

**Blanket Accident
Insurance Certificate**

Baxter Credit Union

**IMPORTANT NOTICES
BLANKET ACCIDENT**

If a Covered Person resides in one of the following states, the important notice will apply.

Illinois residents:

RIGHT TO FILE A COMPLAINT

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS.

PROBLEMS WITH YOUR INSURANCE? Your satisfaction is very important to us. If you are having problems with your insurance, do not hesitate to contact the insurance company to resolve your problem.

**Life Insurance Company of North America
GBS Consumer Advocacy
Attn: Lisa Koller
2000 Park Lane Drive
Pittsburgh, PA 15275
Email: GBSConsumerAdvocacy@newyorklife.com
Toll-free: (888) 842-4462
Fax: (646) 706-4296**

You can also contact the Illinois Department of Insurance and file a complaint. You can contact the Illinois Department of Insurance by contacting:

**Illinois Department of Insurance
320 W. Washington Street
Springfield, Illinois 62767
Toll-free: 1-866-445-5364
Tel: 217-782-4515
Fax: 217-782-5020
TDD: 1-866-323-5321**

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

**BLANKET ACCIDENT
CERTIFICATE OF INSURANCE**

We, Life Insurance Company of North America, called We, Us or Our, have issued a Blanket Accident Policy, ABL 963212 to Baxter Credit Union.

We certify that We insure all Eligible Persons who are enrolled according to the terms of the Blanket Accident Policy. Your coverage will begin according to the terms set forth in the Eligibility for Insurance and Effective Date of Insurance provisions shown in the *Eligibility, Effective Date and Termination Provisions*.

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

This is not the insurance contract. It does not waive or alter any terms of the Policy. You may examine the Policy at the office of the Policyholder.

This Certificate replaces any and all Certificates which may have been issued to You in the past under the Blanket Accident Policy.



Scott Berlin, President

**THIS CERTIFICATE PROVIDES LIMITED COVERAGE FOR ACCIDENT ONLY.
PLEASE READ YOUR CERTIFICATE CAREFULLY.
IT DOES NOT PAY BENEFITS FOR LOSS DUE TO SICKNESS.
THIS CERTIFICATE PAYS BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENT ONLY.**

BA-01-CE1000.00

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SCHEDULE OF BENEFITS

This Certificate is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, please read all the provisions carefully.

The *Schedule of Benefits* provides a brief outline of your coverage and benefits provided by this Certificate. Please read the *Conditions of Coverage* and *Description of Indemnity Benefits* sections for full details.

Certificate Effective Date: January 1, 2024
Policy Aggregate Maximum \$2,500,000
Applies To All benefits provided by this Policy

Not more than the Policy Aggregate Maximum specified above will be paid for all Covered Losses for all Covered Persons as the result of any one Covered Accident. If this amount does not allow all Covered Persons to be paid the amounts this policy otherwise provides, the amount paid will be the proportion of the Covered Person's loss to the total of all losses, multiplied by the Policy Aggregate Maximum.

Eligible Persons: Class 1 - All active, Employees of the Employer regularly working a minimum of 20 hours per week in the United States, who are citizens or permanent resident aliens of the United States.

CONDITIONS OF COVERAGE

The benefits provided by this Policy will be paid, subject to applicable conditions, limitations and exclusions, under the following coverages.

Business Travel Coverage
Personal Deviations covered No

Exposure and Disappearance Coverage

Felonious Assault and Violent Crime Coverage

BA-01-CE1100.00

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Principal Sum: 4 times Annual Compensation rounded to the next higher \$1,000, if not already a multiple thereof, subject to a maximum of \$500,000
Loss must occur within: 365 days of the Covered Accident

SCHEDULE OF COVERED LOSSES

Covered Loss	Benefit
Loss of Life	100% of the Principal Sum
Loss of Two or More Hands or Feet	100% of the Principal Sum
Loss of Sight of Both Eyes	100% of the Principal Sum
Loss of One Hand or One Foot and Sight in One Eye	100% of the Principal Sum
Loss of Speech and Hearing (in both ears)	100% of the Principal Sum
Quadriplegia	100% of the Principal Sum
Paraplegia	75% of the Principal Sum
Hemiplegia	50% of the Principal Sum
Uniplegia	25% of the Principal Sum
Coma	
Monthly Benefit	1% of the Principal Sum
Number of Monthly Benefits	11

Covered Loss	Benefit
When Payable	At the end of each month during which the Covered Person remains comatose
Lump Sum Benefit	100% of the Principal Sum
When Payable	Beginning of the 12th month
Loss of One Hand or Foot	50% of the Principal Sum
Loss of Sight in One Eye	50% of the Principal Sum
Loss of Speech	50% of the Principal Sum
Loss of Hearing (in both ears)	50% of the Principal Sum
Severance and Reattachment of One Hand or Foot	50% of the Principal Sum
Loss of Thumb and Index Finger of the Same Hand	25% of the Principal Sum
Loss of all Four Fingers of the Same Hand	25% of the Principal Sum
Loss of all the Toes of the Same Foot	20% of the Principal Sum

Age Reductions

The Covered Person's Accidental Death and Dismemberment Benefit will be reduced to the percentage of his Benefit in effect on the date preceding the first reduction, as shown below.

Age	Percentage of Benefit Amount
Age 70 or over -	50%

Benefit reductions will be effective on the Policy Anniversary Date coinciding with or next following the Covered Person's attainment of age as specified in schedule above.

ADDITIONAL ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Any benefits payable under these Additional Accident Benefits shown below are in addition to any other Accidental Death and Dismemberment benefits payable.

BEREAVEMENT AND TRAUMA COUNSELING BENEFIT

Benefit Amount	\$50 per session
Maximum Number of Sessions	5 sessions
Maximum Benefit Per Covered Accident	\$250

CHILD CARE CENTER BENEFIT

Benefit Amount	5% of the Employee's Principal Sum subject to a maximum of \$5,000 per year
Maximum Benefit Period	4 years or until the child turns 13 for each surviving Dependent Child
Default Benefit	\$1,000

FELONIOUS ASSAULT AND VIOLENT CRIME BENEFIT

Accidental Death and Dismemberment Benefit	10% multiplied by the percentage of the Principal Sum applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses</i> , subject to a maximum of \$10,000
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HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT

Benefit	10% of the Principal Sum subject to a maximum of \$10,000
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REHABILITATION BENEFIT

Benefit per Covered Accident	5% of the Principal Sum, subject to a maximum of \$10,000
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SEATBELT AND AIRBAG BENEFIT

Seatbelt Benefit	10% of the Principal Sum subject to a maximum of \$10,000
Airbag Benefit	5% of the Principal Sum subject to a maximum of \$5,000
Default Benefit	\$1,000

SPECIAL EDUCATION BENEFIT

Surviving Dependent Child Benefit	3% of the Principal Sum subject to a Maximum Benefit of \$3,000
Surviving Spouse Benefit	3% of the Principal Sum subject to a Maximum Benefit of \$3,000
Maximum Number of Annual Payments For Each Surviving Dependent Child	4
For Surviving Spouse	4
Default Benefit	\$1,000

BA-01-1101.14

GENERAL DEFINITIONS

Please note that certain words used in this Certificate have specific meanings. The words defined below and capitalized within the text of this Certificate have the meanings set forth below.

Aircraft

A vehicle which:

1. has a valid certificate of airworthiness; and
2. is being flown by a pilot with a valid license to operate the Aircraft.

Annual Compensation

An Employee's annual earnings for normal work established by the Policyholder for his job classification. It includes earnings received from commissions but not bonuses, overtime or other extra compensation.

Commissions will be averaged for the 12 months just prior to the date of the Covered Loss, or the months employed, if less than 12 months.

Changes in the Covered Person's amount of insurance resulting from a change in the Employee's amount of Annual Compensation take effect, subject to any Active Service requirement, on the date of change in Annual Compensation.

Covered Accident

An unforeseeable event that results directly, and independent of disease or bodily infirmity, in a Covered Injury or Covered Loss and meets all of the following conditions:

1. occurs while the Covered Person is insured under this Policy;
2. occurs under one of the Conditions of Coverage specified in the *Schedule of Benefits*;
3. is not contributed to by disease, Sickness, or mental or bodily infirmity;
4. is not otherwise excluded under the terms of this Policy.

Covered Injury

Any bodily harm that results directly, and independent of disease or bodily infirmity, from a Covered Accident.

Covered Person

An Eligible Person, as defined in the *Schedule of Benefits*, for whom required premium has been paid when due and for whom coverage under this Policy remains in force.

Employee

An Employee of the Employer who is in one of the Covered Classes.

Employer

The Policyholder and any affiliates, subsidiaries or divisions shown in the *Schedule of Affiliates* covered under this Policy on its effective date or a later date agreed to by Us.

He, His, Him

Refers to any individual, male or female.

Hospital

An institution that meets all of the following:

1. it is licensed as a Hospital pursuant to applicable law;
2. it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. it is managed under the supervision of a staff of medical doctors;
4. it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);
5. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis;
6. it charges for its services.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:

1. rehabilitation, convalescent, custodial, educational or nursing care;
2. the aged, drug addicts or alcoholics;
3. a Veteran's Administration Hospital or Federal Government Hospitals unless the Covered Person incurs an expense.

Nurse

A licensed graduate registered nurse (R.N.) or a licensed practical nurse (L.P.N.) who is not:

1. the Covered Person;
2. a parent, sibling, spouse or child of either the Covered Person or the Covered Person's spouse;
3. a person living in the Covered Person's household; or
4. a person employed or retained by the Policyholder.

Personal Deviation

An activity which:

1. is neither reasonably related to or incidental to the purpose of travel for which coverage is provided by this Policy; and
2. the Covered Person performs before, during or after covered travel.

When coverage is provided during a Personal Deviation, the time period covered is shown in the *Conditions of Coverage* section of the *Schedule of Benefits*.

Physician

A licensed health care provider practicing within the scope of his license and rendering care and treatment to the Covered Person that is appropriate for the condition and locality, and who is not:

1. the Covered Person;
2. a parent, sibling, spouse or child of either the Covered Person or the Covered Person's spouse;
3. a person living in the Covered Person's household;
4. a person employed or retained by the Policyholder; or
5. a person providing homeopathic, aroma-therapeutic, or herbal therapeutic services.

Policyholder

The entity, named on this Policy's face page, to which We issue this Policy.

Private Passenger Automobile

A validly registered, four wheel private passenger car, including Policyholder-owned cars, campers, motor homes, station wagons, sport utility vehicles, pick-up trucks and van-type cars that are not licensed commercially or being used for commercial purposes. Any vehicle being used as a taxicab, bus, or other public conveyance will not be considered a Private Passenger Automobile.

Sickness

A physical or mental illness, including pregnancy.

We, Us, Our

Life Insurance Company of North America

BA-01-1200.14

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

Policy Effective Date

The Insurance Company agrees to provide Accident Insurance Benefits described in this Policy in consideration of the Policyholder's application and payment of the Initial Premium when due. Insurance begins on the Policy Effective Date shown on this Policy's first page.

Effective Date for Newly-Acquired Affiliates

Insurance becomes effective for any newly-acquired affiliate of the Policyholder on the date it is acquired, if: We have been notified in writing within the time period specified in the *Schedule of Affiliates* and have agreed to provide insurance, and additional premium has been paid when due. If We are not notified within the required time period, insurance for the affiliate will become effective on the date we agree in writing to insure it and receive any additional premium due.

Individuals who are employees of an affiliate on its effective date of insurance under this Policy will be eligible for insurance on that date.

Eligibility

A person is eligible for insurance under this Policy when he meets the definition of Eligible Person shown in the *Schedule of Benefits*. An Eligible Person may be insured under only one Covered Class, even though he may be eligible under more than one Covered Class.

Effective Date for Individuals

Insurance becomes effective for the Eligible Person on the latest of the following dates:

1. the Policy Effective Date;
2. the date the person becomes eligible.

In no event will insurance for the Eligible Person become effective before the Policy Effective Date.

Effective Date of Changes

Any increase or decrease in the amount of insurance for the Covered Person resulting from:

1. a change in benefits provided by this Policy; or
2. a change in the Employee's Covered Class will take effect on the date of such change.

Termination of Insurance

Insurance for the Covered Person will end on the earliest of:

1. the date the person is no longer in an Eligible Class; and
2. the date the person enters full time active duty in any Armed Forces. We will refund any premium paid for any period of active duty when We receive proof of active duty. Active duty does not include Reserve or National Guard duty for training; and
3. the end of the period for which the last premium is paid; and
4. the date this Policy ends.

Termination does not affect a claim for a Covered Loss due to a Covered Accident that occurs before the termination date. However, in no instance will benefits extend beyond the earliest of:

1. the end of the Benefit Period; and
2. the date benefits equal to any applicable Benefit Limit, as shown in the *Schedule of Benefits*, have been paid; and
3. the date benefits equal to any applicable Policy Aggregate Maximum, as shown in the *Schedule of Benefits*, have been paid.

BA-01-1300.00

COMMON EXCLUSIONS

In addition to any benefit-specific exclusion, benefits will not be paid for any Covered Injury or Covered Loss which results directly and independent of disease or bodily infirmity from any of the following unless coverage is specifically provided for by name in the *Conditions of Coverages* and *Description of Indemnity Benefits* sections.

1. Intentionally self-inflicted Injury, suicide or any attempt thereat while sane or insane;
2. commission or attempt to commit a felony or being engaged in an illegal occupation;
3. commission of or active participation in a riot or insurrection;
4. declared or undeclared war or act of war;
5. flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface:
 - a. except as a fare-paying passenger on a regularly scheduled commercial or charter airline;
 - b. being flown by the Covered Person or in which the Covered Person is a member of the crew;
 - c. being used for:
 - i. crop dusting, spraying or seeding, giving and receiving flying instruction, fire fighting, sky writing, sky diving or hang-gliding, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; or
 - ii. any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on);
 - d. an ultra-light or glider;
 - e. being used by any military authority, except an Aircraft used by the Air Mobility Command or its foreign equivalent;
 - f. being used for the purpose of parachuting or skydiving;
 - g. designed for flight above or beyond the earth's atmosphere;
6. Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, including exposure, whether or not accidental, to viral, bacterial or chemical agents except for any injury or infection which results from accidental involuntary or unintentional ingestion of a contaminated substance;
7. travel in any Aircraft owned, leased or controlled by the Policyholder, or any of its subsidiaries or affiliates. An Aircraft will be deemed to be 'controlled' by the Policyholder if the Aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year;
8. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
9. a Covered Accident that occurs while engaged in the activities of active duty service in the military, navy or air force of any country or international organization. Covered Accidents that occur while engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days;
10. operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Accident occurred.

In addition, benefits will not be paid for services or treatment rendered by any person who is:

1. employed or retained by the Policyholder;
2. living in the Covered Person's household;
3. a parent, sibling, spouse or child of either the Covered Person or the Covered Person's spouse;
4. the Covered Person.

BA-01-1400.14

CLAIM PROVISIONS

Beneficiary

The beneficiary is the person or persons the Covered Person names or changes on a form executed by him and satisfactory to Us. This form may be in writing or by any electronic means agreed upon between Us and the Policyholder. Consent of the beneficiary is not required to affect any changes, unless the beneficiary has been designated as an irrevocable beneficiary, or to make any assignment of rights or benefits permitted by this Policy.

A beneficiary designation or change will become effective on the date the Covered Person executes it. However, We will not be liable for any action taken or payment made before We record notice of the change at our Home Office.

If more than one person is named as beneficiary, the interests of each will be equal unless the Covered Person has specified otherwise. The share of any beneficiary who does not survive the Covered Person will pass equally to any surviving beneficiaries unless otherwise specified.

If there is no named beneficiary or surviving beneficiary, or if the Covered Person dies while benefits are payable to him, We may make direct payment to the first surviving class of the following classes of persons:

1. spouse;
2. child or children;
3. parents;
4. siblings;
5. estate of the Covered Person.

Claim Forms

We send forms for filing proof of loss when We receive the notice of claim. If claim forms are not sent within 15 days after We receive notice, the proof requirements will be met by submitting, within the time fixed in this Policy for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which claim is made.

Legal Actions

No action at law or in equity will be brought to recover benefits under this Policy less than 60 days after satisfactory proof of loss has been furnished as required by this Policy. No such action will be brought after expiry of the applicable statute of limitations from the time proof of loss is required to be furnished.

Notice of Claim

Written or authorized electronic/telephonic notice must be given to Us or Our agent within 31 days after a Covered Accident occurs or the loss begins or as soon as reasonably possible, but in no case any longer than 15 months after the date of loss. If written or authorized electronic/telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic/telephonic notice was given as soon as was reasonably possible. Notice can be given at Our home office in Philadelphia, Pennsylvania, such other place as We may designate for the purpose, or to Our authorized agent. Notice should include the Policyholder's name and policy number and the Covered Person's name and address.

Manner of Payment of Claims

The Policyholder authorizes that any benefit payment due as a lump sum of \$5,000 or more shall be credited to a draft account with the Insurance Company, in the name of the beneficiary. The beneficiary may withdraw the entire proceeds at any time by issuing one or more drafts, or may withdraw lesser amounts, subject to a minimum account balance set by the Insurance Company from time to time. Interest shall be credited to such account at rates as determined from time to time by the Insurance Company.

Payment of Claims

All benefits will be paid in United States currency. Benefits for loss of life will be payable in accordance with the Beneficiary provision and these Claim Provisions. All other proceeds payable under this Policy, unless otherwise stated, will be payable to the Covered Person or to his estate. If any payee of benefits is a minor or otherwise legally incompetent, we will pay benefits to the person designated as his legal guardian or conservator.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay \$1,000 to a relative by blood or marriage whom We believe is equitably entitled. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment and release Us from all liability.

Physical Examination and Autopsy

We, at Our own expense, have the right and opportunity to examine the Covered Person when and as often as We may reasonably require while a claim is pending and to make an autopsy in case of death where it is not forbidden by law.

Proof of Loss

Written or authorized electronic proof of loss satisfactory to Us must be given to Us at Our office, within 90 days of the loss for which claim is made. If: (a) benefits are payable as periodic payments; and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which We are liable. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible. In any case, written or authorized electronic proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to the lack of legal capacity.

Recovery of Overpayment

If benefits are overpaid, We have the right to recover the amount overpaid by either of the following methods.

1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this Policy.

If there is an overpayment due when the Covered Person dies, We may recover the overpayment from the Covered Person's estate.

Time of Payment

We will pay benefits due under this Policy for any loss, other than a loss for which this Policy provides any periodic payment, immediately upon receipt of due written or authorized electronic proof of such loss. Subject to due written or authorized electronic proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us, unless otherwise shown in the *Benefits* sections of this Policy.

BA-01-1500.14 as modified by RA-BA-1000.00

ADMINISTRATIVE PROVISIONS

Premiums

Premium rates are expressed in, and premiums are payable in, United States currency. The premiums for this Policy will be based on the rates set forth in the *Rate Table*, the plan and amounts of insurance in effect for Covered Persons and the premium mode selected, as shown in the *Schedule of Benefits*. If Your coverage amounts are reduced due to age, premium will be based on the amounts of coverage in force on the day after the reduction took place. We will provide notifications of premiums due or premium changes, by mail to the most current address in our files, to the Policyholder.

Draft Accounts

The Insurance Company shall be entitled to retain, as part of its compensation, any earnings on draft accounts created in connection with benefit claims, in excess of interest credited under the terms of the policy.

Premium Rate Changes

We may change premium rates at the end of any Policy Term or any Premium Rate Guarantee Period with at least 31 days advance notice mailed to the last known address of the Policyholder. We will not increase premium rates more frequently than annually, unless certain changes shown in the Policy occur.

Any increase or decrease in rate will take effect on the date of the applicable change specified above. A pro rata adjustment will apply from the date of the change to the end of any period for which premium has been paid.

BA-01-CE1600.00 as modified by RA-BA-1000.00

GENERAL PROVISIONS

Assignment

We will be bound by an assignment of the Covered Person's insurance under this Policy only when the original assignment or a certified copy of the assignment, signed by the Covered Person and any irrevocable beneficiary, is filed with Us. The assignee may exercise all rights and receive all benefits assigned only while the assignment remains in effect and insurance under this Policy for the Covered Person remains in force.

This insurance may not be levied on, attached, garnisheed, or otherwise taken for a person's debts unless contrary to law.

Clerical Error

A person's coverage will not be affected by error or delay in keeping records of insurance under this Policy. If such error or delay is found, We will adjust the premium fairly.

Conformity with Statutes

Any provision in this Policy that is in conflict with the requirements of any state or federal law that apply to this Policy are automatically changed to satisfy the minimum requirements of such laws.

Misstatement of Fact

If the Policyholder has misstated any fact, all amounts payable under this Policy will be such as the premium paid would have purchased had such fact been correctly stated.

Workers Compensation Insurance

This Policy is not in place of and does not affect any requirements for coverage under any Workers' Compensation Insurance.

BA-01-CE1700.00

CONDITIONS OF COVERAGE

This Section describes the Conditions of Coverage under which benefits provided by this Policy become payable. Any benefits are payable only once, even though more than one Condition of Coverage may apply. Please read these and the *Common Exclusions* sections in order to understand all of the terms, conditions and limitations of coverage.

BA-01-2000.00

BUSINESS TRAVEL COVERAGE

We will pay benefits provided by this Policy, subject to all applicable conditions and exclusions, if the Covered Person suffers a Covered Loss caused directly, independent of disease or bodily infirmity, by a Covered Accident which occurs while the Covered Person is:

1. travelling:
 - a. on business of the Policyholder; and
 - b. in the course of the business of the Policyholder; and
 - c. on a trip authorized in advance by the Policyholder; and
 - d. away from the premises of the Policyholder; or
2. making a Short Stay away from the Policyholder's premises in his City of Permanent Assignment.

Definitions

For purposes of this coverage:

Short Stay means a trip on business for the Employer and authorized in advance by the Employer and lasting less than 60 days.

City of Permanent Assignment means the city where the Covered Person normally works.

Exclusions

Coverage for business travel is not provided during any of the following:

1. normal commuting between the Covered Person's home and place of work;
2. travel to another location where the Covered Person is expected to be assigned for more than 60 days;
3. any activity not authorized or organized, or not reimbursable, by the Policyholder;
4. the Covered Person's Personal Deviation, unless shown in the *Schedule of Benefits*;
5. the Covered Person's driving any vehicle or Private Passenger Automobile for pay or hire;
6. Business Travel Coverage is not in effect while the Covered Person is performing job duties: (a) during work hours; and (b) in a residence work area, which are specified in a written telecommuting agreement between him and his employer.

Other exclusions that apply to this coverage are in the *Common Exclusions* Section.

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EXPOSURE AND DISAPPEARANCE COVERAGE

We will pay benefits provided by this Policy, subject to all applicable conditions and exclusions, if the Covered Person suffers a Covered Loss which results directly, independent of disease or bodily infirmity, from a Covered Accident that causes the Covered Person's unavoidable exposure to the elements following the forced landing, sinking, stranding or wrecking of a vehicle.

If the Covered Person disappears and is not found within one year from the date of wrecking, sinking or disappearance of the conveyance in which the Covered Person was riding in the course of a trip which would otherwise be covered under this Policy, it will be presumed that the Covered Person's death resulted directly, independent of disease or bodily infirmity, from a Covered Accident.

Travel or trip must have been authorized in advance by the Policyholder.

Exclusions

Exclusions that apply to this coverage are in the *Common Exclusions* Section.

BA-01-2006.14

FELONIOUS ASSAULT AND VIOLENT CRIME COVERAGE

We will pay benefits provided by this Policy, subject to all applicable conditions and exclusions, when the Covered Person suffers a Covered Loss resulting directly, independent of disease or bodily infirmity, from a Covered Accident that occurs during a violent crime or felonious assault as described below. A police report detailing the felonious assault or violent crime must be provided before any benefits will be paid. The Covered Accident must occur while the Covered Person is on the business or premises of the Policyholder.

To qualify for benefit payment, the Covered Accident must occur during any of the following:

1. actual or attempted robbery or holdup;
2. actual or attempted kidnapping;
3. any other type of intentional assault that is a crime classified as a felony by the governing statute or common law in the state where the felony occurred.

Exclusions

Benefits will not be paid for treatment of any Covered Injury sustained or Covered Loss incurred during any violent crime or felonious assault committed by the Covered Person.

Other exclusions that apply to this coverage are in the *Common Exclusions* Section.

BA-01-2007.14

DESCRIPTION OF INDEMNITY BENEFITS

This *Description of Indemnity Benefits* section describes the Accident Indemnity Benefits provided by this Policy. Benefit amounts, benefit periods and any applicable aggregate and benefit-specific maximums are shown in the *Schedule of Benefits*. Please read these and the *Common Exclusions* sections in order to understand all of the terms, conditions and limitations applicable to these Benefits.

BA-01-2200.00

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Covered Loss We will pay the benefit for any one of the Covered Losses listed in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if the Covered Person suffers a Covered Loss resulting directly, independent of disease or bodily infirmity, from a Covered Accident within the applicable time period specified in the *Schedule of Benefits*.

If the Covered Person sustains more than one Covered Loss as a result of the same Covered Accident, We will pay the Benefit for the Covered Loss for which the largest benefit is payable. If a Covered Accident causes the Covered Person's death, the total of all Benefits We will pay for Accidental Death and any other Covered Losses will not exceed the Principal Sum.

Definitions **Loss of a Hand or Foot** means complete Severance through or above the wrist or ankle joint.

Loss of Sight means the total, permanent Loss of Sight of one eye. The Loss of Sight must be irrecoverable by natural, surgical or artificial means.

Loss of Speech means total and permanent loss of audible communication which is irrecoverable by natural, surgical or artificial means.

Loss of Hearing means total and permanent loss of ability to hear any sound in both ears which is irrecoverable by natural, surgical or artificial means.

Loss of a Thumb and Index Finger of the Same Hand or Loss of Four Fingers of the Same Hand means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).

Loss of Toes means complete Severance through the metatarsalphalangeal joint.

Paralysis or Paralyzed means total loss of use. A Physician must determine the loss of use to be complete and not reversible at the time the claim is submitted.

Quadriplegia means total Paralysis of both upper and lower limbs.

Hemiplegia means total Paralysis of the upper and lower limbs on one side of the body.

Paraplegia means total Paralysis of both lower limbs or both upper limbs.

Uniplegia means total Paralysis of one upper or one lower limb.

Coma means a profound state of unconsciousness from which the Covered Person is not likely to be aroused through powerful stimulation. The Coma must begin within 30 days of the Covered Accident, continue for 60 consecutive days and must be diagnosed and treated regularly by a Physician. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment of a Covered Injury unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of injuries sustained in that Covered Accident.

Severance means complete separation and dismemberment of the part from the body.

Exclusions Exclusions that apply to this benefit are in the *Common Exclusions* section.

BA-01-2202.14

BEREAVEMENT AND TRAUMA COUNSELING BENEFIT

We will pay the benefit shown in the *Schedule of Benefits* for counseling sessions, subject to all applicable conditions and exclusions, when the Covered Person and/or Immediate Family Member requires bereavement and trauma counseling because the Covered Person suffered a Covered Loss that resulted directly, independent of disease or bodily infirmity, from a Covered Accident. Such counseling must meet all of the following conditions:

1. covered bereavement and trauma counseling expenses must be incurred within one year from the date of the Covered Accident causing the Covered Loss;
2. the expense is charged for a bereavement or trauma counseling session for the Covered Person and/or one or more of his Immediate Family Members;
3. counseling is provided under the care, supervision or order of a Physician;
4. a charge would have been made if no insurance existed.

Definitions

For purposes of this benefit:

Immediate Family Member means a person who is related to the Covered Person in any of the following ways: Spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister) or child (includes legally adopted child or stepchild).

Exclusions

Exclusions that apply to this benefit are in the *Common Exclusions* Section.

BA-01-2209.14

CHILD CARE CENTER BENEFIT

We will pay benefits shown in the *Schedule of Benefits* for the care of each surviving Dependent Child in a Child Care Center if the Covered Person's death results directly, independent of disease or bodily infirmity, from a Covered Accident and he is survived by one or more Dependent Children under Age 13; who

1. was enrolled in a Child Care Center on the date of the Covered Accident; or
2. enrolls in a Child Care Center within 365 days from the date of the Covered Accident.

This benefit will be payable to the Surviving Spouse if the Spouse has custody of the child. If the Surviving Spouse does not have custody of the child, benefits will be paid to the child's legally appointed guardian. Payments will be made at the end of each 12 month period that begins after the date of the Covered Person's death. A claim must be submitted to Us at the end of each 12 month period with proof of enrollment and attendance. A 12 month period begins:

1. when the Dependent Child enters a Child Care Center for the first time, within the period specified in 2. above, after the Covered Person's death; or
2. on the first of the month following the Covered Person's death, if the Dependent Child was enrolled in a Child Care Center before the Covered Person's death.

Each succeeding 12-month period begins on the day immediately following the last day of the preceding period. Pro rata payments will be made for periods of enrollment in a Child Care Center of less than 12 months.

If there is no surviving Dependent Child at the time of the Covered Person's Covered Accidental Death, the Default Benefit shown in the *Schedule of Benefits* will be paid to the Covered Person's beneficiary.

Definitions

For purposes of this benefit:

Child Care Center is a facility which:

1. is licensed and run according to laws and regulations applicable to child care facilities; and
2. provides care and supervision for children in a group setting on a regular, daily basis.

A Child Care Center does not include any of the following:

1. a Hospital;
2. the child's home;
3. care provided during normal school hours while a child is attending grades one through twelve.

Dependent Child means a Covered Person's unmarried child who is one of the following.

1. A child from live birth to 19 years old.
2. A child who is 19 or more years old but less than 26 years old, enrolled in a school as a full-time student and primarily supported by the Covered Person. Coverage will continue during any period between school terms or school years as long as We are provided satisfactory proof that he has enrolled for the next following school term or year.
3. A child who is 19 or more years old, primarily supported by the Covered Person, and incapable of self-sustaining employment by reason of mental or physical handicap.

A child, for purposes of this provision, includes the Covered Person's:

1. natural child;
2. adopted child, beginning with any waiting period pending finalization of the child's adoption;
3. stepchild who resides with the Covered Person;
4. child for whom the Covered Person is legal guardian, as long as the child resides with the Covered Person and depends on him for financial support. Financial support means that the Covered Person is eligible to claim the dependent for purposes of Federal and State income tax returns.

Spouse means the Covered Person's lawful spouse.

Surviving Spouse will include the Covered Person and covered Spouse.

Exclusions

Exclusions that apply to this benefit are in the *Common Exclusions* Section.

BA-01-2218.14

FELONIOUS ASSAULT AND VIOLENT CRIME BENEFIT

We will pay the benefit shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, when the Covered Person suffers a Covered Loss resulting directly, independent of disease or bodily infirmity, from a Covered Accident that occurs during a violent crime or felonious assault as described below. A police report detailing the felonious assault or violent crime must be provided before any benefits will be paid. The Covered Accident must occur while the Covered Person is on the business or premises of the Policyholder.

To qualify for benefit payment, the Covered Accident must occur during any of the following:

1. actual or attempted robbery or holdup;
2. actual or attempted kidnapping;
3. any other type of intentional assault that is a crime classified as a felony by the governing statute or common law in the state where the felony occurred.

Exclusions

Benefits will not be paid for treatment of any Covered Injury sustained or Covered Loss incurred during any violent crime or felonious assault committed by the Covered Person.

Other exclusions that apply to this benefit are in the *Common Exclusions* Section.

BA-01-2222.14

HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT

We will pay the benefit shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, when the Covered Person suffers a Covered Loss other than a Loss of Life, resulting directly, independent of disease or bodily infirmity, from a Covered Accident.

This benefit will be payable if all of the following conditions are met:

1. before the date of the Covered Accident causing such Covered Loss, the Covered Person did not require the use of any adaptive devices or adaptation of residence and/or vehicle;
2. as a direct result of such Covered Loss, the Covered Person now requires such adaptive devices or adaptation of residence and/or vehicle to maintain an independent lifestyle;
3. the Covered Person requires home alteration or vehicle modification within one year of the date of the Covered Accident.

Exclusions

Exclusions that apply to this benefit are in the *Common Exclusions* Section.

BA-01-2224.14

REHABILITATION BENEFIT

We will pay the benefit shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, when the Covered Person requires Rehabilitation after sustaining a Covered Loss resulting directly, independent of disease or bodily infirmity, from a Covered Accident.

The Covered Person must require Rehabilitation within two years after the date of the Covered Loss.

Definition

For purposes of this benefit:

Rehabilitation means medical services, supplies, or treatment, or Hospital confinement (or part of a Hospital confinement) that satisfies all of the following conditions:

1. are essential for physical rehabilitation required due to the Covered Person's Covered Loss; and
2. meet generally accepted standards of medical practice; and
3. are performed under the care, supervision or order of a Physician; and
4. prepare the Covered Person to return to his or any other occupation.

Exclusions

Exclusions that apply to this benefit are in the *Common Exclusions* Section.

BA-01-2231.14

SEATBELT AND AIRBAG BENEFIT

We will pay the benefit shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, when the Covered Person's death results directly, independent of disease or bodily infirmity, from a Covered Accident while wearing a seatbelt and operating or riding as a passenger in a Private Passenger Automobile. An additional benefit is provided if the Covered Person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag).

Verification of proper use of the seatbelt at the time of the Covered Accident and that the Supplemental Restraint System properly inflated upon impact must be a part of an official police report of the Covered Accident or be certified, in writing, by the investigating officer(s) and submitted with the Covered Person's claim to Us.

If such certification or police report is not available or it is unclear whether the Covered Person was wearing a seatbelt or positioned in a seat protected by a properly functioning and properly deployed Supplemental Restraint System, We will pay a default benefit shown in the *Schedule of Benefits* to the Covered Person's beneficiary.

Definitions

For purposes of this benefit:

Supplemental Restraint System means an airbag that inflates upon impact for added protection to the head and chest areas.

Exclusions

Exclusions that apply to this benefit are in the *Common Exclusions* Section.

BA-01-2233.14

SPECIAL EDUCATION BENEFIT

We will pay the benefit, up to the Maximum Benefit shown in the *Schedule of Benefits*, for each qualifying Dependent Child and surviving Spouse of the Covered Person whose death resulted directly, independent of disease or bodily infirmity, from a Covered Accident for which an Accidental Death Benefit is payable under this Policy. This benefit is subject to the conditions and exclusions described below.

A qualifying surviving Dependent Child must:

1. begin studies as a full-time student at a school of higher learning before reaching the limiting Age shown in the Dependent Child definition below; and
2. continue his education as a full-time student; and
3. incur expenses for tuition, fees, books, room and board, transportation and any other costs payable directly to, or approved and certified by, such school.

A qualifying surviving Spouse must:

1. begin studies in any accredited school for the purpose of retraining or refreshing skills needed for employment within one year of the date of the Covered Person's Covered Accident; and
2. continue studies in such accredited school; and
3. incur expenses payable directly to, or approved by, such school.

Payments will be made to each qualifying Dependent Child or to the child's legal guardian, if the child is a minor at the end of each year for the number of years shown in the *Schedule of Benefits*. We must receive proof satisfactory to Us of the Dependent Child's enrollment and attendance within 31 days of the end of each year. The first year for which a Special Education Benefit is payable will begin on the first of the month following the date the Covered Person died, if the surviving Dependent Child was a full-time student on that date in an accredited school of higher learning beyond the 12th grade; otherwise on the date he begins studies in such school. Each succeeding year for which benefits are payable will begin on the date following the end of the preceding year.

If no Dependent Child qualifies for Special Education Benefits within 365 days of the Covered Person's death, We will pay the default benefit shown in the *Schedule of Benefits* to his beneficiary.

Payments will be made to the surviving Spouse at the end of each year for the number of years shown in the *Schedule of Benefits*. We must receive proof satisfactory to Us of the Spouse's enrollment and attendance within 31 days of the end of each year. The first year for which a Special Education Benefit is payable will begin on the date the surviving Spouse begins studies in an accredited school for the first time following the date the Covered Person died. Each succeeding year for which benefits are payable will begin on the date following the end of the preceding year.

If a surviving Spouse does not qualify for Special Education Benefits within 365 days of the Covered Person's death, We will pay the default benefit shown in the *Schedule of Benefits* to his beneficiary.

Definitions

For the purposes of this benefit:

Dependent Child means a Covered Person's unmarried child who is one of the following.

1. A child from live birth to 19 years old.
2. A child who is 19 or more years old but less than 26 years old, enrolled in a school as a full-time student and primarily supported by the Covered Person. Coverage will continue during any period between school terms or school years as long as We are provided satisfactory proof that he has enrolled for the next following school term or year.
3. A child who is 19 or more years old, primarily supported by the Covered Person, and incapable of self-sustaining employment by reason of mental or physical handicap.

A child, for purposes of this provision, includes the Covered Person's:

1. natural child;
2. adopted child, beginning with any waiting period pending finalization of the child's adoption;
3. stepchild who resides with the Covered Person;
4. child for whom the Covered Person is legal guardian, as long as the child resides with the Covered Person and depends on him for financial support. Financial support means that the Covered Person is eligible to claim the dependent for purposes of Federal and State income tax returns.

Spouse means the Covered Person's lawful Spouse.

Exclusions

Exclusions that apply to this benefit are in the *Common Exclusions* Section.

BA-01-2235.14

LIFE INSURANCE COMPANY OF NORTH AMERICA

AMENDATORY RIDER TRAVEL ASSISTANCE SERVICES

Policyholder: Baxter Credit Union
Policy No.: ABL 963212

Effective Date: January 1, 2024

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

Travel Assistance Services

We will pay the cost of the Covered Services described below, subject to all applicable conditions and exclusions, resulting directly and independently of all other causes, from a Covered Medical Emergency. The Covered Medical Emergency must occur and Covered Services must be incurred during the course of travel or other activities covered by the Policy, and while the Covered Person is either more than 100 miles from his permanent residence or outside of his country of permanent residence.

To obtain services, the Covered Person must contact Us or our authorized service provider at the phone number provided by the Policyholder. All services must be provided by our authorized service provider unless authorized by Us.

Covered Services

Covered Services includes the reasonable costs for medically necessary services provided by Us or by our authorized service provider, and which are provided by our authorized service provider unless authorized by Us, for any of the following.

Emergency Medical Evacuation

Medically necessary expenses for Transportation of the Covered Person to the nearest adequate medical facility, if adequate medical care is not available at the Covered Person's location.

Cost of any medically necessary services or equipment that the Covered Person receives during transportation covered under this provision.

Cost of transporting qualified and licensed medical professional(s) or an Immediate Family Member or a Travel Companion if medically required to escort the Covered Person during transportation covered under this provision.

Transportation will be provided by medically equipped specialty aircraft, commercial airline, train or ambulance depending upon the medical needs and available transportation specific to each case.

Return Transportation

Any increase in the cost of the Covered Person's return transportation to his or her home or work location following emergency medical evacuation covered under this benefit, above the cost of the Covered Person's original scheduled return transportation.

Any increased cost of the transportation for an Immediate Family Member or Travel Companion of the Covered Person to return to his or her primary residence, if he or she accompanied the Covered Person on the trip where the emergency occurred, and was as a result not able to return to his or her primary residence when originally scheduled.

Unless it is medically necessary for another means of transportation to be provided, such return transportation costs will be covered for the same class of travel as the Covered Person's original transportation.

In the case of an Immediate Family Member who is a child under age 18, who is left without a parent, guardian or other adult to accompany the child, we will cover the reasonable cost of an escort to accompany the child to the nearest airport. If under the applicable rules of the airline, the child is too young to travel unaccompanied by an adult, we will pay the round trip economy airfare for an adult family member from the child's place of residence to the airport nearest the child.

Immediate Family Member Visit

Expenses for an Immediate Family Member or Friend of the Covered Person to visit the Covered Person during hospitalization away from the Covered Person's primary residence, if the Covered Person is hospitalized or expected to remain hospitalized for 7 or more consecutive days following emergency medical evacuation covered under this benefit. Such expenses shall be limited to one person only, and shall include round-trip economy airfare, and an allowance of \$150.00 per day for up to 7 days for meals and lodging.

If a Dependent Child is evacuated, we will pay the expenses of an adult Immediate Family Member who accompanied the Dependent Child on the trip where the emergency occurred, to accompany the Dependent Child during the evacuation and during the Dependent Child's return to his or her place of residence. If the Dependent Child was not accompanied by an adult Immediate Family Member on the trip where the emergency occurred, we will pay expenses described in the preceding paragraph, without regard to the expected duration on the hospitalization.

Repatriation of Remains

If the Covered Person dies as a result of a Covered Medical Emergency, or during a Medical Evacuation covered by this Policy, the following expenses will be covered:

1. Embalming;
2. Cremation in the locality where death occurred and urn for return ashes;
3. A container appropriate for transportation of remains;
4. Autopsy if required by law;
5. Expenses of securing documentation necessary for return of remains;
6. Transportation of the body or remains to the Covered Person's place of permanent residence.

Definitions

"Covered Medical Emergency" means an injury, illness or disease diagnosed by a Physician which causes severe or acute symptoms that, if not provided with immediate care or treatment, would reasonably be expected to result in serious deterioration of the Covered Person's health or place his life in jeopardy; and which first manifests itself suddenly and unexpectedly during the travel or other hazards covered by the Policy.

"Immediate Family Member" means a spouse, parent, child, step-parent, step-child, brother or sister, step-brother or step-sister, grandparent, or Domestic Partner.

"Travel Companion" means an individual, other than an Immediate Family Member, who accompanied the Covered Person on the trip where the emergency occurred.

"Friend" means a person chosen by the Covered Person, other than an Immediate Family Member who is able to visit the Covered Person.

Limitations

Covered Expenses are secondary to, and in excess of, any expenses for medical or transportation services paid or payable under any workers' compensation law.

No payment will be made for services without authorization of those services by Us or the express written approval of Our designated approved vendor.

If coverage for these services is provided under more than one policy issued by the Insurance Company, we will only provide or pay for these services under one such policy.

Exclusions

The exclusions listed in the Policy's Common Exclusions section will not apply to Medical Evacuation and Repatriation Expenses, except for exclusions relating to war or acts of war, suicide or intentionally self-inflicted injury. In addition, the following exclusions apply specifically to this coverage:

1. Non-Emergency, routine or minor medical problems, tests and exams where there is no clear or significant risk of death or imminent serious Injury or harm to the Covered Person;
2. a condition which would allow for treatment at a future date convenient to the Covered Person and which does not require Emergency evacuation or repatriation;
3. expenses incurred if a purpose of the Covered Person's trip is to obtain medical treatment;
4. services provided for which no charge is normally made, in the absence of insurance;
5. transportation for the Covered Person's vehicle and/or other personal belongings;
6. Initial transport by ambulance following a Covered Medical Emergency occurring in the United States;
7. services incurred while serving in the armed forces of any country;
8. services required or obtained in any location which, due to war, insurrection, natural disaster or other reasons, is not reasonably accessible to our designated service provider, unless approved in advance by us;
9. claim payments that are illegal under applicable law;
10. expenses which are paid or payable under any workers' compensation law;
11. Medical care or services scheduled for your or your doctor's convenience which are not considered an emergency.

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

LIFE INSURANCE COMPANY OF NORTH AMERICA



Scott Berlin, President

BA-01-2410b.00

**AMENDATORY RIDER
DOMESTIC PARTNER/CIVIL UNION PARTNER COVERAGE**

Policyholder: Baxter Credit Union
Policy No.: ABL 963212

Effective Date: January 1, 2024

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

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

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

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

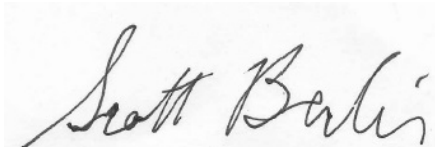
TL-007153

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

1. The definition of “Spouse” remains unchanged.
2. For purposes of any provision of the policy providing for payment of benefits to relatives of the Employee, a Domestic Partner/Civil Union Partner shall be included only if:
 - a. the Domestic Partner/Civil Union Partner meets the requirements of the definition of Domestic Partner/Civil Union Partner referenced in item 1, or;
 - b. the Employee and Domestic Partner have furnished the Employer or the Insurance Company with a signed statement affirming that the requirements referenced in item 2 within the definition of Domestic Partner are met.
3. A Domestic Partner/Civil Union Partner shall be deemed eligible to be enrolled for insurance or eligible for Additional Benefits on the latest of:
 - a. the date of registration under Item 1 of the definition of Domestic Partner/Civil Union Partner;
 - b. the date that the Employee is eligible for insurance under the Policy; or;
 - c. the effective date of this Amendment to the Policy.
4. A child of a Domestic Partner/Civil Union Partner may only be eligible to be insured or eligible for Additional Benefits if:
 - a. the child is primarily dependent on the Employee for financial support;
 - b. the Employee has a legal obligation of support of the child; or
 - c. the Employee is the child’s legal guardian.

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

LIFE INSURANCE COMPANY OF NORTH AMERICA

A handwritten signature in cursive script that reads "Scott Berlin". The signature is written in black ink on a light-colored background.

Scott Berlin, President

TL-007153

**SUPPLEMENTAL INFORMATION
for**

BCU Health and Welfare plan (“Plan”)

**required by the Employee Retirement
Income Security Act of 1974**

As a Plan participant in Baxter Credit Union's Plan, you are entitled to certain information, rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

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

IMPORTANT INFORMATION ABOUT THE PLAN

- The Plan is established and maintained by Baxter Credit Union, the Plan Sponsor.
- The Employer Identification Number (EIN) is 23-7250155.
- The Plan Number is 501.
- The Insurance Plan is administered directly by the Plan Administrator with benefits provided, in accordance with the provisions of the group insurance contract, ABL 963212 (“Policy”), issued by LIFE INSURANCE COMPANY OF NORTH AMERICA (“Insurance Company”).
- The Plan Administrator is:
Baxter Credit Union
340 North Milwaukee Avenue
Vernon Hills, IL 60061
8476023429

The Plan Administrator has authority to control and manage the operation and administration of the Plan.

- The Plan Sponsor may terminate, suspend, withdraw or amend the Plan, in whole or in part, at any time, subject to the applicable provisions of the Policy. (Your rights upon termination or amendment of the Plan are set forth in your Certificate.)
- The agent for service of legal process is the Plan Administrator.
- The Plan of benefits is financed by the Employer.
- The date of the end of the Plan Year is December 31.

YOUR RIGHTS AS SET FORTH BY ERISA

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

WHAT YOU SHOULD DO AND EXPECT IF YOU HAVE A CLAIM

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

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

A disability "claim" is any claim which requires a determination of disability by the Insurance Company regardless of the type of policy under which it arises (for example, short/long term disability, waiver of premium, etc.). A disability claim is "filed" as of the date the Insurance Company first receives, in writing (including electronically) or by telephone (through the Insurance Company's intake department), notice that a claimant is seeking disability benefits under the Policy. The

notice of claim received should provide the date of disability/loss, the claimant's name and address, and the group Policy holder's name and address. Properly filed claims will be decided with independence and impartiality.

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

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

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

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

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

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

A written request for appeal must be received by the Insurance Company within 180 days from the date the claimant received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived. The Insurance Company has 45 days from the date it receives a request for appeal to provide its decision. Under

special circumstances, the Insurance Company may require more time to review the claim and can extend the time for decision, once, by an additional 45 days. If this should happen, the Insurance Company must provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Insurance Company's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Insurance Company receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

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

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

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

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

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

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

A non-disability "claim" is any claim which does not require a determination of disability by the Insurance Company regardless of the type of policy under which it arises (for example, a death claim, an accident claim, etc.). A non-disability

claim is “filed” as of the date the Insurance Company first receives, in writing or by telephone (through the Insurance Company’s intake department), notice that a claimant is seeking benefits under the Policy. The notice of claim should include the group Policy holder’s name, the Policy and Certificate number and the claimant’s name and address.

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

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

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

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

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

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

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

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

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

**UNDERWRITTEN BY:
LIFE INSURANCE COMPANY OF NORTH AMERICA
a New York Life Insurance company**

Class 1

02/2024



**GROUP BENEFIT
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