Group Short Term Disability Insurance Certificate

Vanderbilt University

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 Tennessee and will be governed by its laws. If you reside in a state other than Tennessee, 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.

LIFE INSURANCE COMPANY OF NORTH AMERICA
1601 CHESTNUT STREET
PHILADELPHIA, PA 19192-2235
(888) 842-4462 Dial 711 to access telecommunications relay services
A STOCK INSURANCE COMPANY

GROUP INSURANCE CERTIFICATE

We, the LIFE INSURANCE COMPANY OF NORTH AMERICA, certify that we have issued a Group Policy, LK-100150, to Vanderbilt University.

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.

Scott Berlin, President

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SCHEDULE OF BENEFITS

Policy Effective Date: January 1, 2026

Policy Anniversary Date: January 1

Policy Number: LK-100150

Eligible Class Definition:
All active, Full-time Employees of the Employer regularly scheduled to work a minimum of 30 hours per week, who are citizens or permanent resident aliens of the United States, excluding Employees classified as Faculty, Officers, and Temporary and Seasonal.

An Employee will be considered in Active Service during the Employer's summer break if he or she was in Active Service on the last day of the previous school year and is scheduled to return for the next school year.

Eligibility Waiting Period

If you were hired on or before the Policy Effective Date:	The first of the month following 30 days of Active Service
If you were hired after the Policy Effective Date:	The first of the month following 30 days of Active Service

The Eligibility Waiting Period does not apply if you are a former Employee rehired within 30 days after your termination date and you had satisfied the Eligibility Waiting Period prior to your termination date. If you did not fully satisfy the Eligibility Waiting Period prior to your termination date, credit will be given for any time that was satisfied.

Elimination Period

Core Benefit	The later of the end of any form of employer paid salary continuation or the time period shown below. For Accident: 14 calendar days For Sickness: 14 calendar days
Optional Benefit	The time period shown below: For Accident: 14 calendar days For Sickness: 14 calendar days

Gross Disability Benefit

Core Benefit:	66.67%
Optional Benefit:	66.67%

The lesser of the percent of your weekly Covered Earnings listed above, or the Maximum Disability Benefit.

Maximum Disability Benefit

Core Benefit:	$308 per week
Optional Benefit:	$5,000 per week

Minimum Disability Benefit the greater of 10% of an Employee's weekly Covered Earnings or $25 per week

Rehabilitation Benefit 10% of the Employee's weekly pre-disability earnings to a maximum of $500 per week.

Disability Benefit Calculation

The Weekly Benefit payable to you for any week you are Disabled is the Gross Disability Benefit minus 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.

Return to Work Incentive

You may work for wage or profit while Disabled. In any week in which you work and a Disability Benefit is payable, the Return to Work Incentive Benefit Calculation applies.

During any week you have Disability Earnings, your benefits will be calculated as follows:

1. Add your Gross Disability Benefit and Disability Earnings.
2. Compare the sum from 1. to your Covered Earnings.
3. If the sum from 1. exceeds 100% of your Covered Earnings, then subtract the Covered Earnings from the sum in 1.
4. Your Gross Disability Benefit will be reduced by the difference from 3., as well as by Other Income Benefits.
5. If the sum from 1. does not exceed 100% of your Covered Earnings, your Gross Disability Benefit will be reduced by Other Income Benefits.

No Disability Benefits will be paid, and insurance will end if we determine you are able to work under a modified work arrangement and you refuse to do so without Good Cause.

Maximum Benefit Period

Core Benefit:	For Accident:	26 weeks for each period of Disability, measured from the date Disability begins
	For Sickness:	26 weeks for each period of Disability, measured from the date Disability begins
Optional Benefit:	For Accident:	26 weeks for each period of Disability, measured from the date Disability begins
	For Sickness:	26 weeks for each period of Disability, measured from the date Disability begins

ENROLLING FOR INSURANCE

Annual Enrollment Period
During the Annual Enrollment Period, if you are insured for Core Benefits under this Policy, you may elect to be insured for Optional Benefits provided by this Policy by satisfying the Insurability Requirement.

WHO IS ELIGIBLE

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

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 more than 30 days after your termination date, you must satisfy a new Eligibility Waiting Period. You are not required to satisfy a new Eligibility Waiting Period if you are a former Employee and are rehired within 30 days of your termination date or if your insurance ends because you no longer qualify under your Class Definition, but you continue to be employed, and within one year you qualify again.

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.
3. The date the completed enrollment form is received by the Employer or us.

If you apply for coverage during an Annual Enrollment Period, a Life Status Change, or if your enrollment form is received more than 31 days after you are eligible for insurance, you must satisfy the Insurability Requirement before your insurance is effective. If approved, your insurance is effective on the date we agree in writing 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 any occupation for your Employer on a Full-time basis.

TL-004712

WHEN COVERAGE ENDS

Your coverage ends 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 the Policy is terminated;
3. the date you are no longer in an eligible class;
4. the day after the end of the period for which premiums are paid;
5. the date you are no longer in Active Service;
6. the date benefits end because you did not comply with the terms and conditions of the insurance coverage.

If you are entitled to receive Disability Benefits when the Policy terminates, Disability Benefits will be payable to you if you remain disabled and meet the requirements for the insurance. Any later period of Disability, regardless of cause, that begins when you are eligible under another disability coverage provided by any employer, will not be covered.

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WHEN COVERAGE CONTINUES

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. 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 for up to 24 months. 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 a leave for military service, insurance will continue for you for up to 60 months. 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 layoff, 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 Elimination Period is satisfied or the date you are scheduled to return to Active Service.

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TAKEOVER PROVISION

This provision applies to you only if you are eligible under this Policy and were covered for short 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 Elimination Periods.

B. The Elimination 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 weekly 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. An Elimination Period would not apply to the Disability if the Prior Plan had not ended;
   4. The Disability begins within 60 days of your return to Active Service and your insurance under this Policy is continuous from this Policy's Effective Date.

   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.

TL-005108

DESCRIPTION OF BENEFITS
WHAT IS COVERED

Disability Benefits
We will pay Disability Benefits if you become Disabled while covered under this Policy. You must satisfy the Elimination Period, be under the Appropriate Care of a Physician, and meet all the other terms and conditions of the Policy. You must provide to us, at your own expense, satisfactory proof of Disability before benefits will be paid. The Disability Benefit is shown in the Schedule of Benefits.

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

Elimination Period
The Elimination Period is the period of time you must be continuously Disabled before Disability Benefits are payable. The Elimination Period is shown in the Schedule of Benefits.

A period of Disability is not continuous if separate periods of Disability result from unrelated causes.

Disability Benefit Calculation
The Disability Benefit Calculation is shown in the Schedule of Benefits. Weekly Disability Benefits are based on the number of days in a normally scheduled work week for you immediately before the onset of Disability. They will be prorated if payable for any period less than a week. If you are working while Disabled, the Disability Benefit Calculation will be the Return to Work Incentive.

Return to Work Incentive
The Return to Work Incentive is shown in the Schedule of Benefits. You may work for wage or profit while Disabled. In any week in which you work and a Disability Benefit is payable, the Return to Work Incentive applies.

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

Minimum Benefit
We will pay the Minimum Benefit shown in the Schedule of Benefits despite any reductions made for Other Income Benefits. The Minimum Benefit will not apply if benefits are being withheld to recover an overpayment of benefits.

Other Income Benefits
If Disability Benefits are payable to you under this Policy, you may be eligible for benefits from Other Income Benefits. If so, we may reduce the Disability Benefits by the amount of such Other Income Benefits.

Other Income Benefits include:
1. any amounts received (or assumed to be received*) by you or your dependents under:
   - the Canada and Quebec Pension Plans;
   - the Railroad Retirement Act;
   - any local, state, provincial or federal government disability, paid leave or retirement plan or law provided as a result of employment with the Employer, which are payable for an absence from work for which Disability Benefits are payable under this Policy;
   - any salary continuation, or paid time off plan of the Employer;
   - any work loss provision in mandatory "No-Fault" auto insurance.
2. any Social Security disability or retirement benefits you or any third party receive (or are assumed to receive*) on your own behalf or for your dependents; or which your dependents receive (or are assumed to receive*) because of your entitlement to such benefits.
3. any Retirement Plan benefits funded by the Employer, including any income available under a State Teacher Retirement System and union sponsored retirement plans. "Retirement Plan" means any defined benefit or defined contribution plan sponsored or funded by the 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 provided by the Policyholder. If other insurance applies to the same claim for Disability, and contains the same or similar provision for reduction because of other insurance, we will pay for 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 paid because 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. If you notify us before filing suit or settling a claim against such third party, the amount deducted as Other Income will be reduced by a pro rata share of your costs of recovery, including reasonable attorney fees.

Dependents include any person who receives (or is assumed to receive*) benefits under any applicable law because of your entitlement to benefits.

*See the Assumed Receipt of Benefits provision.

Increases in Other Income Benefits
Any increase in Other Income Benefits during a period of Disability due to a cost of living adjustment will not be considered in calculating your Disability Benefits after the first reduction is made for any Other Income Benefits. This section does not apply to any cost of living adjustment for Disability Earnings.

Lump Sum Payments
Other Income Benefits or earnings 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 over five years.

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

Assumed Receipt of Benefits
We will assume you (and your dependents, if applicable) are receiving benefits for which you are eligible from Other Income Benefits. We will reduce your Disability Benefits by the amount from Other Income Benefits we estimate are payable to you and your dependents.

We will waive Assumed Receipt of Benefits, except for Disability Earnings for work you perform while Disability Benefits are payable, if you:

1. provide satisfactory proof of application for Other Income Benefits;
2. sign a Reimbursement Agreement;
3. provide satisfactory proof that all appeals for Other Income Benefits have been made unless we determine that further appeals are not likely to succeed; and
4. submit satisfactory proof that Other Income Benefits were denied.

We will not assume receipt of any pension or retirement benefits that are actuarially reduced according to applicable law, until you actually receive them.

Social Security Assistance
We may help you in applying for Social Security Disability Income (SSDI) Benefits, and may require you to file an appeal if we believe a reversal of a prior decision is possible.

We will reduce Disability Benefits by the amount we estimate you will receive, if you refuse to cooperate with or participate in the Social Security Assistance Program.

Recovery of Overpayment
We have the right to recover any benefits we have overpaid. We may use any or all of the following to recover an overpayment:
1. request a lump sum payment of the overpaid amount;
2. reduce any amounts payable under this Policy; and/or
3. take any appropriate collection activity available to us.

The Minimum Benefit amount will not apply when Disability Benefits are reduced in order to recover any overpayment.

If an overpayment is due when you die, any benefits payable under the Policy will be reduced to recover the overpayment.

Successive Periods of Disability
A separate period of Disability will be considered continuous:
1. if it results from the same or related causes as a prior Disability for which benefits were payable; and
2. if, after receiving Disability Benefits, you return to work in your Regular Occupation for less than 60 days; and
3. if you earn less than the percentage of Covered Earnings that would still qualify you to meet the definition of Disability/Disabled during at least one week.

Any later period of Disability, regardless of cause, that begins when you are eligible for coverage under another group disability plan provided by any employer will not be considered a continuous period of Disability.

For any separate period of disability which is not considered continuous, you must satisfy a new Elimination Period.

TL-007500.43

ADDITIONAL BENEFITS

Rehabilitation During a Period of Disability

Employee Benefit

If you are Disabled, you may be eligible to participate in a Rehabilitation Plan or may be participating in a program that you desire to have approved by us as a Rehabilitation Plan. If you desire to participate in rehabilitation efforts or to have your program approved by us as a Rehabilitation Plan, you may request approval from us. We have the sole discretion to approve your participation in a Rehabilitation Plan and to approve a program as a Rehabilitation Plan.

If, while you are Disabled, we determine that you are a suitable candidate for rehabilitation, you may participate in a Rehabilitation Plan. The terms and conditions of the Rehabilitation Plan must be mutually agreed upon by you and us.

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 the Insured and the Insurance Company in which we agree to provide, arrange or authorize vocational or physical rehabilitation services.

TL-005105

TERMINATION OF DISABILITY BENEFITS

Benefits will end on the earliest of the following dates:

1. the date you earn from any occupation, more than the percentage of Covered Earnings set forth in the definition of Disability;
2. the date we determine you are not Disabled;
3. the end of the Maximum Benefit Period;
4. the date you die;
5. the date you are no longer receiving Appropriate Care;
6. the date you 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 amount due.

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WHAT IS NOT COVERED

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

1. suicide, attempted suicide, or self-inflicted injury while sane or insane.
2. war or any act of war, whether or not declared.
3. active participation in a riot.
4. commission of a felony.
5. the revocation, restriction or non-renewal of your license, permit or certification necessary to perform the duties of your occupation unless due solely to Injury or Sickness otherwise covered by the Policy.
6. any cosmetic surgery or surgical procedure that is not Medically Necessary; "Medically Necessary" means the surgical procedure is: (a) prescribed by a Physician as required treatment of the Injury or Sickness; and (b) appropriate according to conventional medical practice for the Injury or Sickness in the locality in which the surgery is performed. (We will pay benefits if your disability is caused by your donating an organ in a non-experimental organ transplant procedure.)
7. an Injury or Sickness for which you are entitled to benefits from Workers' Compensation or occupational disease law.
8. an Injury or Sickness that is work related.

In addition, we will not pay Disability Benefits for any period of Disability during which you are incarcerated in a penal or correctional institution.

TL-007503.43

CLAIM PROVISIONS

Notice of Claim

Written notice of claim, or notice by any other electronic/telephonic means authorized by us, must be given to us within 31 days after a covered loss occurs or begins or as soon as reasonably possible. If written notice, or notice by any other electronic/telephonic means authorized by us, is not given in that time, the claim will not be invalidated or reduced if it is shown that notice was given as soon as was reasonably possible. Notice can be given at our home office in Philadelphia, Pennsylvania or to our agent. Notice should include the Employer's name, the Policy Number and the claimant's name and address.

Claim Forms
When we receive notice of claim, we will send claim forms for filing proof of loss. If we do not send claim forms 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/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. 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.

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
You must provide written proof of loss to us, or proof by any other electronic/telephonic means authorized by us, within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by us, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by us, must be given not more than one year after the 90 day period. If written proof of loss, or proof by any other electronic/telephonic means authorized by us, is provided outside of these time limits, the claim will be denied. These time limits will not apply due to lack of legal capacity.

Written proof that the loss continues, or proof by any other electronic/telephonic means authorized by us, must be furnished to us at intervals we require. Within 30 days of a request, written proof of continued Disability and Appropriate Care by a Physician must be given to us.

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
Disability Benefits 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 his or her legal guardian. However, if no request for payment has been made by the legal guardian, we may, at our option, make payment to the person or institution appearing to have assumed custody and support.

If you die while any Disability Benefits remain unpaid, we may, at our option, make direct payment to any of your following living relatives: your spouse, your mother, your father, your children, your brothers or 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/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 satisfactory 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.

TL-004724

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 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 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 12 weeks 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, credit will be given for any time that was satisfied.

TL-009960.00

GENERAL PROVISIONS

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 except for fraud or eligibility for insurance.

Misstatement of Age
If an Insured's 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 Law.

Assignment of Benefits
We will not be affected by the assignment of your certificate until the original assignment or a certified copy of the assignment is filed with us. We will not be responsible for the validity or sufficiency of an assignment. An assignment of benefits will operate so long as the assignment remains in force provided insurance under the Policy is in effect. This insurance may not be levied on, attached, garnished, or otherwise taken for a person's debts. This prohibition does not apply where contrary to law.

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

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.

Accident
The term Accident means a sudden, unforeseeable external event that causes you bodily Injury and occurs while your coverage is in force under the Policy.

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

1. You are performing your regular occupation for the Employer on a full-time basis. You must be working 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 or vacation day and you were performing your regular occupation on the preceding scheduled work day.

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.

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.

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.

Covered Earnings
Covered Earnings means your wage or salary as reported by the Employer for work performed for the Employer as in effect just prior to the date your Disability begins. Covered Earnings are determined initially on the date an Employee applies for coverage. A change in the amount of Covered Earnings is effective on the first of the month following the change, if the Employer gives us written notice of the change and the required premium is paid.

It does not include any amounts received as bonus, commissions, overtime pay or other extra compensation.

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

Disability/Disabled
You are considered Disabled if, solely because of Injury or Sickness, you are:
1. unable to perform the material duties of your Regular Occupation; and
2. unable to earn 80% or more of your Covered Earnings from working in your Regular Occupation.

We will require proof of earnings and continued Disability.

Disability Earnings
Any wage or salary for any work performed for any employer during your Disability, including commissions, bonus, overtime pay or other extra compensation.

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. Satisfactory proof of Good Cause must be provided to us.

Injury
Any accidental loss or bodily harm that results directly and independently from all other causes from an Accident.

Insurability Requirement
An eligible person satisfies the Insurability Requirement for an amount of coverage on the day we agree in writing to accept you as insured for that amount. To determine a person's acceptability for coverage, we will require you to provide evidence of good health and may require it be provided at your expense.

Insurance Company
The Insurance Company underwriting the Policy is named on your certificate cover page. 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, the required premium is paid and your coverage is in force under the Policy.

Life Status Change
A Life Status Change is an event recognized by the Employer's Flexible Benefits Plan as qualifying you to make changes in benefit selections at a time other than an Annual Enrollment Period.

If the Employer does not sponsor a Flexible Benefits Plan or if it is no longer in effect, 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, your immediate family (including parents, children, siblings, or spouses of any of the foregoing, whether the relationship derives from blood or marriage), or a person living in your household.

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:

1. That employer's addition to this policy; or
2. With the approval of the Insurance Company, the addition of all employees, or all of a defined group of employees, of an employer, as a result of an agreement to which that employer (or a parent or shareholder of that employer) is a party.

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

TL-010650

Regular Occupation
The occupation you routinely perform at the time the Disability begins. In evaluating the Disability, we will consider the duties of the occupation as it is 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.

Sickness
The term Sickness means a physical or mental illness.

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.

TL-007500.43 as modified by TL-009980

Life Insurance Company of North America
1601 Chestnut Street
Philadelphia, Pennsylvania 19192-2235

AMENDATORY RIDER

Policyholder: Vanderbilt University

Policy No.: LK-100150 Effective Date: January 1, 2016

Applicable to Class(es): Class 1

This Amendatory Rider is attached to and made part of the Policy and Certificate specified above.

The Company and the Policyholder hereby agree that the Policy and Certificate are amended as follows:

REHABILITATION DURING A PERIOD OF DISABILITY

EMPLOYEE BENEFIT

A Disabled Employee may be eligible to participate in a Rehabilitation Plan or may be participating in a program that he or she desires to have approved by the Insurance Company's as a Rehabilitation Plan. If an Employee desires to participate in rehabilitation efforts or to have his or her program approved by the Insurance Company as a Rehabilitation Plan, he or she may request approval from the Insurance Company. The Insurance Company has the sole discretion to approve the Employee's participation in a Rehabilitation Plan and to approve a program as a Rehabilitation Plan.

If, while an Employee is Disabled, the Insurance Company determines that he is a suitable candidate for rehabilitation he may participate in a Rehabilitation Plan. The terms and conditions of the Rehabilitation Plan must be mutually agreed upon by the Employee and the Insurance Company's. The Rehabilitation Plan may, at the the Insurance Company's discretion, allow for payment of the Employee's medical expense, education expense, moving expense, accommodation expense or family care expense while he participates in the program.

It may also include, but is not limited to the following benefits:

1. coordination with the Employer to assist the Employee return to work;
2. adaptive equipment or job accommodations to allow the Employee to work;
3. vocational evaluation to determine how the Employee's disability may impact his or her employment options;
4. job placement services;
5. resume preparation;
6. job seeking skills training; or
7. education and retraining expenses for a new occupation.

If the Employee is participating in the approved Rehabilitation Plan, the Insurance Company will pay an additional monthly Rehabilitation Incentive Benefit, as shown on the Schedule of Benefits. This benefit is not subject to Policy provisions which would otherwise increase or reduce the benefit amount such as Other Income Benefits. However, the Maximum Disability Benefit will apply.

The Rehabilitation Incentive Benefit will cease on the earliest of:
- the date you complete the Rehabilitation Program; or
- the date you cease to participate in the Rehabilitation Program; or
- the date your Short Term Disability benefits cease; or
- 12 months after your Rehabilitation Program began.

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

Life Insurance Company of North America

Scott Berlin, President

TL-030005.00

LIFE INSURANCE COMPANY OF NORTH AMERICA
1601 CHESTNUT STREET
PHILADELPHIA, PA 19192-2235

STATE MODIFYING PROVISIONS AMENDMENT RIDER
Group Disability

Policyholder Name: Vanderbilt University Policy No.: LK-100150

Amendment Effective Date: January 1, 2026

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.

Idaho residents:

NOTICE TO BUYER: THIS POLICY CONTAINS BENEFITS FOR DISABILITY INCOME.

NOTICE: THE POLICY PROVIDES LIMITED BENEFITS. REVIEW YOUR POLICY CAREFULLY.

Right to Examine the Policy for 10 Days: Please examine the Policy. Within 10 days after your certificate is provided, the Policyholder may return the Policy to Life Insurance Company of North America with a request for cancellation. If the Policy is returned, the Policy will be void from the start and a full refund will be made.

The Policy is renewable at the option of the Policyholder unless sufficient notice of nonrenewal is given to the Policyholder in writing by Us.

If the following exclusion is included under the ***Exclusions*** section of your Certificate, it has been revised as follows:

- active participation in a riot; ***has been changed to read*** -participation in a riot;

If the following definitions are included under the ***Definitions*** section of your Certificate, they have been modified to read as follows:

Accident
The term Accident means a sudden, unforeseeable event that causes you bodily Injury and occurs while your coverage is in force under the Policy.

Injury
The term Injury or Injuries means accidental bodily injury, independent of disease which occurs while the coverage is in force.

The term "injury" or "injuries may exclude injuries provided under workers' compensation, employers' liability or similar law; or under a motor vehicle no-fault plan, unless not allowed by law; or injuries occurring while the insured person is engaged in any activity pertaining to a trade, business, employment or occupation for wage or profit.

Louisiana residents:

The percentage of 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.

Life Insurance Company of North America

Scott Berlin, President

TL-01-3000.00

SUPPLEMENTAL INFORMATION
for

Vanderbilt University Welfare Benefit Plan ("Plan")

required by the Employee Retirement
Income Security Act of 1974

As a Plan participant in Vanderbilt University'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 Vanderbilt University, the Plan Sponsor.
- The Employer Identification Number (EIN) is 62-0476822.
- The Plan Number is 513.
- The Insurance Plan is administered directly by the Plan Administrator with benefits provided, in accordance with the provisions of the group insurance contract, LK-100150 ("Policy"), issued by LIFE INSURANCE COMPANY OF NORTH AMERICA ("Insurance Company").
- The Plan Administrator is: Vanderbilt University
  2301 Vanderbilt Place
  Nashville, TN 37235
  615-332-6123
- 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, Social Security Number, date of birth, 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:
LIFE INSURANCE COMPANY OF NORTH AMERICA
a New York Life Insurance company

Class 1
02/2026