Light & Wonder, Inc.

High Plan

Voluntary Hospital Indemnity Coverage

Prudential

NOTICE FOR TEXAS RESIDENTS

Have a complaint or need help?

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

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

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

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

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

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

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

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

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

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

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

Llame con sus preguntas al: 1-800-252-3439
Presente u na queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

Disclosure Notice

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES (see important note for New Mexico residents):

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 VHI1.

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.

FOR NEW MEXICO RESIDENTS: If your Group Insurance Certificate has a Program Date on or after January 1, 2024, NM state specific requirements are included in the Group Insurance Certificate that applies to New Mexico residents.

FOR ARKANSAS RESIDENTS

Prudential's Customer Service Office:

The Prudential Insurance Company of America
Customer Services Department
Voluntary Benefit Services
P.O. Box 71330
Philadelphia, PA 19176-1330

Telephone: 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 ARIZONA RESIDENTS

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

FOR CALIFORNIA RESIDENTS

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

FOR COLORADO RESIDENTS

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

FOR FLORIDA RESIDENTS

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

FOR IDAHO RESIDENTS

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

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

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

FOR INDIANA RESIDENTS

Questions regarding your policy or coverage should be directed to:

The Prudential Insurance Company of America
1-844-455-1002

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

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

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

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

FOR MARYLAND RESIDENTS

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

FOR NORTH CAROLINA RESIDENTS

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

FOR NEW MEXICO RESIDENTS

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

FOR OKLAHOMA RESIDENTS

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

FOR TEXAS RESIDENTS

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

FOR WISCONSIN RESIDENTS

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

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

Prudential's Customer Service Office:
Voluntary Benefit Services

P.O. Box 71330
Philadelphia, PA 19176-1330
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

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA
751 Broad Street
Newark, New Jersey 07102

Group Hospital Indemnity Insurance Schedule of Benefits

This document provides additional information about the coverage available under this Certificate, including Group Contract information, a description of covered classes, and the benefits covered.

GROUP CONTRACT INFORMATION

Contract Holder: LIGHT & WONDER, INC.
Group Contract No.: HG-70354-NV
Contract Anniversary: January 1 of each year, beginning in 2026.
Cost of Insurance: The insurance in this Certificate is Contributory Insurance. You will be informed of the amount of Your contribution when you enroll.
Premium Payment Date: first of the month.
Employment Waiting Period: You may need to work for the Employer for a continuous full-time period before You become eligible for the coverage. The period must be agreed upon by the Employer and Us. Your Employer will inform You of any such Employment Waiting Period for Your class.

COVERED CLASSES

Covered Classes: The Covered Classes are the Employees of the Contract Holder (and its Associated Companies): All active, full-time Employees working a minimum of 30 hours per week who are enrolled in high plan.

Coverage Date: January 1, 2025. This Certificate describes the benefits, conditions, and limitations of coverage as of the Coverage Date.

AMOUNT OF INSURANCE

The Amount of Insurance for You and Your Qualified Dependent(s) are the benefit amounts You elected when enrolling for coverage.

CONTINUED ELIGIBILITY FOR INSURANCE MAXIMUM PERIODS

Family Medical Leave of Absence	84 days
Military Service	365 days

HOSPITAL INDEMNITY BENEFITS

HOSPITALIZATION BENEFITS	**Amount of Insurance**
Hospital Admission Benefit	$2,000 per admission No more than one time per Covered Person, per Covered Loss

	No more than 5 times per Covered Person, per Calendar Year
Hospital Confinement Benefit	$200 per day
	No more than 30 days per Confinement, per Covered Person, per Covered Loss
	No more than 5 Confinements per Covered Person, per Calendar Year
	No more than 15 days per newborn child
Intensive Care Unit (ICU) Admission Benefit	$4,000 per admission
	No more than one time per Covered Person, per Covered Loss
	No more than 5 Confinements per Covered Person, per Calendar Year
Intensive Care Unit (ICU) Confinement Benefit	$400 per day
	No more than 30 days per Confinement, per Covered Person, per Covered Loss
	No more than 5 Confinements per Covered Person, per Calendar Year

ADDITIONAL BENEFITS	**Amount of Insurance**
Health Screening Benefit	$50
	No more than 1 times per Covered Person, per Calendar Year
High Risk Pregnancy Benefit	25%
Hospital Observation Benefit	$750 per each period of observation of at least 24 hours
	No more than 1 days per Covered Person, per Covered Loss
	No more than 6 times per Covered Person, per Calendar Year
Mental Illness/Nervous Disorders Facility Care Benefit	$100 per day
	No more than 30 days per Covered Person, per Calendar Year
	No more than 90 days per Covered Person during their lifetime

Premature Infant and NICU Benefit	25% No more than 5 times under the Certificate
Substance Abuse Facility Care Benefit	$100 per day No more than 30 days per Covered Person, per Calendar Year No more than 60 days per Covered Person during their lifetime

Please note: If more than one of the following benefits listed below are payable for the same day as a result of a Covered Loss, only the benefit paying the highest amount will be paid:

- Hospital Admission Benefit
- Hospital Confinement Benefit
- Intensive Care Unit (ICU) Admission Benefit
- Intensive Care Unit (ICU) Confinement Benefit
- Mental Illness/Nervous Disorder Facility Care Benefit
- Substance Abuse Facility Care Benefit

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA
751 Broad Street
Newark, New Jersey 07102

Group Hospital Indemnity Insurance Certificate

We are pleased to present You with this Certificate. It describes the Hospital Indemnity coverage We have arranged for You and what You must do to be covered for these benefits. We believe this Hospital Indemnity coverage provides worthwhile protection for You and Your Qualified Dependents.

Please read this Certificate carefully. If You have any questions about the coverage, We will be happy to answer them. This is Your Certificate and it should be kept in a safe place.

This Certificate provides evidence of Your coverage under the Group Contract and the benefits offered. Everything contained in this Certificate is subject to the provisions in the Group Contract. The Contract Holder has a copy of the Group Contract and You may review it at any reasonable time. Only one of Our executive officers may authorize a change to the Group Contract.

Right to Examine this Certificate: You may cancel this Certificate for any reason, within 30 days after You receive it. If You cancel Your coverage within this period, the insurance will be void the date it would otherwise take effect, and We will refund Your Premium contributions, if any. We will deduct any benefits already paid from the refund.

This Certificate replaces all previous certificates and riders regarding this coverage.

THIS CERTIFICATE PROVIDES LIMITED BENEFIT COVERAGE. READ IT CAREFULLY.

THIS COVERAGE IS A SUPPLEMENT TO MEDICAL COVERAGE. IT IS NOT A SUBSTITUTE FOR ESSENTIAL HEALTH BENEFITS COVERAGE AS DEFINED IN FEDERAL HEALTH LAW. IT IS NOT MEDICARE SUPPLEMENT INSURANCE. INSUREDS ELIGIBLE FOR MEDICARE SHOULD REVIEW THE GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE AVAILABLE FROM US.

Margaret M. Gray

Secretary

Chas F. Fy.

Chief Executive Officer

Table of Contents

Definitions

Actively at Work means that You are performing all the regular, material, and substantial duties of Your job 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 must be working at least 30 hours per week and being paid for the work performed. 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 work day preceding such time off.

Annual Enrollment Period means the 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.

Associated Company means an employer who is the Contract Holder's subsidiary or affiliate and are reported to Us in writing for inclusion under the Group Contract, provided that We have approved such request.

Calendar Year means the time period that begins on Your coverage effective date and continues through December 31 of that year; thereafter, it means January 1 through December 31.

Certificate means this document and any attached riders, if any, which explains Your insurance coverage.

Child/Children means Your unmarried Children from live birth to 26 years old. Your Children include:

- Biological children;
- Legally adopted children, children placed with You for adoption prior to legal adoption, and each of Your stepchildren;
- Foster children;
- Your Spouse's children; and
- Children for whom You or Your Spouse:
    - have been appointed the legal guardian; and
    - claim as a dependent on Your or Your Spouse's federal income tax returns.

A Child who is Your or Your Spouse'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 Children also include a Child who is older than 25 years of age and is:

- incapable of self-sustaining employment because of a mental or physical disability; and
- chiefly dependent on You for support and maintenance.

Proof of disability must be provided upon Our request. We may request proof of continued disability, but not more than once per year.

Complications of Pregnancy means a condition for which diagnosis is distinct from pregnancy but is adversely affected or caused by pregnancy.

Complications of Pregnancy includes, but is not limited to, non-elective Cesarean section; termination of ectopic pregnancy; spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible; acute nephritis or nephrosis; cardiac decompensation; missed abortion; and similar medical and surgical conditions of comparable severity.

Complications of Pregnancy do not include false labor; occasional spotting; morning sickness; Doctor prescribed rest; hyperemesis gravidarum; pre-eclampsia or any other condition associated with the

management of a difficult pregnancy not consisting of a nosologically distinct complication of pregnancy.

Confined or Confinement means the assignment to a bed as a resident inpatient in a medical facility (including a Hospital, Hospital Intensive Care Unit (ICU) or ICU Step Down Unit) on the advice of a Doctor; or Confinement in an Observation Unit within a Hospital for a period of more than 24 hours on the advice of a Doctor.

Contributory Insurance means insurance for which the Contract Holder has the right to require You to pay all or any portion of the Premium payments. The Schedule of Benefits shows whether Your insurance is Contributory Insurance or Non-Contributory Insurance.

Covered Loss means a loss, treatment, Sickness, Injury, or other condition for which benefits are payable under this Certificate.

Covered Person means You and Your Spouse and/or Child/Children who are covered under this Certificate**.**

Doctor means a licensed practitioner of the healing arts who is acting within the scope of their license. The term Doctor does not include a Covered Person or any Family Member.

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

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

Employer means, collectively, all employers included under the Group Contract.

Family Member means a Covered Person's Spouse, parents, stepparents, in-laws, brothers, sisters, stepbrothers, stepsisters, Children or grandchildren.

Group Contract means the insurance contract to which this Certificate is attached that was issued to the Contract Holder shown in the Group Contract Information section on the Schedule of Benefits.

High Risk Pregnancy means a pregnancy that includes increased risk of health problems before, during, or after delivery that can be caused by advanced maternal age, lifestyle choices, maternal health problems, Complications of Pregnancy, multiple pregnancy, or factors in a pregnancy history that indicates high risk.

Hospice Facility means a designated facility staffed by licensed health care professionals which is primarily engaged in providing medical services, emotional support and spiritual resources for people who are in the last stages of a serious Terminal Illness.

Hospital means an institution that:

- is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations;
- provides diagnostic, medical, and surgical treatment to sick or injured persons on an inpatient basis (or has such facilities available under a prearranged contract);
- has 24 hour a day supervision by a staff of Doctors; and
- has 24 hour a day nursing service by registered graduate Nurses.

Hospital does not include: a nursing home; a Rehabilitation Facility; an Urgent Care Facility; convalescent facility rest home; Hospice Facility; Skilled Nursing Facility, care for the aged or drug

addicts or treatment of alcoholics; or furnishes mainly homelike or custodial care, or training in the routines of daily living; or solely provides psychiatric services to mentally ill patients.

Infectious Disease means a condition that has been diagnosed by a Doctor as one of the following diseases: anthrax, bacterial cerebrospinal meningitis, cholera, covid-19, diphtheria, encephalitis, legionnaire's disease, lyme disease, malaria, methicillin-resistant staphylococcus aureus (MRSA), necrotizing fasciitis, osteomyelitis, pertussis (whooping cough), rabies, rocky mountain spotted fever, sepsis, tetanus, tuberculosis, or typhoid fever.

Injury means the bodily damage as the result of an unforeseeable and unexpected traumatic event. This must be the direct result of an accident and not the result of Sickness.

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

- provides the highest level of care and is restricted to the treatment of patients who are in acute and critical condition;
- is permanently furnished with emergency life-saving equipment and supplies that are immediately at hand;
- staffed 24 hours a day by Nurses who are specially trained to work in an ICU;
- equipped and staffed to monitor each patient's vital signs around-the-clock; and
- operates pursuant to any jurisdictional requirements for Intensive Care Units (ICU) 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 (ICU); 2) cardiac care units (CCU); and 3) Neonatal Intensive Care Units (NICU).

Intensive Care Units (ICU) 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.

Neonatal Intensive Care Unit (NICU) means a unit of a licensed hospital facility that provides around the clock, high level of care to its newborn patients.

Newborn Routine Confinement means a Hospital stay due to routine well-baby care provided immediately after a Child's birth.

Non-Contributory Insurance means 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 Your insurance is Contributory Insurance or Non-Contributory Insurance.

Nurse means 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 a Covered Person or any Family Member.

Observation Unit means a specified area within a Hospital, separate from the Emergency Room, where a patient can be monitored following a Surgical Procedure performed on an outpatient basis or treatment in the Emergency Department. The Observation Unit must:

- be under the direct supervision of a Doctor or Nurse;
- be staffed by Nurses assigned specifically to that unit; and
- provide care 24 hours per day, seven days per week.

Premium means the amount required to pay for Your insurance.

Qualified Dependent(s) means the Employee's Spouse or Child(ren) who meet the requirements within the Eligibility section of this Certificate.

Qualified Life Event means any of the following which constitute a change in family status:

- Your marriage or divorce or dissolution of partnership;
- the death of Your Spouse or Child(ren);
- the birth or adoption of Your Child(ren);
- employment or termination of employment of Your Spouse;
- switching from part-time to full-time employee status (or vice versa) by You or Your Spouse;
- You or Your Spouse taking an unpaid leave of absence; or
- a significant change in Your health coverage that is attributable to Your Spouse's employment.

Rehabilitation Facility means an appropriately licensed facility that provides rehabilitation care services on an inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by accidental Injury or Sickness to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of Doctors.

The Rehabilitation Facility may be part of a Hospital or a freestanding facility.

A Rehabilitation Facility is not a nursing home; an Urgent Care Facility; extended care facility; Skilled Nursing Facility; a rest home or home for the aged; a Hospice Facility; a place for alcoholics or drug addicts; or an assisted living facility.

Routine Childbirth means the vaginal delivery of a Child or Children, or the delivery of a Child or Children by elective cesarean section.

Routine Pregnancy means a normal pregnancy that does not have Complications of Pregnancy.

Sickness means any disorder of the body or mind of a Covered Person including Complications of Pregnancy. Sickness includes Routine Pregnancy and Routine Childbirth.

The term Sickness does not include:
- routine nursery care or well-baby care for a newborn child; or
- an Injury.

Skilled Nursing Facility means an institution or distinct part of an institution which:
- provides skilled nursing care for sick and injured persons;
- is supervised at all times by a Doctor or registered professional Nurse;
- has a Doctor available at all times;
- meets all licensing and legal requirements;
- 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
- 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 by extended care services.

Spouse means the person recognized as Your Spouse under the laws of the state in which the marriage was entered into. We reserve the right to request proof of the legally recognized status of a marriage.

Substance Abuse Facility means a residential treatment facility that provides specialized treatment, rehabilitation, or habilitation for persons with chemical dependencies, is licensed as such by the governing jurisdiction if required; and is not owned or operated by a Covered Person or a Family Member.

Surgical Procedure means the cutting into the skin or other organ to accomplish any of the following goals:
- further explore the condition for the purpose of diagnosis;

- take a biopsy of a suspicious lump;
- remove diseased tissues or organs;
- remove an obstruction;
- reposition structures to their normal position;
- redirect channels;
- transplant tissue or whole organs;
- implant mechanical or electronic devices;
- repair an area that has been injured or affected by trauma, overuse, or disease; or
- restore proper function.

Terminal Illness means a Doctor certifies that a Covered Person's Injury or Sickness is likely to result in their death within 24 months.

Urgent Care Facility means a health care facility:
- that maintains all appropriate licensing for a facility that provides urgent or immediate care;
- that is supervised by a Doctor;
- that is separate from a Hospital or is a separate unit within a Hospital; and
- the primary purpose of which is the offering and provision of immediate, short-term medical care.

We, Us, Our, Ours means The Prudential Insurance Company of America.

You, Your, Yours means an Employee.

Benefit Descriptions

HOSPITALIZATION BENEFITS

This coverage pays the following benefits for Hospital Indemnity. Benefit amounts and limitations are described within the Schedule of Benefits.

HOSPITAL ADMISSION BENEFIT

We will pay the amount shown in the Schedule of Benefits if a Covered Person is admitted for Confinement to a Hospital (Hospital Admission) due to a Covered Loss, subject to all of the following:

- The admission must occur within 90 days after the Covered Loss occurs; and
- The Hospital Admission Benefit is not payable for Emergency Room treatment, outpatient treatment, or a stay in an Observation Unit.

If the Covered Person moves from or to an Intensive Care Unit (ICU) after initial admission to a Hospital, We will pay the greater of the Hospital Admission Benefit and the Intensive Care Unit (ICU) Admission Benefit but not both.

This benefit is payable for a Covered Person only once per Hospital Admission, even if the Hospital Admission is caused by more than one Covered Loss. If the Covered Person is eligible for multiple Admission benefits on the same day, only the benefit paying the highest amount will be paid.

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

This benefit is not payable during a newborn Child's Newborn Routine Confinement.

HOSPITAL CONFINEMENT BENEFIT

We will pay the amount shown in the Schedule of Benefits for each 24-hour period, after the day of admission to the Hospital, that the Covered Person is Confined in the Hospital for treatment of a Covered Loss, subject to all of the following:

- The initial Hospital Confinement must begin within 90 days after the Covered Loss occurs; and
- The Hospital Confinement Benefit is not payable for a day in which the Intensive Care Unit (ICU) Confinement Benefit, Hospital Admission Benefit or Intensive Care Unit (ICU) Admission Benefit is payable or for a Confinement of less than 24 hours.

This benefit is payable for a Covered Person only once per day during a period of Confinement, even if the Confinement is caused by more than one Covered Loss.

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

This benefit is payable for a newborn Child's Newborn Routine Confinement following their birth.

INTENSIVE CARE UNIT (ICU) ADMISSION BENEFIT

We will pay the amount shown in the Schedule of Benefits, if a Covered Person, upon initial admission as an inpatient to a Hospital for treatment of a Covered Loss, is admitted to an Intensive Care Unit (ICU). The admission must occur within 90 days after the Covered Loss occurs.

If the Covered Person moves from or to an Intensive Care Unit (ICU) after initial admission to a Hospital, We will pay the greater of the Hospital Admission Benefit and the Intensive Care Unit (ICU) Admission Benefit but not both.

This benefit is payable for a Covered Person only once per ICU Admission, even if the ICU Admission is caused by more than one Covered Loss. If the Covered Person is eligible for multiple Admission benefits on the same day, only the benefit paying the highest amount will be paid.

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

INTENSIVE CARE UNIT (ICU) CONFINEMENT BENEFIT

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

- The Confinement in the ICU must begin within 90 days after the Covered Loss occurs; and
- The Intensive Care Unit (ICU) Confinement Benefit is not payable for a day in which the Hospital Confinement Benefit, Hospital Admission Benefit or Intensive Care Unit (ICU) Admission Benefit is payable or for a Confinement of less than 24 hours.

This benefit is payable for a Covered Person only once per day during a period of ICU Confinement, even if the Confinement is caused by more than one Covered Loss.

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

ADDITIONAL BENEFITS

An additional benefit may be payable under this coverage. Benefit amounts and limitations are described within the Schedule of Benefits.

HEALTH SCREENING BENEFIT

We will pay the amount shown in the Schedule of Benefits if a Covered Person takes one of the screening prevention measures listed below. Upon submission of proof, We will pay the Health Screening Benefit shown in the Schedule of Benefits for the day that the measure is taken subject to all of the following:

- We will not pay a Health Screening Benefit for a screening/prevention measure if benefits are paid or are payable for that same screening/prevention measure under another section of this Certificate.

We will pay the amount shown in the Schedule of Benefits if the Covered Person receives one of the following health screening tests while not Confined in a Hospital:

- annual physical;
- biopsies for cancer;
- blood chemistry panel;
- blood test to determine total cholesterol;
- blood test to determine triglycerides;
- bone marrow testing;
- breast MRI;
- breast sonogram;
- breast ultrasound;
- cancer antigen 15-3 blood test for breast cancer (CA 15-3);
- cancer antigen 125 blood test for ovarian cancer (CA 125);
- carcinoembryonic antigen blood test for colon cancer (CEA);
- carotid doppler;
- chest x-rays;
- clinical testicular exam;
- colonoscopy;
- complete blood count (CBC);
- dental exam;
- digital rectal exam (DRE);
- doppler screening for cancer;
- doppler screening for peripheral vascular disease;
- echocardiogram;
- electrocardiogram (EKG);
- electroencephalogram (EEG);
- endoscopy;
- eye exam;
- fasting blood glucose test;
- fasting plasma glucose test;
- flexible sigmoidoscopy;
- hearing test;
- hemoccult stool specimen;
- hemoglobin A1C;
- human papillomavirus (HPV) vaccination;
- immunization;
- lipid panel;
- mammogram;
- oral cancer screening;
- pap smears or thin prep pap test;
- prostate-specific antigen (PSA) test;
- serum cholesterol test to determine LDL and HDL levels;
- serum protein electrophoresis;
- skin cancer biopsy;
- skin cancer screening;
- skin exam;
- stress test on bicycle or treadmill;
- successful completion of smoking cessation program;
- tests for sexually transmitted infections (STIs);
- thermography;
- two-hour post-load plasma glucose test;
- ultrasounds for cancer detection;
- ultrasound screening of the abdominal aorta for abdominal aortic aneurysms;
- virtual colonoscopy.

HIGH RISK PREGNANCY BENEFIT

The Amount of Insurance shown in the Schedule of Benefits will be increased by the percentage shown under the High Risk Pregnancy Benefit in the Schedule of Benefits, for a Confinement due to a Covered Loss that is caused by complications due to High Risk Pregnancy.

This increased amount only applies to the Hospital Admission Benefit, Intensive Care Unit (ICU) Admission Benefit, Hospital Confinement Benefit, Intensive Care Unit (ICU) Confinement Benefit, and Hospital Observation Benefit.

The High Risk Pregnancy Benefit applies only to a Confinement due to Complications of Pregnancy of the Employee or Spouse and not to benefits paid for a Child.

HOSPITAL OBSERVATION BENEFIT

We will pay the amount shown in the Schedule of Benefits if a Covered Person incurs charges for and receives treatment in an Observation Unit in a Hospital for a period of at least 24 hours as a result of a Covered Loss, subject to the following:

- Treatment must be received within 180 days after the Covered Loss occurs.

This benefit is not payable for treatment received in an Emergency Room, Urgent Care Facility, or facility other than a Hospital.

MENTAL ILLNESS/NERVOUS DISORDER FACILITY CARE BENEFIT

We will pay the amount shown in the Schedule of Benefits for each day a Covered Person is being cared for at a facility, or unit of a Hospital, specializing in psychiatric care due to a Covered Loss. The benefit will be paid for each day of Confinement in a facility for Mental Illness or Nervous Disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders V (DSM-5).

The Mental Illness and Nervous Disorder medical care must meet all of the following:

- The medical care must be at the direction and under the care of a Doctor or licensed health care professional; and
- The medical care must begin within 30 days following a related Hospital Confinement or Intensive Care Unit (ICU) Confinement for 1 consecutive days or more.

If a Covered Person leaves a facility providing Mental Illness or Nervous Disorder care and becomes Confined again within 180 days for the same or related condition, We will treat the Confinement as a continuation of the prior Confinement. If more than 180 days have passed between the periods of Confinement, We will treat this additional Confinement as a new Confinement.

PREMATURE INFANT AND NEONATAL INTENSIVE CARE UNIT (NICU) BENEFIT

The Amount of Insurance shown in the Schedule of Benefits will be increased by the percentage shown under the Premature Infant and Neonatal Intensive Care Unit (NICU) Benefit in the Schedule of Benefits when a Covered Person has a qualified newborn Child who receives care in the NICU prior to discharge from the Hospital due to the following reasons diagnosed by a Doctor that requires special care by a NICU:

- Premature infant born before 37 weeks of pregnancy and has a low birth weight of 5.5 pounds or less; or

- has a medical condition diagnosed by a Doctor that requires special care by a Neonatal Intensive Care Unit (NICU).

The Premature Infant and Neonatal Intensive Care Unit (NICU) Benefit is subject to all of the following conditions:

- The Benefit applies only to a Confinement that begins within 10 days of the infant's birth; and
- The Benefit applies only to benefits paid for the Confinement of the Child and not to benefits paid for an Employee or Spouse.

This increased amount only applies to the Hospital Admission Benefit, Intensive Care Unit (ICU) Admission Benefit, Hospital Confinement Benefit, and Intensive Care Unit (ICU) Confinement Benefit.

SUBSTANCE ABUSE FACILITY CARE BENEFIT

We will pay the amount shown in the Schedule of Benefits for each day a Covered Person is Confined for care at a Substance Abuse Facility.

The Substance Abuse Facility Care must meet all of the following:

- The care must be at the direction and supervision of a Doctor or licensed health care professional;
- The care must begin within 30 day(s) following a related Hospital Confinement or Intensive Care Unit (ICU) Confinement of 1 consecutive days or more; and
- The Substance Abuse Facility must charge room and board for services.

If a Covered Person leaves a Substance Abuse Facility and becomes Confined again within 180 days for the same or related condition, We will treat the Confinement as a continuation of the prior Confinement. If more than 180 days have passed between the periods of Confinement, We will treat the Confinement as a new Confinement in the Substance Abuse Facility.

Eligibility, Effective Date and Termination

ELIGIBILITY

Employee Insurance
You may need to work for Your Employer for a continuous full-time period before You become eligible for the coverage. This is called the Employment Waiting Period. The Employment Waiting Period must be agreed upon by the Employer and Us and it will be shown in the Schedule of Benefits if applicable.

Subject to the Employment Waiting Period, You are eligible for Employee Insurance if You are a member of a Covered Class as shown in the Schedule of Benefits. You must also be Actively at Work and under the age of .

If You are an Employee of more than one Employer included under the Group Contract, 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.

Qualified Dependent Insurance
A Spouse or Child is eligible for Dependent Insurance on the later of:
- the date You are eligible for Employee Insurance; or
- the date they become a Qualified Dependent.

A Spouse may be a Qualified Dependent or an Employee under the Certificate, but not both at the same time.

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

Your Spouse or Child is not Your Qualified Dependent while they:
- are on active duty in the armed forces of any country; or
- are insured under the Group Contract as an Employee.

EFFECTIVE DATE

Enrollment
For Contributory Insurance, You must enroll on a form approved by Us and agree to pay the required contributions. You may enroll for Contributory Insurance:
- Within 31 days of when You could first be covered;
- Within 31 days of a Qualified Life Event; or
- During the Annual Enrollment Period.

Employee Insurance
If You enroll in coverage under this Certificate during the Annual Enrollment Period or when You could first be covered, Your coverage starts on the date Your enrollment is approved by Us, so long as the required Premium, including Your Cost of Insurance, is paid when due.

If You enroll in coverage under this Certificate due to a Qualified Life Event, Your coverage becomes effective on the date of the Qualified Life Event.

Qualified Dependent Insurance
If You have a Qualified Dependent when You become eligible for coverage and You elect Dependent

coverage, Your Qualified Dependent's coverage will begin on the date Your coverage begins. If additional Premium is required for Qualified Dependent coverage, it must be paid when due for coverage to be valid.

If You enroll a Qualified Dependent in coverage under this Certificate due to a Qualified Life Event, their coverage becomes effective on the date of the Qualified Life Event.

There are special rules for Qualified Dependent Children described below.

Newborn or Newly Adopted Qualified Dependent Child(ren) Insurance
Your Qualified Dependent Child(ren) who are born or placed in Your home for adoption while You are covered under the Group Contract are covered automatically for 31 days from the moment of live birth or date of placement for adoption.

If You have not elected Qualified Dependent Child(ren) insurance coverage at the time of the birth or date of placement, You must notify Us within 31 days of the newly eligible Dependent Child's birth or date of placement for adoption and pay the required additional Premium for Dependent Child insurance to continue coverage beyond the initial 31 day period.

Effective Date Delay for Employee Insurance
Your Employee Insurance will be delayed if You are not Actively at Work on the day Your insurance would otherwise begin. Instead, it will begin on the first day You are Actively at Work and meet 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 are not Actively at Work on the day that change would take effect, it will take effect on the first day You are Actively at Work. This Effective Date Delay rule does not apply to any decreases in Your insurance.

Effective Date Delay for Qualified Dependent Insurance
If a Qualified Dependent is confined for medical care or treatment, at home or elsewhere, on the day that Your Qualified Dependent Insurance, 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.

CHANGES TO COVERAGE

Increases and Decreases - Employee
You may elect to have Your Amount of Insurance under the coverage changed within 31 days of a Qualified Life Event. You must do this on a form approved by Us and agree to make any required Premium contributions.

If You request a decrease, the amount of Your insurance will be decreased on the first of the month following the date of Your written request.

Increases and Decreases - Qualified Dependents
You may elect to have the Amount of Insurance on Your Qualified Dependents changed within 31 days of a Qualified Life Event. You must do this on a form approved by Us and agree to make any required Premium contributions.

If You request a decrease in the Amount of Insurance for a Qualified Dependent, the Amount of Insurance for the Qualified Dependent will be decreased on the first of the month following the date of Your written request.

Changing Plans at Annual Enrollment - Employee
You may elect to have Your Amount of Insurance under the coverage changed during the Annual Enrollment Period. You must do this on a form approved by Us and agree to make any required

Premium contributions.

Changes will become effective on the date designated by the Contract Holder. The Effective Date Delay section applies to all changes except decreases.

Changing Plans at Annual Enrollment - Qualified Dependents
You may elect to have Your Qualified Dependent's Amount of Insurance under the coverage changed during the Annual Enrollment Period. You must do this on a form approved by Us and agree to make any required Premium contributions.

Changes will become effective on the date designated by the Contract Holder. The Effective Date Delay section applies to all changes except decreases.

TERMINATION

Your Employee Insurance, subject to the continuation options, will end on the date the first of the following occurs:

- You are no longer a member of a Covered Class;
- Your class is removed from the Covered Classes for the insurance;
- the Group Contract providing the insurance ends;
- You reach age 100;
- You die; or
- for Contributory Insurance, You fail to pay, when due, any required Premium contribution for Your insurance.

Insurance for a Qualified Dependent will end on the date the first of the following occurs:

- Your Employee Insurance ends;
- the Qualified Dependent ceases to be a Qualified Dependent;
- the Qualified Dependent Spouse reaches age 100;
- the Qualified Dependent dies;
- We receive written notice of Your request to terminate coverage for one or more of Your Qualified Dependents, applicable only to the Qualified Dependent(s) identified in Your request for termination; or
- the dissolution of Your marriage or partnership for Qualified Dependent Spouse coverage.

Continuation of Coverage

Continuation of Your Coverage
You may elect to continue coverage for You and Your Qualified Dependents when coverage for You and Your Qualified Dependents under the Group Contract would have otherwise ended due to Your termination of coverage for the following reasons:

- You are no longer part of a Covered Class; or
- Your insurance would have ended because the Group Contract, in the absence of this provision, would have ended.

To qualify for continuation of coverage, You must have been continuously insured under the Group Contract and/or the Employer's prior plan for at least 30 days immediately prior to the date Your insurance would have otherwise ended for one of the reasons shown above.

The coverage that may be continued is that which You had on the date Your coverage would have ended. We will mail to You a notice of Your right to continue the coverage. The notice will state the amount of the payments required for the continued coverage and the manner in which payments must be made.

If You want to continue coverage, Your first Premium payment must be sent to Us within 30 days after You elect to continue coverage.

Your continued coverage will end on the date the first of the following occurs:

- You reach age 100;
- You die; or
- You fail to make, when due, any Premium payment required for the continued coverage.

Qualified Dependent coverage will end on the date the first of the following occurs:

- Your continued coverage ends;
- the Qualified Dependent ceases to be a Qualified Dependent;
- the Qualified Dependent Spouse reaches age 100;
- the Qualified Dependent dies;
- We receive written notice of Your request to terminate coverage for one or more of Your Qualified Dependents, applicable only to the Qualified Dependent(s) identified in Your request for termination; or
- the dissolution of Your marriage or partnership for Qualified Dependent Spouse coverage.

Continued Eligibility for Insurance
Subject to the limitations described within this provision, We will continue to consider You eligible for insurance under the Group Contract if You cease to be Actively at Work as a result of one or more of the following:

- **Family Medical Leave of Absence:** If Your Actively at Work status ends due to an Employer approved family or medical leave, Your eligibility for insurance will continue up to the Maximum Period shown in the Schedule of Benefits.
- **Military Service:** If Your Actively at Work status ends due to entry into the armed forces that is subject to Uniform Services Employment and Reemployment Rights Act of 1994 (USERRA), Your eligibility for insurance will continue up to the Maximum Period shown in the Schedule of Benefits.

Continued eligibility for insurance under this provision will end upon the earliest of the following:

- The end of the Maximum Period shown in the Schedule of Benefits that is applicable to the specific reason for continued eligibility;
- The date that You become employed on a full-time basis with another employer, or in a different position with the Employer;

- The end of the period for which any required Premium contribution is not made, subject to the Grace Period;
- If continued eligibility is the result of military service, the day You fail to return to Actively at Work status following the end of military service subject to USERRA.

Premiums are required to continue Your eligibility for insurance under this provision, including Your Premium contributions, if any.

Unless otherwise stated, continued eligibility for insurance begins when You are no longer Actively at Work. If more than one continued eligibility provision applies, only the one with the longer duration will be applicable.

Notwithstanding any other provision of the Group Contract, if You are no longer Actively at Work due to termination of Your employment with the Employer, Your coverage under the Group Contract will terminate and continued eligibility under this provision will not apply.

Premium Provisions

Contributory Insurance Payment of Premiums
Premium contributions are to be paid by You to the Contract Holder. If Premium is not paid when due according to the Premium Payment Date shown in the Schedule of Benefits, insurance will end, subject to the Grace Period provision below.

Grace Period
A Grace Period of 31 days will be granted to You for payment of the required Premium contributions if You are billed directly for insurance. Your coverage will remain in force during the Grace Period. We will reduce any benefits payable for any claims incurred during the Grace Period by the amount of Premium due. Insurance will end on the last day of the Grace Period if the required Premium has not been paid.

Reinstatement
If any Premium is not paid when due, a later acceptance of Premium by Us or by any agent duly authorized by Us to accept such Premium, without requiring an application for reinstatement, shall reinstate Your coverage. However, if We or Our agent require an application for reinstatement, Your coverage will be reinstated upon the earlier of the approval of the application by Us, or the 45th day following the date the Premium was received by Us, unless We have previously notified You in writing of Our disapproval of the application.

The reinstated insurance shall cover only loss that occurs more than 10 days after the date of reinstatement. In all other respects, all parties shall have the same rights as under the Group Contract immediately before the due date of the defaulted Premium.

Any Premium accepted in connection with a reinstatement shall be applied to a period for which Premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

Claim Provisions

Notice of Claim
Notice of claim must be submitted to Us within 365 days of the date of loss. If You are not able to provide notice within this time, You must send it as soon as reasonably possible. Notice given to Us or to Our authorized agent with information sufficient to identify the Covered Person is considered notice to Us.

Claim Forms
Upon receipt of a notice of claim, We will provide claim forms to the claimant. If claim forms are not provided within 15 days after receiving notice of claim, the claimant can satisfy the proof of loss requirements of this Certificate by submitting written proof covering the occurrence, the character and the extent of the loss for which claim is made within the time required in this Certificate for providing proofs of loss.

Proof of Loss
You must send Us proof of loss satisfactory to Prudential by mail or electronically within 90 days after the date of loss. If it was not reasonably possible to provide proof of loss in that time, Your claim will not be invalidated or reduced due to late proof of loss. However, no proof of loss provided later than one year from time of loss will be accepted, unless You did not have the legal capacity to provide it.

When Benefits are Paid
Benefits that are payable for a Covered Loss will be paid immediately, but no later than the 30th day, after Our receipt of the necessary proof of loss.

To Whom Payable
We will pay all benefits to You. Any benefits that We owe You that have not been paid before You die will be paid to the first of the following: Your (a) surviving Spouse; (b) surviving Child(ren) in equal shares; (c) surviving parents in equal shares; (d) surviving siblings in equal shares; (e) estate.

Limits on Assignments
You have the absolute right to assign Your interests and obligations under the Group Contract. This includes, but is not limited to, the obligation to make contributions to keep the insurance in force and the right to benefits payable. We will recognize an assignment made by You if it is duly executed and a copy of the assignment is provided to Us and acknowledged.

Physical Exam
We, at Our own expense, have the right to examine the person whose loss is the basis of claim. We may do this when and as often as is reasonable while the claim is pending.

Legal Action
You may not initiate a legal action to recover benefits under Your coverage until 60 days after We receive sufficient proof of loss regarding the claim. No legal action shall be brought after 3 years from the time written proof of loss was required to be provided.

General Provisions

Time Limit on Certain Defenses
We have the right to void coverage if misstatements are made in the application for coverage. After 2 years from a Covered Person's coverage effective date, no misstatements, except fraudulent misstatements, made in the application for coverage will be used to void the Covered Person's coverage or deny a claim for a loss occurring after that 2-year period.

Any statement made by a Covered Person is a representation and not a warranty. No statement made by a Covered Person will be used to contest coverage unless the statement is in writing and signed, and a copy of the statement is given to the Covered Person, their representative, or beneficiary.

Entire Contract
The Group Contract, the Contract Holder's signed application, Your enrollment form, this Certificate, and any other attached riders, endorsements, or papers make up the entire contract of insurance.

Changes to the Contract
No change to the contract will be valid unless it was approved by Our executive officer and attached in writing. No agent has the authority to change the Group Contract or this Certificate or to waive any of its provisions.

Unpaid Premiums
If You owe Us Premiums when a claim is made, We may recover the unpaid Premium by reducing the benefit amount payable.

Workers' Compensation
The coverage provided by this plan doesn't replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

Conformity with State Statutes
Any provision of this Certificate that conflicts with the laws of the state where the Group Contract is issued on Your coverage effective date is amended to conform to the requirements of the state's laws.

Misstatement of Age
If Your age was misstated on Your enrollment form, We may adjust Premiums or benefit amounts to reflect the coverage that would have been provided for the correct age or void coverage if the correct age exceeds the maximum eligible age.

Exclusions

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

- suicide or attempted suicide.
- intentionally self-inflicted Injuries, or any attempt to inflict such Injuries.
- taking part in any riot or insurrection.
- war, or any act of war. War means declared or undeclared war and includes resistance to armed aggression.
- commission of a felony for which You have been convicted under state or federal law except the act of domestic violence.
- medical malpractice.
- an accident that occurs while the person is serving on full-time active duty for more than 31 days in any armed forces. But this does not include Reserve or National Guard active duty for training.
- participation in these hazardous activities: scuba diving; bungee jumping; base jumping; skydiving; ziplining; parachuting; hang gliding; paragliding; paramotoring; parascending; or ballooning.
- treatment for dental care or dental procedures, unless treatment is the result of a Covered Loss.
- elective procedures and/or reconstructive surgery, unless it is a result of trauma, infection or other diseases.
- cosmetic surgery, except when such surgery is performed to treat a Covered Loss, correct a disorder of normal bodily function or structure that was caused by a Covered Loss 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 a Covered Loss for which coverage is not otherwise excluded under this Certificate.

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

Light & Wonder, Inc. Hospital Indemnity Insurance Plan

Plan Number

501

Type of Plan

Employee Welfare Benefit Plan

Plan Sponsor

Light & Wonder, Inc.
6601 Bermuda Road
Las Vegas, Nevada 89119

Employer Identification Number

81-0422894

Plan Administrator

Light & Wonder, Inc.
Attention: Human Resources Department
6601 Bermuda Road
Las Vegas, Nevada 89119

702-525-0531

Agent for Service of Legal Process

Light & Wonder, Inc.
Attention: Human Resources Department
6601 Bermuda Road
Las Vegas, Nevada 89119

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 from the expiration of the initial 45-day appeal 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 Office of Outreach, Education and Assistance, 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.