Carlisle Companies Incorporated

Voluntary Hospital Indemnity Coverage

Prudential

Disclosure Notice

FOR ARKANSAS RESIDENTS

Prudential's Customer Service Office:

The Prudential Insurance Company of America
Voluntary Benefit Services
P.O. Box 696035
San Antonio, TX 78269-6035
1-844-455-1002

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

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

FOR FLORIDA RESIDENTS

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

FOR IDAHO RESIDENTS

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

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

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

FOR INDIANA RESIDENTS

Questions regarding your policy or coverage should be directed to:

The Prudential Insurance Company of America
(844) 455-1002

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

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

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

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

FOR MARYLAND RESIDENTS

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

FOR NORTH CAROLINA RESIDENTS

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

FOR TEXAS RESIDENTS

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

FOR WISCONSIN RESIDENTS

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

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

Prudential's Customer Service Office:

The Prudential Insurance Company of America
Voluntary Benefit Services
P.O. Box 696035
San Antonio, TX 78269-6035
1-844-455-1002

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

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

THIS NOTICE IS FOR TEXAS RESIDENTS ONLY

IMPORTANT NOTICE

To obtain information or make a complaint:

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

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007

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

Email: consumerprotection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES:

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

ATTACH THIS NOTICE TO YOUR POLICY:

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

AVISO IMPORTANTE

Para obtener información o para someter una queja:

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

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007

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

Email: consumerprotection@tdi.texas.gov

DISPUTAS SOBRE PRIMAS O RECLAMOS:

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

UNA ESTE AVISO A SU POLIZA:

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

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

Certificate of Coverage

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

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

Coverage and Amounts: The available Coverage and the amounts of insurance are described in the Booklet.

If You are insured, Your Certificate of Coverage form Your Group Insurance Certificate. Together they replace any older booklet certificates issued to You for the Coverage in the Booklet's Schedule of Benefits. All Benefits are subject in every way to the entire Group Contract which includes the Group Insurance Certificate.

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

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

Prudential's Address:

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

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

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

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

The Group Contract provides Hospital Indemnity Coverage ONLY.

VOLUNTARY HOSPITAL INDEMNITY COVERAGE

Welcome Message

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

We believe this Program provides worthwhile protection for You and Your family.

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

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

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: *There are state-specific requirements that may change the provisions under the Coverage(s) described in this Group Insurance Certificate. If You live in a state that has such requirements, those requirements will apply to Your Coverage(s) and are made a part of Your Group Insurance Certificate. Prudential has a website that describes these state-specific requirements. You may access the website at www.prudential.com/etonline. When You access the website, You will be asked to enter Your state of residence and Your Access Code.* ***Your Access Code is HIP1.***

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

Table of Contents

Schedule of Benefits

Covered Classes: The “Covered Classes” are these Employees of the Contract Holder (and its Associated Companies): All active, Full-time and Part-time Employees working a minimum of 30 hours per week.

Program Date: January 1, 2022. This Booklet describes the benefits under the Group Program as of the Program Date.

This Booklet, and the Certificate of Coverage together form Your Group Insurance Certificate. The Coverages in this Booklet are insured under a Group Contract issued by Prudential. All benefits are subject in every way to the entire Group Contract which includes the Group Insurance Certificate. It alone forms the agreement under which payment of insurance is made.

This Booklet describes all of the options available under the Group Contract.

VOLUNTARY HOSPITAL INDEMNITY COVERAGE FOR YOU AND YOUR DEPENDENTS

The items below are only highlights of Your Coverage. For a full description please read this entire Group Insurance Certificate.

The amount of insurance is the amount for your Benefit Class. You may enroll for the plan shown below. If you choose the amount of insurance or if there are options from which to select, the amount for which you enroll will be recorded by your Employer and reported to Prudential.

Benefit Class

All Employees

For Your Spouse or Domestic Partner

For Your Child

Core Benefit	**Amount of Insurance**
Daily In-Hospital Stay Benefit:	
Daily Benefit Amount	$150.00
Maximum Benefit	5 times per Calendar Year
Hospital Admission:	
Annual Benefit	$1,000
Maximum Benefit	5 times per Calendar Year
ICU Admission Benefit:	
Daily Benefit Amount	$1,000
Maximum Benefit	5 times per Calendar Year

Intensive Care Unit Stay Benefit:

Daily Benefit Amount	$300.00
Maximum Benefit	5 times per Calendar Year

Wellness Benefit:

Daily Benefit Amount	$50.00
Maximum Benefit	1 time per Calendar Year

OTHER INFORMATION

Contract Holder: CARLISLE COMPANIES INCORPORATED

Group Contract No.: HG-70817-AZ

Associated Companies: Associated Companies are employers who are the Contract Holder's subsidiaries or affiliates and are reported to Prudential in writing for inclusion under the Group Contract, provided that Prudential has approved such request.

Contract Anniversary: January 1 of each year, beginning in 2023

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

Prudential's Address:

The Prudential Insurance Company of America
80 Livingston Avenue
Roseland, New Jersey 07068

WHEN YOU HAVE A CLAIM

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

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

General Definitions

FOR YOU AND YOUR DEPENDENTS

Some of the terms used in the Coverage:

Active Work Requirement: A requirement that You be actively at work on a Full-Time basis at the Employer's place of business, or at any other place that the Employer's business requires You to go. You are considered actively at work during weekends or Employer-approved vacations, holidays or business closures if You were actively at work on the last scheduled workday preceding such time off.

Annual Enrollment Period: There is a period each year during which You may enroll for Coverage or request a change in Coverage for the following Calendar Year. The Contract Holder will notify You of when this Annual Enrollment Period begins and ends.

Calendar Year: A year starting January 1.

Confined or Confinement: The assignment to a bed as a resident inpatient in a Hospital (including a Hospital Intensive Care Unit (ICU) on the advice of a Physician or Confinement in an observation area within a Hospital for a period of no less than 24 hours on the advice of a Doctor.

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

Non-contributory Insurance: Non-contributory Insurance is insurance for which the Contract Holder does not have the right to require You to pay any portion of the Premium payment. The Schedule of Benefits shows whether insurance under a Coverage is Contributory Insurance or Non-contributory Insurance.

Coverage: A part of the Booklet consisting of:

(1) A benefit page labeled as a Coverage in its title.

(2) Any page or pages that continue the same kind of benefits.

(3) A Schedule of Benefits entry and other benefit pages or forms that by their terms apply to that kind of benefits.

Covered Accident: A sudden, unforeseeable, external event that results, directly and independently of all other causes, in a 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) occurs while the Covered Person is attending, participating in, or traveling to and from any event sponsored by the Policyholder

(4) is not otherwise excluded under the terms of this Policy.

Covered Illness: A physical or mental disease or disorder including pregnancy and Complications of Pregnancy, that results in a Covered Loss. A Covered Illness includes medically-necessary quarantine in a Hospital in conjunction with medically-necessary preventive treatment due to an identifiable exposure to a life-threatening contagious and infectious disease.

Covered Injury: Any bodily harm that results directly and independently of all other causes from a Covered Accident and results in a Covered Loss

Covered Person: Under a Coverage an Employee who is insured for Employee Insurance under that Coverage; a Qualified Dependent for whom an Employee is insured for Dependents Insurance under that Coverage.

Daily In-Hospital Stay: A Hospital or a Skilled Nursing Facility stay, for at least one full day, for which a room and board charge is made by the Hospital.

Dependents Insurance: Insurance on the person of a dependent.

Doctor: A licensed practitioner of the healing arts acting within the scope of the license. Prudential will not recognize any relative including, but not limited to, You, Your Spouse, Your Domestic Partner, or a Child, brother, sister, or parent of You or Your Spouse or Domestic Partner as a Doctor for a claim that You send to us.

Domestic Partner: A person of the same or opposite sex who:

(1) Satisfies the requirements for being a Domestic Partner, registered Domestic Partner or party to a civil union under the law of Your jurisdiction of residence; or

(2) Is a person of the same or opposite sex who satisfies all of the following:

  (a) is age 18 or older; and

  (b) is not related to You by blood or a degree of closeness that would prohibit marriage in the law of the jurisdiction in which You reside; and

  (c) is mentally competent to consent to contract; and

  (d) is not married to another person under statutory or common law nor in a Domestic Partnership, registered Domestic Partnership or civil union with another person; and

  (e) is not otherwise a Qualified Dependent under the Program; and

  (f) is in a single dedicated, serious and committed relationship with You; and

  (g) has shared a single permanent residence with You for at least 12 consecutive months; and

  (h) is financially interdependent with You.

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

Employee: A person employed by the Employer; a proprietor or partner of the Employer.

Employee Insurance: Insurance on the person of an Employee.

The Employer: Collectively, all employers included under the Group Contract.

Full-Time: Active Work on the Group Policyholder's regular work schedule for the class of Employees to which You belong. The work schedule must be at least 30 hours per week.

Group Policyholder: The Employer named on the first page of this Certificate.

Hospital: An institution that meets either of these tests:

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

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

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

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

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

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

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

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

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

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

(5) Operates pursuant to any jurisdictional requirements for Intensive Care Units and is listed in the current edition of the American Hospital Association Guide or is eligible to be listed therein. This guide lists three types of units that meet this definition: 1) Intensive Care Units; 2) cardiac care units; and 3) infant (neonatal) Intensive Care Units.

Intensive Care Units do not include surgical recovery rooms, privately monitored rooms, observation units, labor or delivery rooms, step-down units, Sub-Acute Intensive Care Units or any other facilities, regardless of name, that do not meet the above requirements.

Life Event: A Life Event includes:

(1) Marriage, divorce, legal separation or annulment.

(2) Becoming or ceasing to be a Domestic Partner.

(3) Birth, adoption or placement for adoption of a child.

(4) A change in the number of Your Qualified Dependents.

(5) A change in Your or Your Qualified Dependent's employment status (including a change in work site or change in place of residence) if it causes You or Your dependent to gain or lose eligibility for group Coverage.

(6) You previously did not enroll for Coverage for You or Your Qualified Dependent because You had other group Coverage, but that Coverage has ceased due to:

(a) loss of eligibility for the other group Coverage;

(b) attainment of the other group Coverage's lifetime limit on all benefits.

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

The term Nurse does not include:

(1) You;

(2) Your Spouse or anyone to whom You are related by blood or marriage;

(3) anyone with whom You are residing;

(4) Your adopted or stepchild;

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

(6) Your Employee.

Part-Time: Active Work on the Group Policyholder's regular work schedule for the class of Employees to which You belong. The work schedule must be at least 30 hours per week.

Prudential: The Prudential Insurance Company of America.

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

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

The term Sickness does not include:

(1) Routine Pregnancy or Routine Childbirth;

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

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

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

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

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

(3) has a Doctor available at all times;

(4) meets all licensing and legal requirements;

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

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

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

Urgent Care Facility: A health care facility:

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

(2) that is supervised by a Doctor;

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

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

We: The Prudential Insurance Company of America.

You and Your: An Employee.

Benefit Definitions

CORE BENEFITS

FOR YOU AND YOUR DEPENDENTS

This Coverage pays the following benefits for Hospital Indemnity.

Hospital Admissions: Prudential will pay the benefit shown in the Schedule of Benefits section, if a Covered Person is admitted for Confinement to a Hospital for treatment of a Covered Accident, Covered Injury or Covered Illness subject to all of the following:

(a) the admission must occur within 90 days after the Covered Accident, Covered Injury or Covered Illness occurs.

(b) The Admission Benefit is not payable for Emergency Room treatment, outpatient treatment, or a stay of less than 24 hours in an observation area.

(c) We will only pay one Covered Accident, Covered Injury or Covered Illness-Hospital Admission Benefit per Covered Person, per Covered Accident, Covered Injury or Covered Illness. The Admission Benefit for a Covered Person for one Hospital Admission at a time, even if the admission is caused by more than one Covered Accident, Covered Injury and/or Covered Illness.

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

(i) one time per Covered Person, per Covered Accident, Covered Injury or Covered Illness; and

(ii) 5 times per Covered Person, per Calendar Year.

If a Covered Person is Confined in a Hospital and becomes Confined again within 90 days for the same or related condition, we will treat the Confinement as a continuation of the prior Confinement. If more than 90 days have passed between the periods of Confinement, we will treat this Confinement as a new Confinement.

ICU Admission Benefit: Prudential will pay the benefit shown in the Schedule of Benefits section, if a Covered Person, upon initial admission for Confinement to a Hospital for treatment of a Covered Accident, Covered Injury or Covered Illness, is admitted to an ICU, subject to the following:

(1) The admission must meet the requirements for payment of the Admission Benefit.

(2) The admission must occur within 90 days after the Covered Accident, Covered Injury or Covered Illness occurs.

(3) The ICU Admission Benefit is not payable for a stay of less than 24 hours.

(4) If the Covered Person moves to an ICU after initial admission to a Hospital, We will not pay the ICU Admission Benefit.

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

(a) one time per Covered Person, per Covered Accident or Covered Injury; and

(b) 5 times per Calendar Year.

If a Covered Person is Confined in a Hospital Intensive Care Unit (ICU) and becomes Confined again within 90 days for the same or related condition, we will treat the Confinement as a continuation of the prior Confinement. If more than 90 days have passed between the periods of Confinement, we will treat this Confinement as a new Confinement.

Daily In-Hospital Stay: Prudential will pay the Daily In-Hospital Stay Benefit shown in the Schedule of Benefits for each day, after the day of admission to the Hospital, if the Covered Person is Confined in the Hospital for treatment of a Covered Accident, Covered Injury or Covered Illness, subject to all of the following:

(a) The initial Hospital Confinement must begin within 90 days after the Covered Accident, Covered Injury or Covered Illness occurs.

(b) The Daily In-Hospital Stay Benefit is not payable for a day in which the Hospital Admission or ICU Admission benefit is payable or for a Confinement of less than 24 hours.

(c) The Daily In-Hospital Stay Benefit is payable for up to 30 days per Covered Person, per Covered Accident, Covered Injury or Covered Illness.

(d) We will only pay the Daily In-Hospital Stay Benefit for a Covered Person for one Hospital Confinement at a time, even if the Confinement is caused by more than one Covered Accident, Covered Injury or Covered Illness.

(e) We will only pay one Covered Accident, Covered Injury or Covered Illness-Daily In-Hospital Stay Benefit per day. If the Covered Person has a non-ICU Hospital Confinement and an Intensive Care Unit Confinement on the same day, We will only pay the Covered Accident, Covered Injury or Covered Illness-Daily In-Hospital Stay Benefit that applies to Intensive Care Unit Confinement.

(f) We will pay the Daily In-Hospital Stay Benefit no more than:

(i) one time per Covered Person, per Covered Accident, Covered Injury or Covered Illness; and

(ii) 5 times per Covered Person, per Calendar Year.

If a Covered Person is Confined in a Hospital and becomes Confined again within 90 days for the same or related condition, we will treat the Confinement as a continuation of the prior Confinement. If more than 90 days have passed between the periods of Confinement, we will treat this Confinement as a new Confinement.

Hospital Intensive Care Unit (ICU): Prudential will pay the ICU Intensive Care Unit Benefit shown in the Schedule of Benefits section, for each day the Covered Person is Confined in an Intensive Care Unit for treatment of a Covered Accident, Covered Injury or Covered Illness and meets the requirements for payment of the Daily In-Hospital Stay Benefit, subject to both of the following additional requirements:

(a) Confinement in the Intensive Care Unit must begin within 90 days after the Covered Accident, Covered Injury or Covered Illness occurs.

(b) The Daily ICU Benefit is not payable for a day in which the Hospital Admission or ICU Admission Benefit is payable or for a Confinement of less than 24 hours.

(c) The ICU Confinement Benefit is payable for up to 30 days per Covered Person, per Covered Accident, Covered Injury or Covered Illness.

(d) We will only pay one Covered Accident, Covered Injury or Covered Illness-Daily In-Hospital Stay Benefit per day. If the Covered Person has a non-ICU Hospital Confinement and an Intensive Care Unit Confinement on the same day, We will only pay the Covered Accident, Covered Injury or Covered Illness -Daily In-Hospital Stay Benefit that applies to Intensive Care Unit Confinement.

(e) 5 times per Calendar Year.

If a Covered Person is Confined in a Hospital Intensive Care Unit (ICU) and becomes Confined again within 90 days for the same or related condition, we will treat the Confinement as a continuation of the prior Confinement. If more than 90 days have passed between the periods of Confinement, we will treat this Confinement as a new Confinement.

ADDITIONAL BENEFITS

FOR YOU AND YOUR DEPENDENTS

An additional benefit may be payable under this Coverage. Any such benefit is payable in addition to any other benefit payable under this Coverage. A Covered Person's Lifetime Maximum Benefit under this Coverage will not be reduced by the amount of any additional benefit payable under this part of the Coverage. Any additional conditions that apply to an additional benefit are shown below. An additional benefit is payable only if those conditions are met.

Wellness: Prudential will pay the benefit shown in the Schedule of Benefits section 1 time per Calendar Plan year per insured if the Covered Person has a Wellness Test performed listed below, upon submission of Proof, We will pay the Wellness Benefit shown on the Schedule for the day that the measure is taken, subject to all of the following:

(1) We will not pay Wellness Benefit for a test if benefits are paid or payable for that same test under another section of this Certificate.

(2) We will only pay one Wellness Benefit per Covered Person, per day.

(3) We will pay the Wellness Benefit no more than the number of times shown on the Schedule.

The tests for which a Wellness Benefit may be paid are:

(1) routine health check-up exam;

(2) biopsies for cancer;

(3) blood chemistry panel;

(4) blood test to determine total cholesterol;

(5) blood test to determine triglycerides;

(6) bone marrow testing;

(7) breast MRI;

(8) breast ultrasound;

(9) breast sonogram;

(10) cancer antigen 15-3 blood test for breast cancer (CA 15-3);

(11) cancer antigen 125 blood test for ovarian cancer (CA 125);

(12) carcinoembryonic antigen blood test for colon cancer (CEA);

(13) carotid doppler;

(14) chest x-rays;

(15) clinical testicular exam;

(16) colonoscopy;

(17) complete blood count (CBC);

(18) dental exam;

(19) digital rectal exam (DRE);

(20) Doppler screening for cancer;

(21) Doppler screening for peripheral vascular disease;

(22) echocardiogram;

(23) electrocardiogram (EKG);

(24) electroencephalogram (EEG);

(25) endoscopy;

(26) eye exam;

(27) fasting blood glucose test;

(28) fasting plasma glucose test;

(29) flexible sigmoidoscopy;

(30) hearing test;

(31) hemoccult stool specimen;

(32) hemoglobin A1C;

(33) human papillomavirus (HPV) vaccination;

(34) immunization;

(35) lipid panel;

(36) mammogram;

(37) oral cancer screening;

(38) pap smears or thin prep pap test;

(39) prostate-specific antigen (PSA) test;

(40) serum cholesterol test to determine LDL and HDL levels;

(41) serum protein electrophoresis;

(42) skin cancer biopsy;

(43) skin cancer screening;

(44) skin exam;

(45) stress test on bicycle or treadmill;

(46) successful completion of smoking cessation program;

(47) tests for sexually transmitted infections (STIs);

(48) thermography;

(49) two hour post-load plasma glucose test;

(50) ultrasounds for cancer detection;

(51) ultrasound screening of the abdominal aorta for abdominal aortic aneurysms;

(52) virtual colonoscopy.

Who is Eligible to Become Insured

FOR EMPLOYEE INSURANCE

You are eligible for Employee Insurance while:

- You are a Full-Time or Part-Time Employee of the Employer; and
- You are in a Covered Class; and
- You have completed the Employment Waiting Period, if any. You may need to work for the Employer for a continuous Full-Time or Part-Time period before You become eligible for the Coverage. The period must be agreed upon by the Employer and Prudential. Your Employer will inform You of any such Employment Waiting Period for Your class.

You are Full-time if You are regularly working for the Employer at least the number of hours in the Employer's normal Full-time work week for Your class, but not less than 30 hours per week. You are Part-Time if You are regularly working for the Employer at least the number of hours in the Employer's normal Part-Time work week for Your class, but not less than 30 hours per week. If You are a partner or proprietor of the Employer, that work must be in the conduct of the Employer's business.

Your class is determined by the Contract Holder. This will be done under its rules, on dates it sets. The Contract Holder must not discriminate among persons in like situations. You cannot belong to more than one class for insurance on each basis, Contributory or Non-contributory Insurance, under the Coverage. “Class" means Covered Class, Benefit Class or anything related to work, such as position or Earnings, which affects the insurance available.

This applies if You are an Employee of more than one Employer included under the Group Contract: For the insurance, You will be considered an Employee of only one of those Employers. Your service with the others will be treated as service with that one.

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

FOR DEPENDENTS INSURANCE

You are eligible for Dependents Insurance while:

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

Qualified Dependents:

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

- A person under age 65 who is Your Spouse or Domestic Partner prior to their enrollment for Dependents Insurance.

  Your Spouse means Your lawful Spouse.

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

  (1) Satisfies the requirements for being a Domestic Partner, registered Domestic Partner or party to a civil union under the law of Your jurisdiction of residence; or

(2) Is a person of the same or opposite sex who satisfies all of the following:

(a) is age 18 or older; and

(b) is not related to You by blood or a degree of closeness that would prohibit marriage in the law of the jurisdiction in which You reside; and

(c) is mentally competent to consent to contract; and

(d) is not married to another person under statutory or common law nor in a Domestic Partnership, registered Domestic Partnership or civil union with another person; and

(e) is not otherwise a Qualified Dependent under the Program; and

(f) is in a single dedicated, serious and committed relationship with You; and

(g) has shared a single permanent residence with You for at least 12 consecutive months; and

(h) is financially interdependent with You.

Where requested by Prudential, You and/or Your Domestic Partner certify that all of the above requirements are satisfied. Such certification shall be in a format satisfactory to Prudential.

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

- Your unmarried Children from live birth to 26 years old.

  Your Children include Your:

  (1) Biological children;

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

  (3) Foster children;

  (4) Domestic Partner’s children; and

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

  (a) have been appointed the legal guardian; and

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

  A Child who is Your, Your Spouse’s or Your Domestic Partner’s ward under a legal guardianship will be considered a Qualified Dependent from the effective date of court order granting the legal guardianship, and is treated as though the Child was Your newborn child.

- Your Incapacitated Children.

Your Incapacitated Children means each Child (as defined above) who satisfies all of the following:

(1) Your Child is incapable of self-sustaining employment because of a mental or physical Injury or Illness.

(2) Your Child is so incapacitated before the Child reaches the age limit for a Qualified Dependent Child.

You must provide Prudential with satisfactory proof that Your Child satisfies the above conditions within 31 days of:

(1) the covered Child's attainment of the age limit for a Qualified Dependent Child; or

(2) the date You first become eligible for Coverage with respect to that Child over the age limit for a Qualified Dependent Child.

Periodically, Prudential may request that You provide proof that Your Child continues to satisfy the above conditions.

Failure to provide the proof required or requested above will cause Your Coverage with respect to that Child to end.

Exceptions:

(1) Your Spouse, Domestic Partner, or Child is not Your Qualified Dependent while:

(a) on active duty in the armed forces of any country; or

(b) insured under the Group Contract as an Employee; or

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

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

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

(2) the Employee who has the longest continuous service with the Employer, based on the Contract Holder's records.

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

When You Become Insured

FOR EMPLOYEE INSURANCE

Your Employee Insurance under the Coverage will begin the first day of the month following the date on which:

- You have enrolled, if the Coverage is Contributory; and
- You are eligible for Employee Insurance; and
- You are in a Covered Class for that insurance; and
- You have met any evidence requirement for Employee Insurance (see the rules for when evidence is required below); and
- Your insurance is not being delayed under the Delay of Effective Date section below; and
- that Coverage is part of the Group Contract.

For Contributory Insurance, You must enroll on a form approved by Prudential and agree to pay the required contributions. You may enroll for Contributory Insurance (1) within 31 days of when You could first be covered, (2) within 31 days of a Life Event, or (3) during the Annual Enrollment Period without evidence of insurability. Your Employer will tell You whether contributions are required and the amount of any contribution when You enroll.

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

The General Definitions section explains what “Annual Enrollment Period” and “Life Event” means.

When evidence is required: In any of these situations, You must give evidence of insurability. This requirement will be met when Prudential decides the evidence is satisfactory.

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

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

FOR DEPENDENTS INSURANCE

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

- You have enrolled for Dependents Insurance under the Coverage, if the Coverage is Contributory.
- The person is Your Qualified Dependent.
- You are in a Covered Class for that insurance.
- You are insured for the Employee Insurance under the Coverage.
- You have met any evidence requirement for that Qualified Dependent.

- Your insurance for that Qualified Dependent is not being delayed under the Delay of Effective Date section below.

- Dependents Insurance under the Coverage is part of the Group Contract.

For Contributory Insurance, You must enroll your Qualified Dependent on a form approved by Prudential and agree to pay the required contributions. You may enroll for Contributory Dependents Insurance (1) within 31 days of when You could first be covered, (2) within 31 days of a Life Event, or (3) during the Annual Enrollment Period without evidence of insurability. Your Employer will tell You whether contributions are required and the amount of any contribution when You enroll your Qualified Dependent.

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

The General Definitions section explains what “Annual Enrollment Period” and “Life Events” means.

When evidence is required: In any of these situations, You must give evidence of insurability for a Qualified Dependent. For each Qualified Dependent, this requirement will be met when Prudential decides the evidence is satisfactory.

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

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

Change in Family Status: It is important that You inform the Employer promptly when You first acquire a Qualified Dependent. You should also inform the Employer if Your Dependents Insurance status changes from one to another of these categories:

- No Qualified Dependents.

- Qualified Dependent Spouse or Domestic Partner only.

- Qualified Dependent Spouse or Domestic Partner and Children.

- Qualified Dependent Children only.

If You are insured under the Coverage for one or more Children, You need not report additional Children.

Forms are available for reporting these changes.

Delay of Effective Date

FOR EMPLOYEE INSURANCE

Your Employee Insurance under the Coverage will be delayed if You do not meet the Active Work Requirement on the day Your insurance would otherwise begin. Instead, it will begin on the first day You meet the Active Work Requirement and the other requirements for the insurance. The same delay rule will apply to any increase in Your insurance that is subject to this section. If You do not meet the Active Work Requirement on the day that change would take effect, it will take effect on the first day You meet that requirement. This delay rule does not apply to any decreases in Your insurance.

FOR DEPENDENTS INSURANCE

A Qualified Dependent may be Confined for medical care or treatment, at home or elsewhere. If a Qualified Dependent is so Confined on the day that Your Dependents Insurance under the Coverage for that Qualified Dependent, or any change in that insurance that is subject to this section, would take effect, it will not then take effect. The insurance or change will take effect upon the Qualified Dependent's final medical release from all such Confinement. The other requirements for the insurance or change must also be met.

Newborn Child Exception: This section does not apply to a Child of Yours at that Child's birth if the Child is born to You and either:

(1) is Your first Qualified Dependent; or

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

Also, this section does not apply to any age increase in the amount of insurance for a Child under the Dependents Coverage.

When Your Insurance Ends

EMPLOYEE AND DEPENDENTS INSURANCE

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

- Your membership in the Covered Classes for the insurance ends because Your employment ends (see below) or for any other reason.
- Your class is removed from the Covered Classes for the insurance.
- The date the Group Contract providing the insurance ends.
- You reach age 100.
- You die.
- For Contributory Insurance under the Coverage, You fail to pay, when due, any required contribution. But, if Employee Insurance is Contributory, failure to contribute for Dependents Insurance will not cause Your Employee Insurance to end.
- The insurance is Dependents Insurance, and Your Employee Insurance under the Coverage ends.
- Your Dependents Insurance for a Qualified Dependent under the Coverage will end on the first of these to occur:
- That person ceases to be a Qualified Dependent for the Coverage. A Spouse or Domestic Partner will cease to be a Qualified Dependent at age 100. (See Continued Coverage for an Incapacitated Child below.)

End of Employment: For insurance purposes, Your employment will end when You are no longer a Full-time or Part-time Employee actively at work for the Employer. But, under the terms of the Group Contract, the Employer may consider You as still employed in the Covered Classes during certain types of absences from Full-time or Part-time work. This is subject to any time limits or other conditions stated in the Group Contract.

Your employment in the Covered Classes will not be considered to end while You are absent from work due to leave for which insurance is required to be continued under the Federal Family and Medical Leave Act of 1993 or a state law requiring similar continuation, as reported to Prudential by the Employer.

If You stop active Full-Time or Part-time work for any reason, You should contact the Employer at once to determine what arrangements, if any, have been made to continue any of Your insurance.

Continued Coverage for an Incapacitated Child: This applies only to the Dependents Insurance You have for a Child under the Coverage. The insurance for the Child will not end on the date the age limit in the definition of Qualified Dependent is reached if both of these are true:

(1) The Child is then mentally or physically incapable of earning a living. Prudential must receive proof of this within the next 31 days.

(2) The Child otherwise meets the definition of Qualified Dependent.

If these conditions are met, the age limit will not cause the Child to stop being a Qualified Dependent under that Coverage. This will apply as long as the Child remains so incapacitated.

Continuation of Coverage at Your Option:

Your Coverage becomes portable and You may elect to continue Coverage for You and Your Qualified Dependents if all of these conditions are met:

(1) Coverage for You and Your Qualified Dependents under the Group Contract would have ended because:

(a) Your employment ended for a reason other than gross misconduct; or

(b) Your work hours were reduced.

(2) You have been continuously insured under the Group Contract and/or the Employer's prior plan for at least 30 days just before the date Your employment ended or Your work hours were reduced.

The Coverage that may be continued is that which You had on the date Your employment ended or Your work hours were reduced.

Your Employer will give to You or mail to You a notice of Your right to continue the Coverage. The notice will state the amount of the payments required for the portable Coverage and the manner in which payments must be made.

If You want to continue the Coverage, the election notice must be completed and returned to Your Employer, along with the required first payment, by the later of:

(1) 31 days after the Coverage would otherwise have ended; and

(2) 15 days after You receive the notice informing You of Your right to continue. But, in no event may election be made if You do not apply for continuation of Coverage and pay the first payment prior to 92 days after You cease to be covered for the Coverage.

If this is done, the portable Coverage will be continued from the date it would have ended until the first of these occurs:

(1) You reach age 100.

(2) You die.

(3) You fail to make, when due, any payment required for the continued Coverage. But failure to contribute for Dependents Insurance will not cause Your Employee Insurance to end.

(4) The insurance is Dependents Insurance, and Your Employee Insurance under the Coverage ends.

(5) You become covered under any other group Hospital indemnity plan.

Your Dependents Insurance for a Qualified Dependent under the continued Coverage will end on the first of these to occur:

(1) The Qualified Dependent reaches the Lifetime Maximum Benefit for that Qualified Dependent.

(2) That person ceases to be a Qualified Dependent for the Coverage. A Spouse or Domestic Partner will cease to be a Qualified Dependent at age 100. (See Continued Coverage for an Incapacitated Child above.)

(3) You reach age 100.

While Hospital Indemnity Coverage is continued under this part, all other terms of the Group Contract apply, except:

(1) Your Amount of Insurance may not be more than 100% of Your Amount of Insurance under the Group Contract when the Coverage would have ended. The Amount of Insurance on each dependent may not be more than the Amount of Insurance on the dependent under the Group Contract when the Coverage would have ended.

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

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

(4) Once Coverage is being continued under this part, no other continuation provisions may apply, except for the Continued Coverage for an Incapacitated Child provision above.

EXTENSION OF BENEFITS

If a Covered Person is Confined on the date Your insurance ends and You do not continue insurance under the Continuation of Coverage at Your Option section, we will pay certain benefits for such Covered Person if the Confinement continues after Your insurance ends, in accordance with, and subject to all of the following:

- No benefits will be available under this Extension of Benefits provision if Your insurance ends due to non-payment of premium.
- The Hospital Admissions Benefit, the Daily In-Hospital Stay Benefit, the Hospital Intensive Care Unit Benefit (ICU) and the Inpatient Surgery Procedure Benefit and will be payable if requirements for payment of those benefits are met while the Covered Person is Confined. No other benefits will be payable.
- Benefits payable under this Extension of Benefits provision will be paid in accordance with and subject to the terms and conditions of this Certificate, except as set forth in this provision.
- Benefits under this Extension of Benefits provision will end on the earlier of:
- the date the Covered Person is no longer Confined; or
- the end of the number of days that Confinement Benefits are payable for the Confinement, not to exceed 30 days.
- If the Covered Person is again Confined at any time after discharge, no further benefits will be payable.

Amount of Extended Benefit: This amount is determined as if You had remained a Covered Person under the Hospital indemnity plan. But it is reduced by any amount payable under the Schedule of Benefits or any Prudential group insurance that replaces this Coverage for a class of Employees.

Effect of Continuation: Continued insurance under the Continuation of Coverage at Your Option provision will be in place of all rights under this Section. But if You have met the requirements of this Section, You can obtain these rights in exchange for all benefits of the continued insurance. Premiums paid under the continued insurance will be refunded.

CHANGE IN CLASS

If there is more than one class eligible for insurance under the Group Policy, and each class has its own certificate, instead of receiving a new certificate when You move between classes, You will remain insured under this Certificate if:

- You move to a class that is eligible for Hospital Indemnity Insurance under the Group Policy; and
- the benefits available to Your new class are identical to the benefits available under this Certificate.

In all other cases when You move between classes, Your insurance under this Certificate will end on the date You are no longer a Member of the class eligible for insurance under this Certificate.

General Information

A. CLAIM RULES.

These rules apply to payment of benefits under the Coverage.

Notice of Claim: Written notice of claim should be sent to Prudential within 20 days of the date of a loss.

Claim Forms: Upon receipt of a notice of claim, Prudential will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this Group Insurance Certificate as to proof of loss upon submitting, within the time fixed in the Group Insurance Certificate for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Use a claim form and follow the instructions on the form.

If You do not have a claim form, contact Your Employer, or You can request a claim form from us. If You do not receive the form within 15 days of Your request, send Prudential written proof of claim without waiting for the form.

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

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

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

To Whom Payable: Benefits are payable to you with these exceptions:

(1) Benefits for any of your Losses that are unpaid at your death or become payable on account of your death will be paid to the first of the following: Your (a) surviving spouse or Domestic Partner; (b) surviving Child(ren) in equal shares; (c) surviving parents in equal shares; (d) surviving siblings in equal shares; (e) estate.

(2) If you are not living, benefits for a dependent's Losses are payable to your Spouse or Domestic Partner if your Spouse or Domestic Partner is living.

(3) If neither you nor your Spouse or Domestic Partner is living, then benefits for a Spouse's or Domestic Partner's Losses will be paid to your Spouse's or Domestic Partner's estate.

(4) If neither you nor your Spouse or Domestic Partner is living, then benefits for a Qualified Dependent Child's Losses will be paid to the Child who suffered the Loss. If that Qualified Dependent Child is not living, the benefits will be paid to the Child's estate.

Physical Exam: Prudential, at its own expense, has the right to examine the person for whom the claim is made. Prudential may do this when and as often as is reasonable while the claim is pending.

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

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

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

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

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

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

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

C. LIMITS ON ASSIGNMENTS.

You may assign Your insurance under the Coverage on forms satisfactory to Prudential. Insurance under the Coverage may be assigned only as a gift assignment. Any rights, benefits or privileges that You have as an Employee may be assigned. This includes any right You have to continue Coverage under the Group Contract. Prudential will not decide if an assignment does what it is intended to do. Prudential will not be held to know that one has been made unless it or a copy is filed with Prudential through the Contract Holder.

D. PAYMENT OF PREMIUMS – GRACE PERIOD.

Premiums are to be paid by You to the Contract Holder. Each Premium must be paid by the Premium Payment Date.

Premium Payment Date: The first premium is due on the date You become insured under the Group Contract. Subsequent premiums are due semi-annually. But, at Your written request, You may elect to pay premiums monthly, quarterly or annually, or change back to semi-annually. The Premium Payment Date for each subsequent Premium is the first day of each subsequent payment period.

Grace Period: You may pay each Premium other than the first within 31 days of the Premium Payment Date without being charged interest. Those days are known as the grace period.

If You fail to pay any Premium required for an insurance of the Group Contract by the end of its grace period, Your insurance will end when the grace period ends. You are liable to pay Premiums to the Contract Holder for the time Your insurance is in force.

E. REINSTATEMENT.

If Your insurance ends because You did not pay any Premium by the end of its grace period, You may be eligible to reinstate the insurance subject to these rules:

(1) You must request reinstatement within 180 days of the date of the first unpaid Premium;

(2) You must pay all overdue Premiums; and

(3) If You request reinstatement more than 60 days after the end of the grace period, You must complete a Request for Reinstatement with attestation of good health.

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

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

Exclusions

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

(1) Suicide or attempted suicide, while sane.

(2) Intentionally self-inflicted Injuries, or any attempt to inflict such Injuries.

(3) Taking part in any riot or insurrection.

(4) War, or any act of war. War means declared or undeclared war, and includes resistance to armed aggression. Terrorism is not considered an act of war.

Terrorism means the deliberate use of violence or the threat of violence against civilians to create an emotional response through the suffering of victims or to achieve military, political, religious or social objectives.

(5) An Accident that occurs while the person is serving on Full-Time active duty for more than days in any armed forces. But this does not include Reserve or National Guard active duty for training.

(6) Travel or flight in any vehicle used for aerial navigation, if:

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

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

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

This includes getting in, out, on or off any such vehicle.

(7) Commission of or attempt to commit an assault or a felony.

(8) Being under the influence of alcohol or alcohol intoxication, including but not limited to having a blood alcohol level above the limit for permissible operation of a motor vehicle in the jurisdiction where the Accident occurred, regardless of whether the person: (a) was operating a motor vehicle; and (b) was convicted of an alcohol related offense.

(9) Being under the influence of or taking any non-prescription drug, medication, narcotic, stimulant, hallucinogen, barbiturate, amphetamine, gas, fumes or inhalants, poison or any other controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless prescribed by and administered in accordance with the advice of the person's Doctor.

(10) Participation in these hazardous sports: scuba diving; bungee jumping; base jumping; skydiving; ziplining; parachuting; hang gliding; paragliding; paramotoring; parascending; or ballooning.

(11) Treatment for dental care or dental procedures, unless treatment is the result of a Covered Accident, Covered Injury or Covered Illness;

(12) Elective procedures and/or cosmetic surgery or reconstructive surgery, unless it is a result of trauma, infection or other diseases;

(13) Cosmetic Surgery, except when such Surgery is performed to:

- treat a Covered Accident, Covered Injury or Covered Sickness;
- correct a disorder of normal bodily function or structure that was caused by an Accident Injury or Sickness for which Coverage is not otherwise excluded under this Certificate; or
- reconstruct a part of the body which was disfigured or removed as a result of an Accident, Injury or Sickness for which Coverage is not otherwise excluded under this Certificate;

(14) The Covered Person's mental illness, or the diagnosis or treatment of such mental illness, except for the Covered Person's use of:

- any drug, medication or sedative that is taken or used as prescribed by a Doctor; or
- an "over the counter" drug, medication or sedative taken as directed; or
- activities required by the Covered Person's service in the armed forces or any auxiliary unit of the armed forces of any country or international authority;

(15) Hospital Confinement caused by, contributed to by, or resulting from Mental Illness. However, dementia as a result of stroke, trauma, viral infection, Alzheimer's disease or other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment are covered under this Policy.

Additional Information About Your Plan

The Certificate of Coverage and the following Additional Information (together, the Booklet, are intended to comply with the disclosure requirements of the regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act (ERISA) of 1974. ERISA requires that your employer provide you with a "Summary Plan Description" which describes the plan and informs you of your rights under it. Information about eligibility rules, benefits amounts, benefit limitations, and exclusions from coverage is contained in the Certificate of Coverage. The following Additional Information about your plan is provided at the request of your Employer/Plan Sponsor.

Plan Name

Carlisle Companies Incorporated

Plan Number

501

Type of Plan

Employee Welfare Benefit Plan

Plan Sponsor

Carlisle Companies Incorporated
16430 N Scottsdale Road Suite 400
Scottsdale, AZ 85254

Employer Identification Number

23-0457510

Plan Administrator

Carlisle Companies Incorporated
Attention: Human Resources Department
16430 N Scottsdale Road Suite 400
Scottsdale, AZ 85254
717-706-6416

Agent for Service of Legal Process

Carlisle Companies Incorporated
Attention: Human Resources Department
16430 N Scottsdale Road Suite 400
Scottsdale, AZ 85254

Service of legal process may also be made upon the plan administrator at the address above.

Plan Year Ends

December 31

Plan Benefits Provided by

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

Plan Sponsor's Designation of Prudential As Claims Administrator

It is the Plan Sponsor's intention and direction that The Prudential Insurance Company of America as Claims Administrator has the sole discretion to interpret the terms of the plan, to make factual findings, and to determine eligibility for benefits. The Plan Sponsor has determined that benefits are payable under the plan only if The Prudential Insurance Company of America, in its sole discretion, determines that they are due. The decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. *

* This paragraph does not apply to residents of AK, AR, CA, CO, DC, IL, KY, MD, ME, MI, NJ, NY, OR, PR, RI, SD, TX, VT, WA

Plan Sponsor, Policyholder and Employer not Agents of Prudential

The Group Contract underwritten by The Prudential Insurance Company of America provides insured benefits under your Employer/Policyholder/Plan Sponsor's ERISA plan(s). For all purposes associated with the plan or the Group Contract under which The Prudential Insurance Company of America provides benefits, the Employer/Policyholder/Plan Sponsor acts on its own behalf or as an agent of its employees. Under no circumstances will the Employer/Policyholder/Plan Sponsor be deemed the agent of The Prudential Insurance Company of America, absent a written authorization of such status executed between the Employer/Policyholder/Plan Sponsor and The Prudential Insurance Company of America. Nothing in these documents shall, of themselves, be deemed to be such a written authorization.

Allocation of Contributions

The insurance benefit coverages described in this Booklet are being offered to you under a single ERISA plan. Coverages described as non-contributory or as being paid entirely by the Employer/Policyholder/Plan Sponsor (if any) are those paid for directly by the Employer/Policyholder/Plan Sponsor such that you have no out of pocket expense for such coverages. However, the premium rate that the Employer/Policyholder/Plan Sponsor pays for insurance coverage offered to you under the Plan may be determined, or in some cases, reduced, in part, based on your contributions for other coverages or other benefits offered under the Plan. When this occurs, your contributions for one benefit coverage may cover some or all of the costs or plan expenses for another benefit coverage offered to you under the Plan.

Loss of Benefits

You must continue to be a member of a class of eligible employees or beneficiaries to which the plan pertains and continue to make any contributions or payments that are due, including those you agreed to when you enrolled for coverage. Failure to make required contributions may result in partial or total loss of your benefits.

Plan Sponsor May Amend or Terminate the Plan at any Time

It is intended that this plan will be continued for an indefinite period of time. But, the Plan Sponsor reserves the right to change or terminate the plan at any time. This Booklet elsewhere describes your rights upon termination of the plan.

Claim Procedures

1. Determination of Benefits

Prudential shall notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the plan. A written notice of the extension, the reason for the extension and the date by which the plan expects to decide your claim, shall be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the plan. A written notice of the additional extension, the reason for the additional extension and the date by which the plan expects to decide on your claim, shall be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by Prudential will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the earlier of the date on which you respond to the request for additional information or the 45th day following the expiration of the initial 45-day claim review period.

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will include:

(a) the specific reason(s) for the denial, which will include a discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of healthcare professionals treating you and vocational experts who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) an award of Social Security Administration disability benefits,

(b) references to the specific plan provisions on which the benefit determination was based,

(c) a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary,

(d) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits,

(e) a description of Prudential's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals,

(f) a statement that, if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request, and

(g) copies of any internal rules, guidelines, protocols, standards or other similar criteria relied upon in making this determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist.

2. Appeals of Adverse Determination

If your claim for benefits is denied, you or your representative may appeal your denied claim in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. Similarly, if Prudential does not decide your claim within the time described in Section 1 above, you may appeal, although you are not required to do so. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by Prudential, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

Prudential shall make a determination on your appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the earlier of the date on which you respond to the request for additional information or the 45th day following the expiration of the initial 45-day claim review period.

Prudential will provide you, free of charge and prior to any adverse decision on appeal, with any new or additional evidence that is considered by Prudential in connection with the claim (including evidence that may be the basis for denial as well as any evidence that may support granting the claim), and any new or additional rationale that will form the basis for the Prudential's decision on appeal. Any such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination must be provided in order to give you a reasonable opportunity to respond prior to that date.

If the appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will include:

(a) the specific reason(s) for the adverse determination, which will include a discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of healthcare professionals treating you and vocational experts who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) an award of Social Security Administration disability benefits,

(b) references to the specific plan provisions on which the determination was based,

(c) a statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request,

(d) a description of Prudential's review procedures and applicable time limits,

(e) a statement that if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request,

(f) copies of any internal rules, guidelines, protocols, standards or other similar criteria relied upon in making this determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist and

(g) a statement describing any appeals procedures offered by the plan, and your right to bring a civil suit under ERISA.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

If the appeal of your benefit claim is denied, you or your representative may make a second, voluntary appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. Similarly, if Prudential does not decide your appeal within the time described in Section 1 above, you may appeal again, although you are not required to do so. You may submit with your second appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

Prudential shall make a determination on your second claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the earlier of the date on which you respond to the request for additional information or the 45th day following the expiration of the second 45-day appeal review period.

Your decision to submit a benefit dispute to this voluntary second level of appeal has no effect on your right to any other benefits under this plan. If you elect to initiate a lawsuit without submitting to a second level of appeal, the plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second level of appeal, the plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If the claim on appeal is denied in whole or in part for a second time, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include the same information that was included in the first adverse determination letter. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

Time Limit To File Suit

If your claim for benefits and any required appeals are denied (or not decided within the time periods discussed above), you may file suit as discussed below. If you elect to file suit, you should do so as soon as possible. However, you must file suit no later than three years after proof of your claim was first due as explained elsewhere in this Booklet, regardless of whether your claim is still pending in the claim or appeal process.

Rights and Protections

As a participant in this plan, 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 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 Benefits 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 plan administrator may make a reasonable charge for the copies.

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including the Plan Sponsor, 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 a fine that accrues on a daily basis (based on amounts set by the Department of Labor) from the time the materials were due to you 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 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.