Annual Compensation in the year of hire is annualized base salary.

Any increase in your Covered Earnings will not be effective during a period of continuous Disability.

Disability/Disabled
For purposes of coverage under the Policy, you will be considered Disabled if, because of Injury or Sickness, you are unable to perform the material duties of your regular occupation, or solely due to Injury or Sickness, you are unable to earn more than 80% of your Indexed Covered Earnings.

After Disability Benefits have been payable for 24 months, you will be considered Disabled if your Injury or Sickness makes you unable to perform the material duties of any occupation for which you may reasonably become qualified based on education, training or experience, or solely due to Injury or Sickness, you are unable to earn more than 80% of your Indexed Covered Earnings.

Employee
For eligibility purposes, you are an Employee if you work for the Employer and are in one of the "Classes of Eligible Employees." Otherwise, you are an Employee if you are an employee of the Employer who is insured under the Policy.

Employer
The Policyholder and any affiliates or subsidiaries covered under the Policy. The Employer is acting as your agent for transactions relating to this insurance. You shall not consider any actions of the Employer as actions of the Insurance Company.

Full-time
Full-time means the number of hours set by the Employer as a regular work day for Employees in your eligibility class.

Furlough
Furlough means a temporary suspension or alteration of Active Service initiated by the Employer, for a period of time specified in advance not to exceed 30 days at a time.

Good Cause
A medical reason preventing participation in the Rehabilitation Plan or in a Transitional Work Arrangement. Satisfactory proof of Good Cause must be provided to us.

Indexed Covered Earnings
For the first year you are Disabled, your Indexed Covered Earnings will be equal to your Covered Earnings. After you have been Disabled for 1 year, your Indexed Covered Earnings will be your Covered Earnings plus an increase applied on each annual anniversary of the date you became Disabled. The amount of each increase will be the lesser of:
1. 10% of your Indexed Covered Earnings during the preceding year of Disability; or
2. the rate of increase in the Consumer Price Index (CPI-W) during the preceding calendar year.

Injury
Any bodily harm, including all related conditions and recurring symptoms of the injuries, that results directly or indirectly from an Accident and independently of all other causes.

Insurability Requirement
You will be considered to have satisfied the Insurability Requirement on the day we agree in writing to accept you as covered under the Policy. To determine a person's acceptability for insurance, we will require evidence of good health and may require it be provided at your own expense.

Insurance Company
The Insurance Company underwriting the Policy is CIGNA Life Insurance Company of New York. References to the Insurance Company have been changed to "we", "our", "ours", and "us" throughout the certificate.

Insured
You are an Insured if you are eligible for insurance under the Policy, insurance is elected for you, any applicable Insurability Requirement is met, the required premium is paid and your insurance is in force under the Policy.

Physician
Physician means a licensed doctor practicing within the scope of his or her license and rendering care and treatment to an Insured that is appropriate for the condition and locality. The term does not include you, your spouse, your immediate family (including parents, children, siblings or spouses of any of the foregoing, whether related by blood or marriage) of either you or your spouse, or a person living in your household.

Policy Anniversary
A Policy Anniversary is the date so stated on the Policy cover and the same date that follows every 12 months for as long as the Policy is in effect.

Policy Effective Date
The Policy Effective Date is the date so stated on the Policy cover.

Prior Plan
The Prior Plan refers to the plan of insurance providing similar benefits sponsored by the Employer in effect directly prior to the Policy Effective Date.

Sickness
The term Sickness means a physical or mental illness. It also includes pregnancy.

Temporary Layoff
Temporary Layoff means a temporary suspension of Active Service for a period of time determined in advance by the Employer, other than a Furlough as defined. Temporary Layoff does not include the permanent termination of Active Service (including but not limited to a job elimination), which shall be treated as termination of employment.

TY-005153-1 as modified by TY-010045

AMENDATORY RIDER
DOMESTIC PARTNER/CIVIL UNION PARTNER COVERAGE

Policy No. NYK-980036 Effective Date: January 1, 2022

This rider amends the Policy and Certificate to which it is attached. It is effective on the Effective Date shown above, and expires when the Policy expires.

A. Domestic Partner/Civil Union Partner means any of the following:

1. A person with whom the Employee has a registered civil union or domestic partnership under state law which imposes legal obligations on the parties substantially similar to marriage. Such person will continue to be recognized as a Domestic Partner or Civil Union Partner unless and until: (1) the civil union or domestic partnership is dissolved under applicable law; or (2) either the Employee or the Domestic Partner/Civil Union Partner marries another person.

2. A person meeting all of the following requirements, with respect to an Employee:

   a. Shares a permanent residence with the Employee;
   b. Has resided with the Employee for at least 6 months and is expected to continue to reside with the Employee indefinitely;
   c. Has not been legally married to any other person within the previous six months, and has no Domestic Partner other than the Employee during the previous six months, and is the Employee's sole Domestic Partner;
   d. Has signed a Domestic Partner declaration with the Employee, if the Employee resides in a jurisdiction which provides for Domestic Partner declarations;
   e. Has not signed a Domestic Partner declaration with any other person within the last 6 months;
   f. Is interdependent with the Employee in three or more of the following ways:
      1. Both partners are registered under any municipal ordinance as domestic partners.
      2. Both partners are jointly parties to a lease, mortgage or deed.
      3. Both partners jointly own one or more motor vehicles.
      4. Both partners jointly own one or more bank or credit accounts.
      5. The Employee has named the Domestic Partner as attorney-in-fact under a durable power of attorney with authority over health care decisions.
      6. The Employee has designated the Domestic Partner as beneficiary under a retirement plan or a life insurance policy.
      7. The Employee has designated the Domestic Partner as beneficiary of the Employee's will.
      8. Each partner has agreed in writing to assume the financial responsibility for the welfare of the other.
   g. Is not so closely related by blood to the Employee as to prohibit legal marriage in their state of residence;
   h. Is no less than 18 years of age.

   The Employee and Domestic Partner must furnish the Employer and Insurance Company with a signed declaration that the above requirements are met, and an agreement to notify the Employer and Insurance Company if the requirements cease to be met, on a form acceptable to the Employer and Insurance Company.

B. The Survivor Benefit is modified in the Policy and Certificate as follows:

1. All references to the term “Spouse” are replaced by "Spouse or Domestic Partner/Civil Union Partner" except for the following references:
   a. The first reference to “Spouse” in the Survivor Benefit text is changed to “Spouse, or Domestic Partner/Civil Union Partner” if there is no Spouse”.
   b. The text pertaining to the definition of “Spouse" remains unchanged.

C. Survivor benefits will be payable as follows: (1) to the Employee’s spouse or Domestic Partner/Civil Union Partner; (2) if there is none, in equal shares to the Employee’s surviving Children; or (3) if there is none, to the Employee’s estate.

D. A child of a Domestic Partner/Civil Union Partner may only be eligible for benefits if:
   a. the child is primarily dependent on the Employee for financial support;
   b. the Employee has a legal obligation of support of the child; or
   c. the Employee is the child’s legal guardian.

Except for the above this rider does not change the Policy or Certificate to which it is attached.

CIGNA LIFE INSURANCE COMPANY OF NEW YORK

Scott Berlin, President

TY-008926

CIGNA Life Insurance Company of New York
a stock insurance company

Rider to Certificate Made a Part of Group Policy No. NYK-980036
Effective Date of Rider: January 1, 2022, or if later the Effective Date of the Employee's Certificate

MODIFICATION OF GROUP DISABILITY CERTIFICATE
TO ADD DOMESTIC PARTNER AS ELIGIBLE SURVIVOR UNDER THE SURVIVOR BENEFIT

The Survivor Benefit are modified in the Policy and Certificate as follows:

1. All references to the term "Spouse" are replaced by "Spouse or Domestic Partner" except for the following references:
   a. The first reference to "Spouse" in the benefit text is changed to "Spouse, or Domestic Partner if there is no Spouse,"
   b. The text pertaining to the definition of "Spouse" remains unchanged.

2. The following definition of Domestic Partner is added.

   Domestic Partner means: a person who meets all of the following requirements.
   a. Shares continuously the Employee's permanent residence for at least one year and is expected to continue to reside with the Employee indefinitely.
   b. Is financially interdependent with the Employee in each of the following ways:
      i.. By holding one or more credit or bank accounts, including a checking account, as joint owners;
      ii. By owning or leasing with the Employee their permanent residence as joint tenants;
      iii By naming, or being named by, the Employee as a beneficiary of life insurance or under a will; and
      iv. By each agreeing in writing to assume financial responsibility for the welfare of the other.
   c. Has signed a domestic partner declaration with the Employee, if the Employee resides in a jurisdiction which provides for domestic partner declarations.
   d. Has not signed a domestic partner declaration with any other person within the last 12 months.
   e. Is no less than 18 years of age nor more than 70 years of age.
   f. Is not currently legally married to any other person.
   g. Is not a blood relative any closer than would prohibit legal marriage.

   In addition to the above requirements, consent of either party to the Domestic Partner relationship must not have been obtained by force, duress, or fraud.

An Employee's Domestic Partner is eligible for this benefit on the later of the Employee's eligibility date or the date the person becomes the Employee's Domestic Partner and if all the following conditions are met.

a. The Employee has not been married to any person within the last 12 months.
b. The Domestic Partner is the only person meeting the Policy's definition of "Domestic Partner" with respect to the Employee.
c. The Employee and Domestic Partner furnish a notarized affidavit or signed statement reflecting these requirements, and an agreement to notify the Insurance Company if the requirements cease to be met, on a form acceptable to the Insurance Company.

Except for the above, this Rider does not change the Group Certificate to which it is attached.

CIGNA Life Insurance Company of New York

Scott Berlin, President

TY-008925

CIGNA LIFE INSURANCE COMPANY OF NEW YORK
140 EAST 45TH STREET
NEW YORK, NY 10017-3144

STATE MODIFYING PROVISIONS AMENDMENT RIDER
Group Disability

Policyholder Name: New York Life Insurance Company Policy No.: NYK-980036

Amendment Effective Date: January 1, 2022

This amendment is attached to and made part of the Policy/Certificate specified above. Its provisions are intended to conform this Policy/Certificate to the laws of the state in which the insured resides.

The Policy delivered under the Group Policy is amended as follows:

IMPORTANT CHANGES FOR STATE REQUIREMENTS

If an Employee resides in one of the following states, the provisions of the certificate are modified for residents of the following states. The modifications listed apply only to residents of that state.

Louisiana residents:

The percentage of Indexed Covered Earnings, if any, that qualifies an insured to meet the definition of Disability/Disabled may not be less than 80%.

Massachusetts residents:

Continuation of Insurance after leaving the group
If you leave the group covered under the Policy, insurance for you will be continued until the earliest of the following dates:
1. 31 days from the date you leave the group;
2. The date you become eligible for similar benefits.

Continuation of Insurance due to a Plant Closing or Partial Closing
If you leave the group due to termination of employment resulting from a Plant Closing or Partial Closing, insurance for you will be continued until the earliest of the following dates:
1. 90 days from the date of the Plant Closing or Partial Closing;
2. The date you become eligible for similar benefits.

Definitions : For purposes of this provision:

Plant Closing means a permanent cessation or reduction of business at a facility which results or will result as determined by the director in the permanent separation of at least 90% of the employees of said facility within a period of six months prior to the date of certification or with such other period as the director shall prescribe, provided that such period shall fall within the six month period prior to the date of certification.

Partial Closing means a permanent cessation of a major discrete portion of the business conducted at a facility which results in the termination of a significant number of the employees of said facility and which affects workers and communities in a manner similar to that of Plant Closings.

Minnesota residents:

The Pre-existing Condition Limitation, if any, may not be longer than 24 months from the insured's most recent effective date of insurance.

Oregon residents:

NOTICE: MUST PROVIDE DOMESTIC PARTNER COVERAGE FOR OREGON RESIDENTS

If the Policy provides coverage/benefits to a Spouse, a *Domestic Partner* will be afforded the same coverage/benefits provided to a Spouse.

1. Domestic Partner means any of the following:

   A person with whom the Employee has a registered domestic partnership under Oregon law which imposes legal obligations on the parties substantially similar to marriage. Such person will continue to be recognized as a Domestic Partner unless and until: (1) the domestic partnership is dissolved under applicable law; or (2) either the Employee or the Domestic Partner marries another person.

2. The Spouse Rehabilitation Benefit and Survivor Benefit (if any) are modified in the Policy and Certificate as follows:

   All references to the term "Spouse" are replaced by "Spouse or Domestic Partner" except for the following references:
   a. The first reference to "Spouse" in the Survivor Benefit text is changed to "Spouse or Domestic Partner" if there is no Spouse".
   b. The text pertaining to the definition of "Spouse" remains unchanged.

3. Survivor benefits (if any) will be payable as follows: (1) to the Employee's spouse or Domestic Partner; (2) if there is none, in equal shares to the Employee's surviving Children; or (3) if there is none, to the Employee's estate.

4. A child of a Domestic Partner may only be eligible for benefits if:
   a. the child is primarily dependent on the Employee for financial support; or
   b. the Employee has a legal obligation of support of the child; or
   c. the Employee is the child's legal guardian.

Texas residents:

Any provision offsetting or otherwise reducing any benefit by an amount payable under an individual or franchise policy will not apply.

Vermont Residents:

To the extent the Policy provides insurance coverage to a spouse, the identical consideration must be applied to same sex marriages and civil unions. The language is as follows:

1. Civil Union Partner means:
   a. A person with whom the Employee has a registered civil union under Vermont law which imposes obligations on the parties substantially similar to marriage. Such person will continue to be recognized as a Civil Union Partner unless and until:
      (1) the civil union is dissolved under applicable law; or
      (2) either the Employee or the Civil Union Partner marries another person.

2. Spouse means:
   a. "Lawful spouse" and includes a lawful spouse of the same sex.
   b. This also includes a partner to a civil union recognized under Vermont Law.

Washington residents:

NOTICE: Any domestic partner of an employee who is registered as a domestic partner under Washington state law, will be deemed to be eligible on the same basis as a Spouse.

PLEASE REFER TO YOUR CERTIFICATE OF INSURANCE WHICH DESCRIBES THE BENEFIT PROVISIONS AND LIMITATIONS APPLICABLE TO YOU AS A RESIDENT OF THIS STATE.

CIGNA Life Insurance Company of New York

Scott Berlin, President

TY-01-3000a

SUPPLEMENTAL INFORMATION
for

Group Plan for New York Life Employees ("Plan")
required by the Employee Retirement
Income Security Act of 1974

As a Plan participant in New York Life Insurance Company's Plan, you are entitled to certain information, rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

The benefits described in your Certificate are provided under a group insurance Policy issued by the Insurance Company. The Policy is incorporated into the Plan. The Certificate, along with the following Supplemental Information, makes up the Summary Plan Description as required by ERISA.

IMPORTANT INFORMATION ABOUT THE PLAN

- The Plan is established and maintained by New York Life Insurance Company, the Plan Sponsor.
- The Employer Identification Number (EIN) is 13-5582869.
- The Plan Number is 501.
- The Insurance Plan is administered directly by the Plan Administrator with benefits provided, in accordance with the provisions of the group insurance contract, NYK-980036 ("Policy"), issued by CIGNA LIFE INSURANCE COMPANY OF NEW YORK ("Insurance Company").
- The Plan Administrator is: Maria Mauceri, VP and Actuary
  51 Madison Avenue, Room 513
  New York, NY 10010
  212-576-5707
- The Plan Administrator has authority to control and manage the operation and administration of the Plan.
- The Plan Sponsor may terminate, suspend, withdraw or amend the Plan, in whole or in part, at any time, subject to the applicable provisions of the Policy. (Your rights upon termination or amendment of the Plan are set forth in your Certificate.)
- The agent for service of legal process is the Plan Administrator.
- The Plan of benefits is financed by the Employer and Employees.
- The date of the end of the Plan Year is December 31.

YOUR RIGHTS AS SET FORTH BY 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, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit 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 Benefit Security Administration.

WHAT YOU SHOULD DO AND EXPECT IF YOU HAVE A CLAIM

The Plan Administrator designates and names the Insurance Company the named fiduciary for deciding claims and appeals for benefits under the Plan. The Insurance Company shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Insurance Company shall be final and binding on Participants and Beneficiaries to the full extent permitted by applicable law.

Claims for Disability Benefits (applies to all claims filed on or after April 1, 2018)

A disability "claim" is any claim which requires a determination of disability by the Insurance Company regardless of the type of policy under which it arises (for example, short/long term disability, waiver of premium, etc.). A disability claim is "filed" as of the date the Insurance Company first receives, in writing (including electronically) or by telephone (through the Insurance Company's intake department), notice that a claimant is seeking disability benefits under the Policy. The notice of claim received should provide the date of disability/loss, the claimant's name and address, and the group Policy holder's name and address. Properly filed claims will be decided with independence and impartiality.

The Insurance Company has 45 days from the date it receives a claim for disability benefits to determine whether or not benefits are payable in accordance with the terms of the Policy. The Insurance Company may require more time to review the claim if necessary due to matters beyond its control. The review period may be extended for up to two additional 30 day periods. If this should happen, the Insurance Company must provide its extension notice in writing before expiration of the current decision period, explaining the circumstances requiring extension and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Insurance Company's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Insurance Company receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

During the review period, the Insurance Company may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company will notify the claimant, in writing, stating what information is needed and why it is needed.

If the claim is approved, the Insurance Company will pay the appropriate benefit. If the claim decision is adverse, in whole or in part, the Insurance Company will provide written or electronic notice which will include the following information:

1. The specific reason(s) for the decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A description of any additional information required to perfect the claim, and the reason this information is necessary;
4. A description of the review procedures and the time limits applicable to those procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA after the claimant appeals and after the claimant receives an adverse decision on appeal;
5. A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Insurance Company of the health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the claimant's adverse benefit decision, without regard to whether the advice was relied upon in making the benefit decision; and (iii) a disability decision regarding the claimant presented by the claimant to the Insurance Company made by the Social Security Administration;
6. Either the specific internal rules, guidelines, protocols, standards or other similar plan criteria the Insurance Company relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar plan criteria do not exist;.
7. If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Policy to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
8. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; and
9. A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA.

Appeal of Denied Disability Claims (applies to all claims filed on or after April 1, 2018)

Whenever a claim decision is fully or partially adverse, unless ERISA provides otherwise, the claimant must appeal once to the Insurance Company. As part of the claimant's appeal, the claimant may receive, upon request, free of charge, copies of all documents, records, and other information relevant to the claim for benefits, and the claimant may submit to the Insurance Company, written comments, documents, records, and other information relating to the claim. The review will take into account all comments, documents, records and other information the claimant submits related to the claim, without regard to whether such information was submitted or considered in the initial claim decision. Once an appeal request has been received by the Insurance Company, a full and fair review of the claim appeal will take place.

A written request for appeal must be received by the Insurance Company within 180 days from the date the claimant received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived. The Insurance Company has 45 days from the date it receives a request for appeal to provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim and can extend the time for decision, once, by an additional 45 days. If this should happen, the Insurance Company must provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Insurance Company's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Insurance Company receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

The review will give no deference to the original claim decision. The review will not be made by the person who made the initial claim decision, or a subordinate of that person. When deciding an appeal based in whole or in part upon medical judgment, the Insurance Company will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment. Any medical or vocational experts consulted by the Insurance Company for the review will be identified and will not be the expert who was consulted during the initial claim decision or a subordinate of that expert.

During the appeal, the Insurance Company may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company will notify the claimant, in writing, stating what information is needed and why it is needed.

Before the Insurance Company issues an adverse benefit decision on appeal, if the Insurance Company considered, relied upon, or generated any new or additional evidence in connection with the claim, and/or if the Insurance Company intends to rely on any new or additional rationale in connection with that review, then such evidence and/or rationale will be provided to the claimant, free of charge, as soon as possible and sufficiently in advance of the date that the decision on appeal is required to be made, giving the claimant a reasonable opportunity to respond.

If the claim is approved, the Insurance Company will pay the appropriate benefit. If the claim decision on appeal is adverse, in whole or in part, the Insurance Company will provide written or electronic notice that includes:

1. The specific reason(s) for the decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
4. A statement describing any voluntary appeal procedures offered, and the claimant's right to obtain the information about those procedures;
5. A statement of claimant's right to bring a civil action under section 502(a) of ERISA, including a description of any applicable contractual limitations period that applies to the claimant's right to bring such an action, and the calendar date on which the contractual limitations period expires for the claim;
6. A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Insurance Company of the health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse decision, without regard to whether the advice was relied upon in making the adverse decision; and (iii) a disability decision regarding the claimant presented by the claimant to the Insurance Company made by the Social Security Administration;
7. Either the specific internal rules, guidelines, protocols, standards or other similar plan criteria the Insurance Company relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar plan criteria do not exist;
8. If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Policy to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
9. A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA.

Claims for Non-Disability Benefits (applies to all claims filed on or after April 1, 2018)

A non-disability "claim" is any claim which does not require a determination of disability by the Insurance Company regardless of the type of policy under which it arises (for example, a death claim, an accident claim, etc.). A non-disability claim is "filed" as of the date the Insurance Company first receives, in writing or by telephone (through the Insurance Company's intake department), notice that a claimant is seeking benefits under the Policy. The notice of claim should include the group Policy holder's name, the Policy and Certificate number and the claimant's name and address.

The Insurance Company has 90 days from the date the claim is filed to determine whether or not benefits are payable in accordance with the terms of the Policy. The Insurance Company may require more time to review the claim if special circumstances exist. The review period may be extended for up to one additional 90 day period. If this should happen, the Insurance Company will provide the extension notice in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected.

During the review period, the Insurance Company may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company must notify the claimant, in writing, stating what information is needed and why it is needed.

If the claim is approved, the Insurance Company will pay the appropriate benefit. If the claim decision is adverse, in whole or in part, the Insurance Company will provide written or electronic notice which will include the following information:

1. The specific reason(s) for the claim decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A description of any additional information required to perfect the claim, and the reason this information is necessary; and
4. A description of the review procedures and the time limits applicable to those procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA after the claimant appeals and after the claimant receives an adverse decision on appeal.

Appeal of Denied Non-Disability Claims (applies to all claims filed on or after April 1, 2018)

Whenever a claim decision is fully or partially adverse, the claimant must appeal once to the Insurance Company. As part of the claimant's appeal, the claimant may receive, upon request, free of charge, copies of all documents, records, and other information relevant to the claim for benefits, and the claimant may submit to the Insurance Company, written comments, documents, records, and other information relating to the claim. The review will take into account all comments, documents, records and other information the claimant submits related to the claim, without regard to whether such information was submitted or considered in the initial claim decision. Once an appeal request has been received by the Insurance Company, a full and fair review of the claim appeal will take place.

A written request for appeal must be received by the Insurance Company within 60 days from the date the claimant received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived. The Insurance Company has 60 days from the date it receives a request for appeal to provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim and extend the time for decision, once, by an additional 60 days. If this should happen, the Insurance Company will provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected.

If the appeal decision is adverse, in whole or in part, the Insurance Company will provide written or electronic notice that includes:

1. The specific reason(s) for the claim decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
4. A statement describing any voluntary appeal procedures offered, and the claimant's right to obtain the information about those procedures, and
5. A statement of the claimant's right to bring a civil action under section 502(a) of ERISA.

ER-03-2

UNDERWRITTEN BY:
CIGNA LIFE INSURANCE COMPANY OF NEW YORK
a New York Life Insurance company

Class 1
12/2023

EXHIBIT D

GROUP ACCIDENT (AD&D) INSURANCE CERTIFICATE

Group Accident
Insurance Certificate

New York Life Insurance Company

IMPORTANT NOTICES
GROUP ACCIDENT

If you reside in one of the following states, please read the important notices below:

Arizona residents:

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

California residents:

FOR CALIFORNIA RESIDENTS: REVIEW THIS CERTIFICATE CAREFULLY. IF YOU ARE 65 OR OLDER ON THE EFFECTIVE DATE OF THIS CERTIFICATE, YOU MAY RETURN IT TO US WITHIN 30 DAYS FROM THE DATE YOU RECEIVE IT AND WE WILL REFUND ANY PREMIUM YOU PAID. IN THIS CASE, THIS CERTIFICATE WILL BE CONSIDERED TO NEVER HAVE BEEN ISSUED.

Florida residents:

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

Maryland residents:

This Certificate may omit some of the benefits required for a Certificate issued and delivered in Maryland.

New Mexico residents:

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

TL-00-6000-1.NM

North Carolina residents:

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

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE, WHICH IS AVAILABLE FROM LIFE INSURANCE COMPANY OF NORTH AMERICA.

The Policy is a legal contract between the Policyholder and Us.

BENEFITS MAY BE REDUCED. PLEASE SEE THE SCHEDULE OF BENEFITS

IMPORTANT CANCELLATION INFORMATION – PLEASE READ "POLICY TERMINATION" PROVISION

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL: (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

Texas residents:

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

CIGNA Life Insurance Company of New York
140 East 45th Street
New York, New York 10017

CLAIM PAYMENT NOTICE

Manner of Payment of Claims
The Policyholder authorizes that any benefit payment due as a lump sum of $5,000 or more shall be credited to a draft account with the Insurance Company, in the name of the beneficiary. The beneficiary may withdraw the entire proceeds at any time by issuing one or more drafts, or may withdraw lesser amounts, subject to a minimum account balance set by the Insurance Company from time to time. Interest shall be credited to such account at rates as determined from time to time by the Insurance Company.

Draft Accounts
The Insurance Company shall be entitled to retain, as part of its compensation, any earnings on draft accounts created in connection with benefit claims, in excess of interest credited under the terms of the policy.

CIGNA Life Insurance Company of New York

51 Madison Avenue, New York, New York 10010

A Stock Insurance Company

GROUP ACCIDENT CERTIFICATE

THIS CERTIFICATE PROVIDES LIMITED COVERAGE.
PLEASE READ YOUR CERTIFICATE CAREFULLY.

We, the CIGNA Life Insurance Company of New York, has issued a Group Policy, YOK 980021 to New York Life Insurance Company.

We certify that we insure all eligible persons who are enrolled according to the terms of the Group Policy. Your coverage will begin according to the terms set forth in the *Eligibility and Effective Date* provision.

This Certificate describes the benefits and basic provisions of Your coverage. It is not the insurance contract and does not waive or alter any terms of the Policy. If questions arise, the Policy language will govern. You may examine the Policy at the office of the Policyholder.

This Certificate replaces all prior Certificates issued to You under the Group Policy.

Scott Berlin, President

THIS CERTIFICATE IS ISSUED UNDER AN ACCIDENT ONLY POLICY. IT DOES NOT PAY BENEFITS FOR LOSS CAUSED BY SICKNESS.

GA-00-CE1000.33

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

This Certificate is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, please read all the provisions carefully.

The *Schedule of Benefits* provides a brief outline of your coverage and benefits. Please read the *Description of Coverages and Benefits* Section for full details.

Policyholder: New York Life Insurance Company

Effective Date of Policyholder Participation: January 1, 2022

Certificate Effective Date: January 1, 2024

Covered Class: Class 1 - All active Employees of the Employer who are (i) classified as either full-time by the Employer at the location at which the Employee is employed or part-time regularly scheduled to work a minimum of 20 hours per week and (ii) who are citizens or permanent residents of the United States employed and residing in the United States (other than Puerto Rico).

The following persons are not eligible for coverage and are not eligible Employees:

- Agents of New York Life Insurance Company ("Company"), including (but not limited to) "Training Allowance Subsidy" insurance agents;
- Individuals hired by the Company (or an affiliate) on a temporary basis;
- Any individual who performs services for the Company (or an affiliate) as an independent contractor, including any individual who performs services for the Company (or an affiliate) under an agreement or arrangement (as evidenced by a writing, oral statement or payroll practice) between the Company (or an affiliate) and the individual or another organization that provides the individual services to the Company (or an affiliate) under which the individual is treated as an independent contractor or an employee or agent of an entity other than the Company (or an affiliate), irrespective of whether such individual is treated as an Employee or agent of the Company (or an affiliate) under common-law principles, state insurance law or the provisions of the Code (including sections 414(m), 414(n) or 414(o)) or is later appointed or reclassified by the courts, the Internal Revenue Service ("IRS"), the U.S. Department of Labor ("DOL") or other governmental agency as an Employee of the Company (or an affiliate);
- Individuals who are employees of an affiliate of the Company that does not participate in the Group Plan for New York Life Employees and who perform services for the Company or an Employer, without regard to whether such individuals are reclassified by a court, the IRS, the DOL or another governmental agency as an Employee of the Company or an Employer; and
- Individuals who are employees of another entity, even if working on the premises of the Company or an affiliate or otherwise serving the Company or an affiliate.

SCHEDULE OF BENEFITS

This *Schedule of Benefits* shows maximums, benefit periods and any limitations applicable to benefits provided for each Covered Person unless otherwise indicated. Principal Sum, when referred to in this Schedule, means the Employee's Principal Sum in effect on the date of the Covered Accident causing the Covered Injury or Covered Loss unless otherwise specified.

Eligibility Waiting Period
The Eligibility Waiting Period is the period of time the Employee must be in a Covered Class to be eligible for coverage.

For Employees hired on or before the Policy Effective Date:	No Waiting Period
For Employees hired after the Policy Effective Date:	No Waiting Period

Time Period for Loss:

Any Covered Loss must occur within:	365 days of the Covered Accident

Maximum Age for Insurance: None

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Employee Principal Sum:	units of $50,000
Maximum Principal Sum:	$300,000

SCHEDULE OF COVERED LOSSES

Covered Loss	**Benefit**
Loss of Life	100% of the Principal Sum
Loss of Two or More Hands or Feet	100% of the Principal Sum
Loss of Sight of Both Eyes	100% of the Principal Sum
Loss of One Hand or One Foot and Sight in One Eye	100% of the Principal Sum
Loss of Speech and Hearing (in both ears)	100% of the Principal Sum
Quadriplegia	100% of the Principal Sum
Paraplegia	75% of the Principal Sum
Hemiplegia	50% of the Principal Sum
Uniplegia	25% of the Principal Sum
Coma	
Monthly Benefit	1% of the Principal Sum
Number of Monthly Benefits	11
When Payable	At the end of each month during which the Covered Person remains comatose
Lump Sum Benefit	100% of the Principal Sum
When Payable	Beginning of the 12th month
Loss of One Hand or Foot	50% of the Principal Sum
Loss of Sight in One Eye	50% of the Principal Sum
Severance and Reattachment of One Hand or Foot	50% of the Principal Sum
Loss of Speech	50% of the Principal Sum
Loss of Hearing (in both ears)	50% of the Principal Sum
Loss of all Four Fingers of the Same Hand	25% of the Principal Sum
Loss of Thumb and Index Finger of the Same Hand	25% of the Principal Sum
Loss of all the Toes of the Same Foot	20% of the Principal Sum

ADDITIONAL ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGES

Accidental Death and Dismemberment benefits are provided under the following coverages. Any benefits payable under them are as shown in the S*chedule of Covered Losses* and are not paid in addition to any other Accidental Death and Dismemberment benefits.

EXPOSURE AND DISAPPEARANCE COVERAGE provides the Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the *Schedule of Covered Losses*.

ADDITIONAL ACCIDENT BENEFITS

Any benefits payable under these *Additional Accident Benefits* shown below are paid in addition to any other Accidental Death and Dismemberment benefits payable.

CHILD CARE CENTER BENEFIT

Benefit Amount	5% of the Employee's Principal Sum subject to a maximum of $5,000 per year
Maximum Benefit Period	the earlier of 5years or until the child turns 13 for each surviving Dependent Child

SEATBELT AND AIRBAG BENEFIT

Seatbelt Benefit	10% of the Principal Sum subject to a Maximum Benefit of $25,000
Airbag Benefit	5% of the Principal Sum subject to a Maximum Benefit of $5,000
Default Benefit	$1,000

SPECIAL EDUCATION BENEFIT

Surviving Dependent Child Benefit	5% of the Principal Sum subject to a Maximum Benefit of $5,000
Maximum Number of Annual Payments For Each Surviving Dependent Child	4
Default Benefit	$1,000

SPOUSE RETRAINING BENEFIT

Benefit	5% of the Principal Sum subject to a Maximum Benefit of $5,000

GA-00-1100.33

GENERAL DEFINITIONS

Please note that certain words used in this Certificate have specific meanings. The words defined below and capitalized within the text of this Certificate have the meanings set forth below.

Active Service
An Employee will be considered in Active Service with the Employer on a day which is one of the Employer's scheduled work days if either of the following conditions are met.

1. He or she is actively at work. This means the Employee is performing his or her regular occupation for the Employer on a Full-time basis or a part-time basis regularly working a minimum of 20 hours per week, either at one of the Employer's usual places of business or at some location to which the Employer's business requires the Employee to travel.
2. The day is a scheduled holiday, vacation day or period of Employer approved paid leave of absence, other than disability or sick leave after 7 days.

An Employee is considered in Active Service on a day which is not one of the Employer's scheduled work days only if he or she was in Active Service on the preceding scheduled work day.

Age
A Covered Person's Age, for purposes of initial premium calculations, is his Age attained on the date coverage becomes effective for him under this Policy. Thereafter, it is his Age attained on his last birthday.

Aircraft
A vehicle which:

1. has a valid certificate of airworthiness; and
2. is being flown by a pilot with a valid license to operate the Aircraft.

Covered Accident
A sudden, unforeseeable event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and meets all of the following conditions:

1. occurs while the Covered Person is insured under this Policy;
2. is not contributed to by disease, Sickness, mental or bodily infirmity;
3. is not otherwise excluded under the terms of this Policy.

Covered Injury
Any bodily harm that results directly and independently of all other causes from a Covered Accident.

Covered Loss
A loss that is all of the following:

1. the result, directly and independently of all other causes, of a Covered Accident;
2. one of the Covered Losses specified in the *Schedule of Covered Losses*;
3. suffered by the Covered Person within the applicable time period specified in the *Schedule of Benefits*.

Covered Person
An eligible person, as defined in the *Schedule of Benefits*, for whom an enrollment form has been accepted by Us and required premium has been paid when due and for whom coverage under this Policy remains in force.

Employee
For eligibility purposes, an Employee of the Employer who is in one of the Covered Classes.

Employer
The Policyholder and any affiliates, subsidiaries or divisions shown in the Schedule of Covered Affiliates and which are covered under this Policy on the date of issue or subsequently agreed to by Us.

He, His, Him
Refers to any individual, male or female.

Nurse
A licensed graduate Registered Nurse (R.N.), a licensed practical Nurse (L.P.N.) or a licensed vocational Nurse (L.V.N.) and who is not:
1. employed or retained by the Policyholder;
2. living in the Covered Person's household; or
3. a parent, sibling, spouse or child of the Covered Person.

Physician
A licensed health care provider practicing within the scope of his license and rendering care and treatment to a Covered Person that is appropriate for the condition and locality and who is not:
1. employed or retained by the Policyholder;
2. living in the Covered Person's household;
3. a parent, sibling, spouse or child of the Covered Person.

Prior Plan
The plan of insurance providing similar benefits, sponsored by the Employer in effect immediately prior to this Policy's Effective Date.

Sickness
A physical or mental illness.

Spouse
The Employee's lawful spouse under age 70.

Totally Disabled or Total Disability
Totally Disabled or Total Disability means either:
1. inability of the Covered Person who is currently employed to do any type of work for which he is or may become qualified by reason of education, training or experience; or
2. inability of the Covered Person who is not currently employed to perform all of the activities of daily living including eating, transferring, dressing, toileting, bathing, and continence, without human supervision or assistance.

We, Us, Our
CIGNA Life Insurance Company of New York.

You, Your
The person to whom the certificate is issued.

GA-00-1200.33

ELIGIBILITY AND EFFECTIVE DATE PROVISIONS

Policy Effective Date
The Insurance Company agrees to provide Accident Insurance Benefits described in this Policy in consideration of the Policyholder's application and payment of the initial premium when due. Insurance coverage begins on the Policy Effective Date shown on this Policy's first page.

Eligibility
An Employee becomes eligible for insurance under this Policy on the datehe meets all of the requirements of one of the Covered Classes and completes any Eligibility Waiting Period, as shown in the *Schedule of Benefits.*

Effective Date for Individuals
Insurance becomes effective for an eligible Employee who applies and agrees to make required contributions within 31 days of eligibility, and subject to the *Deferred Effective Date* provision below, on the latest of the following dates:
1. the effective date of this Policy;
2. the date the Employee becomes eligible;
3. the date We receive the Employee's completed enrollment form and the required first premium, during his lifetime.

DEFERRED EFFECTIVE DATE
Active Service
The effective date of insurance will be deferred for any Employee who is not in Active Service on the date coverage would otherwise become effective. Coverage will become effective on the later of the date he returns to Active Service and the date coverage would otherwise have become effective.

Effective Date of Changes
Any increase or decrease in the amount of insurance for the Covered Person resulting from:
1. a change in benefits provided by this Policy; or
2. a change in the Employee's Covered Class will take effect on the date of such change.

Increases will take effect subject to any Active Service requirement.

TERMINATION OF INSURANCE
The insurance on a Covered Person will end on the earliest date below:
1. the date this Policy or insurance for a Covered Class is terminated;
2. the next premium due date after the date the Covered Person is no longer in a Covered Class or satisfies eligibility requirements under this Policy;
3. the last day of the last period for which premium is paid;
4. the next premium due date after the Covered Person attains the maximum Age for insurance under this Policy.

Termination will not affect a claim for a Covered Loss or Covered Injury that is the result, directly and independently of all other causes, of a Covered Accident that occurs while coverage was in effect.

CONTINUATION OF INSURANCE
Continuation for Leave of Absence, Military Leave of Absence, Non-Medical Leave of Absence or Family Medical Leave
Insurance for an Employee may be continued until the earliest of the following dates if: (a) an Employee is on an Employer-approved paid or unpaid leave of absence, military leave of absence, non-medical leave of absence or an Employer-approved family medical leave; and (b) required premium contributions are paid when due.
1. for an Employer-approved leave of absence: up to 26 weeks.
2. for an Employer-approved military leave of absence: up to 90 days.
3. for an Employer-approved non-medical leave of absence: up to 90 days.
4. for an Employer-approved family medical leave: up to the later of the period of the approved FMLA leave or the leave period required by law in the state in which the Employee is employed.

COMMON EXCLUSIONS

In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Injury or Covered Loss which, directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the *Description of Benefits* Section:

1. intentionally self-inflicted injury, suicide or any attempt thereat;
2. commission or attempt to commit a felony;
3. bungee jumping; parachuting; skydiving; parasailing; hang-gliding;
4. declared or undeclared war or act of war;
5. aviation, except as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline;
6. Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
7. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
8. operating any type of vehicle while under the influence of alcohol or any drug , narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Accident occurred.

Benefits will not be paid for services or treatment rendered by a Physician, Nurse or any other person who is retained or employed by the Policyholder or is a parent, sibling, spouse or child of the Covered Person.

GA-00-1403.33

CLAIM PROVISIONS

Notice of Claim
Written or authorized electronic/telephonic notice of claim must be given to Us within 31 days after a Covered Loss occurs or begins or as soon as reasonably possible. If written or authorized electronic/telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic/telephonic notice was given as soon as was reasonably possible. Notice can be given to Us at Our Home Office in Philadelphia, Pennsylvania, such other place as We may designate for the purpose, or to Our authorized agent. Notice should include the Policyholder's name and policy number and the Covered Person's name, address, policy and certificate number.

Claim Forms
We will send claim forms for filing proof of loss when We receive notice of a claim. If such forms are not sent within 15 days after We receive notice, the proof requirements will be met by submitting, within the time fixed in this Policy for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

Claimant Cooperation Provision
Failure of a claimant to cooperate with Us in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Proof of Loss
Written or authorized electronic proof of loss satisfactory to Us must be given to Us at Our office, within 90 days of the loss for which claim is made. If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which We are liable. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible.

Time of Payment of Claims
We will pay benefits due under this Policy for any loss other than a loss for which this Policy provides any periodic payment immediately upon receipt of due written or authorized electronic proof of such loss. Subject to due written or authorized electronic proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us.

Payment of Claims
All benefits will be paid in United States currency. Benefits for loss of life will be payable in accordance with the Beneficiary provision and these Claim Provisions. All other proceeds payable under this Policy, unless otherwise stated, will be payable to the covered Employee or to his estate.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay $1,000 to a relative by blood or marriage whom We believe is equitably entitled. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment and release Us from all liability.

Payment of Claims to Foreign Employees
The Policyholder may, in a fiduciary capacity, receive and hold any benefits payable to covered Employees whose place of employment is other than the United States of America.

We will not be responsible for the application or disposition by the Policyholder of any such benefits paid. Our payments to the Policyholder will constitute a full discharge of Our liability for those payments under this Policy.

Physical Examination and Autopsy
We, at Our own expense, have the right and opportunity to examine the Covered Person when and as often as We may reasonably require while a claim is pending and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions
No action at law or in equity may be brought to recover under this Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by this Policy. No such action will be brought more than three years after the time such written proof of loss must be furnished.

Beneficiary
The beneficiary is the person or persons the Employee names or changes on a form executed by him and satisfactory to Us. This form may be in writing or by any electronic means agreed upon between Us and the Policyholder. Consent of the beneficiary is not required to affect any changes, unless the beneficiary has been designated as an irrevocable beneficiary, or to make any assignment of rights or benefits permitted by this Policy.

A beneficiary designation or change will become effective on the date the Employee executes it. However, We will not be liable for any action taken or payment made before We record notice of the change at our Home Office.

If more than one person is named as beneficiary, the interests of each will be equal unless the Employee has specified otherwise. The share of any beneficiary who does not survive the Covered Person will pass equally to any surviving beneficiaries unless otherwise specified.

If there is no named beneficiary or surviving beneficiary, or if the Employee dies while benefits are payable to him, We may make direct payment to the first surviving class of the following classes of persons:
1. spouse;
2. child or children;
3. mother or father;
4. sisters or brothers;
5. estate of the Covered Person.

Recovery of Overpayment
If benefits are overpaid, We have the right to recover the amount overpaid by either of the following methods.
1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this Policy.

If there is an overpayment due when the Covered Person dies, Us may recover the overpayment from the Covered Person's estate.

GA-00-CE1600.33

ADMINISTRATIVE PROVISIONS

Premiums
All premium rates are expressed in, and all premiums are payable in, United States currency. The premiums for this Policy will be based on the rates set forth in the *Schedule of Benefits*, the plan and amounts of insurance in effect. If a Covered Person's insurance amounts are reduced due to age, premium will be based on the amounts of insurance in force on the day after the reduction took place.

Grace Period
A Grace Period of 60 days will be granted for payment of required premiums under this Policy. Insurance under this Policy for You will remain in force during the Grace Period. We will reduce any benefits payable for any claims incurred during the grace period by the amount of premium due. If no such claims are incurred and premium is not paid during the grace period, insurance will end on the last day of the period for which premiums were paid.

GA-00-CE1701.00

GENERAL PROVISIONS

Misstatement of Fact
If the Covered Person has misstated any fact, all amounts payable under this Policy will be such as the premium paid would have purchased had such fact been correctly stated.

30 Day Right To Examine Certificate
If a Covered Person does not like the Certificate for any reason, it may be returned to Us within 30 days after receipt. We will return any premium that has been paid and the Certificate will be void as if it had never been issued.

Multiple Certificates
The Covered Person may have in force only one certificate at a time under this Policy. If at any time the Covered Person has been issued more than one certificate, then only the largest shall be in effect. We will refund premiums paid for the others for any period of time that more than one certificate was issued.

Assignment
We will be bound by an assignment of a Covered Person's insurance under this Policy only when the original assignment or a certified copy of the assignment, signed by the Covered Person and any irrevocable beneficiary, is filed with Us. The assignee may exercise all rights and receive all benefits assigned only while the assignment remains in effect and insurance under this Policy and the Covered Person's certificate remains in force.

Incontestability
All statements made by the Employer or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement has been furnished to the claimant. In the event of death or legal incapacity, the beneficiary or representative must receive the copy.

After two years from a Covered Person's effective date of insurance, or from the effective date of any added or increased benefits, no such statement will cause insurance to be contested except for fraud or eligibility for coverage.

Reinstatement
This Policy may be reinstated if it lapsed for nonpayment of premium. Requirements for reinstatement are written application of the Policyholder satisfactory to Us and payment of all overdue premiums. Any premium accepted in connection with a reinstatement will be applied to a period for which premium was not previously paid.

Clerical Error
Insurance for You will not be affected by error or delay in keeping records of insurance under this Policy. If such error or delay is found, We will adjust the premium fairly.

Policy Changes
No changes in this Policy will be valid until approved and signed by one of Our executive officers and the Policyholder and endorsed on or attached to this Policy signed by the Policyholder and Us.

Workers' Compensation Insurance
This Policy is not in place of and does not affect any requirements for coverage under any Workers' Compensation law.

GA-00-CE1800.33

DESCRIPTION OF COVERAGES AND BENEFITS

This *Description of Coverages and Benefits* Section describes the Accident Coverages and Benefits provided to You. Benefit amounts, benefit periods and any applicable aggregate and benefit maximums are shown in the *Schedule of Benefits.* Certain words capitalized in the text of these descriptions have special meanings within this Certificate **and are defined in the *General Definitions* section. Please read these and the *Common Exclusions* sections in order to understand all of the terms, conditions and limitations applicable to these coverages and benefits.**

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Covered Loss We will pay the benefit for any one of the Covered Losses listed in the *Schedule of Benefits,* if the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident within the applicable time period specified in the *Schedule of Benefits*.

If the Covered Person sustains more than one Covered Loss as a result of the same Covered Accident, benefits will be paid for the Covered Loss for which the largest available benefit is payable. If the loss results in death, benefits will only be paid under the Loss of Life benefit provision. Any Loss of Life benefit will be reduced by any paid or payable Accidental Dismemberment benefit. However, if such Accidental Dismemberment benefit equals or exceeds the Loss of Life benefit, no additional benefit will be paid.

Definitions **Loss of a Hand or Foot** means complete Severance through or above the wrist or ankle joint.

Loss of Sight means the total, permanent loss of all vision in one eye which is irrecoverable by natural, surgical or artificial means.

Loss of Speech means total and permanent loss of audible communication which is irrecoverable by natural, surgical or artificial means.

Loss of Hearing means total and permanent loss of ability to hear any sound in both ears which is irrecoverable by natural, surgical or artificial means.

Loss of a Thumb and Index Finger of the Same Hand or Four Fingers of the Same Hand means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).

Loss of Toes means complete Severance through the metatarsalphalangeal joint.

Paralysis or Paralyzed means total loss of use of a limb. A Physician must determine the loss of use to be complete and irreversible.

Quadriplegia means total Paralysis of both upper and both lower limbs.

Hemiplegia means total Paralysis of the upper and lower limbs on one side of the body.

Paraplegia means total Paralysis of both lower limbs or both upper limbs.

Uniplegia means total Paralysis of one upper or one lower limb.

Coma means loss of use of all limbs and consciousness which resulted directly and independently from all other causes from a Covered Accident, and from which the Covered Person is not likely to be aroused through powerful stimulation. This condition must be diagnosed and treated regularly by a Physician. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment of a Covered Injury unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of that Covered Accident.

Severance means the complete and permanent separation and dismemberment of the part from the body.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* section.
GA-00-2100.33

ADDITIONAL ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGES
Accidental Death and Dismemberment benefits are provided under the following coverages. Any benefits payable under them are shown in the *Schedule of Covered Losses* and will not be paid in addition to any other Accidental Death and Dismemberment benefits payable.

EXPOSURE AND DISAPPEARANCE COVERAGE
Benefits for Accidental Death and Dismemberment, as shown in the *Schedule of Covered Losses*, will be payable if a Covered Person suffers a Covered Loss which results directly and independently of all other causes from unavoidable exposure to the elements following a Covered Accident.

If the Covered Person disappears and is not found within one year from the date of the wrecking, sinking or disappearance of the conveyance in which the Covered Person was riding in the course of a trip which would otherwise be covered under this Policy, it will be presumed that the Covered Person's death resulted directly and independently of all other causes from a Covered Accident.

Exclusions The exclusions that apply to this coverage are in the *Common Exclusions* Section.
GA-00-2202.00

ADDITIONAL ACCIDENT BENEFITS
Accidental Death and Dismemberment benefits are provided under the following Additional Benefits. Any benefits payable under them will be paid in addition to any other Accidental Death and Dismemberment benefit payable.

CHILD CARE CENTER BENEFIT
We will pay benefits shown in the *Schedule of Benefits* for the care of each surviving Dependent Child in a Child Care Center if death of the covered Employee results directly and independently of all other causes from a Covered Accident and he is survived by one or more surviving Dependent Children under Age 13; who
a. was enrolled in a Child Care Center on the date of the Covered Accident; or
b. enrolls in a Child Care Center within 90 days from the date of the Covered Accident.

This benefit will be payable to the Surviving Spouse if the Spouse has custody of the child. If the Surviving Spouse does not have custody of the child, benefits will be paid to the child's legally appointed guardian. Payments will be made at the end of each 12 month period that begins after the date of the covered Employee's death. A claim must be submitted to Us at the end of each 12 month period. A 12 month period begins:
1. when the Dependent Child enters a Child Care Center for the first time, within the period specified in (2b) above, after the covered Employee's death; or
2. on the first of the month following the covered Employee's death, if the Dependent Child was enrolled in a Child Care Center before the covered Employee's death.

Each succeeding 12 month period begins on the day immediately following the last day of the preceding period. Pro rata payments will be made for periods of enrollment in a Child Care Center of less than 12 months.

Definitions For purposes of this benefit:
Child Care Center is a facility which:
1. is licensed and run according to laws and regulations applicable to child care facilities; and
2. provides care and supervision for children in a group setting on a regular, daily basis.

A Child Care Center does not include any of the following:
1. a Hospital;
2. the child's home;
3. care provided during normal school hours while a child is attending grades one through twelve.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.

GA-00-2222.00

SEATBELT AND AIRBAG BENEFIT
We will pay the benefit shown in the *Schedule of Benefits*, subject to the conditions and exclusions described below, when the Covered Person dies directly and independently of all other causes from a Covered Accident while wearing a seatbelt and operating or riding as a passenger in an Automobile. An additional benefit is provided if the Covered Person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag).

Verification of proper use of the seatbelt at the time of the Covered Accident and that the Supplemental Restraint System properly inflated upon impact must be a part of an official police report of the Covered Accident or be certified, in writing, by the investigating officer(s) and submitted with the Covered Person's claim to Us.

Definitions For purposes of this benefit:
Supplemental Restraint System means an airbag that inflates upon impact for added protection to the head and chest areas.

Automobile means a self-propelled, private passenger motor vehicle with four or more wheels which is a type both designed and required to be licensed for use on the highway of any state, province or country. Automobile includes, but is not limited to, a sedan, station wagon, sport utility vehicle, or a motor vehicle of the pickup, van, camper, or motor-home type. Automobile does not include a mobile home or any motor vehicle which is used in mass or public transit.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.
GA-00-2251.00

SPECIAL EDUCATION BENEFIT
We will pay the benefit, up to the Maximum Benefit shown in the *Schedule of Benefits*, for each qualifying Dependent Child of the covered Employee whose death resulted, directly and independently of all other causes from a Covered Accident for which an Accidental Death Benefit is payable under this Policy. This benefit is subject to the conditions and exclusions described below.

A qualifying Dependent Child must:
1. a. be full-time student in an accredited school of higher learning beyond the 12th grade level on the date of the covered Employee's Covered Accident; or
   b. be at the 12th grade level on the date of the covered Employee's Covered Accident and then become a full-time student at an accredited school of higher learning within 365 days from the date of the Covered Accident and continue his education as a full-time student;
2. continue his education as a full-time student in such accredited school of higher learning; and
3. incur expenses for tuition, fees, books, room and board, transportation and any other costs payable directly to, or approved and certified by, such school.

Payments will be made to each qualifying Dependent Child or to the child's legal guardian, if the child is a minor at the end of each year for the number of years shown in the *Schedule of Benefits*. We must receive proof satisfactory to Us of the Dependent Child's enrollment and attendance within 31 days of the end of each year. The first year for which a Special Education Benefit is payable will begin on the first of the month following the date the covered Employee died, if the surviving Dependent Child was a full-time student on that date in an accredited school of higher learning beyond the 12th grade; otherwise on the date he begins studies in such school. Each succeeding year for which benefits are payable will begin on the date following the end of the preceding year.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.

GA-00-2252.33

SPOUSE RETRAINING BENEFIT
We will pay expenses incurred, as described below, up to the Maximum Benefit shown in the *Schedule of Benefits*, to enable the covered Employee's Spouse to obtain occupational or educational training needed for employment if the covered Employee dies directly and independently of all other causes from a Covered Accident. This benefit is subject to the conditions and exclusions described below.

This benefit will be payable if the covered Employee dies within one year of a Covered Accident and is survived by his Spouse who:

1. enrolls, within three years after the covered Employee's death in any accredited school for the purpose of retraining or refreshing skills needed for employment; and
2. incurs expenses payable directly to, or approved and certified by, such school.

Definitions For the purposes of this benefit:

Spouse will include the Employee's lawful spouse under age 70.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.

GA-00-2254a.00

CIGNA LIFE INSURANCE COMPANY OF NEW YORK

AMENDATORY RIDER
TRAVEL ASSISTANCE SERVICES

Policyholder: New York Life Insurance Company
Policy No.: YOK 980021 Effective Date: January 1, 2022

This rider amends the Policy and Certificate to which it is attached. It is effective on the Effective Date shown above, and expires when the Policy expires.

Travel Assistance Services

We will pay the cost of the Covered Services described below, subject to all applicable conditions and exclusions, resulting, directly and independently of all other causes, from a Covered Medical Emergency. The Covered Medical Emergency must occur and Covered Services must be incurred during the course of travel or other activities covered by the Policy, and while the Covered Person is either more than 100 miles from his permanent residence or outside of his country of permanent residence.

To obtain services, the Covered Person must contact Us or our authorized service provider at the phone number provided by the Policyholder. All services must be provided by our authorized service provider unless authorized by Us.

Covered Services

Covered Services includes the reasonable costs for medically necessary services provided by Us or by our authorized service provider, and which are provided by our authorized service provider unless authorized by Us, for any of the following.

Emergency Medical Evacuation

Medically necessary expenses for Transportation of the Covered Person to the nearest adequate medical facility, if adequate medical care is not available at the Covered Person's location.

Cost of any medically necessary services or equipment that the Covered Person receives during transportation covered under this provision.

Cost of transporting qualified and licensed medical professional(s) or an Immediate Family Member or a Travel Companion if medically required to escort the Covered Person during transportation covered under this provision.

Transportation will be provided by medically equipped specialty aircraft, commercial airline, train or ambulance depending upon the medical needs and available transportation specific to each case.

Return Transportation

Any increase in the cost of the Covered Person's return transportation to his or her home or work location following emergency medical evacuation covered under this benefit, above the cost of the Covered Person's original scheduled return transportation.

Any increased cost of the transportation for an Immediate Family Member or Travel Companion of the Covered Person to return to his or her primary residence, if he or she accompanied the Covered Person on the trip where the emergency occurred, and was as a result not able to return to his or her primary residence when originally scheduled.

Unless it is medically necessary for another means of transportation to be provided, such return transportation costs will be covered for the same class of travel as the Covered Person's original transportation.

In the case of an Immediate Family Members who is a child under age 18, who is left without a parent, guardian or other adult to accompany the child, we will cover the reasonable cost of an escort to accompany the child to the nearest airport. If under the applicable rules of the airline, the child is too young to travel unaccompanied by an adult, we will pay the round trip economy airfare for an adult family member from the child's place of residence to the airport nearest the child.

Immediate Family Member Visit

Expenses for an Immediate Family Member or Friend of the Covered Person to visit the Covered Person during hospitalization away from the Covered Person's primary residence, if the Covered Person is hospitalized or expected to remain hospitalized for 7 or more consecutive days following emergency medical evacuation covered under this benefit. Such expenses shall be limited to one person only, and shall include round-trip economy airfare, and an allowance of $150.00 per day for up to 7 days for meals and lodging.

If a Dependent Child is evacuated, we will pay the expenses of an adult Immediate Family Member who accompanied the Dependent Child on the trip where the emergency occurred, to accompany the Dependent Child during the evacuation and during the Dependent Child's return to his or her place of residence. If the Dependent Child was not accompanied by an adult Immediate Family Member on the trip where the emergency occurred, we will pay expenses described in the preceding paragraph, without regard to the expected duration on the hospitalization.

Repatriation of Remains

If the Covered Person dies as a result of a Covered Medical Emergency, or during a Medical Evacuation covered by this Policy, the following expenses will be covered:

1. Embalming;
2. Cremation in the locality where death occurred and urn for return ashes;
3. A container appropriate for transportation of remains;
4. Autopsy if required by law;
5. Expenses of securing documentation necessary for return of remains;
6. Transportation of the body or remains to the Covered Person's place of permanent residence.

Definitions

"Covered Medical Emergency" means an injury, illness or disease diagnosed by a Physician which causes severe or acute symptoms that, if not provided with immediate care or treatment, would reasonably be expected to result in serious deterioration of the Covered Person's health or place his life in jeopardy; and which first manifests itself suddenly and unexpectedly during the travel or other hazards covered by the Policy.

"Immediate Family Member" means a spouse, parent, child, step-parent, step-child, brother or sister, step-brother or step-sister, grandparent, or Domestic Partner.

"Travel Companion" means an individual, other than an Immediate Family Member, who accompanied the Covered Person on the trip where the emergency occurred.

"Friend" means a person chosen by the Covered Person, other than an Immediate Family Member who is able to visit the Covered Person.

Limitations

Covered Expenses are secondary to, and in excess of, any expenses for medical or transportation services paid or payable under any workers' compensation law.

No payment will be made for services without authorization of those services by Us or the express written approval of Our approved vendor.

If coverage for these services is provided under more than one policy issued by the Insurance Company, we will only provide or pay for these services under one such policy.

Exclusions

The exclusions listed in the Policy's Common Exclusions section will not apply to Medical Evacuation and Repatriation Expenses, except for exclusions relating to war or acts of war, suicide or intentionally self-inflicted injury. In addition, the following exclusions apply specifically to this coverage:

1. Non-Emergency, routine or minor medical problems, tests and exams where there is no clear or significant risk of death or imminent serious Injury or harm to the Covered Person;
2. a condition which would allow for treatment at a future date convenient to the Covered Person and which does not require Emergency evacuation or repatriation;
3. expenses incurred if a purpose of the Covered Person's trip is to obtain medical treatment;
4. services provided for which no charge is normally made, in the absence of insurance;
5. transportation for the Covered Person's vehicle and/or other personal belongings;
6. Initial transport by ambulance following a Covered Medical Emergency occurring in the United States;
7. services incurred while serving in the armed forces of any country;
8. services required or obtained in any location which, due to war, insurrection, natural disaster or other reasons, is not reasonably accessible to our designated service provider, unless approved in advance by us;
9. claim payments that are illegal under applicable law;
10. expenses which are paid or payable under any workers' compensation law;
11. Medical care or services scheduled for your or your doctor's convenience which are not considered an emergency.

Except for the above this rider does not change the Policy or Certificate to which it is attached.

CIGNA LIFE INSURANCE COMPANY OF NEW YORK

Scott Berlin, President

GA-00-2230c.00

SUPPLEMENTAL INFORMATION
for

Group Plan for New York Life Employees ("Plan")
required by the Employee Retirement
Income Security Act of 1974

As a Plan participant in New York Life Insurance Company's Plan, you are entitled to certain information, rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

The benefits described in your Certificate are provided under a group insurance Policy issued by the Insurance Company. The Policy is incorporated into the Plan. The Certificate, along with the following Supplemental Information, makes up the Summary Plan Description as required by ERISA.

IMPORTANT INFORMATION ABOUT THE PLAN

- The Plan is established and maintained by New York Life Insurance Company, the Plan Sponsor.
- The Employer Identification Number (EIN) is 13-5582869.
- The Plan Number is: 501.
- The Insurance Plan is administered directly by the Plan Administrator with benefits provided, in accordance with the provisions of the group insurance contract, YOK 980021 ("Policy"), issued by CIGNA LIFE INSURANCE COMPANY OF NEW YORK ("Insurance Company").
- The Plan Administrator is: Maria Mauceri, VP and Actuary
  New York Life Insurance Company
  51 Madison Avenue, Room 513
  New York, NY 10010
  212-576-5707
- The Plan Administrator has authority to control and manage the operation and administration of the Plan.
- The Plan Sponsor may terminate, suspend, withdraw or amend the Plan, in whole or in part, at any time, subject to the applicable provisions of the Policy. (Your rights upon termination or amendment of the Plan are set forth in your Certificate.)
- The agent for service of legal process is the Plan Administrator.
- The Plan of benefits is financed by the Employees.
- The date of the end of the Plan Year is December 31.

YOUR RIGHTS AS SET FORTH BY 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, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit 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 Benefit Security Administration.

WHAT YOU SHOULD DO AND EXPECT IF YOU HAVE A CLAIM

The Plan Administrator designates and names the Insurance Company the named fiduciary for deciding claims and appeals for benefits under the Plan. The Insurance Company shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Insurance Company shall be final and binding on Participants and Beneficiaries to the full extent permitted by applicable law.

Claims for Disability Benefits (applies to all claims filed on or after April 1, 2018)

A disability "claim" is any claim which requires a determination of disability by the Insurance Company regardless of the type of policy under which it arises (for example, short/long term disability, waiver of premium, etc.). A disability claim is "filed" as of the date the Insurance Company first receives, in writing (including electronically) or by telephone (through the Insurance Company's intake department), notice that a claimant is seeking disability benefits under the Policy. The notice of claim received should provide the date of disability/loss, the claimant's name and address, and the group Policy holder's name and address. Properly filed claims will be decided with independence and impartiality.

The Insurance Company has 45 days from the date it receives a claim for disability benefits to determine whether or not benefits are payable in accordance with the terms of the Policy. The Insurance Company may require more time to review the claim if necessary due to matters beyond its control. The review period may be extended for up to two additional 30 day periods. If this should happen, the Insurance Company must provide its extension notice in writing before expiration of the current decision period, explaining the circumstances requiring extension and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Insurance Company's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Insurance Company receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

During the review period, the Insurance Company may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company will notify the claimant, in writing, stating what information is needed and why it is needed.

If the claim is approved, the Insurance Company will pay the appropriate benefit. If the claim decision is adverse, in whole or in part, the Insurance Company will provide written or electronic notice which will include the following information:

1. The specific reason(s) for the decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A description of any additional information required to perfect the claim, and the reason this information is necessary;
4. A description of the review procedures and the time limits applicable to those procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA after the claimant appeals and after the claimant receives an adverse decision on appeal;
5. A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Insurance Company of the health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the claimant's adverse benefit decision, without regard to whether the advice was relied upon in making the benefit decision; and (iii) a disability decision regarding the claimant presented by the claimant to the Insurance Company made by the Social Security Administration;
6. Either the specific internal rules, guidelines, protocols, standards or other similar plan criteria the Insurance Company relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar plan criteria do not exist;.
7. If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Policy to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
8. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; and
9. A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA.

Appeal of Denied Disability Claims (applies to all claims filed on or after April 1, 2018)

Whenever a claim decision is fully or partially adverse, unless ERISA provides otherwise, the claimant must appeal once to the Insurance Company. As part of the claimant's appeal, the claimant may receive, upon request, free of charge, copies of all documents, records, and other information relevant to the claim for benefits, and the claimant may submit to the Insurance Company, written comments, documents, records, and other information relating to the claim. The review will take into account all comments, documents, records and other information the claimant submits related to the claim, without regard to whether such information was submitted or considered in the initial claim decision. Once an appeal request has been received by the Insurance Company, a full and fair review of the claim appeal will take place.

A written request for appeal must be received by the Insurance Company within 180 days from the date the claimant received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived. The Insurance Company has 45 days from the date it receives a request for appeal to provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim and can extend the time for decision, once, by an additional 45 days. If this should happen, the Insurance Company must provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Insurance Company's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Insurance Company receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

The review will give no deference to the original claim decision. The review will not be made by the person who made the initial claim decision, or a subordinate of that person. When deciding an appeal based in whole or in part upon medical judgment, the Insurance Company will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment. Any medical or vocational experts consulted by the Insurance Company for the review will be identified and will not be the expert who was consulted during the initial claim decision or a subordinate of that expert.

During the appeal, the Insurance Company may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company will notify the claimant, in writing, stating what information is needed and why it is needed.

Before the Insurance Company issues an adverse benefit decision on appeal, if the Insurance Company considered, relied upon, or generated any new or additional evidence in connection with the claim, and/or if the Insurance Company intends to rely on any new or additional rationale in connection with that review, then such evidence and/or rationale will be provided to the claimant, free of charge, as soon as possible and sufficiently in advance of the date that the decision on appeal is required to be made, giving the claimant a reasonable opportunity to respond.

If the claim is approved, the Insurance Company will pay the appropriate benefit. If the claim decision on appeal is adverse, in whole or in part, the Insurance Company will provide written or electronic notice that includes:

1. The specific reason(s) for the decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
4. A statement describing any voluntary appeal procedures offered, and the claimant's right to obtain the information about those procedures;
5. A statement of claimant's right to bring a civil action under section 502(a) of ERISA, including a description of any applicable contractual limitations period that applies to the claimant's right to bring such an action, and the calendar date on which the contractual limitations period expires for the claim;
6. A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Insurance Company of the health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse decision, without regard to whether the advice was relied upon in making the adverse decision; and (iii) a disability decision regarding the claimant presented by the claimant to the Insurance Company made by the Social Security Administration;
7. Either the specific internal rules, guidelines, protocols, standards or other similar plan criteria the Insurance Company relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar plan criteria do not exist;
8. If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Policy to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
9. A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA.

Claims for Non-Disability Benefits (applies to all claims filed on or after April 1, 2018)

A non-disability "claim" is any claim which does not require a determination of disability by the Insurance Company regardless of the type of policy under which it arises (for example, a death claim, an accident claim, etc.). A non-disability claim is "filed" as of the date the Insurance Company first receives, in writing or by telephone (through the Insurance Company's intake department), notice that a claimant is seeking benefits under the Policy. The notice of claim should include the group Policy holder's name, the Policy and Certificate number and the claimant's name and address.

The Insurance Company has 90 days from the date the claim is filed to determine whether or not benefits are payable in accordance with the terms of the Policy. The Insurance Company may require more time to review the claim if special circumstances exist. The review period may be extended for up to one additional 90 day period. If this should happen, the Insurance Company will provide the extension notice in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected.

During the review period, the Insurance Company may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company must notify the claimant, in writing, stating what information is needed and why it is needed.

If the claim is approved, the Insurance Company will pay the appropriate benefit. If the claim decision is adverse, in whole or in part, the Insurance Company will provide written or electronic notice which will include the following information:

1. The specific reason(s) for the claim decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A description of any additional information required to perfect the claim, and the reason this information is necessary; and
4. A description of the review procedures and the time limits applicable to those procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA after the claimant appeals and after the claimant receives an adverse decision on appeal.

Appeal of Denied Non-Disability Claims (applies to all claims filed on or after April 1, 2018)

Whenever a claim decision is fully or partially adverse, the claimant must appeal once to the Insurance Company. As part of the claimant's appeal, the claimant may receive, upon request, free of charge, copies of all documents, records, and other information relevant to the claim for benefits, and the claimant may submit to the Insurance Company, written comments, documents, records, and other information relating to the claim. The review will take into account all comments, documents, records and other information the claimant submits related to the claim, without regard to whether such information was submitted or considered in the initial claim decision. Once an appeal request has been received by the Insurance Company, a full and fair review of the claim appeal will take place.

A written request for appeal must be received by the Insurance Company within 60 days from the date the claimant received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived. The Insurance Company has 60 days from the date it receives a request for appeal to provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim and extend the time for decision, once, by an additional 60 days. If this should happen, the Insurance Company will provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected.

If the appeal decision is adverse, in whole or in part, the Insurance Company will provide written or electronic notice that includes:

1. The specific reason(s) for the claim decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
4. A statement describing any voluntary appeal procedures offered, and the claimant's right to obtain the information about those procedures, and
5. A statement of the claimant's right to bring a civil action under section 502(a) of ERISA.

UNDERWRITTEN BY:
CIGNA LIFE INSURANCE COMPANY OF NEW YORK
a New York Life Insurance Company

Class 1

12/2023

Important Information

This SPD is not a contract of insurance. The Plan document and this SPD (including, the Certificates) contain the complete terms and conditions governing the Employee Life, Dependent Life, LTD and AD&D Coverages, and STD Benefits under the Plan for Eligible Employees of an Employer.

In general, as noted above, the term “Employer” means New York Life Insurance Company and any other entity which is a member of the same “controlled group” as the Company, and which has adopted the Plan with the approval of the Company.

Except as otherwise indicated below, as of January 1, 2024, each of the following is an Employer for purposes of the Employee Life, Dependent Life, LTD and AD&D Coverages and for STD Benefits:

- New York Life Insurance Company
- New York Life Investment Management LLC
- NYL Investors LLC
- Life Insurance Company of North America
- New York Life Group Insurance Company of NY
- Apogem Capital LLC
- IndexIQ LLC
- IndexIQ Advisors LLC
- New York Life Enterprises LLC
- New York Life Trust Company
- NYLINK Insurance Agency, Incorporated

The Company reserves the right to amend, suspend, change, eliminate or terminate all or any part of the Plan (including without limitation, the Employee Life, Dependent Life, LTD and AD&D Coverages, and STD Benefits) at any time, including without limitation, the right to terminate or modify any coverage or benefits (or costs thereof) under the Plan for any and all Eligible Employees of an Employer, including those not yet covered or receiving benefits, and those already covered or receiving benefits.

An Employer may terminate its participation in the Plan at any time.

Your eligibility for, or your right to benefits described in this SPD is not a guarantee of employment.