Group Life
Insurance Certificate

The Broad Institute Inc.
IMPORTANT NOTICES

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

Arizona, Florida and Maryland residents:

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

Texas residents:

IMPORTANT NOTICE: To obtain information or make a complaint:

You may call Life Insurance Company of North America toll free telephone number for information or to make a complaint at:
1-800-547-5515

You may also write to Life Insurance Company of North America at:

ATT: Charlene Bush
1601 Chestnut Street, TL16D
Philadelphia, PA 19192

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:
1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax (512) 475-1771
Web: http://www.tdi.state.tx.us
Email: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim you should contact Life Insurance Company of North America first. If the dispute is not resolved, you may contact the Texas Department of Insurance
AVISO IMPORTANTE: Para obtener información o para someter una queja:

Usted puede llamar al número de teléfono gratis de Connecticut General Life Insurance Company’s para información o para someter una queja al: **1-800-547-5515**

Usted también puede escribir a Life Insurance Company of North America at:

ATT: Charlene Bush
1601 Chestnut Street, TL16D
Philadelphia, PA 19192

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos o quejas al:
**1-800-252-3439**

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
Fax (512) 475-1771
Web: http://www.tdi.state.tx.us
Email: ConsumerProtection@tdi.state.tx.us

**DISPUTAS SOBRE PRIMAS O RECLAMOS:**

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el Life Insurance Company of North America primero. Si no resuelve la disputa, puede entonces comunicarse con el departamento (TDI).
**Washington Residents:**

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

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

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

Benefits paid under the Accelerated Benefits provision will reduce the Death Benefit payable for life insurance.

Benefits payable under the Accelerated Benefits provision may be taxable. If so, the Employee or the Employee’s beneficiary may incur a tax obligation. As with all tax matters, an Employee should consult with a personal tax advisor to assess the impact of this benefit. Accelerated Benefits are not payable if life insurance coverage under the Policy is not in force.

TL-004788
FOREWORD

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

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

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

Insurance benefits described in the following pages will apply to you if your Employer has made this coverage available to you at no cost or you have elected the benefit and authorized payroll deduction for the required premium.
We, the LIFE INSURANCE COMPANY OF NORTH AMERICA, have issued a Group Policy, FLX-965450, to TRUSTEE OF THE GROUP INSURANCE TRUST FOR EMPLOYERS IN THE SERVICES INDUSTRY on behalf of The Broad Institute Inc.

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

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

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

William J. Smith, President
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SCHEDULE OF BENEFITS

Policy Effective Date: January 1, 2014
Certificate Effective Date: January 1, 2020
Policy Anniversary Date: January 1
Policy Number: FLX-965450

Class Definition

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

All active, Full-time Employees of the Employer that are not citizens of the United States and are working in the United States, regularly working a minimum of 20 hours per week.

Your Eligibility Waiting Period

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

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

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

LIFE INSURANCE BENEFITS

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

Employee Benefits

Basic Benefit
   Guaranteed Issue Amount: the lesser of 2 times your Annual Compensation
   Maximum Benefit: the lesser of 2 times Annual Compensation or $800,000

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

Voluntary Benefit
   Guaranteed Issue Amount: 1, 2, 3, 4 or 5 times your Annual Compensation
   the greater of a) or b) below:
   a) the lesser of 3 times Annual Compensation or $200,000, or
   b) an amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan
   Maximum Benefit: the lesser of 5 times Annual Compensation or $1,500,000
   Benefit Level: 1 times Annual Compensation to a maximum of $200,000

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

When you are age 65 or older, your Life Insurance Benefit will reduce to the percentage shown below:

- 65% of the Life Insurance Benefit at age 65
- 42% of the Life Insurance Benefit at age 70
- 27% of the Life Insurance Benefit at age 75
- 20% of the Life Insurance Benefit at age 80
- 15% of the Life Insurance Benefit at age 85
- 12% of the Life Insurance Benefit at age 90
- 7% of the Life Insurance Benefit at age 95

A change in Life Insurance Benefits due to a change in your age will become effective on the date of the change coinciding with or next following your birthday.

Terminal Illness Benefit

Maximum Benefit: The insured can elect up to $500,000

Automatic Increase Feature

If your Voluntary Life Insurance Benefit is based on Annual Compensation, it will automatically increase. It will automatically increase, subject to the conditions below.

Conditions for Automatic Increase:
1. the Employer provides the Insurance Company with the required notice of an increase in Annual Compensation; and
2. you are in Active Service on the effective date of the increase.

If you are not in Active Service on that date, your benefit will not increase until you return to Active Service.

You may stop the Automatic Increase Feature at any time. If you stop the feature, it may not be restarted at a later date.

Spouse or Domestic Partner Benefits

Voluntary Benefit

Guaranteed Issue Amount: An amount elected in units of $10,000
the greater of a) or b) below:

- a) $50,000, or
- b) an amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan

Maximum Benefit: $100,000

Terminal Illness Benefit

Maximum Benefit: $80,000
**Dependent Child Benefits**

Voluntary Benefit  
An amount elected in units of $1,000

Maximum Benefit:  
$10,000

The Maximum Benefit for a Dependent Child who is less than 6 months old is $1,000.

All Dependent Child benefits are Guaranteed Issue.

**Annual Enrollment Period**

*For Employees*

During an Annual Enrollment Period, if you are currently insured under the Voluntary Life Insurance portion of this Policy, you may increase your Voluntary Life Insurance Benefit by one Benefit Level, as long as the total Benefit does not exceed the Guaranteed Issue Amount, without satisfying the Insurability Requirement. Guaranteed Issue Amounts and Benefit Levels are shown above. Insurance will be effective on the Policy Anniversary following the Annual Enrollment Period.

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

Insurance Benefits for you may be reduced at any time. A request for a Benefit reduction received during an Annual Enrollment Period will become effective on the Policy Anniversary following the Annual Enrollment Period. Any other Benefit reduction will be effective on the date the Insurance Company receives the completed change form.

**Life Status Change**

*For Employees*

Within 31 days after a Life Status Change, if you are currently insured under the Voluntary Life Insurance portion of this Policy, you may increase your Voluntary Life Insurance Benefit by one Benefit Level, as long as the total Benefit does not exceed the Guaranteed Issue Amount, without satisfying the Insurability Requirement. Guaranteed Issue Amounts and Benefit Levels are shown above. Insurance will be effective on the Policy Anniversary following the Life Status Change.

You may increase coverage for a Benefit in excess of amounts described above, only if you satisfy the Insurability Requirement. Any excess amounts will be effective on the later of the Policy Anniversary following the Life Status Change or the date the Insurance Company agrees in writing to insure you.

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

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

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

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

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

Spouse
Your Spouse is eligible to be insured on the date you are eligible or the date he or she becomes your Spouse, if later. You must be insured for Voluntary Life Insurance in order to elect spouse coverage.

For eligibility purposes, your Spouse must be a lawful Spouse and not legally separated from, divorced from, or widowed by you. He or she must be under age 70 to be eligible.

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

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

WHEN COVERAGE BEGINS

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

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

If you are required to contribute to the cost of this insurance, you may elect insurance for yourself, your Spouse and Dependent Children only by authorizing payroll deduction in a form approved by the Employer and us. The effective date of this insurance depends on the date and amount of insurance elected.
If you elect coverage within 31 days after you become eligible to enroll or increase coverage, the Guaranteed Issue Amount will be effective on the latest of the following dates:
1. The Policy Effective Date.
2. The date you authorize payroll deduction for this insurance.
3. The date the Employer or Insurance Company receives the completed enrollment form.

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

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

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

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

TL-004712

**Takeover Provision**

*Special Terms Applicable to Previously Insured Employees Not in Active Service*

If you are not in Active Service on the Policy Effective Date, you are not covered under the Policy. However, We agree to provide a death benefit equal to the lesser of:
1. the amount due under this Policy (without regard to the Active Service provision), or
2. the amount that would have been due under the Prior Plan had it remained in force.

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

These special terms will end on the earliest of the following dates:
1. the date you meet the Active Service requirements;
2. the date insurance terminates for one of the reasons stated in the When Coverage Ends provision;
3. 12 months after the Policy Effective Date; or
4. the last day you would have been covered under the Prior Plan if that plan was still in force.

TL-009020
WHEN COVERAGE ENDS

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

WHEN COVERAGE CONTINUES

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

In these circumstances, your insurance may continue as follows.
1. For an Employer approved unpaid leave of absence, up to 6 months.
2. For layoff, up to 1 month.
3. For an Employer approved family medical leave, up to the later of the period of the approved FMLA leave or the leave period required by the laws of the state in which the Employee is employed.

Continuation for Disability for Employees over Age 60
If you become Disabled and are age 60 or over, the Life Insurance Benefits shown in the Schedule of Benefits will be continued, provided premiums are paid, until the earlier of the following dates:
1. The date you are no longer Disabled.
2. The date you are Disabled for 12 consecutive months.
3. The date coinciding with the end of the last period for which premiums are paid.
4. The date the Policy is terminated by us.

Amount of Insurance
If you die while you are Disabled and coverage is continued under this provision, we will pay a Death Benefit equal to the amount in effect on the date you became Disabled. However, the Life Insurance Benefit will be subject to the provisions of the Policy that reduce the coverage amount because of age, retirement, payment of an Accelerated Benefit or a change in class. Automatic increases in Life Insurance Benefits will end while coverage is continued under this provision. We will pay benefits only if due proof of your continuous Disability is received within one year of the date of the loss.

“Disability”/”Disabled” means because of Injury or Sickness you are unable to perform all the material duties of your Regular Occupation; or are receiving disability benefits under the Employer’s plan.

“Regular Occupation” means the occupation you routinely perform at the time the Disability begins. We will consider the duties of the occupation as it is normally performed in the general labor market in the national economy.
Extended Death Benefit with Waiver of Premium

Extended Death Benefit
If you become Disabled and are less than age 60, the Life Insurance Benefits shown in the Schedule of Benefits will be extended without premium payment until the earlier of the following dates:
1. The date you are no longer Disabled; or
2. 12 months after the end of your Active Service.

Amount of Insurance
If you die while you are Disabled and coverage is extended under this provision, we will pay a Death Benefit equal to the amount in effect on the date you became Disabled. However, the Life Insurance Benefit will be subject to the provisions of the Policy that reduce the coverage amount because of age, retirement, payment of an Accelerated Benefit or a change in class. Automatic increases in Life Insurance Benefits will end while premiums are waived. We will pay benefits only if due proof of your continuous Disability is received within one year of the date of the loss.

“Disability”/“Disabled” means because of Injury or Sickness you are unable to perform the material duties of your Regular Occupation; or are receiving disability benefits under the Employer’s plan.

“Regular Occupation” means the occupation you routinely perform at the time the Disability begins. We will consider the duties of the occupation as it is normally performed in the general labor market in the national economy.

Waiver of Premium
If you submit satisfactory proof that you have been continuously Disabled for 9 months, coverage will be extended up to Social Security Normal Retirement Age.

Such proof must be submitted to us no later than 3 months after the date the Waiver Waiting Period ends. Premiums will be waived from the date we agree in writing to waive premiums for you.

After premiums have been waived for 12 months, they will be waived for future periods of 12 months, if you remain Disabled and submit satisfactory proof that Disability continues. Satisfactory proof must be submitted to us 3 months before the end of the 12-month period.

Amount of Insurance
If you die while you are Disabled and coverage is continued under this provision, we will pay a Death Benefit equal to the amount in effect on the date you became Disabled. However, the Life Insurance Benefit will be subject to the provisions of the Policy that reduce the coverage amount because of age, retirement, payment of an Accelerated Benefit or a change in class. Automatic increases in Life Insurance Benefits will end while premiums are waived. We will pay benefits only if due proof of your continuous Disability is received within one year of the date of the loss.

Termination of Waiver
Your insurance will end on the earliest of the following dates.
1. The date you are no longer Disabled;
2. The date you refuse to submit to any physical examination required by us;
3. The date you refuse to participate in a Rehabilitation Plan for which the Insurance Company determines you to be eligible;
4. The last day of the 12-month period of Disability during which you fail to submit satisfactory proof of continued Disability;
5. Social Security Normal Retirement Age.
“Disability/Disabled” means because of Injury or Sickness you are unable to perform the material duties of your Regular Occupation, or are receiving disability benefits under the Employer's plan, during the initial 9 months of Disability. Thereafter, you must be unable to perform all of the material duties of any occupation which you may reasonably become qualified based on education, training or experience, or are subject to the terms of a Rehabilitation Plan approved by the Insurance Company.

“Regular Occupation” means the occupation the Employee routinely performs at the time the Disability begins. The Insurance Company will consider the duties of the occupation as it is normally performed in the general labor market in the national economy.

Rehabilitation During a Period of Disability
If the Insurance Company determines that you are a suitable candidate for rehabilitation, the Insurance Company may require you to participate in an assessment and Rehabilitation Plan, not to exceed 18 months, at our expense. The Insurance Company has the sole discretion to approve your participation in a Rehabilitation Plan and to approve a program as a Rehabilitation Plan. If you fail to fully cooperate in all required phases of the Rehabilitation Plan and assessment without Good Cause, your insurance under the Policy will end.

“Good Cause” means a medical reason preventing participation, in whole or in part, in the Rehabilitation Plan. Satisfactory proof of Good Cause must be provided to the Insurance Company.

“Rehabilitation Plan” means a written plan designed to enable the Employee to return to work. The Rehabilitation Plan will consist of one or more of the following phases:
1. Rehabilitation, under which the Insurance Company may provide, arrange or authorize educational, vocational or physical rehabilitation or other appropriate services;
2. Work, which may include modified work and work on a Part-time basis.

“Part-time” means regularly working less than the number of full time hours set by the Employer as a regular work day for Employees in an Eligible Class of Employees in the Policy.

WHAT IS COVERED

LIFE INSURANCE BENEFITS

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

Accelerated Benefits
Any benefits payable under this Accelerated Benefits provision will reduce the Death Benefit payable for Life Insurance. Any automatic increases in Life Insurance Benefits will end when benefits are payable under this provision.

Terminal Illness Benefit
We will pay a Terminal Illness Benefit if we determine you or your Spouse are Terminally Ill. The amount of this benefit is up to 80% of the Life Insurance Benefit in effect for you or your Spouse on the date we determine you are Terminally Ill up to the Maximum Benefit Amount shown in your Schedule of Benefits for this option. The Terminal Illness Benefit is payable only once in an Insured's lifetime.
Determination of Terminal Illness

For the purpose of determining the existence of a Terminal Illness, we will require you to submit the following proof:
1. A written diagnosis and prognosis by two Physicians licensed to practice in the United States.
2. Supportive evidence satisfactory to us, including but not limited to radiological, histological or laboratory reports documenting the Terminal Illness.

We may require, at our expense, you to be examined and a review of the documented evidence by a Physician of our choice.

"Terminal Illness" means a person is diagnosed by a Physician to have a prognosis of 12 months or less to live.

LIFE INSURANCE EXCLUSIONS

If an Insured commits suicide, while sane or insane, within 2 years from the date the Insured's insurance under the Policy becomes effective, Voluntary Life Insurance Benefits will be limited to a refund of the premiums paid on the Insured's behalf. The suicide exclusion applies from the effective date of any additional benefits or increases in Life Insurance Benefits.

Except for any amount of benefits in excess of the Prior Plan's benefits, this exclusion will not apply to you if you were covered under the Prior Plan for more than two years. If you were not insured for two years under the Prior Plan, credit will be given for the time you were insured.

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

CLAIM PROVISIONS

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

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

Claim Forms
When we receive notice of claim, we will send claim forms for filing proof of loss. If we do not send claim forms within 15 days after notice is received by us, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof, or proof by any other electronic/telephonic means authorized by us, of the nature and extent of the loss.
Claimant Cooperation Provision
If you fail to cooperate with us in our administration of your claim, we may terminate the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

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

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

Written proof, or any other electronic/telephonic means authorized by us, of loss for Accelerated Benefits must be furnished 90 days after the date of diagnosis. This proof must describe the occurrence, character and diagnosis for which claim is made.

In case of claim for any other loss, proof must be furnished within 90 days after the date of such loss.

If it is not reasonably possible to submit proof of loss within these time periods, we will not deny or reduce any claim if proof is furnished as soon as reasonably possible. Proof must, in any case, be furnished not more than a year later, except for lack of legal capacity.

Time of Payment
Benefits due under the Policy for a loss, other than a loss for which the Policy provides installment payments, will be paid immediately upon receipt of due written proof of such loss.

Subject to the receipt of satisfactory written proof of loss, all accrued benefits for loss for which the Policy provides installment payments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof, unless otherwise stated in the Description of Benefits.

Manner of Payment of Claims
The Policyholder authorizes that any benefit payment due as a lump sum of $5,000.00 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.

To Whom Payable
Death Benefits will be paid to the Insured's named beneficiary, if any, on file at the time of payment or to the certificate owner if alive. If there is no named beneficiary or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives: spouse; child or children; mother or father; brothers or sisters; or to the executors or administrators of the Insured's estate. We may reduce the amount payable by any indebtedness due.
All benefits payable under the Accelerated Benefits section are payable to the Insured, if living. If the Insured dies prior to the payment of an eligible claim for an Accelerated Benefit, benefits will be paid in accordance with the provisions applicable to the payment of Life Insurance proceeds, unless the Insured has directed us otherwise in writing. However, any payment made by us prior to notice of the Insured's death shall discharge us of any benefit that was paid.

All other benefits unless otherwise stated in the Policy, will be payable to the Insured or the certificate owner if other than the Insured.

Any other accrued benefits which are unpaid at your death will, at our option, be paid either to your beneficiary or to the executor or administrator of your estate.

If we pay benefits to the executor or administrator of your estate or to a person who is incapable of giving a valid release, we may pay up to $1,000 to a relative by blood or marriage whom we believe is equitably entitled. This good faith payment satisfies our legal duty to the extent of that payment.

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

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

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

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

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

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

TL-004724
ADMINISTRATIVE PROVISIONS

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

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

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

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.

Reinstatement of Insurance
Your coverage may be reinstated without satisfying the Insurability Requirement, if your insurance ends because you are on an unpaid leave of absence and you apply for Reinstatement within 31 days of your return to Active Service.

After your insurance ends, it may be reinstated at any date prior to five years after the date of termination if the following conditions are met.
1. The Policy is still in force.
2. You are eligible under the Policy.
3. You send us a written request for reinstatement and a new enrollment form.
4. The required premium is paid.
5. The Insurability Requirement, if applicable, is satisfied.

GENERAL PROVISIONS

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

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

Misstatement of Age
If an Insured's age has been misstated, we will adjust all benefits to the amounts that would have been purchased for the correct age.
Workers' Compensation Insurance
The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance Law.

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

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

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

DEFINITIONS

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

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

Active Service
If you are an Employee, you are in Active Service with the Employer on a day which is one of the Employer's scheduled work days if either of the following conditions are met.
1. You are actively at work. This means you are performing your regular occupation for the Employer on a Full-time basis, either at one of the Employer's usual places of business or at some location to which the Employer's business requires you to travel.
2. The day is a scheduled holiday, vacation day or period of Employer approved paid leave of absence, other than disability or sick leave after 7 days.
You are considered in Active Service on a day which is not one of the Employer's scheduled work days only if you were in Active Service on the preceding scheduled work day.

Annual Compensation
Annual Compensation means an Employee's annual wage or salary as reported by the Employer for work performed for the Employer as of the date the covered loss occurs. It does not include amounts received as bonuses, commissions, overtime pay or other extra compensation.
**Dependent Child**
Your unmarried child who meets the following requirements.
1. A child from live birth but less than 26 years old;
2. A child who is 26 or more years old, primarily supported by you and incapable of self-sustaining employment by reason of mental or physical incapacity.

The term "child" means:
   a. your natural child;
   b. your legally adopted child, beginning with any waiting period pending finalization of the child’s adoption. It also means the legally adopted child of your Spouse provided the child is living with, and is financially dependent upon you;
   c. a stepchild born to your Spouse and who is living with and financially dependent upon you;
   d. a child less than 26 years old (unless the child otherwise satisfies the requirement of paragraph 2 above) for whom you are the court-appointed legal guardian and who resides with and is financially dependent upon you.

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

**Employer**
The Employer who has subscribed to the Policyholder and for the benefit of whose Employees this policy has been issued. The Employer, named as the Subscriber on the front of this Policy, includes any affiliates or subsidiaries covered under the Policy. The Employer is acting as your agent for transactions relating to this insurance. You shall not consider any actions of the Employer as actions of the Insurance Company.

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

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

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

**Insurance Company**
The Insurance Company underwriting the Policy is named on your certificate cover page. References to the Insurance Company have been changed to "we", "our", "ours", and "us" throughout the certificate.

**Insured**
You are an Insured if you are eligible for insurance under the Policy, insurance is elected for you, the required premium is paid and your coverage is in force under the Policy.
Life Status Change
A Life Status Change is an event recognized by the Employer's Flexible Benefits Plan as qualifying you to make changes in benefit selections at a time other than an Annual Enrollment Period.

If the Employer does not sponsor a Flexible Benefits Plan or if it is no longer in effect, the following events are Life Status Changes.
1. Marriage
2. Divorce, annulment or legal separation
3. Birth or adoption of a child
4. Death of your spouse
5. Termination of your spouse's employment
6. A change in the benefit plan available to your spouse
7. A change in employment status for you or your spouse that affects your eligibility for benefits

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

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

Sickness
The term Sickness means a physical or mental illness.

Spouse
Your current lawful spouse under age 70.
AMENDATORY RIDER
DOMESTIC PARTNER/CIVIL UNION PARTNER COVERAGE

Policy No. FLX-965450
Effective Date: January 1, 2014

Eligible Classes to which this Rider applies: All Classes

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 or Former 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 not been legally married to any other person within the previous six months, and has no Domestic Partner/Civil Union Partner other than the Employee during the previous six months, and is the Employee’s sole Domestic Partner/Civil Union Partner;
   c. Has signed a Domestic Partner/Civil Union declaration with the Employee, if the Employee resides in a jurisdiction which provides for Domestic Partner/Civil Union Partner declarations;
   d. Has not signed a Domestic Partner/Civil Union Partner declaration with any other person within the last 6 months;
   e. 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/civil union 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/Civil Union 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/Civil Union Partner as beneficiary under a retirement plan or a life insurance policy.
      7. The Employee has designated the Domestic Partner/Civil Union Partner as beneficiary of the Employee’s or Former Employee’s will.
      8. Each partner has agreed in writing to assume the financial responsibility for the welfare of the other.
f. Is not so closely related by blood to the Employee’s or Former Employee as to prohibit legal marriage in their state of residence.

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

3. A person who was legally married to the Employee under the laws of a state permitting marriage of partners of the same sex, where the Employee and Domestic Partner/Civil Union Partner currently reside in a state that does not recognize a valid marriage. This shall not apply if:
   a. the marriage has been terminated by legal process, or;
   b. either the Employee or the Domestic Partner/Civil Union Partner has entered into a valid marriage, civil union or domestic partnership under state law.

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 3, or;
   b. the Employee, and Domestic Partner/Civil Union 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/Civil Union Partner are met.

3. A Domestic Partner/Civil Union Partner shall be deemed eligible to be enrolled for insurance on the latest of:
   a. the date of registration under Item 1 of the definition of Domestic Partner/Civil Union Partner;
   b. the date that the Employee is eligible for insurance under the Policy; 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 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.
Any provision of the Policy that otherwise excludes any person who is not legally able to marry the Employee is changed by the following:

In the case of any person of the same sex as the Employee, the exclusion of persons legally able to marry will not apply for the first 12 months that the Employee’s or Former Employee’s state of residence allows same-sex couples to marry.

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

LIFE INSURANCE COMPANY OF NORTH AMERICA

William J. Smith, President

TL-007153
SUPPLEMENTAL INFORMATION
for
The Broad Institute Welfare Benefits Plan
required by the Employee Retirement
Income Security Act of 1974

As a Plan participant in The Broad Institute Inc.’s Insurance Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

You should refer to the attached Certificate for a description of when you will become eligible under the Plan, the amount and types of benefits available to you, and the circumstances under which benefits are not available to you or may end. 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 The Broad Institute Inc., the Plan Sponsor.

- The Employer Identification Number (EIN) is 26-3428781.

- 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, FLX-965450, issued by LIFE INSURANCE COMPANY OF NORTH AMERICA.

- The Plan Administrator is: The Broad Institute Inc.
  415 Main Street
  Cambridge, MA 02142
  ATTN: Benefits Office
  617-714-7000

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

- The Plan Sponsor may terminate, suspend, withdraw or amend the Plan, in whole or in part, at any time, subject to the applicable provisions of the Policy. (Your rights upon termination or amendment of the Plan are set forth in your Certificate.)

- The agent for service of legal process is the Plan Administrator.

- The Plan of benefits is financed by the Employer and Employees.

- The date of the end of the Plan Year is December 31.
WHAT YOU SHOULD DO AND EXPECT IF YOU HAVE A CLAIM

When you are eligible to receive benefits under the Plan, you must request a claim form or obtain instructions for submitting your claim telephonically or electronically, from the Plan Administrator. All claims you submit must be on the claim form or in the electronic or telephonic format provided by the Insurance Company. You must complete your claim according to directions provided by the Insurance Company. If these forms or instructions are not available, you must provide a written statement of proof of loss. After you have completed the claim form or written statement, you must submit it to the Plan Administrator.

The Plan Administrator has appointed the Insurance Company as the named fiduciary for adjudicating claims for benefits under the Plan, and for deciding any appeals of denied claims. 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 law.

The Insurance Company has 45 days from the date it receives your claim for disability benefits, or 90 days from the date it receives a claim for any other benefit, to determine whether or not benefits are payable to you in accordance with the terms and provisions of the Policy. The Insurance Company may require more time to review your claim if necessary due to circumstances beyond its control. If this should happen, the Insurance Company must notify you in writing that its review period has been extended for up to two additional periods of 30 days (in the case of a claim for disability benefits), or one additional period of 90 days (in the case of any other benefit). If this extension is made because you must furnish additional information, these extension periods will begin when the additional information is received. You have up to 45 days to furnish the requested information.

During the review period, the Insurance Company may require a medical examination of the Insured, at its own expense; or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify you of the date and time of the examination and the physician’s name and location. It is important that you keep any appointments made since rescheduling examinations will delay the claim process. If additional information is required, the Insurance Company must notify you, in writing, stating the information needed and explaining why it is needed.

If your claim is approved, you will receive the appropriate benefit from the Insurance Company.

If your claim is denied, in whole or in part, you must receive a written notice from the Insurance Company within the review period. The Insurance Company’s written notice must include the following information:

1. The specific reason(s) the claim was denied.
2. Specific reference to the Policy provision(s) on which the denial was based.
3. Any additional information required for your claim to be reconsidered, and the reason this information is necessary.
4. In the case of any claim for a disability benefit, identification of any internal rule, guideline or protocol relied on in making the claim decision, and an explanation of any medically-related exclusion or limitation involved in the decision.
5. A statement informing you of your right to appeal the decision, and an explanation of the appeal procedure, including a statement of your right to bring a civil action under Section 502(a) of ERISA if your appeal is denied.
Appeal Procedure for Denied Claims

Whenever a claim is denied, you have the right to appeal the decision. You (or your duly authorized representative) must make a written request for appeal to the Insurance Company within 60 days (180 days in the case of any claim for disability benefits) from the date you receive the denial. If you do not make this request within that time, you will have waived your right to appeal.

Once your request has been received by the Insurance Company, a prompt and complete review of your claim must take place. This review will give no deference to the original claim decision, and will not be made by the person who made the initial claim decision. During the review, you (or your duly authorized representative) have the right to review any documents that have a bearing on the claim, including the documents which establish and control the Plan. Any medical or vocational experts consulted by the Insurance Company will be identified. You may also submit issues and comments that you feel might affect the outcome of the review.

The Insurance Company has 60 days from the date it receives your request to review your claim and notify you of its decision (45 days, in the case of any claim for disability benefits). Under special circumstances, the Insurance Company may require more time to review your claim. If this should happen, the Insurance Company must notify you, in writing, that its review period has been extended for an additional 60 days (45 days in the case of any claim for disability benefits). Once its review is complete, the Insurance Company must notify you, in writing, of the results of the review and indicate the Plan provisions upon which it based its decision.

YOUR RIGHTS AS SET FORTH BY ERISA

As a participant in The Broad Institute Inc.'s Insurance 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.
IMPORTANT CHANGES FOR STATE REQUIREMENTS

If you reside in one of the following states, please read the important changes below. The provisions of your certificate are modified for residents of the following states. The modifications listed apply only to residents of that state.

California Residents:

Conversion Privilege for Life Insurance

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

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

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

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

Missouri residents:

Applicable to Voluntary Life Insurance Benefits

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

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

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

North Dakota residents:

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