THE PRUDENTIAL INSURANCE COMPANY OF AMERICA (PRUDENTIAL)

CRITICAL ILLNESS COVERAGE ONLY

OUTLINE OF COVERAGE

The certificate is a group certificate. The certificate provides critical illness coverage ONLY. The certificate does NOT provide comprehensive medical or hospital insurance, Medicare supplement insurance, long-term care insurance, nursing home insurance only, home health care insurance only, or nursing home and home care insurance. You may also contact your local social security office or Prudential and obtain a copy of the Guide to Health Insurance for People with Medicare.

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: *There are state-specific requirements that may change the provisions under the Coverage described in this Outline of Coverage. If you live in a state that has such requirements, those requirements will apply to your Coverage and are made a part of your Outline of Coverage. This means the requirements of the state where you reside at the time of loss could change the benefits to which you may be entitled if you become insured under the Coverage. Prudential has a website that describes these state-specific requirements. You may access the website at www.prudential.com/etonline. When you access the website, you will be asked to enter your state of residence and your Access Code.* ***Your Access Code is CVGCR.***

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

CRITICAL ILLNESS COVERAGE FOR YOU AND YOUR DEPENDENTS

The items below are only highlights of your coverage. For a full description please read the entire Group Insurance Certificate.

COVERAGE FOR CERTAIN CRITICAL ILLNESSES:

This Coverage pays benefits for certain Critical Illnesses.

Critical Illnesses means the person's:

- Alzheimer's Disease
- Benign Brain Tumor

- Cancer - *Invasive*
- Cancer - *Non-Invasive, other than Skin Cancer*
- Cancer - *Non-Invasive, Skin Cancer*
- Cerebral Palsy
- Cleft Lip or Cleft Palate
- Coma
- Cystic Fibrosis
- Down Syndrome
- Heart Attack
- Major Organ Failure
- Muscular Dystrophy
- Paralysis of Limbs
- Renal (kidney) Failure
- Severe Coronary Artery Disease
- Sickle Cell Anemia
- Spina Bifida
- Stroke
- Third Degree Burns

See the Benefit Definitions pages of your group certificate for a definition of each Critical Illness.

Benefits for a Critical Illness are payable only if:

(1) the person is diagnosed with the Critical Illness while a Covered Person; and

(2) that diagnosis occurs during the Covered Person's lifetime; and

(3) after the Covered Person completes the applicable Waiting Period.

Not all such Critical Illnesses are covered. See Critical Illnesses Not Covered below.

First Occurrence Benefit Amount Payable: The amount payable for the First Occurrence of a Critical Illness depends on the type of Critical Illness as shown below and the Amount of Insurance you elect as explained on the next page. Benefits are subject to the Lifetime Maximum Benefit as described below.

Percent of the Person's Amount of Insurance or Benefit Amount Payable

Critical Illness:

Alzheimer's Disease	100%
Benign Brain Tumor	100%
Cancer - *Invasive*	100%
Cerebral Palsy	100%
Cleft Lip or Cleft Palate	100%
Coma	100%
Cystic Fibrosis	100%
Down Syndrome	100%
Heart Attack	100%
Major Organ Failure	100%
Muscular Dystrophy	100%
Paralysis of Limbs	100%
Renal (kidney) Failure	100%
Severe Coronary Artery Disease	100%
Sickle Cell Anemia	100%
Spina Bifida	100%
Stroke	100%
Third Degree Burns	100%
Cancer - *Non-Invasive, other than Skin Cancer*	25%
Cancer - *Non-Invasive, Skin Cancer*	$250

Reoccurrence Benefit Amount Payable for Critical Illness other than Skin Cancer: The amount payable for a Reoccurrence of a Critical Illness other than Skin Cancer is 100% of the amount paid to the person for the First Occurrence of the Critical Illness.

Reoccurrence of a Critical Illness other than Skin Cancer means:

(1) a person is positively diagnosed by a Doctor as having an additional occurrence or reoccurrence of a Critical Illness other than Skin Cancer for which a benefit was paid under this Coverage; and

(2) the date of the diagnosis of the additional occurrence or reoccurrence is more than 180 days after the date of the last medical treatment for the previous occurrence.

Reoccurrence Benefit Amount Payable for Skin Cancer: The amount payable for a Reoccurrence of Skin Cancer is $250, subject to the Annual Limit for Skin Cancer.

Reoccurrence of Skin Cancer means a person is positively diagnosed by a Doctor as having an additional occurrence or reoccurrence of Skin Cancer for which a benefit was paid under this Coverage.

Annual Limit for Skin Cancer: $250 per Calendar Year for each Covered Person.

Lifetime Maximum Benefit for all Critical Illnesses other than Skin Cancer: No more than the Lifetime Maximum Benefit will be paid for all of a Covered Person's Critical Illnesses other than Skin Cancer.

The Lifetime Maximum Benefit for a Covered Person is 500% of the person's Amount of Insurance.

BENEFIT AMOUNTS FOR YOU:

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

Amount of Insurance For Each Benefit Class:

Benefit Classes	Amount of Insurance
All Employees	
Option 1	$10,000
Option 2	$20,000
Option 3	$30,000
Option 4	$40,000

BENEFIT AMOUNTS FOR YOUR DEPENDENTS:

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

Qualified Dependents Classification	Amount of Insurance*
Your Spouse or Domestic Partner	
	$5,000
	$10,000
	$15,000
	$20,000
	$25,000
	$30,000
	$35,000
	$40,000
Your Children	50% of the amount for which you are insured under the Critical Illness Coverage.

- The amount of insurance on your Qualified Dependent Spouse or Domestic Partner will not exceed 100% of the amount for which you are insured under the Critical Illness Coverage.

CRITICAL ILLNESSES NOT COVERED:

A Critical Illness is not covered if it is caused by, contributed to by, or resulting from, directly or indirectly, any of these:

(1) Attempted suicide, while sane or insane.

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

(3) War, or any act of war. “War" means declared or undeclared war and includes resistance to armed aggression.

(4) Travel or flight in any vehicle used for aerial navigation. This includes getting in, out, on or off any such vehicle. This (4) does not apply if the person is riding as a fare paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports.

(5) Commission of a felony for which you have been convicted under state or federal law.

(6) Being under the influence of alcohol, or alcohol intoxication, as defined by the laws of the jurisdiction in which the Critical Illness occurred. Conviction is not required for a determination of being intoxicated.

(7) Being under the influence or taking any narcotic, unless prescribed by and administered in accordance with the advice of the Covered Person's Doctor.

WELLNESS BENEFIT:

This additional benefit for wellness pays benefits for a Covered Person's health screening test and is payable in lieu of National Cancer Institute Evaluation Benefit payment, if applicable, upon submission of proof, only if the Covered Person receives one of the following health screening tests while not confined in a hospital:

- routine health check-up exam;
- biopsies for cancer;
- blood chemistry panel;
- blood test to determine total cholesterol;
- blood test to determine triglycerides;
- bone marrow testing;
- breast MRI;
- breast ultrasound;
- breast sonogram;
- cancer antigen 15-3 blood test for breast cancer (CA 15-3);

- cancer antigen 125 blood test for ovarian cancer (CA 125);
- carcinoembryonic antigen blood test for colon cancer (CEA);
- carotid doppler;
- chest x-rays;
- clinical testicular exam;
- colonoscopy;
- complete blood count (CBC);
- dental exam;
- digital rectal exam (DRE);
- Doppler screening for cancer;
- Doppler screening for peripheral vascular disease;
- echocardiogram;
- electrocardiogram (EKG);
- electroencephalogram (EEG);
- endoscopy;
- eye exam;
- fasting blood glucose test;
- fasting plasma glucose test;
- flexible sigmoidoscopy;
- hearing test;
- hemoccult stool specimen;
- hemoglobin A1C;
- human papillomavirus (HPV) vaccination;
- immunization;
- lipid panel;
- mammogram;
- oral cancer screening;
- pap smears or thin prep pap test;
- prostate-specific antigen (PSA) test;

- serum cholesterol test to determine LDL and HDL levels;
- serum protein electrophoresis;
- skin cancer biopsy;
- skin cancer screening;
- skin exam;
- stress test on bicycle or treadmill;
- successful completion of smoking cessation program;
- tests for sexually transmitted infections (STIs);
- thermography;
- two hour post-load plasma glucose test;
- ultrasounds for cancer detection;
- ultrasound screening of the abdominal aorta for abdominal aortic aneurysms;
- virtual colonoscopy.

Wellness Benefit Amount Payable: $50.

Wellness Benefit Annual Limit: The Wellness Benefit is limited to one benefit payment per Calendar Year for each Covered Person.

BENEFIT FOR NATIONAL CANCER INSTITUTE (NCI) EVALUATION:

This additional benefit for NCI evaluation pays benefits for a Covered Person's evaluation or consultation at an NCI-designated cancer center only if both of these conditions are met:

(1) The Covered Person is seeking the evaluation or consultation as a result of receiving a diagnosis of Cancer.

(2) The purpose of the evaluation or consultation is to determine the appropriate course of treatment.

National Cancer Institute (NCI) Evaluation Benefit Amount Payable: An amount equal to:

(1) $500; plus

(2) $250 for the transportation and lodging of the Covered Person requiring the evaluation if the NCI facility is more than 100 miles from the Covered Person's primary residence.

NCI Evaluation Benefit Lifetime Limit: The NCI Evaluation Benefit is payable once during the lifetime of each Covered Person.

TRANSPORTATION BENEFIT:

This additional benefit for transportation pays benefits for the travel expenses associated with a Covered Person's round trip travel between the Covered Person's primary residence and a hospital or medical facility only if both of these conditions are met:

(1) The Covered Person needs to travel to the hospital or medical facility to receive treatment for a Critical Illness.

(2) The hospital or medical facility is more than 50 miles from the Covered Person's primary residence.

Transportation Benefit Amount Payable: An amount equal to the lesser of:

(1) the actual charges incurred for travel by train, plane or bus, plus $0.50 per mile for travel by personal car; and

(2) $1,000.

Transportation Benefit Annual Limit: The Transportation Benefit is limited to one benefit payment per Calendar Year for each Covered Person receiving treatment during that visit.

LODGING BENEFIT:

This additional benefit for lodging pays benefits for a Covered Person's lodging expenses only if all of these conditions are met:

(1) The Covered Person needs to stay overnight in order to receive treatment for a Critical Illness at a hospital or medical facility.

(2) The hospital or medical facility is more than 50 miles from the Covered Person's primary residence.

(3) The lodging occurs not more than 24 hours prior to the treatment, and not more than 24 hours after the treatment.

Lodging Benefit Amount Payable: $100 per day.

Lodging Benefit Annual Limit: The Lodging Benefit is limited to 60 days per Calendar Year for each Covered Person receiving treatment during that visit.

Continuation of Coverage at Your Option:

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

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

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

  (b) your work hours were reduced.

(2) You have been continuously insured under the Group Contract and/or the Employer's prior plan for at least 12 months just before the date your employment ended or your work hours were reduced.

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

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

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

(1) the thirty-first day after the Coverage would otherwise have ended; and

(2) the fifteenth day after you receive the notice informing you of your right to continue. But, in no event may election be made if you do not apply for continuation of Coverage and pay the first payment prior to the ninety-second day after you cease to be covered for the Coverage.

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

(1) You reach your Lifetime Maximum Benefit.

(2) You die.

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

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

(5) You become covered under any other group critical illness plan.

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

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

(2) That person ceases to be a Qualified Dependent for the Coverage.

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

(1) Your Amount of Insurance may not be more than 100% of your Amount of Insurance under the Group Contract when the Coverage would have ended, but not less than $1,000. The Amount of Insurance on each dependent may not be more than the Amount of Insurance on the dependent under the Group Contract when the Coverage would have ended.

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

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

(4) Once Coverage is being continued under this part, no other continuation provisions may apply.

This outline of coverage is a very brief summary of your certificate.

The certificate itself sets forth the rights and obligations of both you and the insurance company. It is therefore imperative that you READ YOUR CERTIFICATE carefully.

The anticipated loss ratio for this certificate is 75 percent. This ratio is the portion of future premiums which Prudential expects to return as benefits, when averaged over all people with this certificate.