SUN LIFE ASSURANCE COMPANY OF CANADA

Executive Office:
One Sun Life Executive Park
Wellesley Hills, MA 02481

(800) 247-6875
www.sunlife.com/us

Sun Life Assurance Company of Canada certifies that it has issued and delivered a Group Insurance Policy to the Policyholder shown below.

Policy Number:	948706-006
Policy Effective Date:	January 1, 2022
Policyholder:	Ambarella Corp
Employer:	Ambarella Corp
Issue State:	California

NOTICE TO BUYER: THIS IS A LIMITED BENEFIT HEALTH CERTIFICATE. THIS CERTIFICATE PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES

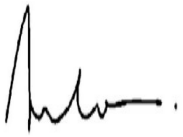
This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal health law. Not all specified diseases are covered by this Policy. Benefits for Coronary Artery Bypass Graft, Angioplasty, Non-Invasive Cancer, Skin Cancer, Advanced Alzheimer's Disease and Advanced Parkinson's Disease are provided at a reduced amount.

PLEASE READ YOUR CERTIFICATE CAREFULLY.

This Certificate contains the terms of the Group Insurance Policy that affect your insurance. This Certificate is part of the Group Insurance Policy.

This Certificate is governed by the laws of the Issue State shown above unless preempted by the federal Employee Retirement Income Security Act.

Signed at Wellesley Hills, Massachusetts.



Dean A. Connor
President and Chief Executive Officer

Troy Krushel
Vice-President, Associate General Counsel and Corporate Secretary

Group Specified Disease Insurance Certificate

Non-Participating

Sun Life Financial®

NOTICE TO CERTIFICATEHOLDER

THIS NOTICE IS TO ADVISE YOU THAT SHOULD YOU HAVE ANY QUESTIONS OR COMPLAINTS REGARDING YOUR SUN LIFE GROUP INSURANCE PLAN, YOU MAY CONTACT THE FOLLOWING:

SUN LIFE ASSURANCE COMPANY OF CANADA
ATTN: CUSTOMER RELATIONS, SC321
PO BOX 9133
WELLESLEY HILLS, MA 02481
(800) 247-6875

ALSO AVAILABLE TO YOU IS

THE CONSUMER SERVICES DIVISION OF THE CALIFORNIA INSURANCE DEPARTMENT
300 SOUTH SPRING STREET, SOUTH TOWER, 11TH FLOOR, LOS ANGELES, CALIFORNIA 90013

(800) 927-4357
Website Address: http://www.insurance.ca.gov/01-consumers

THE INSURANCE DEPARTMENT SHOULD BE CONTACTED ONLY AFTER DISCUSSIONS WITH THE INSURER HAVE FAILED TO PRODUCE A SATISFACTORY RESOLUTION TO THE PROBLEM

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1. BENEFIT HIGHLIGHTS

Eligible Classes: All Full-Time United States Employees working in the United States scheduled to work at least 25 hours per week.

Eligibility Waiting Period: None

1. BENEFIT HIGHLIGHTS

At the time of enrollment, you may be eligible to select an amount of Specified Disease insurance and specific Specified Diseases. We will pay benefits corresponding to the elections you made as shown below. You may change your or your Spouse's and Dependent Children's amount of Specified Disease insurance according to the When can you make Changes in Insurance provision.

Any limitation applies separately to you, your Spouse and Dependent Children. Please see Covered Conditions and Exclusions and Limitations for a complete description of benefits, limitations and exclusions.

Insurance Amounts

Employee Insurance	Minimum: $10,000 Maximum: $40,000 Change Increment Amount: $10,000
Spouse Insurance	Minimum: $10,000 Maximum: $40,000 Change Increment Amount: $10,000
Dependent Children Insurance	Minimum: $5,000 Maximum: $20,000 Change Increment Amount: $5,000

The Spouse and Dependent Children Insurance Amount will not be more than 100% of your Insurance Amount.

1. BENEFIT HIGHLIGHTS

If you enrolled in this option, your insurance will be based on the following.

Core Conditions Category – Employee, Spouse and Dependent Children Insurance

Covered Condition	Benefit Percentages	Recurrence Benefit Percentages
Heart Attack	100%	100%
Stroke	100%	100%
Major Organ Failure	100%	100%
End-stage Kidney Disease	100%	100%
Coronary Artery Bypass Graft	25%	25%
Angioplasty	5%	5%

Cancer Conditions Category – Employee, Spouse and Dependent Children Insurance

Covered Condition	Benefit Percentages	Recurrence Benefit Percentages
Invasive Cancer	100%	100%
Non-Invasive Cancer	25%	25%
Skin Cancer	5%	5%

Other Conditions Category – Employee, Spouse and Dependent Children Insurance

Covered Condition	Benefit Percentages	Recurrence Benefit Percentages
Benign Brain Tumor	100%	N/A
Coma	100%	N/A
Complete Blindness	100%	N/A
Paralysis	100%	N/A
Loss of Speech	100%	N/A
Complete Loss of Hearing	100%	N/A
Advanced ALS/Lou Gehrig's Disease	100%	N/A
Advanced Alzheimer's Disease	25%	N/A
Advanced Parkinson's Disease	25%	N/A
Severe Burns	100%	N/A

Childhood Conditions Category – Dependent Children Insurance

Covered Condition	Benefit Percentages	Recurrence Benefit Percentages
Down Syndrome	100%	N/A
Cerebral Palsy	100%	N/A
Complex Congenital Heart Disease	100%	N/A
Cystic Fibrosis	100%	N/A
Spina Bifida	100%	N/A
Cleft Lip/Palate	100%	N/A
Type 1 Diabetes Mellitus	100%	N/A
Muscular Dystrophy	100%	N/A

Maximum Benefits Payable for each Insured under this Certificate:

- Each Covered Condition is payable 1x during the lifetime of the Policy (except as described in the Recurrence Benefit provision).

1. BENEFIT HIGHLIGHTS

Wellness Screening Benefit: $100 per Benefit Year if any one of the wellness screening tests described in this Certificate is performed for you. $100 each Benefit Year if any one of the wellness screening tests described in this Certificate is performed for your insured Spouse and Dependent Children.

Contributions: The cost of your insurance is paid for entirely by you. This is your Contributory insurance.

2. DEFINITIONS

Actively at Work means that you perform all the regular duties of your job for a full work day at your Employer's normal place of business, a site approved by your Employer or a site where your Employer's business requires you to travel.

You will be considered Actively at Work if you usually perform the regular duties of your job at your home as long as you can perform all the regular duties of your job for a full work day and could do so at your Employer's normal place of business.

You are considered Actively at Work on any day that is not your regular scheduled work day (e.g., you are on vacation or holiday) as long as you were Actively at Work on your immediately preceding scheduled work day, and you are neither Confined nor disabled due to an Injury or sickness.

Benefit Percentage means the percentage that is applied to the Insurance Amount to determine the amount of Specified Disease benefits payable under the Policy.

Benefit Year means a calendar year beginning on January 1 of any year and ending on December 31 of that year.

Clinical Diagnosis means a Diagnosis of cancer based on observation and history, diagnostic and laboratory studies, and symptoms.

Confined or Confinement means:
- confined to a hospital or similar facility; or
- confined at home due to a sickness or Injury and under the care of a Physician.

Contributory means you pay all or part of the premium.

Coronary Artery Disease means acute coronary occlusion, coronary atherosclerosis, aneurysm and dissection of the coronary arteries or coronary atherosclerosis due to plaque.

Dependent means your insured Spouse and Dependent Children.

Dependent Child (Dependent Children) means your unmarried child from live birth to under age 26.

Dependent Child includes:
- your step-child;
- a foster child placed with you by a licensed agency;
- your adopted child, including any child placed with you for adoption; or
- a child of your Spouse.

If an unmarried child is age 26 or older and is:
- incapable of self-sustaining employment because of an intellectual disability, developmental disability or physical handicap; and
- chiefly dependent on you for his or her support;

that child will continue to be considered a Dependent Child under the Policy for as long as these conditions exist.

No person may be considered to be a Dependent Child of more than one Employee.

Dependent Child does not include:
- any person who is insured as an Employee; or
- any person residing outside the United States or Canada.

2. DEFINITIONS

Diagnosed, Diagnosis or Diagnoses means an evaluation of an Insured's medical condition that is performed by a Physician whose specialty is appropriate for the condition being evaluated. The evaluation must be consistent with the most current medically accepted diagnostic standards. A Diagnosis must be based on conditions, clinical signs on examination, or test results that have changed substantially since becoming insured under the Policy. In addition, if cognitive function is being evaluated, the conclusions must be confirmed with neuropsychological testing conducted by a Physician.

Eligibility Waiting Period means the length of time you must be a member in an Eligible Class before you can apply for insurance. The Eligibility Waiting Period is shown in the Benefit Highlights.

Employee means a person who is:
- employed by the Employer within the United States;
- a U.S. citizen or a U.S. resident;
- scheduled to work at least the minimum hours shown in the Benefit Highlights;
- paid regular earnings in accordance with applicable state and federal wage and hour laws; and
- has a legitimate federal tax identification number.

Employee does not include a seasonal or temporary employee whose annual work schedule is less than 12 months during a calendar year.

Employer means the Employer named on the cover page of this Certificate and includes any subsidiary or affiliated company named in the application.

Enrollment Period means the period of time each year not to exceed 30 days during which eligible Employees may elect, or change, or cancel insurance under the Policy. The Enrollment Period cannot exceed 30 days or occur more than once in any 12-month period, unless we agree in Writing.

Family Member means: (a) your Spouse, civil union partner or domestic partner and (b) the following relatives of you or your Spouse, civil union partner or domestic partner: (1) parent; (2) grandparent; (3) child; (4) grandchild; (5) brother, (6) sister; (7) aunt; (8) uncle; (9) first cousin; (10) nephew or niece. This includes adopted, in-law and step-relatives.

Family Status Change means one of the following events:
- your marriage or divorce;
- the birth of your child;
- the adoption of a child by you;
- the placement of a child with you, pending adoption;
- the death of your Spouse or child;
- the commencement or termination of employment of your Spouse.

Initial Enrollment means the first date you are eligible to enroll for Employee Insurance, Spouse Insurance and Dependent Children Insurance.

Injury means unintentional physical damage or harm caused directly by an accident occurring while insured under the Policy and not due to sickness, disease or any other causes.

Insurance Amount means the amount of insurance available under the Policy as shown in the Benefit Highlights and for which a person covered under the Policy is insured.

Insured means any person covered under the Policy.

Intoxicated means:
- under the influence of alcohol, illegal drugs or prescription drugs other than as prescribed by your Physician; or
- at or above the minimum blood alcohol level for which you would be considered operating a motorized vehicle under the influence of alcohol in the jurisdiction where the Intoxication occurred.

For the purposes of this definition, "operating" includes allowing the engine to run even if not seated in the vehicle and "motorized vehicle" includes, but is not limited to, automobiles, motorcycles, boats and snowmobiles.

Late Entrant means you apply for any insurance more than 90 days after you first become eligible to enroll in it.

Layoff means that you are temporarily not Actively at Work for a period of time your Employer agreed to in Writing. Your normal vacation time is not considered a temporary Layoff.

Leave of Absence means that you are temporarily not Actively at Work for a period of time your Employer agreed to in Writing. Your normal vacation time is not considered a temporary Leave of Absence.

Participation in a Riot, Rebellion or Insurrection, the words "Participation" and "Riot" in this phrase mean:
Participation includes promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but will not include actions taken in defense of public or private property, or actions taken in your own defense, if such actions of defense are not taken against persons seeking to maintain or restore law and order including but not limited to police officers and firefighters.

Riot includes all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether or not acting with a common intent and whether or not damage to person or property or unlawful act or acts is the intent or the consequence of such disorder.

Physician means a person who is operating within the scope of his or her license and is either:
- licensed in the United States or Canada as a medical doctor and authorized to practice medicine and prescribe and administer drugs or to perform surgery; or
- any other duly licensed medical practitioner who is deemed by applicable state or provincial law to have the same authority as a legally qualified medical doctor.

The Physician cannot be you, a business associate or any Family Member.

Policy means the group insurance policy under which this Certificate is issued.

Policyholder means the entity to which the Policy is issued.

Prior Policy means the group insurance policy(ies) for Specified Disease Insurance issued to the Policyholder that was in effect immediately prior to the Policy.

Proof means any medical, financial or other information that we require to make a claim determination.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.

Specified Disease means only the illnesses defined in the Covered Conditions section of this Certificate for which benefits are payable.

Spouse means any person who is a party to a marriage and:
- under state, federal or provincial law is recognized as a spouse, a partner in a civil union, a partner in a registered domestic partnership as defined in California Family Code Section 297; or
- is a domestic partner as defined by the Policyholder.

2. DEFINITIONS

Spouse does not include;

- any person who is insured as an Employee; or
- any person residing outside the United States or Canada.

Treatment means a Physician's consultation, care or services; diagnostic measures; or the prescription, refill or taking of prescribed drugs or medicines.

We, Us, Our (we, us, our) means Sun Life Assurance Company of Canada.

Written or Writing means a record which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.

You, Your (you, your) means an Employee who is eligible for insurance under the Policy.

3. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF EMPLOYEE INSURANCE

When are you eligible for Employee Specified Disease Insurance?
You are initially eligible for Employee Specified Disease Insurance on the latest of:

- January 1, 2022;
- your first day of employment; or
- the date you first are Actively at Work in an Eligible Class.

You are also eligible for Employee Specified Disease Insurance during any Enrollment Period or as a result of a Family Status Change, provided you are Actively at Work and in an Eligible Class.

When must you enroll for Employee Specified Disease Insurance?
You must enroll within 90 days of the date you are initially eligible for Employee Specified Disease Insurance otherwise you will be considered a Late Entrant.

If you refuse your insurance or do not enroll when you are eligible, then you will not be allowed to enroll until the next Enrollment Period or until a Family Status Change.

When does your Employee Specified Disease Insurance start?
For Contributory Employee Specified Disease Insurance, your insurance starts on the later of the date:

- you are eligible; or
- you enroll and agree to make any required contribution toward the cost of insurance; and

you are Actively at Work on that date.

If you are not Actively at Work on that date, your insurance will not start until you resume being Actively at Work.

When can you make changes in Employee Specified Disease Insurance?
You may request a change in your Employee Specified Disease Insurance Amount or benefit elections during any Enrollment Period after you are covered under the Policy and Actively at Work.

You may also request a change in Employee Specified Disease Insurance at any time due to a Family Status Change. Such request must be made within 31 days of the date the Family Status Change occurred.

Any amount or increase in Employee Insurance is subject to the Pre-Existing Conditions limitation. A pre-existing condition will be considered to have occurred in relation to the effective date of the change, not the original effective date of your coverage.

You may only increase or decrease your Employee Insurance Amount within the limits shown in the Benefit Highlights.

When does a change in Employee Specified Disease Insurance start?
If you are Actively at Work, any increase in Employee Specified Disease Insurance or benefits, for reasons other than a Family Status Change, will start onon the January 1st following the date of change, when you apply for a different incremental amount coverage option and you agree to make any required contribution toward the cost of insurance.

If you are not Actively at Work on that date, any increase in Employee Specified Disease Insurance will not start until you resume being Actively at Work.

Whether or not you are Actively at Work, any reduction in Employee Specified Disease Insurance or benefits, for reasons other than a Family Status Change, will start on the January 1st following the date of change, when you apply for a different coverage option.

3. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF EMPLOYEE INSURANCE

If you are Actively at Work, any increase in insurance or benefits due to a Family Status Change will start on the latest of:

- the date you apply for such change in Employee Specified Disease Insurance, if you apply within 31 days of the Family Status Change and you agree to make any required contribution toward the cost of insurance; or
- the date of your Family Status Change.

If you are not Actively at Work on that date, any increase due to a Family Status Change in Employee Specified Disease Insurance or benefits will not start until you resume being Actively at Work.

Whether or not you are Actively at Work, any reduction in Employee Specified Disease Insurance or benefits due to a Family Status Change will start on the date of your Family Status Change.

Any change is subject to all the terms of the Policy.

When does Employee Specified Disease Insurance end?
Your Employee Specified Disease Insurance under the Policy will end on the earliest of the following to occur:

- the date the Policy terminates;
- the last day of the period for which any required premium has been paid for your Employee Specified Disease Insurance or any part of your insurance;
- the date you request in Writing to cancel your Employee Specified Disease Insurance;
- the date all benefits paid or payable for you under the Policy reach the maximum amount payable as described herein; or
- the date you die.

Your Employee Specified Disease Insurance will also end when any of the following occur, but coverage may be extended subject to any allowed continuation as specified in the Insurance Continuation section:

- the date you are no longer in an Eligible Class;
- the date you enter active duty in any armed service;
- the date you retire;
- the date your class is no longer included for insurance; or
- the last day you are Actively at Work, subject to any applicable Portability provision provided.

If your coverage has ended, can it be reinstated?
If your insurance ends for any reason other than you have voluntarily terminated your insurance, then your insurance may be reinstated within 12 months from when your insurance ended. To reinstate your insurance, you must submit a Written request within 31 days after you return to being Actively at Work in an Eligible Class.
Reinstatement will be effective on the latest date when all of the following have occurred:

- you agree to make any required contribution toward the cost of your insurance; and
- you return to being Actively at Work.

Any Diagnosis occurring between your termination date and your reinstatement effective date will not be considered a Covered Benefit.

A new Eligibility Waiting Period will not apply.

Your reinstated insurance will be subject to all the terms and provisions of the Policy.

Coverage will not be reinstated for any amount of insurance which you continued under the Portability provision, unless you cancel such coverage.

4. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF SPOUSE INSURANCE

When are you eligible for Spouse Specified Disease Insurance?
If you are in an Eligible Class, you are initially eligible for Spouse Specified Disease Insurance on the latest of:

- January 1, 2022;
- the date you are eligible for Employee Specified Disease Insurance; or
- the date you acquire a Spouse.

You are also eligible for Spouse Specified Disease Insurance during any Enrollment Period or as a result of a Family Status Change, provided you are in an Eligible Class and have a Spouse.

When must you enroll for Spouse Specified Disease Insurance?
You must enroll within 90 days of the date you are initially eligible for Spouse Specified Disease Insurance otherwise you will be considered a Late Entrant.

If you refuse your Spouse insurance or do not enroll when you are eligible, then you will not be allowed to enroll your Spouse until the next Enrollment Period or until a Family Status Change.

When does Spouse Specified Disease Insurance start?
For Contributory Spouse Specified Disease Insurance, your insurance starts on the latest of the date:

- you are eligible for Spouse Specified Disease Insurance; or
- you are insured under the Policy for Employee Specified Disease Insurance; or
- you enroll for Spouse Specified Disease Insurance and you agree to make any required contribution toward the cost of insurance; and

you are Actively at Work on that date and your Spouse is not Confined on that date.

If you are not Actively at Work on that date, your Spouse Specified Disease Insurance will not start until you resume being Actively at Work.

If your Spouse is Confined on the date your Spouse Specified Disease Insurance would normally start, your Spouse Specified Disease Insurance will not start until your Spouse is no longer Confined.

When can you make changes in Spouse Specified Disease Insurance?
You may request a change in your Spouse Insurance Amount or benefit elections during any Enrollment Period after you are covered under the Policy and Actively at Work.

You may also request a change in Spouse Specified Disease Insurance at any time due to a Family Status Change. Such request must be made within 31 days of the date the Family Status Change occurred.

Any amount or increase in Spouse Specified Disease Insurance is subject to the Pre-existing Conditions limitation. A pre-existing condition will be considered to have occurred in relation to the effective date of the change, not the original effective date of your coverage.

You may only increase or decrease your Spouse Insurance Amount within the limits shown in the Benefit Highlights.

When does a change in Spouse Specified Disease Insurance start?
If you are Actively at Work, any increase in your Spouse Insurance Amount or benefits, for reasons other than a Family Status Change, will start on the January 1st following the date of change, when you apply for a different coverage option and you agree to make any required contribution toward the cost of insurance.

Your Spouse must not be Confined on the date of the increase in benefits.

If you are not Actively at Work on that date, any increase in Spouse Specified Disease Insurance or benefits will not start until you resume being Actively at Work.

If your Spouse is Confined on that date, your increase in Spouse Specified Disease Insurance or benefits will not start until your Spouse is no longer Confined.

Whether or not you are Actively at Work, any reduction in Spouse Specified Disease Insurance or benefits for reasons other than a Family Status Change will start on the January 1st following the date of change, when you apply for a different coverage option.

If you are Actively at Work, any increase in Spouse Specified Disease Insurance or benefits due to a Family Status Change will start on the latest of:

- the date you apply for such change in Spouse Specified Disease Insurance, if you apply within 31 days of the Family Status Change and you agree to make any required contribution toward the cost of insurance; or
- the date of your Family Status Change.

Your Spouse must not be Confined on the date of the increase in benefits.

If you are not Actively at Work on that date, any increase due to a Family Status Change in Spouse Specified Disease Insurance or benefits will not start until you resume being Actively at Work.

If your Spouse is Confined on that date, your increase in Spouse Specified Disease Insurance or benefits will not start until your Spouse is no longer Confined.

Whether or not you are Actively at Work, any reduction in Spouse Specified Disease Insurance or benefits due to a Family Status Change will start on the date of your Family Status Change.

When does Spouse Specified Disease Insurance end?

Spouse Specified Disease Insurance under the Policy will end on the earliest of the following to occur:

- the date the Policy terminates;
- the last day of the period for which any required premium has been paid for your insurance or your Spouse Specified Disease Insurance or any part of your insurance or your Spouse Insurance;
- the date you request in Writing to cancel your Spouse Specified Disease Insurance;
- the date all benefits paid or payable for you under this Policy reach the maximum amount payable as described herein;
- the date all benefits paid or payable for your Spouse under the Policy reach the maximum amount payable for your Spouse as described herein;
- the date you die; or
- the date your Spouse dies.

Your Spouse Specified Disease Insurance will also end when any of the following occur, but coverage may be extended subject to any allowed continuation as specified in the Insurance Continuation section:

- the date you are no longer in an Eligible Class;
- the date you are no longer insured under the Policy;
- the date your Spouse no longer meets the definition of Spouse as described in this Certificate;
- the date your Spouse enters active duty in any armed service;
- the date you retire;
- the date your class is no longer included for insurance; or
- the last day you are Actively at Work, subject to any applicable Portability provision provided.

5. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF DEPENDENT CHILDREN INSURANCE

When are you eligible for Dependent Children Specified Disease Insurance?
If you are in an Eligible Class, then you are initially eligible for Dependent Children Specified Disease Insurance on the latest of:

- January 1, 2022 or;
- the date you are eligible for Employee Specified Disease Insurance; or
- the date you acquire your Dependent Children.

You are also eligible for Dependent Children Specified Disease Insurance during any Enrollment Period or as a result of a Family Status Change, provided you are in an Eligible Class and have one or more Dependent Children.

When must you enroll for Dependent Children Specified Disease Insurance?
You must enroll within 90 days of the date you are initially eligible for Dependent Children Specified Disease Insurance otherwise you will be considered a Late Entrant.

If you refuse your Dependent Child insurance or do not enroll when you are eligible, then you will not be allowed to enroll until the next Enrollment Period or until a Family Status Change.

When does Dependent Children Specified Disease Insurance start?
For Contributory Dependent Children Specified Disease Insurance, your insurance starts on the latest of the date:

- you are eligible for Dependent Children Specified Disease Insurance;
- you are first insured under the Policy, for Employee Specified Disease Insurance; or
- you enroll for Dependent Children Specified Disease Insurance and you agree to make any required contribution toward the cost of insurance, and

if you are Actively at Work on that date and your Dependent Child is not Confined on that date.

If you are not Actively at Work on that date, your Dependent Children Specified Disease Insurance will not start until you resume being Actively at Work.

If your Dependent Child is Confined on the date your Dependent Children Specified Disease Insurance would normally start, your Dependent Children Specified Disease Insurance for that Child will not start until your Child is no longer Confined. Confinement does not apply to a newborn child or a newly adopted child.

When can you make changes in Dependent Children Specified Disease Insurance?
You may request a change in your Dependent Children Insurance Amount or benefit elections during any Enrollment Period after you are covered under the Policy and Actively at Work.

You may also request a change in Dependent Children Specified Disease Insurance at any time due to a Family Status Change. Such request must be made within 31 days of the date the Family Status Change occurred.

Any amount or increase in Dependent Children Specified Disease Insurance is subject to the Pre-existing Conditions limitation. A pre-existing condition will be considered to have occurred in relation to the effective date of the change, not the original effective date of your coverage.

You may only increase or decrease your Dependent Children Insurance Amount within the limits shown in the Benefit Highlights.

When does a change in Dependent Children Specified Disease Insurance start?
If you are Actively at Work, any increase in Dependent Children Specified Disease Insurance or benefits, for reasons other than a Family Status Change, will start on the January 1st following the date of change, when you apply for a different coverage option and you agree to make any required contribution toward the cost of insurance.

5. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF DEPENDENT CHILDREN INSURANCE

Your Dependent Child must not be Confined on the date of the increase in benefits.

If your Dependent Child is Confined on that date, your increase in Dependent Children Specified Disease Insurance or benefits will not start until your Dependent Child is no longer Confined.

If you are not Actively at Work on that date, any increase in Dependent Children Specified Disease Insurance or benefits will not start until you resume being Actively at Work.

Whether or not you are Actively at Work, any reduction in Dependent Children Specified Disease Insurance or benefits, for reasons other than a Family Status Change, will start on the January 1st following the date of chang, when you apply for a different coverage option.

If you are Actively at Work, any increase in Dependent Children Specified Disease Insurance or benefits due to a Family Status Change will start on the latest of:

- the date you apply for such change in Dependent Children Specified Disease Insurance, if you apply within 31 days of the Family Status Change and you agree to make any required contribution toward the cost of insurance; or
- the date of your Family Status Change.

Your Dependent Child must not be Confined on the date of the increase in benefits.

If you are not Actively at Work on that date, any increase due to a Family Status Change in Dependent Children Specified Disease Insurance or benefits will not start until you resume being Actively at Work.

If your Dependent Child is Confined on that date, your increase in Dependent Children Specified Disease Insurance or benefits will not start until your Dependent Child is no longer Confined.

Whether or not you are Actively at Work, any reduction in Dependent Children Specified Disease Insurance or benefits due to a Family Status Change will start on the date of your Family Status Change.

How can you add a child or children to your Dependent Children Specified Disease Insurance?
After you and a Dependent Child are covered under the Policy, and you are Actively at Work, any child who becomes one of your Dependent Children will automatically be covered.

How does Dependent Children Specified Disease Insurance apply to newborn children, newly placed foster children or newly adopted children?
If you are insured under the Policy but do not have Dependent Children Specified Disease Insurance when a newborn child, newly placed foster child or newly adopted child becomes one of your Dependent Children, then such child will automatically be covered for 31 days from the date he or she becomes your Dependent Child. To continue coverage beyond 31 days, you must:

- enroll for Dependent Children Specified Disease Insurance within 31 days from the date the newborn child, newly placed foster child or newly adopted child becomes your Dependent Child; and
- pay the required premium to continue your Dependent Children Specified Disease Insurance.

If you are covered under the Policy and have Dependent Children Specified Disease Insurance when a newborn child, newly placed foster child or newly adopted child becomes one of your Dependent Children, then such child will automatically be covered.

When does Dependent Children Specified Disease Insurance end?
Dependent Children Specified Disease Insurance under the Policy will end on the earliest of the following to occur:

- the date the Policy terminates;
- the last day of the period for which any required premium has been paid for your insurance or your Dependent Children Specified Disease Insurance or any part of the insurance;
- the date you request in Writing to cancel your Dependent Children Specified Disease Insurance;

- the date all benefits paid or payable for you under this Policy reach the maximum amount payable as described herein;
- the date all benefits paid or payable for a specific Dependent Child reach the maximum amount payable as described herein;
- the date you die; or
- the date your Dependent Child dies.

Your Dependent Children Specified Disease Insurance will also end when any of the following occur, but coverage may be extended subject to any allowed continuation as specified in the Insurance Continuation section:

- the date you are no longer in an Eligible Class;
- the date you are no longer insured under the Policy;
- the date your Dependent Child no longer meets the definition of Dependent Child as described in this Certificate, but only with respect to that person;
- the date your Dependent Child enters active duty in any armed service;
- the date you retire; or
- the date your class is no longer included for insurance; or
- the last day you are Actively at Work, subject to any applicable Portability provision provided.

6. BENEFIT PROVISIONS

What benefits are payable?
We will pay you a lump-sum benefit for the insurance in force when any eligible Insured, on or after the effective date of insurance, is Diagnosed with a Specified Disease condition as defined in the Covered Conditions section of this Certificate.

Any benefits payable are subject to the limitations, exclusions and other conditions stated in the Policy.

How is the amount of the benefit determined?
We will multiply the Insured's Insurance Amount by the Benefit Percentage for the applicable Covered Condition as shown in the Benefit Highlights to determine the benefit to be paid.

If benefits for a particular Specified Disease have been paid, an Insured is not eligible for any additional benefits if the Insured is ever Diagnosed with that Specified Disease again except as described in Recurrence Benefit.

If an Insured is Diagnosed with more than one Specified Disease on the same date, we will pay only the benefit for the Specified Disease with the largest Benefit Percentage.

Additional Occurrence

When is an additional benefit payable?
If we pay benefits for a particular Specified Disease, we will pay benefits for a different Specified Disease listed in the Benefit Highlights, if there are more than 6 consecutive months between Diagnoses.

Recurrence Benefit

When is a Recurrence Benefit payable?
We will pay a Recurrence Benefit, as shown in the Benefit Highlights, if:

- benefits have been paid under this Policy because an Insured was Diagnosed with a Specified Disease; and
- an Insured is Diagnosed with the same Specified Disease more than 12 consecutive months later; and
- the Insured has not received Treatment for the same Specified Disease for 12 consecutive months after the Diagnosis for the Specified Disease. For the purposes of this provision, we will not consider follow-up visits to a Physician or prescription medications other than cytotoxic medications (cancer chemotherapy) to be Treatment.

How is the amount of the Recurrence Benefit determined?
We will multiply the Insured's Insurance Amount by the Recurrence Benefit Percentage for the applicable Covered Condition as shown in the Benefit Highlights to determine the benefit to be paid.

What is the maximum benefit payable under the Recurrence Benefit?
We will pay the Recurrence Benefit for an Insured for each applicable Covered Condition.

7. COVERED CONDITIONS

What Specified Disease conditions are covered?
The Specified Disease conditions listed below are covered under the Policy.

CORE CONDITIONS CATEGORY

Heart Attack means, that while insured under the Policy, the Insured has been Diagnosed with Coronary Artery Disease that results in the death of heart muscle due to acute obstruction of a coronary artery that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction and includes at least one of the following:

- heart attack symptoms; or
- new electrocardiogram (ECG) changes consistent with a Heart Attack.

The Diagnosis of Heart Attack must be made by a Physician.

Exclusions:
Heart Attack does not include:

- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty; or
- silent myocardial infarction, including ECG or imaging changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.

Stroke means, that while insured under the Policy, the Insured has been Diagnosed with cerebrovascular disease resulting in a brain tissue infarction or hemorrhage documented by brain imaging in association with acute onset of new neurologic deficits consistent with central nervous system damage.

The Diagnosis of Stroke must be made by a Physician.

Exclusions:
For the purposes of this Policy, Stroke does not include:

- Transient Ischemic Attacks (TIAs) or “mini-stroke”, which means a neurological event due to a temporary lack of adequate blood and oxygen to the brain that results in the signs and symptoms similar to a stroke that subside within a short period of time;
- Transient Global Amnesia (TGA); or
- External trauma causing Injury to the brain.

Major Organ Failure means, that while insured under the Policy, the Insured is Diagnosed with any end-stage disease as specified by the most current edition of the International Classification of Diseases (ICD) of the heart, liver, lung, small intestine, pancreas or bone marrow that has resulted in the chronic and irreversible failure of the organ to function.

For all organs listed above, a transplant is recommended as soon as an appropriate donor is located, and the Insured is either registered with the:

- United Network of Organ Sharing (UNOS); or
- National Marrow Donor Program (NMDP).

The Diagnosis of Major Organ Failure must be made by a Physician.

Exclusions:
Major Organ Failure does not include any of the following:

- bone marrow failure that results from the Treatment process for cancer;
- failure of any other organ not listed above; or
- a transplant in which the Insured’s own bone marrow is used.

If multiple organs are to be replaced at the same time, only one benefit for Major Organ Failure is payable.

End-Stage Kidney Disease means, that while insured under the Policy, the Insured has been Diagnosed with a renal disease that has resulted in either:

- the chronic and irreversible failure of both kidneys to function and which requires regular dialysis for a minimum of 90 days; or
- the need for a kidney transplant.

The Diagnosis of End-Stage Kidney Disease must be made by a Physician. In the event a kidney is transplanted at the same time as other organs, only one benefit is payable.

Coronary Artery Bypass Graft means, that while insured under the Policy, an Insured has been Diagnosed with Coronary Artery Disease requiring a procedure to bypass one or more diseased, narrowed or blocked coronary arteries with arterial or venous grafts and is performed by a Physician.

Exclusions:
No benefit will be payable for diseases requiring other procedures such as percutaneous transluminal coronary angioplasty (PTCA) or laser procedures.

Angioplasty means, that while insured under the Policy, the Insured has been Diagnosed with Coronary Artery Disease requiring a procedure to correct the narrowing or blockage of one or more coronary arteries by balloon. Angioplasty does not include a laser based intra-arterial procedure.

CANCER CONDITIONS CATEGORY

Invasive Cancer means, that while insured under the Policy, the Insured has been Diagnosed with a malignant neoplasm, which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of neighboring tissue. Invasive Cancer includes leukemia and lymphoma. Non-invasive conditions or pre-cancerous conditions are not Invasive Cancer.

The Diagnosis must be:

- made by a Physician; and
- supported by pathological confirmation or its equivalent.

A Clinical Diagnosis will be accepted only if it is consistent with professional medical standards.

Exclusions:
No benefit will be payable for the following:

- lesions described as benign, pre-malignant, uncertain, borderline, carcinoma in-situ (Tis), or tumors classified as Ta;
- malignant melanoma of the skin that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- squamous cell or basal cell cancer of the skin or any other non-melanoma of the skin, without lymph node or distant metastasis;
- early prostate cancer classified as T1a or T1b (or equivalent staging) without lymph node or distant metastasis; or
- thyroid cancer less than or equal to 1.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis.

Cancerous tumors that have not spread, such as a tumor in breast that has not led to cancerous tumors elsewhere, or prostate cancer that has not spread from the prostate gland are not considered Invasive Cancer. Such tumors may meet the definition of Non-Invasive Cancer.

No benefit will be payable under this provision for the non-invasive cancers listed in the Non-Invasive Cancer provision below.

7. COVERED CONDITIONS

Non-Invasive Cancer or Cancer in Situ means, that while insured under the Policy, the Insured has been Diagnosed with a cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue.

The Diagnosis must be:
- made by a Physician; and
- supported by pathological confirmation or its equivalent.

A Clinical Diagnosis will be accepted if consistent with professional medical standards.

Non-Invasive Cancer includes, but is not limited to:
- chronic lymphocytic leukemia that has not progressed beyond Rai stage 0;
- Stage 1A (T1a) malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or level V invasion);
- early prostate cancer Diagnosed as T1a or T1b, or equivalent staging without lymph node or distant metastasis;
- thyroid cancer (less than or equal to 1 cm in diameter) and confined to the thyroid and classified as T1a, without lymph node or distant metastasis; and
- ductal carcinoma in situ (DCIS) of the breast.

Exclusions:
Non-Invasive Cancer does not include any of the following:
- pre-malignant lesions (such as intraepithelial neoplasia);
- Benign tumors or polyps;
- squamous cell or basal cell cancer of the skin; or
- Invasive Cancer.

Detailed Example:

The following example shows the relationship between benefit amounts for Invasive Cancer and Non-Invasive Cancer. For the purposes of this example, assume the Insurance Amount is $10,000, of which 100% is payable for a Diagnosis of Invasive Cancer, and 25% is payable for a Diagnosis of Non-Invasive Cancer. Additionally, assume the Age Reduction occurs at 70 and reduces the Insurance Amount by 50%.

If the Insured, at age 40, was Diagnosed with Invasive Cancer and met all the other conditions of the Policy, we would pay $10,000 (100% of the Insurance Amount). Alternatively, if the same Insured, at age 40, was Diagnosed with Non-Invasive Cancer and met all the other conditions of the Policy, we would pay $2,500 (25% of the Insurance Amount).

If the Insured, at age 70, was Diagnosed with Invasive Cancer and met all the other conditions of the Policy, we would pay $5,000 (50% of the Insurance Amount, due to the Age Reduction). Alternatively, if the same Insured, at age 70, was Diagnosed with Non-Invasive Cancer and met all the other conditions of the Policy, we would pay $1,250 (25% of the 50% Age-reduced Insurance Amount).

Skin Cancer means, that while insured under the Policy, the Insured has been Diagnosed with basal cell cancer or squamous cell cancer of the skin. A malignant melanoma of the skin, is not deemed Skin Cancer, but may be covered under the Invasive Cancer or Non-Invasive Cancer benefit, depending on its size. A non-melanoma cancer of the skin that is accompanied by lymph node or distant metastasis (cancer that has spread the lymph nodes or to other areas in addition to the skin) may meet the definition of Invasive Cancer.

OTHER CONDITIONS CATEGORY

7. COVERED CONDITIONS

Advanced Alzheimer's Disease means, that while insured under the Policy, an Insured has:
- been initially Diagnosed with Functional Assessment Staging Scale (FAST) Stage 6 or higher for Alzheimer's related dementia; and
- demonstrated memory impairment; decreased ability to plan, organize, sequence; language disturbance; or other cognitive disturbance.

The Diagnosis of Advanced Alzheimer's Disease must be made by a Physician. In order for a benefit to be paid, the initial Diagnosis of any stage of Alzheimer's disease must occur while insured under the Policy.

Advanced Parkinson's Disease means, that while insured under the Policy, an Insured has:
- been initially Diagnosed with primary idiopathic Parkinson's disease at stage 4 or higher on the Hoehn and Yahr scale; and
- demonstrated resting tremor, rigidity, bradykinesia and dementia despite a generally accepted drug regimen.

The Diagnosis of Advanced Parkinson's Disease must be made by a Physician. In order for a benefit to be paid, the initial Diagnosis of any stage of Parkinson's disease must occur while insured under the Policy.

Advanced ALS or Lou Gehrig's Disease means, that while insured under the Policy, the Insured has:
- been initially Diagnosed with definite amyotrophic lateral sclerosis (ALS) according to criteria established by the World Federation of Neurology; and
- been determined to require either a feeding tube or non-invasive ventilation.

The Diagnosis of Advanced ALS or Lou Gehrig's Disease must be made by a Physician. In order for a benefit to be paid, the initial Diagnosis of any stage of amyotrophic lateral sclerosis (ALS) or Lou Gehrig's Disease must occur while insured under the Policy.

Benign Brain Tumor means, that while insured under the Policy, the Insured is initially Diagnosed with a non-malignant tumor located in the cranial vault and limited to the brain, meninges, or cranial nerves or pituitary gland. The tumor must require surgical or radiation Treatment or cause irreversible objective neurological deficit(s). The Diagnosis of Benign Brain Tumor must be made by a Physician.

Exclusions:
No benefit will be payable for the following:
- hematomas, cysts or granulomas; or
- intracranial malformations of the arteries or veins; or
- pituitary tumors, spine or cranial nerves, including pituitary adenomas less than 10 mm. in diameter, acoustic neuroma or craniopharyngioma.

The Diagnosis of Benign Brain Tumor must be made by a Physician. In order for a benefit to be paid, the initial Diagnosis of Benign Brain Tumor must occur while insured under the Policy.

Complete Blindness means, that while insured under the Policy, the Insured has been initially Diagnosed with an irreversible reduction in sight lasting at least 180 days, that results in a corrected visual acuity of 20/400 or less or a visual field less than 20 degrees when testing both eyes together. Benefits for Complete Blindness are not payable if the condition is a consequence of another condition for which another Specified Disease benefit has been paid.

The Diagnosis of Complete Blindness must be made by a Physician.

Coma means a Diagnosis, while insured under the Policy, of a state of unconsciousness with no reaction to external stimuli and which requires an external life support system, both of which have persisted continuously for at least 168 hours.

The Diagnosis of Coma must be made by a Physician.

Exclusions:
Coma does not include medically induced coma.

Complete Loss of Hearing means, that while insured under the Policy, the Insured has been initially Diagnosed with a condition that results in the total and irreversible loss of hearing in both ears to a point that an Insured is unable to hear sounds at or below 70 decibels. The Diagnosis must be confirmed using audiometric testing.

Complete Loss of Hearing does not include loss of hearing that can be corrected to above 70 decibels by the use of any hearing aid or device. Benefits for Complete Loss of Hearing are not payable if the condition is a consequence of another condition for which another Specified Disease benefit has been paid.

The Diagnosis of Complete Loss of Hearing must be made by a Physician. In order for a benefit to be paid, the initial Diagnosis of Complete Loss of Hearing must occur while insured under the Policy.

Loss of Speech means, that while insured under the Policy, the Insured is initially Diagnosed with total, permanent and irreversible loss of the ability to speak. The loss must:
- be as a result of Injury or sickness affecting the speech organs; and
- have continued without interruption for a period of at least six (6) consecutive months.

Loss of Speech does not include any loss that could be restored, totally or partially, by use of a device or implant. Benefits for Loss of Speech are not payable if the condition is a consequence of another condition for which another Specified Disease benefit has been paid.

The Diagnosis of Loss of Speech must be made by a Physician. In order for a benefit to be paid, the initial Diagnosis of Loss of Speech must occur while insured under the Policy.

Paralysis means, that while insured under the Policy, the Insured has been Diagnosed with total and irreversible loss of use of two or more limbs due to Injury of the spinal cord and that is continuously present for a period of at least 180 days. Limb is defined as the complete arm or the complete leg.

The Diagnosis of Paralysis must be made by a Physician and shall not include any impairment caused by a Stroke or other sickness.

Severe Burns means, that while insured under the Policy, the Insured is initially Diagnosed with third-degree burns over at least 18% of the body surface. Severe Burns must occur while the Insured's insurance is in force to be eligible for a benefit. The Diagnosis of Severe Burns must be made by a Physician.

CHILDHOOD CONDITIONS CATEGORY
The following covered childhood conditions apply only to children who meet the definition of Dependent Children and are insured under this Certificate:

Cerebral Palsy means a Diagnosis of nonprogressive, neurological defect affecting muscle control resulting from an Injury to or congenital abnormality. The initial Diagnosis of Cerebral Palsy must be made by a Physician supported by abnormal brain imaging (MRI or equivalent) while your Dependent Child is under the age of 5 and insured under the Policy.

Exclusions:
No benefit will be payable for the following:
- Autism-as primary Diagnosis; and
- motor deficits due to an underlying medical condition (syndrome, genetic or hereditary condition).

7. COVERED CONDITIONS

Cleft Lip/Palate means that your covered Dependent Child under the age of 18 has been initially Diagnosed with either a cleft lip or a cleft palate. A Cleft Lip means a congenital failure of the upper lip to close and results in a narrow gap in the upper lip that extends to the nostril on one side or both sides of the mouth. A Cleft Palate means a congenital failure to close an opening in the roof of the mouth that extends to the nasal cavity. When a combination of Cleft Lip and Cleft Palate is Diagnosed, only one Diagnosis is eligible for benefits.

The Diagnosis of Cleft Lip/Palate must be made by a Physician. In order for a benefit to be paid, the initial Diagnosis of Cleft Lip/Palate must occur while insured under the Policy.

Complex Congenital Heart Disease means your covered Dependent Child under the age of 18 has been initially Diagnosed with at least one of the following covered heart conditions:

- coarctation of the aorta;
- Ebstein's anomaly;
- Eisenmenger syndrome;
- Tetralogy of Fallot;
- transposition of the great vessels; or
- any other congenital cardiac condition that requires open heart surgery.

The Diagnosis of Complex Congenital Heart Disease must be made and the surgery must be recommended by a Physician. In order for a benefit to be paid, the initial Diagnosis of Complex Congenital Heart Disease must occur while insured under the Policy.

Cystic Fibrosis means evidence of a lung disease that your covered Dependent Child under the age of 18 has been initially Diagnosed with by a Physician while insured under the Policy. The Diagnosis must be confirmed with sweat chloride tests and genetic testing.

Exclusions:
Cystic Fibrosis does not include the following:

- asymptomatic;
- clinical features limited to CABVD (congenital absence of vasdeferens); or
- gastrointestinal issues.

The Diagnosis of Cystic Fibrosis must be made by a Physician. In order for a benefit to be paid, the initial Diagnosis of Cystic Fibrosis must occur while insured under the Policy.

Type 1 Diabetes Mellitus means that your covered Dependent Child under the age of 18 has been initially Diagnosed with a chronic autoimmune, genetic or infectious destruction of the insulin producing cells in the pancreas and that requires continuous, lifelong insulin therapy.

The Diagnosis of Type 1 Diabetes Mellitus must be made by a Physician. In order for a benefit to be paid, the initial Diagnosis of Type 1 Diabetes Mellitus must occur while insured under the Policy.

Down Syndrome means that your covered Dependent Child under the age of 18 has been initially Diagnosed with Down Syndrome by a Physician.

In order for a benefit to be paid, the initial Diagnosis of Down Syndrome must occur while insured under the Policy.

Muscular Dystrophy means your covered Dependent Child under the age of 18 has been initially Diagnosed with either Duchenne muscular dystrophy or Becker muscular dystrophy by specific testing. Clinical evidence of neuromuscular features of muscular dystrophy must be present. The Diagnosis must be made by a Physician.

In order for a benefit to be paid, the initial Diagnosis of Muscular Dystrophy must occur while insured under the Policy.

7. COVERED CONDITIONS

Spina bifida means that your covered Dependent Child under the age of 18 has been initially Diagnosed with congenital conditions of meningocele or myelomeningocele. Spina Bifida does not include spina bifida occulta.

The Diagnosis must be made by a Physician and be associated with neurologic symptoms including motor impairment identified by a Physician. In order for a benefit to be paid, the initial Diagnosis of Spina Bifida must occur while insured under the Policy.

8. EXCLUSIONS AND LIMITATIONS

What exclusions apply to the benefits payable?
In addition to the exclusions stated in the Covered Conditions section of this Certificate, we will not pay any benefit that is due to or results from any Specified Disease condition Diagnosed outside the United States or Canada without confirmation of the Diagnosis by the type of Physician specified for each of the Covered Conditions in Section 7 who practices in the United States or Canada.

We will not pay a benefit for any Specified Disease that is due to or results from:

- Treatment or complications of Treatment not related to a Specified Disease;
- an autologous bone marrow transplant, one in which your own bone marrow is used;
- intentionally self-inflicted injuries;
- active military duty;
- war or any act of war or your active duty in any armed service during a time of war (this does not include acts of terrorism);
- your active Participation in a Riot, Rebellion or Insurrection;
- committing or attempting to commit a felony or be engaged in an illegal occupation;
- your engagement in scuba diving, parachuting, hang gliding, motorized racing, ballooning, kick-boxing, cliff diving, mountain climbing, powerboat racing, heli-skiing, big game hunting, cave exploration, underwater diving, rodeo events, or white water rafting;
- committing or attempting to commit suicide, whether sane or insane;
- incarceration in a penal institution of any kind; or
- being legally Intoxicated or under the influence of any narcotic unless taken on the advice of a Physician and taken as prescribed.

What limitations apply to the benefits payable?
In addition to the limitations stated in the Covered Conditions section of this Certificate, we will not pay any benefit for any Specified Disease that is Diagnosed in the first 12 months following the effective date of any Insured's insurance and results from a Pre-Existing Condition.

Pre-Existing Condition means during the 12 months prior to any Insured's effective date of insurance or the effective date of an increase in any Insured's amount of insurance, any condition for which any Insured:

- received medical Treatment, care or services for the condition; or
- took prescribed drugs or medicines for the condition.

When newborn children, newly placed foster children or newly adopted children are added to your Dependent Children Insurance within 31 days of the birth, placement or adoption, the Pre-Existing Condition limitation does not apply.

9. WELLNESS SCREENING BENEFIT

What is the wellness screening benefit?
While your insurance under the Policy is in force, we will pay you a wellness screening benefit each Benefit Year during which you or your insured Spouse or your insured Dependent Child has any generally medically accepted cancer screening test or one of the following wellness screening tests performed:

- CA15-3 (blood test for breast cancer)
- Breast Cancer Screening (clinical breast exam, mammography, MRI, thermography, ultrasound)
- CA 125 (blood test for ovarian cancer)
- Colorectal Cancer Screening (fecal occult blood test, colonoscopy, sigmoidoscopy)
- CEA (blood test for colon cancer)
- Lipid panel (cholesterol, triglycerides, HDL, LDL)
- Pap smear
- Prostate Cancer Screening (digital rectal exam, PSA blood test)
- Skin Cancer Screening
- Diabetes tests (fasting blood glucose test, hemoglobin A1c)
- Cardiac exercise stress test
- Electrocardiogram (ECG)-resting or stress
- Chest x-ray
- Hemocult stool analysis
- Serum protein electrophoresis
- Carotid Doppler
- Echocardiogram
- Immunizations
- Interscholastic Sports Physical Exam

What is the amount of the wellness screening benefit?
We will pay you the amount as shown in the Benefit Highlights once each Benefit Year if any one of the wellness screening tests described in this Certificate is performed for you regardless of the results of the test. We will pay you the amount as shown in the Benefit Highlights once each Benefit Year if any one of the wellness screening tests described in this Certificate is performed for your insured Spouse. We will pay you the amount as shown in the Benefit Highlights once each Benefit Year if any one of the wellness screening tests described in this Certificate is performed for your insured Dependent Child. The wellness screening benefit is paid in addition to any other benefits payable under the Policy.

What conditions apply to the wellness screening benefit?
To receive this benefit, you must notify us of which wellness screening test was performed.

10. CLAIM PROVISIONS

How is a claim submitted?
To submit a claim, you or someone on your behalf must send us Written notice and Proof of loss on our form within the time limits specified. Your Employer has the notice and Proof of loss forms.

NOTICE OF CLAIM

When does Written notice of claim have to be submitted?
Written notice of claim must be given to us no later than 90 days after the date of Diagnosis or within 180 days of the initial Treatment of the Specified Disease.

If notice cannot be given within the applicable time period, we must be notified as soon as it is reasonably possible.

Notice given by or on behalf of the claimant to us at our Executive Office or to any authorized agent of ours, with information sufficient to identify the Insured, shall be deemed notice to us.

When we receive Written notice of claim, we will send the forms for Proof of loss. If the forms are not received within 15 days after Written notice of claim is sent, Proof of loss may be sent to us without waiting to receive the Proof of loss forms.

PROOF OF LOSS

When does Written Proof of loss have to be submitted?
Written Proof of loss must be given to us no later than 180 days after the date of Diagnosis or Treatment of the Specified Disease.

If Proof cannot be given within the time limit, Proof must be given as soon as reasonably possible. Proof of loss may not be given later than one year after the time Proof is otherwise required unless the individual is legally incompetent.

What is considered Proof of loss?
Proof of loss must consist of at least the following information:
- a description of the Specified Disease;
- the date the Diagnosis occurred;
- the cause of the Specified Disease; and
- any other information we may require to make a loss determination.

Proof of loss may include, but is not limited to, police accident reports, laboratory results, toxicology results, hospital records, x-rays, narrative reports, or other diagnostic testing materials, as required.

We may require as part of the Proof, authorizations to obtain medical and non-medical information.

PAYMENT OF BENEFITS

When are benefits payable?
Benefits are payable upon our receipt of Proof of loss that establishes benefit eligibility according to the provisions of the Policy.

When will a decision on your claim be made?
We will send you a Written notice of our decision on your claim within a reasonable time after we receive the claim but not later than 30 days after receipt of the claim. If we cannot make a decision within 90 days after receiving your claim, we will request a 30 day extension as permitted by U.S. Department of Labor regulations. Any request for extension will specifically explain:
- the standards on which entitlement to benefits is based;
- the unresolved issues that prevent a decision on the claim; and

- the additional information needed to resolve those issues.

If a period of time is extended because you failed to provide necessary information, the period for making the benefit determination is tolled from the date we send notice of the extension to you until the date on which you respond and provide the requested information. You will have 45 days to provide the specified information.

What if your claim is denied?
If we deny all or any part of your claim, you will receive a Written notice of denial stating:

- the specific reason(s) for the denial;
- the specific Policy provision(s) on which the denial is based;
- your right to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits;
- a description of any additional material or information needed to prove entitlement to benefits and an explanation of why such material or information is necessary;
- a description of the appeal procedures and time limits;
- your right to bring a civil action under ERISA, §502(a), if applicable, following an adverse determination on review; and
- the identity of any medical or vocational experts whose advice was obtained in connection with the claim, regardless of whether the advice was relied upon to deny the claim.

Can you request a review of a claim denial?
If all or part of your claim is denied, you may request in Writing a review of the denial within 60 days after receiving notice of denial.

You may submit Written comments, documents, records or other information relating to your claim for benefits, and may request free of charge copies of all documents, records, and other information relevant to your claim for benefits.

We will review the claim on receipt of the Written request for review, and will notify you of our decision within a reasonable time but not later than 60 days after the request has been received. If an extension of time is required to process the claim, we will notify you in Writing of the special circumstances requiring the extension and the date by which we expect to make a determination on review. The extension cannot exceed a period of 60 days from the end of the initial period.

If a period of time is extended because you failed to provide information necessary to decide your claim, the period for making the decision on review is tolled from the date we send notice of the extension to you until the date on which you respond to the request for additional information. You will have at least 45 days to provide the specified information.

What if your claim is denied on review?
If we deny all or any part of your claim on review, you will receive a Written notice of denial stating:

- the specific reasons for the denial;
- the specific Policy provisions on which the denial is based;
- your right to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits;
- your right to bring a civil action under ERISA, §502(a), if applicable; and
- the following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State Insurance regulatory agency.”

10. CLAIM PROVISIONS

To whom are benefits payable?
We will pay you all benefits, upon receipt of Proof, except in the following situations:

- you are a minor. In such case, claim may be made by your duly appointed guardian, conservator or committee and we will pay to such person or persons;
- due to physical or mental incapacity, you cannot, in our judgment, give us a valid receipt for payments. In such case, claim may be made as described above; or
- you die before we pay you. In such case, claim may be made by your executor or the administrator of your estate and we will pay to such person or persons.

If we do not pay you and claim is not made by the appropriate person designated above, we may, at our option, make payments under either or both Methods A or B below. Any decision to pay any benefits, prior to the appointment of the appropriate person designated (as shown above), is solely at our discretion, and we may choose to pay no amounts under any circumstances until such appropriate person is formally appointed.

Method A: We may pay up to the sum of $5,000 to any individual or entity we determine has incurred or paid expenses as a result of funeral services provided to or on your behalf. If we pay such a benefit, we will not have to pay that benefit amount again and the total benefit due under the Policy shall be reduced by the amount paid under this provision.

Method B: We may pay the whole or any part of such benefit:

- to your Spouse, up to a cumulative amount of $5,000; or
- if you have no Spouse, up to a cumulative amount of $5,000 to any one or more of the following relatives in the following order of priority:
- first, your child or children; or
- then, your mother or father.

11. INSURANCE CONTINUATION

Are there any conditions under which your Employer can continue your insurance?
While the Policy is in force and subject to the conditions stated in the Policy, your Employer may continue your insurance that was in force on the date immediately before the date you ceased to be Actively at Work by paying the required premium to us for any of the following reasons and durations:

- absence due to Injury or sickness – up to 12 months
- Layoff – up to 3 months
- Leave of Absence – up to 3 months including Family and Medical Leave of Absences
- Vacation – based on your Employer's policy, not to exceed 3 months

You should contact your Employer for more details.

While the Policy is in force, you may be eligible to continue your insurance pursuant to the Family and Medical Leave Act of 1993, as amended or continue coverage pursuant to a state required continuation period (if any). You should contact your Employer for more details.

While the Policy is in force, you may be eligible to continue your insurance coverage pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA), as amended. You should contact your Employer for more details.

12. PORTABILITY

What is portable insurance and when are you eligible?
Portable insurance is an optional benefit that you may elect to continue your insurance for each Insured up to the later of the day before you attain age 70 or 12 months from the date your portable insurance started if:

- your insurance ends because you are no longer in an Eligible Class; or
- your insurance ends because your class is no longer included for insurance; or
- your insurance ends because you terminate employment; or
- a revision is made to the Policy to reduce your amount of insurance; and
- you meet the following requirements:
  - you reside in the United States or Canada; and
  - you have not exercised your portable insurance right under a similar certificate issued by us; and
  - your insurance is not being continued under any Insurance Continuation provision.

You may not elect portable insurance for your Spouse or Dependent Children if you have not elected portable insurance for yourself.

Your portable insurance will be provided under an insurance policy we make available for this purpose. Your portable insurance may not be identical to your current insurance under the Policy.

When must you apply for portable insurance?
You must complete an application for portable insurance and send it to us with payment of the first premium within 31 days of the date your insurance under the Policy terminates. The application for portable insurance and applicable rates are available from your Employer.

What is the amount of portable insurance?
You may apply for portable insurance in an amount up to 100% of each Insured's remaining amount of insurance in force under the Policy on the date your insurance terminates. You may port to a lower amount of insurance if available. You cannot port to a higher amount of insurance. Your portable insurance policy will not provide any benefits beyond those described in the section of this Certificate titled Benefit Provisions.

When does your portable insurance start?
After your insurance under the Policy terminates, your portable insurance will start on the later of the following:

- the date we approve your application for portable insurance; or
- the date we receive your first premium payment for portable insurance.

If you are Diagnosed with a covered Specified Disease within 31 days after your insurance ends, but before you have applied to port, we will pay any benefits as if you had ported. However, you must pay any premium due.

When is portable insurance available to your Spouse and when is your Spouse eligible?
Portable Insurance is available for your Spouse up to the later of the day before you attain age 70 or 12 months from the date your portable insurance started if all of the following requirements are met:

- you die or divorce your Spouse and your Spouse was Insured under the Policy at the time;
- your Spouse resides in the United States or Canada.

Your Spouse's portable insurance will be provided under an insurance policy we make available for this purpose. Their portable insurance may not be identical to your current insurance under the Policy.

When must your Spouse apply for portable insurance?
Your Spouse must complete an application for portable insurance and send it to us with payment of the first premium within 31 days of the date of your death or divorce. The application for portable insurance and applicable rates are available from your Employer.

12. PORTABILITY

What is the amount of your Spouse's portable insurance?
Your Spouse may apply for portable insurance in an amount up to 100% of the remaining amount of Spouse Insurance and Dependent Children Insurance in force under the Policy on the date of your death or divorce. Your Spouse's portable insurance policy will not provide any benefits beyond those described in the section of this Certificate titled Benefit Provisions.

Your Spouse may not apply for portable insurance for a Dependent Child whose insurance has not terminated under the Policy due to divorce.

When does your Spouse's portable insurance start?
After your death or divorce, your Spouse's portable insurance will start on the later of the following:

- the date we approve your Spouse's application for portable insurance; or
- the date we receive your Spouse's first premium payment for portable insurance.

13. CONTINUITY OF COVERAGE

What happens if your Employer replaces other insurance with this Certificate and the Policy?
If your Employer replaces insurance provided by another insurance company ("Prior Policy") with the insurance provided by this Certificate and the Policy ("This Policy"), the Continuity of Coverage benefits set forth in this Section may be available to you. These benefits will be available if the insurance and level of benefits under the Prior Policy were substantially similar to the insurance provided by This Policy.

What if you are not Actively at Work when your Employer replaces your Prior Policy with This Policy?
You and your Spouse and Dependent Children will be covered under This Policy if you are not Actively at Work on January 1, 2022 if:

- you were insured under the Prior Policy on the day before January 1, 2022;
- you are a member of an Eligible Class;
- your Employer continues to remit premiums for your coverage; and
- you are not receiving or eligible to receive benefits under the Employer's Prior Policy.

If you are Diagnosed with a Specified Disease condition as defined in the Covered Conditions section of This Policy, and were never Actively at Work while covered under This Policy, any benefit payable will be the lesser of:

- the benefit payable under This Policy; or
- the benefit payable under the Prior Policy.

What if your Spouse or Dependent Child is Confined when your Employer's Prior Policy is replaced with This Policy and you are Actively at Work?
Your Spouse and Dependent Children will be covered under This Policy if they are not Confined on January 1, 2022 if:

- your Spouse or Dependent Child was insured under your Employer's Prior Policy on the day before January 1, 2022;
- you are a member of an Eligible Class for Spouse or Dependent Children coverage;
- your employer continues to remit premiums for your Spouse or Dependent Children coverage; and
- your Spouse or Dependent Child not receiving or eligible to receive Spouse or Dependent Child benefits under your Employer's Prior Policy.

Any Spouse or Dependent Child benefit payable will be the lesser of:

- the benefit payable under This Policy; or
- the benefit payable under your Employer's Prior Policy.

Does the Eligibility Waiting Period apply when your Employer's Prior Policy is replaced with This Policy?
We will apply any period of time satisfied under the Prior Policy to meet the requirements of the Eligibility Waiting Period toward the satisfaction of the period of time required by This Policy's Eligibility Waiting Period.

Does the Pre-Existing Condition limitation apply when your Employer's Prior Policy is replaced with This Policy?
We will apply any period of time satisfied under the Prior Policy to meet the requirements of the Pre-Existing Condition limitation toward the satisfaction of the period of time required by This Policy's Pre-Existing Condition limitation.

14. GENERAL PROVISIONS

AGENCY

Can the Policyholder, Employer, or third party administrator act as our agent?
For all purposes of the Policy, the Policyholder, Employer or third party administrator acts on its own behalf or as your agent. Under no circumstances will the Policyholder, Employer or third party administrator be deemed an agent of Sun Life Assurance Company of Canada.

ALTERATION

Who can alter this Certificate?
The only persons with the authority to alter or modify this Certificate or to waive any of its provisions are our president, actuary, secretary or one of our vice presidents and any such changes must be in Writing.

ASSIGNMENT

Can benefit payments be assigned?
You cannot assign any interest in the Policy unless we agree in Writing to such an assignment. We have the right to determine the extent to which any assignment will be honored and the priority of such assignment. We do not assume any responsibility for the validity or sufficiency of any assignment. Any payments made under such assignment after consented to by us will discharge our liabilities under the Policy, to the extent of such payments.

BENEFICIARY

How can you change your Beneficiary?
Unless the Insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the Insured and the consent of the beneficiary or beneficiaries shall not be requisite or beneficiaries shall not be requisite to surrender or assignment of this Policy or to any change of beneficiary or beneficiaries, or to any other changes in the Policy.

CLERICAL ERROR

What happens when there is a clerical error in the administration of the Policy?
Clerical errors in the administration of the Policy or delays in keeping records for the Policy whether by us, the Policyholder, or the Employer:

- will not terminate insurance that would otherwise have been effective; and
- will not continue insurance that would otherwise have ceased or should not have been in effect.

If appropriate, a fair adjustment of premium will be made to correct the error.

This provision does not apply to benefit administration errors by the Policyholder or the Employer which result in an Employee:

- not enrolling for insurance within required time limits;
- failing to request increased amounts of insurance within required time limits.
- failing to provide any required Evidence of Insurability; or
- failing to exercise any available Insurance Continuation or Portability options.

CONFORMITY WITH STATUTES

What is the effect of Conformity with Statutes?
If any provision of the Policy conflicts with any applicable law, the provision will be automatically amended to meet the minimum requirements of the law, except as otherwise pre-empted by federal law.

14. GENERAL PROVISIONS

DISCHARGE OF OUR RESPONSIBILITY

What is the effect of payments under the Policy?
Payment made under the terms of the Policy will, to the extent of such payment, release us from all further obligations under the Policy. We will not be obligated to see to the application of such payment.

EXAMINATION

What are our examination rights?
We, at our expense, have the right to have the person of any Insured whose Specified Disease is the basis of a claim examined by a Physician, other health professional or vocational expert of our choice.

This right may be used as often as we reasonably require. Unless authorized by the examining Physician, the examination may not be recorded nor may another person be present during the examination.

INCONTESTABILITY

What is the Incontestability Provision?
Except for non-payment of premium, or any claims incurred within three years of the effective date of an Insured's initial, increased, additional or reinstated insurance, no statement made by any Insured relating to insurability for such insurance will be used to contest the validity of that insurance after the insurance has been in force for a period of three years during that individual's lifetime. The statement must be contained in a form Signed by that individual.

LEGAL PROCEEDINGS

What are the time limits for legal proceedings?
No legal action may start:

- until 60 days after Proof has been given; nor
- more than 3 years after the time Proof of loss is required.

MISSTATEMENT OF FACTS

What happens if there is a misstatement of facts in the administration of the Policy?
If relevant facts about the Employer or Employee relating to this insurance are determined not to be accurate:

- a fair adjustment of premium will be made; and
- the actual facts will decide whether, and in what amount, and for what duration insurance is valid under the Policy.

NON-PARTICIPATING

Does the Policy participate in dividends?
The Policy is non-participating and will not share in any profits or surplus earnings of Sun Life Assurance Company of Canada, and, therefore, no dividends are payable.

PREMIUM PAYMENTS AS EVIDENCE OF INSURANCE

Does the payment of premiums guarantee coverage under the Policy?
The receipt of premiums by us is not a guarantee of insurance. Eligibility for benefits will be determined at the time of claim submission and in order to receive a benefit under the Policy, all Policy requirements must be satisfied.

If we determine that you, your Spouse or your Dependent Child are not eligible for coverage, you should contact your Employer regarding the refund of premiums due, if any.

14. GENERAL PROVISIONS

REIMBURSEMENT

What if a benefit is underpaid or overpaid?
Reimbursement will be made to us for any overpayments that we may make due to any reason. You must repay us within 60 days unless we agree to a longer time period. Deductions may be made from future benefit payments to recover any such overpayments.

If we have underpaid a benefit for any reason, we will make a lump sum payment for that amount.

Interest does not accrue on any underpaid or overpaid benefit unless required under the applicable law.

STATEMENTS

Are statements warranties?
In the absence of fraud, all statements made in any application are considered representations and not warranties. No representation by you in enrolling for insurance under the Policy will be used to reduce or deny a claim unless a copy of your Written application for insurance is or has been given to you, your beneficiary, if any, or your estate representative.

TIME PERIODS

What time periods apply to this Certificate?
For the purpose of effective dates and termination dates under this Certificate, all days begin at 12:00 midnight and end at 11:59:59 PM at the Policyholder's location.

SUN LIFE ASSURANCE COMPANY OF CANADA

Group Specified Disease Insurance Certificate

Non-Participating

Ambarella Corp Employee Benefit Plan (The Plan) has been established to provide welfare benefits for its employees.

The Employee Retirement Income Security Act of 1974 (ERISA) requires that the Plan Administrator provide you with a Summary Plan Description which discloses required information about the employee benefit plan. The following section entitled "Summary Plan Description" is not part of the Group Insurance Policy. The information in the Summary Plan Description is provided by the Policyholder and is included in this Booklet/Certificate for your convenience. Sun Life Assurance Company of Canada assumes no responsibility for the accuracy or sufficiency of the information in the Summary Plan Description.

SUMMARY PLAN DESCRIPTION

Plan Sponsor: Ambarella Corp
3101 Jay St
Santa Clara, CA 95054

Plan Administrator: Ambarella Corp
3101 Jay St
Santa Clara, CA 95054

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

Subsidiaries/Affiliates: Oculii

Agent for Service of Legal Process: Ambarella Corp
3101 Jay St
Santa Clara, CA 95054

Employer Identification Number (EIN): 83-0385267

Plan Number: 501

End of Plan Year: December 31st

Type of Administration: The Plan is administered by the Plan Administrator. The benefits provided by the Group Insurance Policy issued by Sun Life Assurance Company of Canada are included in the Plan.

Participants: The insured employees described in the Sun Life Assurance Company of Canada Booklet/Certificate.

Plan Changes and Termination: The Plan Administrator may amend, modify or terminate the Plan.

Contributions: The cost of your benefits under the Plan is paid for by your employer and (if applicable) includes the cost of any insurance premiums contributed by you.

Funding: Sun Life provides the Plan Administrator with certain insurance benefits in connection with the Plan. Those insurance benefits are described in your Booklet/Certificate.

Claims Procedure: When you or your beneficiary wish to file a claim under the Plan, you should contact your personnel office for claim forms and instructions for filing. Your Booklet/Certificate explains the procedure for filing a claim under the Group Insurance Policy.

If your claim for benefits is denied in whole or in part, you will receive a written notice within the time required by ERISA from the date you filed your claim, stating the reasons why your claim was denied.

You will then have the right, upon written notice from you or your authorized representative, to review that claim denial. The claim denial notice will include the name and address of the person you may ask for such a review. Additional information about claims submitted and review procedures may be obtained by contacting your Plan Administrator.

Your Rights under 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 Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the 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 benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a 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 Plan 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 of 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 questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits

Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.