Basic and Voluntary Life Policy Documents and Certificates

The following documents regarding your Basic and Voluntary Life Policy are included for informational purposes:

The certificate describes coverage provided to persons who are eligible and who have been properly enrolled under the terms of the policy, and that the terms of the master policy are controlling**.**

NOTICE

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

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

TL-004788

LIFE INSURANCE COMPANY OF NORTH AMERICA
1601 CHESTNUT STREET
PHILADELPHIA, PA 19192-2235
(800) 732-1603 TDD (800) 552-5744
A STOCK INSURANCE COMPANY

GROUP POLICY

POLICYHOLDER:	TRUSTEE OF THE GROUP INSURANCE TRUST FOR EMPLOYERS IN THE RETAIL TRADE INDUSTRY
SUBSCRIBER:	The Reinalt-Thomas Corporation, a Michigan corporation, dba Discount Tire/America's Tire/Discount Tire Direct
POLICY NUMBER:	FLX-980462
POLICY EFFECTIVE DATE:	January 1, 2020
POLICY ANNIVERSARY DATE:	January 1

This Policy describes the terms and conditions of coverage. It is issued in Delaware and shall be governed by its laws. The Policy goes into effect on the Policy Effective Date, 12:01 a.m. at the Policyholder's address.

In return for the required premium, the Insurance Company and the Subscriber have agreed to all the terms of this Policy.

Anna Krishtul, Corporate Secretary

William J. Smith, President

TL-004700

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

Premium Due Date: The last day of each month

Classes of Eligible Employees

On the pages following the definition of eligible employees there is a Schedule of Benefits for each Class of Eligible Employees listed below. For an explanation of these benefits, please see the Description of Benefits provision.

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

Class 1	All active, Full-time Employees of the Employer classified as Special Management regularly working the required number of hours to qualify for benefits according to the Employer's company policy, working in the United States who are citizens or permanent resident aliens of the United States, excluding temporary and seasonal Employees.
Class 2	All active Full-time Employees of the Employer classified as Executives, Corporate Directors, Corporate Managers, Corporate Assistant Managers, Corporate Process Managers, Business Relationship Owners, Project Managers, Risk Litigation Coordinators, Systems Engineers - IT Omni Channel, Regional Office Managers, Store Managers, Store Maintenance Managers, Regional Facilities Managers, Warehouse Managers, Pilots, Flight Department Directors, Flight Department Managers, Aircraft Quality Control Inspectors, Discount Tire Direct (DTD) Directors, DTD Managers, DTD Supervisors, DTD DC Managers, DTD Senior DC Assistant Managers regularly working the required number of hours to qualify for benefits according to the Employer's company policy, working in the United States who are citizens or permanent resident aliens of the United States, excluding temporary and seasonal workers.
Class 3	All active, Full-time Employees of the Employer classified as Store, Warehouse or Maintenance regularly working the required number of hours to qualify for benefits according to the Employer's company policy, working in the United States who are citizens or permanent resident aliens of the United States excluding temporary and seasonal workers.
Class 4	All active, Full-time Employees of the Employer classified as Office or Inside Sales Agents regularly working the required number of hours to qualify for benefits according to the Employer's company policy, working in the United States who are citizens or permanent resident aliens of the United States excluding temporary and seasonal workers.

SCHEDULE OF BENEFITS FOR CLASS 1

Eligibility Waiting Period

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

For Employees hired on or before the Policy Effective Date:	After 90 days of continuous Active Service
For Employees hired after the Policy Effective Date:	After 90 days of continuous Active Service

The *Eligibility Waiting Period* does not apply if a former Employee is rehired within 12 months after his or her termination date and the former Employee had satisfied the *Eligibility Waiting Period* prior to his or her termination date. If a former Employee did not fully satisfy the *Eligibility Waiting Period* prior to his or her termination date, credit will be given for any time that was satisfied.

LIFE INSURANCE BENEFITS

Employee Benefits

Basic Benefit	1.5 times Annual Compensation
Guaranteed Issue Amount:	the lesser of 1.5 times Annual Compensation or $50,000
Maximum Benefit:	the lesser of 1.5 times Annual Compensation or $50,000

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

Basic Terminal Illness Benefit	The insured can elect up to 75% of Basic Life Insurance Benefits in force on the date the insured is determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $37,500.
Voluntary Benefit	An amount elected in units of $10,000
Guaranteed Issue Amount:	the greater of a) or b) below: a) the lesser of 7 times Annual Compensation or $400,000, or b) an amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan
Maximum Benefit:	$500,000

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

Voluntary Terminal Illness Benefit	The insured can elect up to 75% of Voluntary Life Insurance Benefits in force on the date the insured is determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $250,000.

Age Based Reductions	Life Insurance Benefit for an Employee age 65 and over will reduce to the percentage shown below: 65% of the Life Insurance Benefit at age 65 40% of the Life Insurance Benefit at age 70 25% of the Life Insurance Benefit at age 75 Benefit reductions will be effective on the Employee's attainment of age as specified in schedule above.
Continuation Options	
For Layoff	
Maximum Benefit Period:	3 months
For Leave of Absence	
Maximum Benefit Period:	18 months following the date coverage would otherwise end due to exhaustion of Family and Medical Leave Act (FMLA), state leave of absence laws or termination of Short Term Disability benefits under the Employer's Short Term Disability Plan
For Leave for Military Service:	
Maximum Benefit Period:	24 months
For Family Medical Leave	
Maximum Benefit Period:	the later of the period of the approved FMLA leave or the leave period required by the laws of the state in which the Employee is employed
For Disability	
Maximum Benefit Period:	18 months following the date coverage would otherwise end due to exhaustion of Family and Medical Leave Act (FMLA), state leave of absence laws or termination of Short Term Disability benefits under the Employer's Short Term Disability Plan
Applicable Coverages:	Life Insurance Benefits for the Employee, his or her Spouse and Dependent Children, if any
Extended Death Benefit with Waiver of Premium	
Extended Death Benefit	
Applicable Coverages	Life Insurance Benefits for the Employee, his or her Spouse and Dependent Children, if any
Waiver of Premium	
Waiver Waiting Period	6 months from the date the Employee's Active Service ends
Maximum Benefit Period	To Age 65
Applicable Coverages	Life Insurance Benefits for the Employee, his or her Spouse and Dependent Children, if any
Portability Options	
For Employees	See the Former Employee and Spouse of Former Employee sections in this Schedule of Benefits for the amounts of insurance an Insured is eligible to continue under this option.

Automatic Increase Feature for Life Insurance

An increase in an Employee's Life Insurance resulting from an increase in Annual Compensation will not be subject to the Insurability Requirement, even if the increase causes the Life Insurance to exceed the Guaranteed Issue Amount.

If an Employee is not in Active Service on the date the increase would go into effect, his or her benefit will not increase until he or she returns to Active Service.

Premiums must be paid on the basis of any increased amount of Life Insurance resulting from increases in Annual Compensation.

Spouse Benefits

Voluntary Benefit	Units of $5,000
Guaranteed Issue Amount:	the greater of a) or b) below: a) $30,000, or b) an amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan
Maximum Benefit:	$100,000

A Spouse's Life Insurance Benefits cannot exceed 50% of the Employee's Voluntary Life Insurance Benefits.

Age Based Reductions	Spouse Life Insurance Benefits for an Employee age 65 and over will reduce to the percentage shown below: 65% of the Life Insurance Benefit at age 65 40% of the Life Insurance Benefit at age 70 25% of the Life Insurance Benefit at age 75 Benefit reductions will be effective on the Employee's attainment of age as specified in schedule above.
Portability Options	
For Spouse	See the Former Spouse section in this Schedule of Benefits for the amounts of insurance an Insured is eligible to continue under this option.
Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Dependent Child Benefits

Voluntary Benefit	Units of $5,000
Maximum Benefit:	$10,000 The Maximum Benefit for a Dependent Child who is less than 6 months old is $5,000.

All Dependent Child benefits are Guaranteed Issue.

Portability Options	
For Dependent Children	See the Former Dependent Child section in this Schedule of Benefits for the amounts of insurance an Insured is eligible to continue under this option.

Annual Enrollment Period

For Employees
During an Annual Enrollment Period, an Employee currently insured under the Voluntary Life Insurance portion of this Policy may increase his or her Voluntary Life Insurance Benefit, and an Employee who is eligible for the Voluntary Life Insurance portion of this Policy but who has not previously enrolled may become insured under the Policy, as long as the total Benefit does not exceed the Maximum Benefit, by satisfying the Insurability Requirement. Insurance will be effective on the later of January 1st following the Annual Enrollment Period or the date the Insurance Company agrees in writing to insure the Employee.

For Spouses

During an Annual Enrollment Period, an eligible Employee may elect coverage for his or her eligible Spouse. If a Spouse is currently insured under the Voluntary Life Insurance portion of this Policy, his or her Voluntary Life Insurance Benefit may be increased, as long as the total Benefit does not exceed the Maximum Benefit, by satisfying the Insurability Requirement. If a Spouse is eligible for the Voluntary Life Insurance portion of this Policy but has not previously enrolled, he or she may become insured under the Policy, as long as the total Benefit does not exceed the Maximum Benefit, by satisfying the Insurability Requirement. Insurance will be effective on the later of January 1st following the Annual Enrollment Period or the date the Insurance Company agrees in writing to insure the Spouse.

Insurance Benefits for an Employee, his or her Spouse and Dependent Children may be reduced at any time. A request for a Benefit reduction received during an Annual Enrollment Period will become effective on January 1st following the Annual Enrollment Period. Any other Benefit reduction will be effective on the date the Insurance Company receives the completed change form.

TL-008025-1

Life Status Change

For Employees
Within 31 days after a Life Status Change, an Employee currently insured under the Voluntary Life Insurance portion of this Policy may increase his or her Voluntary Life Insurance Benefit, and an Employee who is eligible for the Voluntary Life Insurance portion of this Policy but who has not previously enrolled may become insured under the Policy, as long as the total Benefit does not exceed the Maximum Benefit by satisfying the Insurability Requirement. Insurance will be effective on the later of the first of the month following the Life Status Change or the date the Insurance Company agrees in writing to insure the Employee.

Insurance Benefits for an Employee may be reduced at any time. The reduced amount will be effective on the date the Insurance Company receives the completed change form.

TL-008030-1

Former Employee Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Life Insurance Benefits allowable to an Employee, less any amount of conversion insurance issued under the Conversion Privilege for Life Insurance. Any amount elected in excess of the Life Insurance Benefits in effect on the date he or she no longer qualifies as an Employee will be effective on the date the Insurance Company agrees in writing to insure him or her.

	The Maximum Benefit for Basic Life Insurance Benefits is $50,000.
Maximum Benefit Period	To Age 70
Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $287,500.

Spouse of Former Employee Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Voluntary Life Insurance Benefits available to a Spouse. Any amount elected in excess of the Voluntary Life Insurance Benefits in effect on the date the Employee's employment with the Employer ends will be effective on the date the Insurance Company agrees in writing to insure him or her.
Maximum Benefit Period	To Age 70
Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Former Spouse Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Voluntary Life Insurance Benefits available to a Spouse. Any amount elected in excess of the Voluntary Life Insurance Benefits in effect on the date he or she no longer qualifies as a Spouse will be effective on the date the Insurance Company agrees in writing to insure him or her.
Maximum Benefit Period	To Age 70
Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Former Dependent Child Benefits

Amount of Insurance	Units of $25,000
Guaranteed Issue Amount:	$25,000
Maximum Benefit:	$50,000
Maximum Benefit Period	To Age 70

TL-004774

SCHEDULE OF BENEFITS FOR CLASS 2

Eligibility Waiting Period

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

For Employees hired on or before the Policy Effective Date:	After 90 days of continuous Active Service
For Employees hired after the Policy Effective Date:	After 90 days of continuous Active Service

The *Eligibility Waiting Period* does not apply if a former Employee is rehired within 12 months after his or her termination date and the former Employee had satisfied the *Eligibility Waiting Period* prior to his or her termination date. If a former Employee did not fully satisfy the *Eligibility Waiting Period* prior to his or her termination date, credit will be given for any time that was satisfied.

LIFE INSURANCE BENEFITS

Employee Benefits

Basic Benefit	1.5 times Annual Compensation
Guaranteed Issue Amount:	the lesser of 1.5 times Annual Compensation or $50,000
Maximum Benefit:	the lesser of 1.5 times Annual Compensation or $50,000

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

Basic Terminal Illness Benefit	The insured can elect up to 75% of Basic Life Insurance Benefits in force on the date the insured is determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $37,500.
Voluntary Benefit	An amount elected in units of $10,000
Guaranteed Issue Amount:	the greater of a) or b) below: a) the lesser of 7 times Annual Compensation or $400,000, or b) an amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan
Maximum Benefit:	$500,000

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

Voluntary Terminal Illness Benefit	The insured can elect up to 75% of Voluntary Life Insurance Benefits in force on the date the insured is determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $250,000.

Age Based Reductions	Life Insurance Benefit for an Employee age 65 and over will reduce to the percentage shown below: 65% of the Life Insurance Benefit at age 65 40% of the Life Insurance Benefit at age 70 25% of the Life Insurance Benefit at age 75 Benefit reductions will be effective on the Employee's attainment of age as specified in schedule above.
Continuation Options	
For Layoff	
Maximum Benefit Period:	3 months
For Leave of Absence	
Maximum Benefit Period:	18 months following the date coverage would otherwise end due to exhaustion of Family and Medical Leave Act (FMLA), state leave of absence laws or termination of Short Term Disability benefits under the Employer's Short Term Disability Plan
For Leave for Military Service:	
Maximum Benefit Period:	24 months
For Family Medical Leave	
Maximum Benefit Period:	the later of the period of the approved FMLA leave or the leave period required by the laws of the state in which the Employee is employed
For Disability	
Maximum Benefit Period:	18 months following the date coverage would otherwise end due to exhaustion of Family and Medical Leave Act (FMLA), state leave of absence laws or termination of Short Term Disability benefits under the Employer's Short Term Disability Plan
Applicable Coverages:	Life Insurance Benefits for the Employee, his or her Spouse and Dependent Children, if any
Extended Death Benefit with Waiver of Premium	
Extended Death Benefit	
Applicable Coverages	Life Insurance Benefits for the Employee, his or her Spouse and Dependent Children, if any
Waiver of Premium	
Waiver Waiting Period	6 months from the date the Employee's Active Service ends
Maximum Benefit Period	To Age 65
Applicable Coverages	Life Insurance Benefits for the Employee, his or her Spouse and Dependent Children, if any
Portability Options	
For Employees	See the Former Employee and Spouse of Former Employee sections in this Schedule of Benefits for the amounts of insurance an Insured is eligible to continue under this option.

Automatic Increase Feature for Life Insurance

An increase in an Employee's Life Insurance resulting from an increase in Annual Compensation will not be subject to the Insurability Requirement, even if the increase causes the Life Insurance to exceed the Guaranteed Issue Amount.

If an Employee is not in Active Service on the date the increase would go into effect, his or her benefit will not increase until he or she returns to Active Service.

Premiums must be paid on the basis of any increased amount of Life Insurance resulting from increases in Annual Compensation.

Spouse Benefits

Voluntary Benefit	Units of $5,000
Guaranteed Issue Amount:	the greater of a) or b) below: a) $30,000, or b) an amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan
Maximum Benefit:	$100,000

A Spouse's Life Insurance Benefits cannot exceed 50% of the Employee's Voluntary Life Insurance Benefits.

Age Based Reductions	Spouse Life Insurance Benefits for an Employee age 65 and over will reduce to the percentage shown below: 65% of the Life Insurance Benefit at age 65 40% of the Life Insurance Benefit at age 70 25% of the Life Insurance Benefit at age 75 Benefit reductions will be effective on the Employee's attainment of age as specified in schedule above.
Portability Options	
For Spouse	See the Former Spouse section in this Schedule of Benefits for the amounts of insurance an Insured is eligible to continue under this option.
Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Dependent Child Benefits

Voluntary Benefit	Units of $5,000
Maximum Benefit:	$10,000 The Maximum Benefit for a Dependent Child who is less than 6 months old is $5,000.

All Dependent Child benefits are Guaranteed Issue.

Portability Options	
For Dependent Children	See the Former Dependent Child section in this Schedule of Benefits for the amounts of insurance an Insured is eligible to continue under this option.

Annual Enrollment Period

For Employees
During an Annual Enrollment Period, an Employee currently insured under the Voluntary Life Insurance portion of this Policy may increase his or her Voluntary Life Insurance Benefit, and an Employee who is eligible for the Voluntary Life Insurance portion of this Policy but who has not previously enrolled may become insured under the Policy, as long as the total Benefit does not exceed the Maximum Benefit, by satisfying the Insurability Requirement. Insurance will be effective on the later of January 1st following the Annual Enrollment Period or the date the Insurance Company agrees in writing to insure the Employee.

For Spouses
During an Annual Enrollment Period, an eligible Employee may elect coverage for his or her eligible Spouse. If a Spouse is currently insured under the Voluntary Life Insurance portion of this Policy, his or her Voluntary Life Insurance Benefit may be increased, as long as the total Benefit does not exceed the Maximum Benefit, by satisfying the Insurability Requirement. If a Spouse is eligible for the Voluntary Life Insurance portion of this Policy but has not previously enrolled, he or she may become insured under the Policy, as long as the total Benefit does not exceed the Maximum Benefit, by satisfying the Insurability Requirement. Insurance will be effective on the later of January 1st following the Annual Enrollment Period or the date the Insurance Company agrees in writing to insure the Spouse.

Insurance Benefits for an Employee, his or her Spouse and Dependent Children may be reduced at any time. A request for a Benefit reduction received during an Annual Enrollment Period will become effective on January 1st following the Annual Enrollment Period. Any other Benefit reduction will be effective on the date the Insurance Company receives the completed change form.

TL-008025-1

Life Status Change

For Employees
Within 31 days after a Life Status Change, an Employee currently insured under the Voluntary Life Insurance portion of this Policy may increase his or her Voluntary Life Insurance Benefit, and an Employee who is eligible for the Voluntary Life Insurance portion of this Policy but who has not previously enrolled may become insured under the Policy, as long as the total Benefit does not exceed the Maximum Benefit by satisfying the Insurability Requirement. Insurance will be effective on the later of the first of the month following the Life Status Change or the date the Insurance Company agrees in writing to insure the Employee.

Insurance Benefits for an Employee may be reduced at any time. The reduced amount will be effective on the date the Insurance Company receives the completed change form.

TL-008030-1

Former Employee Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Life Insurance Benefits allowable to an Employee, less any amount of conversion insurance issued under the Conversion Privilege for Life Insurance. Any amount elected in excess of the Life Insurance Benefits in effect on the date he or she no longer qualifies as an Employee will be effective on the date the Insurance Company agrees in writing to insure him or her.

	The Maximum Benefit for Basic Life Insurance Benefits is $50,000.
Maximum Benefit Period	To Age 70
Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $287,500.

Spouse of Former Employee Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Voluntary Life Insurance Benefits available to a Spouse. Any amount elected in excess of the Voluntary Life Insurance Benefits in effect on the date the Employee's employment with the Employer ends will be effective on the date the Insurance Company agrees in writing to insure him or her.
Maximum Benefit Period	To Age 70
Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Former Spouse Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Voluntary Life Insurance Benefits available to a Spouse. Any amount elected in excess of the Voluntary Life Insurance Benefits in effect on the date he or she no longer qualifies as a Spouse will be effective on the date the Insurance Company agrees in writing to insure him or her.
Maximum Benefit Period	To Age 70
Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Former Dependent Child Benefits

Amount of Insurance	Units of $25,000
Guaranteed Issue Amount:	$25,000
Maximum Benefit:	$50,000
Maximum Benefit Period	To Age 70

TL-004774

SCHEDULE OF BENEFITS FOR CLASS 3

Eligibility Waiting Period

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

For Employees hired on or before the Policy Effective Date:	After 90 days of continuous Active Service
For Employees hired after the Policy Effective Date:	After 90 days of continuous Active Service

The *Eligibility Waiting Period* does not apply if a former Employee is rehired within 12 months after his or her termination date and the former Employee had satisfied the *Eligibility Waiting Period* prior to his or her termination date. If a former Employee did not fully satisfy the *Eligibility Waiting Period* prior to his or her termination date, credit will be given for any time that was satisfied.

LIFE INSURANCE BENEFITS

Employee Benefits

Basic Benefit	1.5 times Annual Compensation
Guaranteed Issue Amount:	the lesser of 1.5 times Annual Compensation or $50,000
Maximum Benefit:	the lesser of 1.5 times Annual Compensation or $50,000

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

Basic Terminal Illness Benefit	The insured can elect up to 75% of Basic Life Insurance Benefits in force on the date the insured is determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $37,500.
Voluntary Benefit	An amount elected in units of $10,000
Guaranteed Issue Amount:	the greater of a) or b) below: a) the lesser of 7 times Annual Compensation or $400,000, or b) an amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan
Maximum Benefit:	$500,000

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

Voluntary Terminal Illness Benefit	The insured can elect up to 75% of Voluntary Life Insurance Benefits in force on the date the insured is determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $250,000.

Age Based Reductions	Life Insurance Benefit for an Employee age 65 and over will reduce to the percentage shown below: 65% of the Life Insurance Benefit at age 65 40% of the Life Insurance Benefit at age 70 25% of the Life Insurance Benefit at age 75 Benefit reductions will be effective on the Employee's attainment of age as specified in schedule above.
Continuation Options	
For Layoff	
Maximum Benefit Period:	3 months
For Leave of Absence	
Maximum Benefit Period:	18 months following the date coverage would otherwise end due to exhaustion of Family and Medical Leave Act (FMLA), state leave of absence laws or termination of Short Term Disability benefits under the Employer's Short Term Disability Plan
For Leave for Military Service:	
Maximum Benefit Period:	24 months
For Family Medical Leave	
Maximum Benefit Period:	the later of the period of the approved FMLA leave or the leave period required by the laws of the state in which the Employee is employed
For Disability	
Maximum Benefit Period:	18 months following the date coverage would otherwise end due to exhaustion of Family and Medical Leave Act (FMLA), state leave of absence laws or termination of Short Term Disability benefits under the Employer's Short Term Disability Plan
Applicable Coverages:	Life Insurance Benefits for the Employee, his or her Spouse and Dependent Children, if any
Extended Death Benefit with Waiver of Premium	
Extended Death Benefit	
Applicable Coverages	Life Insurance Benefits for the Employee, his or her Spouse and Dependent Children, if any
Waiver of Premium	
Waiver Waiting Period	6 months from the date the Employee's Active Service ends
Maximum Benefit Period	To Age 65
Applicable Coverages	Life Insurance Benefits for the Employee, his or her Spouse and Dependent Children, if any
Portability Options	
For Employees	See the Former Employee and Spouse of Former Employee sections in this Schedule of Benefits for the amounts of insurance an Insured is eligible to continue under this option.

Automatic Increase Feature for Life Insurance

An increase in an Employee's Life Insurance resulting from an increase in Annual Compensation will not be subject to the Insurability Requirement, even if the increase causes the Life Insurance to exceed the Guaranteed Issue Amount.

If an Employee is not in Active Service on the date the increase would go into effect, his or her benefit will not increase until he or she returns to Active Service.

Premiums must be paid on the basis of any increased amount of Life Insurance resulting from increases in Annual Compensation.

Spouse Benefits

Voluntary Benefit	Units of $5,000
Guaranteed Issue Amount:	the greater of a) or b) below: a) $30,000, or b) an amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan
Maximum Benefit:	$100,000

A Spouse's Life Insurance Benefits cannot exceed 50% of the Employee's Voluntary Life Insurance Benefits.

Age Based Reductions	Spouse Life Insurance Benefits for an Employee age 65 and over will reduce to the percentage shown below: 65% of the Life Insurance Benefit at age 65 40% of the Life Insurance Benefit at age 70 25% of the Life Insurance Benefit at age 75 Benefit reductions will be effective on the Employee's attainment of age as specified in schedule above.
Portability Options	
For Spouse	See the Former Spouse section in this Schedule of Benefits for the amounts of insurance an Insured is eligible to continue under this option.
Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Dependent Child Benefits

Voluntary Benefit	Units of $5,000
Maximum Benefit:	$10,000 The Maximum Benefit for a Dependent Child who is less than 6 months old is $5,000.

All Dependent Child benefits are Guaranteed Issue.

Portability Options	
For Dependent Children	See the Former Dependent Child section in this Schedule of Benefits for the amounts of insurance an Insured is eligible to continue under this option.

Annual Enrollment Period

For Employees
During an Annual Enrollment Period, an Employee currently insured under the Voluntary Life Insurance portion of this Policy may increase his or her Voluntary Life Insurance Benefit, and an Employee who is eligible for the Voluntary Life Insurance portion of this Policy but who has not previously enrolled may become insured under the Policy, as long as the total Benefit does not exceed the Maximum Benefit, by satisfying the Insurability Requirement. Insurance will be effective on the later of January 1st following the Annual Enrollment Period or the date the Insurance Company agrees in writing to insure the Employee.

For Spouses
During an Annual Enrollment Period, an eligible Employee may elect coverage for his or her eligible Spouse. If a Spouse is currently insured under the Voluntary Life Insurance portion of this Policy, his or her Voluntary Life Insurance Benefit may be increased, as long as the total Benefit does not exceed the Maximum Benefit, by satisfying the Insurability Requirement. If a Spouse is eligible for the Voluntary Life Insurance portion of this Policy but has not previously enrolled, he or she may become insured under the Policy, as long as the total Benefit does not exceed the Maximum Benefit, by satisfying the Insurability Requirement. Insurance will be effective on the later of January 1st following the Annual Enrollment Period or the date the Insurance Company agrees in writing to insure the Spouse.

Insurance Benefits for an Employee, his or her Spouse and Dependent Children may be reduced at any time. A request for a Benefit reduction received during an Annual Enrollment Period will become effective on January 1st following the Annual Enrollment Period. Any other Benefit reduction will be effective on the date the Insurance Company receives the completed change form.

TL-008025-1

Life Status Change

For Employees
Within 31 days after a Life Status Change, an Employee currently insured under the Voluntary Life Insurance portion of this Policy may increase his or her Voluntary Life Insurance Benefit, and an Employee who is eligible for the Voluntary Life Insurance portion of this Policy but who has not previously enrolled may become insured under the Policy, as long as the total Benefit does not exceed the Maximum Benefit by satisfying the Insurability Requirement. Insurance will be effective on the later of the first of the month following the Life Status Change or the date the Insurance Company agrees in writing to insure the Employee.

Insurance Benefits for an Employee may be reduced at any time. The reduced amount will be effective on the date the Insurance Company receives the completed change form.

TL-008030-1

Former Employee Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Life Insurance Benefits allowable to an Employee, less any amount of conversion insurance issued under the Conversion Privilege for Life Insurance. Any amount elected in excess of the Life Insurance Benefits in effect on the date he or she no longer qualifies as an Employee will be effective on the date the Insurance Company agrees in writing to insure him or her.

	The Maximum Benefit for Basic Life Insurance Benefits is $50,000.
Maximum Benefit Period	To Age 70
Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $287,500.

Spouse of Former Employee Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Voluntary Life Insurance Benefits available to a Spouse. Any amount elected in excess of the Voluntary Life Insurance Benefits in effect on the date the Employee's employment with the Employer ends will be effective on the date the Insurance Company agrees in writing to insure him or her.
Maximum Benefit Period	To Age 70
Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Former Spouse Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Voluntary Life Insurance Benefits available to a Spouse. Any amount elected in excess of the Voluntary Life Insurance Benefits in effect on the date he or she no longer qualifies as a Spouse will be effective on the date the Insurance Company agrees in writing to insure him or her.
Maximum Benefit Period	To Age 70
Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Former Dependent Child Benefits

Amount of Insurance	Units of $25,000
Guaranteed Issue Amount:	$25,000
Maximum Benefit:	$50,000
Maximum Benefit Period	To Age 70

TL-004774

SCHEDULE OF BENEFITS FOR CLASS 4

Eligibility Waiting Period

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

For Employees hired on or before the Policy Effective Date:	After 90 days of continuous Active Service
For Employees hired after the Policy Effective Date:	After 90 days of continuous Active Service

The *Eligibility Waiting Period* does not apply if a former Employee is rehired within 12 months after his or her termination date and the former Employee had satisfied the *Eligibility Waiting Period* prior to his or her termination date. If a former Employee did not fully satisfy the *Eligibility Waiting Period* prior to his or her termination date, credit will be given for any time that was satisfied.

LIFE INSURANCE BENEFITS

Employee Benefits

Basic Benefit	1.5 times Annual Compensation
Guaranteed Issue Amount:	the lesser of 1.5 times Annual Compensation or $50,000
Maximum Benefit:	the lesser of 1.5 times Annual Compensation or $50,000

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

Basic Terminal Illness Benefit	The insured can elect up to 75% of Basic Life Insurance Benefits in force on the date the insured is determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $37,500.
Voluntary Benefit	An amount elected in units of $10,000
Guaranteed Issue Amount:	the greater of a) or b) below: a) the lesser of 7 times Annual Compensation or $400,000, or b) an amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan
Maximum Benefit:	$500,000

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

Voluntary Terminal Illness Benefit	The insured can elect up to 75% of Voluntary Life Insurance Benefits in force on the date the insured is determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $250,000.

Age Based Reductions	Life Insurance Benefit for an Employee age 65 and over will reduce to the percentage shown below: 65% of the Life Insurance Benefit at age 65 40% of the Life Insurance Benefit at age 70 25% of the Life Insurance Benefit at age 75 Benefit reductions will be effective on the Employee's attainment of age as specified in schedule above.
Continuation Options	
For Layoff	
Maximum Benefit Period:	3 months
For Leave of Absence	
Maximum Benefit Period:	18 months following the date coverage would otherwise end due to exhaustion of Family and Medical Leave Act (FMLA), state leave of absence laws or termination of Short Term Disability benefits under the Employer's Short Term Disability Plan
For Leave for Military Service:	
Maximum Benefit Period:	24 months
For Family Medical Leave	
Maximum Benefit Period:	the later of the period of the approved FMLA leave or the leave period required by the laws of the state in which the Employee is employed
For Disability	
Maximum Benefit Period:	18 months following the date coverage would otherwise end due to exhaustion of Family and Medical Leave Act (FMLA), state leave of absence laws or termination of Short Term Disability benefits under the Employer's Short Term Disability Plan
Applicable Coverages:	Life Insurance Benefits for the Employee, his or her Spouse and Dependent Children, if any
Extended Death Benefit with Waiver of Premium	
Extended Death Benefit	
Applicable Coverages	Life Insurance Benefits for the Employee, his or her Spouse and Dependent Children, if any
Waiver of Premium	
Waiver Waiting Period	6 months from the date the Employee's Active Service ends
Maximum Benefit Period	To Age 65
Applicable Coverages	Life Insurance Benefits for the Employee, his or her Spouse and Dependent Children, if any
Portability Options	
For Employees	See the Former Employee and Spouse of Former Employee sections in this Schedule of Benefits for the amounts of insurance an Insured is eligible to continue under this option.

Automatic Increase Feature for Life Insurance

An increase in an Employee's Life Insurance resulting from an increase in Annual Compensation will not be subject to the Insurability Requirement, even if the increase causes the Life Insurance to exceed the Guaranteed Issue Amount.

If an Employee is not in Active Service on the date the increase would go into effect, his or her benefit will not increase until he or she returns to Active Service.

Premiums must be paid on the basis of any increased amount of Life Insurance resulting from increases in Annual Compensation.

Spouse Benefits

Voluntary Benefit	Units of $5,000
Guaranteed Issue Amount:	the greater of a) or b) below: a) $30,000, or b) an amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan
Maximum Benefit:	$100,000

A Spouse's Life Insurance Benefits cannot exceed 50% of the Employee's Voluntary Life Insurance Benefits.

Age Based Reductions	Spouse Life Insurance Benefits for an Employee age 65 and over will reduce to the percentage shown below: 65% of the Life Insurance Benefit at age 65 40% of the Life Insurance Benefit at age 70 25% of the Life Insurance Benefit at age 75 Benefit reductions will be effective on the Employee's attainment of age as specified in schedule above.
Portability Options	
For Spouse	See the Former Spouse section in this Schedule of Benefits for the amounts of insurance an Insured is eligible to continue under this option.
Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Dependent Child Benefits

Voluntary Benefit	Units of $5,000
Maximum Benefit:	$10,000 The Maximum Benefit for a Dependent Child who is less than 6 months old is $5,000.

All Dependent Child benefits are Guaranteed Issue.

Portability Options	
For Dependent Children	See the Former Dependent Child section in this Schedule of Benefits for the amounts of insurance an Insured is eligible to continue under this option.

Annual Enrollment Period

For Employees
During an Annual Enrollment Period, an Employee currently insured under the Voluntary Life Insurance portion of this Policy may increase his or her Voluntary Life Insurance Benefit, and an Employee who is eligible for the Voluntary Life Insurance portion of this Policy but who has not previously enrolled may become insured under the Policy, as long as the total Benefit does not exceed the Maximum Benefit, by satisfying the Insurability Requirement. Insurance will be effective on the later of January 1st following the Annual Enrollment Period or the date the Insurance Company agrees in writing to insure the Employee.

For Spouses
During an Annual Enrollment Period, an eligible Employee may elect coverage for his or her eligible Spouse. If a Spouse is currently insured under the Voluntary Life Insurance portion of this Policy, his or her Voluntary Life Insurance Benefit may be increased, as long as the total Benefit does not exceed the Maximum Benefit, by satisfying the Insurability Requirement. If a Spouse is eligible for the Voluntary Life Insurance portion of this Policy but has not previously enrolled, he or she may become insured under the Policy, as long as the total Benefit does not exceed the Maximum Benefit, by satisfying the Insurability Requirement. Insurance will be effective on the later of January 1st following the Annual Enrollment Period or the date the Insurance Company agrees in writing to insure the Spouse.

Insurance Benefits for an Employee, his or her Spouse and Dependent Children may be reduced at any time. A request for a Benefit reduction received during an Annual Enrollment Period will become effective on January 1st following the Annual Enrollment Period. Any other Benefit reduction will be effective on the date the Insurance Company receives the completed change form.

TL-008025-1

Life Status Change

For Employees
Within 31 days after a Life Status Change, an Employee currently insured under the Voluntary Life Insurance portion of this Policy may increase his or her Voluntary Life Insurance Benefit, and an Employee who is eligible for the Voluntary Life Insurance portion of this Policy but who has not previously enrolled may become insured under the Policy, as long as the total Benefit does not exceed the Maximum Benefit by satisfying the Insurability Requirement. Insurance will be effective on the later of the first of the month following the Life Status Change or the date the Insurance Company agrees in writing to insure the Employee.

Insurance Benefits for an Employee may be reduced at any time. The reduced amount will be effective on the date the Insurance Company receives the completed change form.

TL-008030-1

Former Employee Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Life Insurance Benefits allowable to an Employee, less any amount of conversion insurance issued under the Conversion Privilege for Life Insurance. Any amount elected in excess of the Life Insurance Benefits in effect on the date he or she no longer qualifies as an Employee will be effective on the date the Insurance Company agrees in writing to insure him or her.

	The Maximum Benefit for Basic Life Insurance Benefits is $50,000.
Maximum Benefit Period	To Age 70
Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $287,500.

Spouse of Former Employee Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Voluntary Life Insurance Benefits available to a Spouse. Any amount elected in excess of the Voluntary Life Insurance Benefits in effect on the date the Employee's employment with the Employer ends will be effective on the date the Insurance Company agrees in writing to insure him or her.
Maximum Benefit Period	To Age 70
Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Former Spouse Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Voluntary Life Insurance Benefits available to a Spouse. Any amount elected in excess of the Voluntary Life Insurance Benefits in effect on the date he or she no longer qualifies as a Spouse will be effective on the date the Insurance Company agrees in writing to insure him or her.
Maximum Benefit Period	To Age 70
Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Former Dependent Child Benefits

Amount of Insurance	Units of $25,000
Guaranteed Issue Amount:	$25,000
Maximum Benefit:	$50,000
Maximum Benefit Period	To Age 70

TL-004774

ELIGIBILITY FOR INSURANCE

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

An Employee who is the Spouse of another Employee may not be insured for Voluntary Life Insurance as both an Employee and as a Spouse at the same time.

Any Employee, who is eligible for Voluntary Life Insurance, will not be eligible to be insured as a Dependent Child of another Employee.

If an Employee is eligible and has enrolled as the Spouse of another Employee, but ceases to be eligible to maintain the amount of insurance for which he or she has enrolled as a Spouse, that Employee may, within 31 days, enroll for coverage as an Employee, in an amount equal to the lesser of (1) the amount of Spouse Voluntary Life Insurance terminating, or (2) the maximum amount of Employee Voluntary Life Insurance for which the Employee is eligible. The Insurability Requirement does not apply. If this amount is not equal to a Voluntary Life Insurance coverage option, it will be adjusted to the next higher available Voluntary Life Insurance coverage option. This provision shall be in lieu of the Policy's provisions, if any, regarding coverage changes following Life Status Changes.

If a Spouse is eligible and has enrolled for Voluntary Life Insurance as an Employee, but ceases to be eligible to maintain the amount of insurance for which he or she has enrolled as an Employee, the Spouse may, within 31 days, instead become enrolled as a Spouse of another Employee, in an amount equal to the lesser of (1) the amount of Employee Voluntary Life Insurance terminating, or (2) the Maximum Benefit Amount of Spouse Voluntary Life Insurance for which the Spouse is eligible. The Insurability Requirement does not apply. If this amount is not equal to a Voluntary Life Insurance coverage option, it will be adjusted to the next higher available Voluntary Life Insurance coverage option.

A Dependent Child of two or more Employees may only be insured once under the Policy. If an Employee who has elected to insure Dependent Children ceases to be eligible to do so, then the Employee's Spouse may, within 31 days, elect to insure Dependent Children, provided he or she is insured as an Employee. In all cases, "Dependent Child" shall be defined with respect to the Employee who has enrolled dependent children.

In all cases, amounts of insurance referred to in these provisions shall be determined before the application of any reductions in benefits due to age.

Any amount of Voluntary Life Insurance Coverage which cannot be continued under the above provisions may be subject to the Conversion Privilege.

Employee
An Employee in one of the Classes of Eligible Employees shown in the Schedule of Benefits is eligible to be insured on the Policy Effective Date or the day after he or she completes the Eligibility Waiting Period, if later. The Eligibility Waiting Period will not apply to an Employee, in Active Service on the Policy Effective Date, who was covered under the Prior Plan and satisfied the Eligibility Waiting Period, if any, of that plan. Credit will be given for any time that was satisfied.

If a person has previously converted his or her insurance under the Policy, he or she will not become eligible until the converted policy is surrendered. This does not apply to any amount of insurance that was previously converted under the Policy due to a reduction in the Employee's Life Insurance Benefits based on age or a change in class unless those conditions no longer affect the amount of coverage available to the Employee.

Except as noted in the Reinstatement Provision, if an Employee terminates coverage and later wishes to reapply, or if a former Employee is rehired after the time period shown for rehires under the Eligibility Waiting Period, a new Eligibility Waiting Period must be satisfied. An Employee is not required to satisfy a new Eligibility Waiting Period, if insurance ends because he or she is no longer in a Class of Eligible Employees, but continues to be employed by the Employer, and within one year becomes a member of an eligible class.

Spouse
If an Insured is eligible to elect Spouse coverage, the Spouse is eligible to be insured on the date the Employee is eligible or the date he or she becomes a Spouse of an Employee, if later. The eligible Employee must be insured for Voluntary Life Insurance in order to elect spouse coverage.

For the purpose of eligibility, the Spouse must be the lawful Spouse of the Employee and not legally separated or divorced from, or widowed by the Employee.

Dependent Child
If an Insured is eligible to elect Dependent Child coverage, the Dependent Child is eligible to be insured on the date the Insured is eligible or on the date the child qualifies as a Dependent Child, if later.

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

TL-004710-1

EFFECTIVE DATE OF INSURANCE

An Employee who is required to contribute to the cost of this insurance may elect insurance for himself or herself and an eligible Spouse or Dependent Child only by authorizing payroll deduction in a form approved by the Employer and the Insurance Company. The effective date of this insurance depends on the date and amount of insurance elected.

If an individual elects coverage within 31 days after becoming eligible to enroll, or for any increases, the Guaranteed Issue Amount will be effective on the latest of the following dates:
1. The Policy Effective Date.
2. The date payroll deduction is authorized for this insurance.
3. The date the Employer or Insurance Company receives the completed enrollment form.

If Employee or Spouse coverage is elected in an amount that exceeds the Guaranteed Issue Amount or an enrollment form is received more than 31 days after becoming eligible to elect coverage, this insurance will be effective on the date the Insurance Company agrees in writing to insure that eligible person. The Insurance Company will require the eligible person to satisfy the Insurability Requirement before it agrees to insure him or her.

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

If an eligible Employee is not in Active Service on the date insurance would otherwise be effective, it will be effective on the date he or she returns to Active Service.

If an eligible Spouse or Dependent Child is:

1. an inpatient in a hospital, hospice, rehabilitation or convalescence center, or custodial care facility; or
2. confined to his or her home under the care of a Physician

on the date insurance would otherwise be effective, it will be effective on the date he or she is no longer an inpatient in these facilities or confined at home. If such Spouse or Dependent Child was covered by the Prior Plan immediately prior to the Policy Effective Date, this provision will not apply to the amount of coverage in effect as of the Policy Effective Date, but will apply to any increase in coverage. This does not apply to a Dependent Child who is age 6 months or less.

TL-004712

Takeover Provision

Special Terms Applicable to Previously Insured Employees Not in Active Service and Their Dependents

Coverage will not go into effect for an Employee, or his or her Spouse and Dependent Children unless the Employee is in Active Service on the date the Employee would have first become eligible to be insured under the Policy.

However:

1. if such Employee, and his or her Spouse or Dependent Children were insured under a Prior Plan on the date immediately prior to the date the Employee would have first become eligible to be insured under this Policy had the Employee satisfied the Active Service requirement, and
2. if such Employee, Spouse or Dependent Child dies, the Insurance Company agrees to provide a Death Benefit only equal to the lesser of:

a. the amount due under this Policy (had the Employee satisfied the Active Service requirement), or
b. the amount that would have been due under the Prior Plan had it remained in force.

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

These special terms will end on the earliest of the following dates:

1. the date the Employee meets the Active Service requirements;
2. the date insurance terminates for one of the reasons stated in the Termination of Insurance provision;
3. 12 months after the date the Employee first becomes eligible under this Policy; or
4. the last day the Employee, Spouse or Dependent Children would have been covered under the Prior Plan if coverage of the Employee, Spouse or Dependent Children under that plan was still in force.

TL-009020-1

TERMINATION OF INSURANCE

An Insured's coverage will end on the earliest of the following dates:

1. the date the Employee is eligible for coverage under a plan intended to replace this coverage;
2. the date the Policy is terminated by the Insurance Company;
3. the date the Insured is no longer in an eligible class;
4. the date coinciding with the end of the last period for which premiums are paid;
5. the date an Employee is no longer in Active Service;
6. for an Employee, Spouse and Dependent Child, the date the Employer cancels participation under the Policy; and
7. the date coverage for the Employee ends, for any insured Spouse and Dependent Child.

TL-004714-1

CONTINUATION OF INSURANCE

If an Employee is no longer in Active Service, he or she may be eligible to continue insurance. The following provisions explain the continuation options available under the Policy. Please see the Schedule of Benefits to determine the applicability of these benefits on a class level.

Continuation for Layoff, Temporary Leave of Absence, Leave for Military Service or Family Medical Leave

If an Employee's Active Service ends due to a layoff, Employer approved unpaid leave of absence, leave for military service or family medical leave of absence, insurance will continue for up to the Maximum Benefit Period shown in the Schedule of Benefits, if the required premium is paid.

Continuation for Disability

If an Employee becomes Disabled, the Life Insurance Benefits shown in the Schedule of Benefits will be continued, provided premiums are paid, until the earlier of the following dates:

1. The date the Employee is no longer Disabled.
2. The date following the Maximum Benefit Period shown in the Schedule of Benefits.
3. The date coinciding with the end of the last period for which premiums are paid.
4. The date the Policy is terminated.

Amount of Insurance

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

"Disability"/"Disabled" means because of Injury or Sickness the Employee is unable to perform all the material duties of his or her Regular Occupation; or is receiving disability benefits under the Employer's plan.

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

Extended Death Benefit with Waiver of Premium

Extended Death Benefit

If an Employee becomes Disabled and is less than age 60, the Life Insurance Benefits shown in the Schedule of Benefits will be extended without premium payment until the earlier of the following dates:

1. The date the Employee is no longer Disabled; or
2. 9 months after the end of Active Service.

Amount of Insurance

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

"Disability"/"Disabled" means because of Injury or Sickness the Employee is unable to perform the material duties of his or her Regular Occupation; or is receiving disability benefits under the Employer's plan.

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

Waiver of Premium

If such an Employee submits satisfactory proof that he or she has been continuously Disabled for the Waiver Waiting Period shown in the Schedule of Benefits, coverage will be extended up to the Maximum Benefit Period shown in the Schedule of Benefits.

Such proof must be submitted to the Insurance Company no later than 3 months after the date the Waiver Waiting Period ends. Premiums will be waived from the date the Insurance Company agrees in writing to waive premiums for that Employee.

After premiums have been waived for 12 months, they will be waived for future periods of 12 months, if the Employee remains Disabled and submits satisfactory proof that Disability continues. Satisfactory proof must be submitted to the Insurance Company 3 months before the end of the 12-month period.

Amount of Insurance

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

Termination of Waiver

Insurance will end for any Employee whose premiums are waived on the earliest of the following dates.

1. The date he or she is no longer Disabled;
2. The date he or she refuses to submit to any physical examination required by the Insurance Company;
3. The date he or she refuses to participate in a Rehabilitation Plan for which the Insurance Company determines him or her to be eligible;
4. The last day of the 12-month period of Disability during which he or she fails to submit satisfactory proof of continued Disability;
5. The date following the end of the Maximum Benefit Period shown in the Schedule of Benefits.

"Disability/Disabled" means because of Injury or Sickness an Employee is unable to perform the material duties of his or her Regular Occupation, or is receiving disability benefits under the Employer's plan, during the initial 6 months of Disability. Thereafter, the Employee must be unable to perform all of the material duties of any occupation which he or she may reasonably become qualified based on education, training or experience, or is subject to the terms of a Rehabilitation Plan approved by the Insurance Company.

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

Rehabilitation During a Period of Disability

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

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

"Rehabilitation Plan" means a written plan designed to enable the Employee to return to work. The Rehabilitation Plan will consist of one or more of the following phases:

1. Rehabilitation, under which the Insurance Company may provide, arrange or authorize educational, vocational or physical rehabilitation or other appropriate services;
2. Work, which may include modified work and work on a Part-time basis.

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

TL-009745 as modified by TL-009745-1

Portability Options

For Employees

If an Employee's coverage under the Policy ends prior to age 70, for any of the following reasons:

a. termination of employment; or
b. termination of membership in an eligible class under the Policy;

Life Insurance Benefits may be continued up to the Maximum Benefit shown in the Schedule of Benefits for this option.

The Employee must apply to the Insurance Company and pay the required premium. If the Employee continues coverage, Spouse or Dependent Child coverage may also be continued by the Employee. The Spouse or Dependent Child must be covered under the Policy on the date coverage would otherwise end. The application must be submitted:

a. within 31 days of the Employee's termination of employment or membership in an eligible class under the Policy; or
b. during the time that the Employee has to exercise the Conversion Privilege.

Coverage under this option may not be elected at a later date.

When applying for this option, the Employee must name a beneficiary. Any beneficiary named previously under the Policy is no longer in effect. If there is no named or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives:

a. spouse;
b. child or children;
c. mother or father;
d. brothers or sisters; or
e. the executors or administrators of the Insured's estate.

When coverage is continued under this option, the Employee becomes a Former Employee. The Spouse becomes a Spouse of a Former Employee. The Dependent Child becomes a Dependent Child of a Former Employee.

If the Former Employee later acquires a Spouse or Dependent Child, he or she may elect coverage for them. The Former Employee must apply to the Insurance Company and pay the required premium. Coverage for the Spouse or Dependent Child will be effective on the date the Insurance Company agrees in writing to insure them. The Insurance Company may require that the Spouse or Dependent Child satisfy the Insurability Requirement before it agrees to insure him or her.

Coverage will end on the earliest of the following dates.
a. The date the Insurance Company cancels coverage for all Former Employees.
b. The end of the period for which premiums are paid.
c. The date an Insured reaches age 70.
d. The date the Maximum Benefit Period shown in the Schedule of Benefits for this option ends.

Also, coverage for any Dependent Child will end on any of the dates listed above or when he or she no longer qualifies as a Dependent Child, if earlier.

For Spouses

If prior to age 70, a Spouse is:
a. legally separated, divorced; or
b. widowed
from an insured Employee or Former Employee, Life Insurance Benefits may be continued. Coverage may be continued up to the Maximum Benefit shown in the Schedule of Benefits for this option. The Spouse must apply to the Insurance Company and pay the required premium.

A Spouse who continues coverage may also continue coverage for a Dependent Child. The Dependent Child must be covered under the Policy on the date coverage would otherwise end. A Spouse must elect to continue insurance under this option within 31 days after coverage ends. Coverage may not be elected at a later date.

When applying for this option, a Spouse must name a beneficiary. Any beneficiary named previously under the Policy is no longer in effect. If there is no named or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives:
a. spouse;
b. child or children;
c. mother or father;
d. brothers or sisters; or
e. the executors or administrators of the Spouse's estate.

When coverage is continued under this option, the Spouse becomes a Former Spouse. A separate certificate of insurance will be issued to the Former Spouse. Coverage will be effective on the date after coverage as a Spouse ends if the required premium is paid.

Coverage will end on the earliest of the following dates.
a. The date the Insurance Company cancels coverage for all Former Spouses.
b. The end of the period for which premiums are paid.
c. The date the Former Spouse reaches age 70.
d. The date the Maximum Benefit Period shown in the Schedule of Benefits for this option ends.

Also, coverage for a Dependent Child will end on any of the dates listed above or when he or she no longer qualifies as a Dependent Child, if earlier.

For Dependent Children

If a Dependent Child is insured under the Policy and is at least 19 years of age, Life Insurance Benefits may be continued under this option. Coverage may be continued up to the Maximum Benefit shown in the Schedule of Benefits for this option.

The Dependent Child must apply to the Insurance Company and pay the required premium. If a Dependent Child does not elect to continue insurance within 31 days after reaching age 19; or the date he or she no longer qualifies as a Dependent Child, if later, coverage under this option may not be elected at a later date.

When applying for this option, a Dependent Child must name a beneficiary. Any beneficiary named previously under the Policy is no longer in effect. If there is no named or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives:

a. spouse;
b. child or children;
c. mother or father;
d. brothers or sisters; or
e. the executors or administrators of the Dependent Child's estate.

When a Dependent Child continues coverage under this option, he or she becomes a Former Dependent Child. A separate certificate of insurance will be issued to the Former Dependent Child. Coverage for a Former Dependent Child will be effective on the following dates.

a. For any Guaranteed Issue Amount, immediately following the date his or her coverage as a Dependent Child ends, provided the Insurance Company receives the required premium.
b. For any amount of insurance that exceeds the Guaranteed Issue Amount, the date the Insurance Company agrees in writing to insure him or her. The Insurance Company will require the Former Dependent Child to satisfy the Insurability Requirement before it agrees to insure him or her.

Coverage will end on the earliest of the following dates.

a. The date the Insurance Company cancels coverage for all Former Dependent Children.
b. The end of the period for which premiums are paid.
c. The date the Former Dependent Child is age 70.
d. The date the Maximum Benefit Period shown in the Schedule of Benefits for this option ends.

TL-004716 as modified by TL-009330

DESCRIPTION OF BENEFITS

The following provisions explain the benefits available under the Policy. Please see the Schedule of Benefits for the applicability of these benefits on a class level.

LIFE INSURANCE BENEFITS

Death Benefit

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

TL-004730

Accelerated Benefits

Any benefits payable under this and under any similar Accelerated Benefits provision accelerated under a Prior Plan will reduce the Death Benefit payable for Life Insurance. We will deduct from any Death Benefit payable under this Policy, the amount of any similar accelerated benefit paid under a Prior Plan.

Any automatic increases in Life Insurance Benefits will end when benefits are payable under this provision, unless the Insured is determined by the Insurance Company not to be eligible for Accelerated Benefits.

Terminal Illness Benefit

The Insurance Company will pay a Terminal Illness Benefit to an Insured who has incurred a Terminal Illness while insured under this provision.

The Terminal Illness Benefit is shown on the Schedule of Benefits.

A claim for a similar terminal illness benefit under a Prior Plan or group policy intended to replace this Policy shall be deemed payable until such time as it is finally determined not to be payable.

Determination of Terminal Illness
For the purpose of determining the existence of a Terminal Illness, the Insurance Company will require the Insured submit the following proof:

1. A written diagnosis and prognosis by a licensed Physician; and
2. Supportive evidence satisfactory to the Insurance Company, including but not limited to, radiological, histological or laboratory reports documenting the Terminal Illness.

The Insurance Company may require, at its expense, an examination of the Insured and a review of the documented evidence by a Physician of its choice.

Such proofs must be submitted to the Insurance Company within the period of time provided in the *Proof of Loss* section of the Policy. For purposes of this Benefit, the date of loss shall be the date of first prognosis of Terminal Illness.

"Terminal Illness" means that, due to an Injury or Sickness, the Insured has a prognosis of 12 months or less to live without reasonable prospect of recovery, as determined by the Insurance Company.

Payment of Terminal Illness Benefit
The Terminal Illness Benefit will be payable in accordance with the provisions of the *To Whom Payable* section of the Policy.

The Terminal Illness Benefit is payable only once under the Policy in an Insured's lifetime.

Conditions Applicable to Coverage
Unless the Insured qualifies for waiver of premium, premium payments must continue to be paid on the full amount of group life insurance, including during any Continuation of Insurance under the Policy, in accordance with the *Premium* section in the *Administrative Provisions.*

The amount of Life Insurance which may be converted under the *Conversion Privilege* cannot exceed the amount of the reduced death benefit payable under the Policy.

Before a Terminal Illness Benefit is paid in a Community Property state, the Insurance Company may require the written consent of the Insured’s Spouse.

Exclusions Applicable to Terminal Illness Benefit
A Terminal Illness Benefit will not be payable:

1. when the Insured has irrevocably assigned group life insurance under this Policy;
2. when all or a portion of group life insurance benefits under this Policy are to be paid to a former spouse as part of a qualified domestic relations order;
3. for any intentionally self-inflicted Injury or Sickness, or suicide attempt;
4. if the Insured’s coverage ends under the *Termination of Insurance* provision prior to the prognosis of Terminal Illness;
5. if the required premium is due and unpaid;
6. if this Policy terminates prior to the prognosis of Terminal Illness;
7. if the Employee or Insured is only provided coverage under the Takeover provision of the Policy (Employees Not in Active Service on the Policy Effective Date); or
8. if the date of first prognosis of Terminal Illness occurs more than 12 months before the submission of the Terminal Illness claim.

TL-004748a

Conversion Privilege for Life Insurance

Each Insured may convert all or any portion of his or her Life Insurance that would end under the Policy due to:

1. termination of employment;
2. termination of membership in an eligible class under the Policy;
3. termination of the Policy.

The Insured may apply for any type of life insurance the Insurance Company offers to persons of the same age in the amount applied for, except the Insured may not:

1. choose term insurance;
2. apply for an amount of insurance greater than the coverage amount terminating under the Policy (also, the conversion policy will not provide accident, disability or other benefits); or
3. apply for more than $10,000 of insurance if the Policy is terminated or amended to terminate the insurance for any class of Insureds, or the Employer cancels participation under the Policy. Conversion in these cases is only permitted if the Insured has been covered by the Policy or, any group life insurance policy issued to the Employer which the Policy replaced, for at least 3 years.

If the Insured becomes eligible for coverage under any group life policy within 31 days of termination of coverage under this Policy, the Insured may not convert an amount of insurance greater than the amount of coverage terminating under the Policy less the amount for which he or she may be covered under the other policy.

To apply for conversion insurance, the Insured must, within 31 days after coverage under the Policy ends:

1. submit an application to the Insurance Company; and
2. pay the required premium.

Evidence of insurability is not required.

Premium for the conversion insurance will be based on the age and class of risk of the Insured and the type and amount of coverage issued.

If the Insured has assigned ownership of his group coverage, the owner/assignee must apply for the individual policy.

Conversion insurance will become effective on the 31st day after the date coverage under the Policy ends provided the application is received by the Insurance Company and the required premium has been paid.

If the Insured dies during the 31-day conversion period, the Life Insurance benefits will be paid under the Policy regardless of whether he or she applied for conversion insurance. If a conversion policy is issued, it will be in exchange for any further benefits for that type and amount of insurance from this Policy.

Extension of Conversion Period

If an Insured is eligible for conversion insurance and is not notified of this right at least 15 days prior to the end of the 31-day conversion period, the conversion period will be extended. The Insured will have 15 days from the date notice is given to apply for conversion insurance. In no event will the conversion period be extended beyond 90 days. Notice, for the purpose of this section, means written notice presented to the Insured by the Employer or mailed to the Insured's last known address as reported by the Employer.

If the Insured dies during the extended conversion period, but more than 31 days after his or her coverage under the Policy terminates, Life Insurance benefits:

1. will not be paid under the Policy; and
2. will be payable under the conversion insurance; provided:
    a. the Insured's application for conversion insurance has been received by the Insurance Company; and
    b. the required premium has been paid.

Prior Conversion Limitation
If an Insured is covered under a life insurance conversion policy previously issued by the Insurance Company, he or she will not be eligible for this Conversion Privilege unless the prior coverage has ended.

TL-009740

LIFE INSURANCE EXCLUSIONS

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

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

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

TL-004752

CLAIM PROVISIONS

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

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

Claim Forms
When the Insurance Company receives notice of claim, the Insurance Company will send claim forms for filing proof of loss. If claim forms are not sent within 15 days after notice is received by the Insurance Company, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof, or proof by any other electronic/telephonic means authorized by the Insurance Company, of the nature and extent of the loss.

Claimant Cooperation Provision
Failure of a claimant to cooperate with the Insurance Company in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

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

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

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

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

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

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

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

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

To Whom Payable
Death Benefits will be paid to the Insured's named beneficiary, if any, on file at the time of payment. If there is no named beneficiary or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives: spouse; child or children; mother or father; brothers or sisters; or to the executors or administrators of the Insured's estate. The Insurance Company may reduce the amount payable by any indebtedness due.

All benefits payable under the Accelerated Benefits section are payable to the Insured, if living. If the Insured dies prior to the payment of an eligible claim for an Accelerated Benefit, benefits will be paid in accordance with the provisions applicable to the payment of Life Insurance proceeds, unless the Insured has directed us otherwise in writing. However, any payment made by us prior to notice of the Insured's death shall discharge us of any benefit that was paid.

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

Any other accrued benefits which are unpaid at the Insured's death may, at the Insurance Company's option, be paid either to the Insured's beneficiary or to the executor or administrator of the Insured's estate.

If the Insurance Company pays benefits to the executor or administrator of the Insured's estate or to a person who is incapable of giving a valid release, the Insurance Company may pay up to $1,000 to a relative by blood or marriage whom it believes is equitably entitled. This good faith payment satisfies the Insurance Company's legal duty to the extent of that payment.

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

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

Physical Examination and Autopsy
The Insurance Company, at its expense, will have the right to examine any person for whom a claim is pending as often as it may reasonably require. The Insurance Company may, at its expense, require an autopsy unless prohibited by law.

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

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

Physician/Patient Relationship
The Insured will have the right to choose any Physician who is practicing legally. The Insurance Company will in no way disturb the Physician/patient relationship.

TL-004724

ADMINISTRATIVE PROVISIONS

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

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

Changes in Premium Rates
The premium rates may be changed by the Insurance Company from time to time with at least 31 days advance written notice. No change in rates will be made until 48 months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12 month period. However, the Insurance Company reserves the right to change the rates even during a period for which the rate is guaranteed if any of the following events take place.

1. The terms of the Policy change.
2. A division, subsidiary, affiliated company or eligible class is added or deleted from the Policy.
3. There is a change in the factors bearing on the risk assumed.
4. Any federal or state law or regulation is amended to the extent it affects the Insurance Company's benefit obligation.
5. The Insurance Company determines that the Employer has failed to promptly furnish any necessary information requested by the Insurance Company, or has failed to perform any other obligations in relation to the Policy.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a pro rata adjustment will apply from the date of the change to the next Premium Due Date.

Reporting Requirements
The Employer must, upon request, give the Insurance Company any information required to determine who is insured, the amount of insurance in force and any other information needed to administer the plan of insurance.

Payment of Premium
The first premium is due on the Policy Effective Date. After that, premiums will be due monthly unless the Employer and the Insurance Company agree on some other method of premium payment.

If any premium is not paid when due, the plan will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Notice of Cancellation
The Employer or the Insurance Company may cancel the Policy as of any Premium Due Date by giving 31 days advance written notice. If a premium is not paid when due, the Policy will automatically be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Policy Grace Period
A Policy Grace Period of 60 days will be granted for the payment of the required premiums under this Policy. This Policy will be in force during the Policy Grace Period. The Employer is liable to the Insurance Company for any unpaid premium for the time this Policy was in force.

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

Grace Period for the Insured
If the required premium is not paid on the Premium Due Date, there is a 60 day grace period after each premium due date after the first. If the required premium is not paid during the grace period, insurance will end on the last day for which premium was paid.

If benefits are paid during the Grace Period for the Insured, the Insurance Company will deduct any overdue premium from the proceeds payable under the Policy.

Reinstatement of Insurance
Coverage may be reinstated without satisfying the Insurability Requirement, if an Employee's insurance ends because he or she is on an unpaid leave of absence and he or she applies for Reinstatement within 31 days of his return to Active Service.

After an Insured's coverage has ceased, it may be reinstated at any date prior to five years after the date of termination if the following conditions are met:

1. The Policy is still in force.
2. The Insured is eligible under the Policy.
3. A written request for reinstatement and a new enrollment form are sent to the Insurance Company.
4. The required premium is paid.
5. The Insurability Requirement, if any, is satisfied.

TL-004720

SCHEDULE OF RATES

The following monthly rates apply to all Classes of Eligible Persons unless otherwise indicated.

FOR EMPLOYEE BENEFITS

Basic Life Insurance $.049 Per $1,000

Voluntary Life Insurance

Monthly Rates are based on units of $1,000

Under Age 20	$.037	Age 60 - 64	$.651
Age 20 - 24	$.037	Age 65 - 69	$.977
Age 25 – 29	$.037	Age 70 - 74	$2.048
Age 30 - 34	$.053	Age 75 - 79	$2.048
Age 35 - 39	$.068	Age 80 - 84	$2.048
Age 40 - 44	$.105	Age 85 - 89	$2.048
Age 45 - 49	$.168	Age 90 - 94	$2.048
Age 50 - 54	$.252	Age 95 and over	$2.048
Age 55 - 59	$.326		

A change in rates due to a change in the Employee's age will become effective on the date of the Employee's birthday.

FOR SPOUSE BENEFITS

Voluntary Life Insurance

Monthly Rates are based on units of $1,000.

Under Age 20	$.037	Age 60 - 64	$.651
Age 20 - 24	$.037	Age 65 - 69	$.977
Age 25 – 29	$.037	Age 70 - 74	$2.048
Age 30 - 34	$.053	Age 75 - 79	$2.048
Age 35 - 39	$.068	Age 80 - 84	$2.048
Age 40 - 44	$.105	Age 85 - 89	$2.048
Age 45 - 49	$.168	Age 90 - 94	$2.048
Age 50 - 54	$.252	Age 95 and over	$2.048
Age 55 - 59	$.326		

Spouse rates are based on the Employee's date of birth. A change in rates due to a change in the Employee's age will become effective on the date of the Employee's birthday.

FOR DEPENDENT CHILD BENEFITS

Voluntary Life Insurance $.084 Per $1,000

FOR FORMER EMPLOYEE BENEFITS

Monthly Rates are based on units of $1,000.

Under Age 20	$.153	Age 45 - 49	$.384
Age 20 - 24	$.144	Age 50 - 54	$.726
Age 25 - 29	$.153	Age 55 - 59	$1.347
Age 30 - 34	$.177	Age 60 - 64	$2.461
Age 35 - 39	$.19	Age 65 - 69	$4.065
Age 40 - 44	$.243		

A change in rates due to a change in the Former Employee's age will become effective on the Policy Anniversary coinciding with or following the Former Employee's birthday.

FOR FORMER SPOUSES OR SPOUSES OF FORMER EMPLOYEE BENEFITS

Monthly Rates are based on units of $1,000.

Under Age 20	$.153	Age 45 - 49	$.384
Age 20 - 24	$.144	Age 50 - 54	$.726
Age 25 - 29	$.153	Age 55 - 59	$1.347
Age 30 - 34	$.177	Age 60 - 64	$2.461
Age 35 - 39	$.19	Age 65 - 69	$4.065
Age 40 - 44	$.243		

Spouse rates are based on the spouse's date of birth. A change in rates due to a change in the Spouse's age will become effective on the Policy Anniversary coinciding with or following the Spouse's birthday.

FOR FORMER DEPENDENT CHILD BENEFITS

Rates are based on $25,000 per Month.

Under Age 20	$2.377	Age 45 - 49	$9.777
Age 20 - 24	$2.777	Age 50 - 54	$16.377
Age 25 - 29	$2.977	Age 55 - 59	$23.477
Age 30 - 34	$3.600	Age 60 - 64	$38.250
Age 35 - 39	$4.177	Age 65 - 69	$54.077
Age 40 - 44	$6.200		

Rates are based on $50,000 per Month

Under Age 20	$4.750	Age 45 - 49	$19.550
Age 20 - 24	$5.550	Age 50 - 54	$32.750
Age 25 - 29	$5.950	Age 55 - 59	$46.950
Age 30 - 34	$7.200	Age 60 - 64	$76.500
Age 35 - 39	$8.350	Age 65 - 69	$108.150
Age 40 - 44	$12.400		

A change in rates due to a change in the Former Dependent Child's age will become effective on the Policy Anniversary Date coinciding with or following the Former Dependent Child's birthday.

TL-004718

GENERAL PROVISIONS

Entire Contract
The entire contract will be made up of the Policy, the application of the Employer, a copy of which is attached to the Policy, and the applications, if any, of the Insureds.

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

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

Misstatement of Age
If an Insured's age has been misstated, the Insurance Company will adjust all benefits to the amounts that would have been purchased for the correct age.

Policy Changes
No change in the Policy will be valid until approved by an executive officer of the Insurance Company. This approval must be endorsed on, or attached to, the Policy. No agent may change the Policy or waive any of its provisions.

Workers' Compensation Insurance
The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance Law.

Certificates
A certificate of insurance will be delivered to the Employer for delivery to Insureds. Each certificate will list the benefits, conditions and limits of the Policy. It will state to whom benefits will be paid.

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

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

Agency
The Employer and Plan Administrator are agents of the Employee for transactions relating to insurance under the Policy. The Insurance Company is not liable for any of their acts or omissions.

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

DEFINITIONS

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

Accident
An Accident is a sudden, unforeseeable external event that causes bodily Injury to an Insured while coverage is in force under the Policy.

Active Service
An Employee will be considered in Active Service with the Employer on a day which is one of the Employer's scheduled work days if either of the following conditions are met.

1. He or she is actively at work. This means the Employee is performing his or her regular occupation for the Employer on a Full-time basis, either at one of the Employer's usual places of business or at some location to which the Employer's business requires the Employee to travel.
2. The day is a scheduled holiday, vacation day or period of Employer approved paid leave of absence, other than disability or sick leave after 7 days.

An Employee is considered in Active Service on a day which is not one of the Employer's scheduled work days only if he or she was in Active Service on the preceding scheduled work day.

Annual Compensation (applicable to Classes 1 and 2)
An Employee's annual wage or salary as reported by the Employer for work performed for the Employer as of the date the covered loss occurs. It includes earnings received as bonuses and overtime pay, but not other extra compensation. Annual Compensation is determined initially on the date an Employee applies for coverage. A change in the amount of Annual Compensation is effective on the date of the change, if the Employer gives the Insurance Company written notice of the change and the required premium is paid.

Bonuses and overtime pay will be averaged for the 12 months just prior to the date the covered loss occurs, or the months employed, if less than 12 months.

Annual Compensation (applicable to Classes 3 and 4)
An Employee's annual wage or salary as reported by the Employer for work performed for the Employer as of the date the covered loss occurs. It includes earnings received as overtime pay, but not bonuses and other extra compensation. Annual Compensation is determined initially on the date an Employee applies for coverage. A change in the amount of Annual Compensation is effective on the date of the change, if the Employer gives the Insurance Company written notice of the change and the required premium is paid.

Overtime pay will be averaged for the 12 months just prior to the date the covered loss occurs, or the months employed, if less than 12 months.

Dependent Child
An unmarried child who meets the following requirements.

1. A child from live birth but less than 26 years old;
2. A child who is 26 or more years old, primarily supported by the Employee and incapable of self-sustaining employment by reason of mental or physical incapacity.
3. A child stillborn during the third trimester.

The term "child" means:

a. the Employee's natural child;
b. the Employee's legally adopted child, beginning with any waiting period pending finalization of the child's adoption. It also means the legally adopted child of the Employee's Spouse provided the child is living with, and is financially dependent upon the Employee;
c. a stepchild born to the Employee's Spouse and who is living with and financially dependent upon the Employee;
d. a child for whom the Employee is the court-appointed legal guardian and who resides with, and is financially dependent upon the Employee.

Employee
For eligibility purposes, an Employee is an employee of the Employer in one of the "Classes of Eligible Employees." Otherwise, Employee means an employee of the Employer who is insured under the Policy.

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

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

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

Insurability Requirement
An eligible person will satisfy the Insurability Requirement for an amount of coverage on the day the Insurance Company agrees in writing to accept him or her as insured for that amount. To determine a person's acceptability for coverage, the Insurance Company will require evidence of good health and may require it be provided at the Employee's expense.

Insurance Company
The Insurance Company underwriting the Policy is named on the Policy cover page.

Insured
A person who is eligible for insurance under the Policy, for whom insurance is elected, the required premium is paid and coverage is in force under the Policy.

Life Status Change
A Life Status Change is an event recognized by the Employer's Flexible Benefits Plan as qualifying an Employee to make changes in benefit selections at a time other than an Annual Enrollment Period.

If there is no Employer sponsored Flexible Benefits Plan, or if it is no longer in effect, the following events are Life Status Changes.

1. Marriage
2. Divorce, annulment or legal separation
3. Birth or adoption of a child
4. Death of a spouse
5. Termination of a spouse's employment
6. A change in the benefit plan available to the Employee's spouse
7. A change in the Employee's or his or her spouse's employment status that affects either person's eligibility for benefits

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

Policy Anniversary
A Policy Anniversary is the date stated on the policy cover and the same date that follows every 12 months for as long the Policy is in effect.

Policy Effective Date
The Policy Effective Date is the date stated on the policy cover.

Prior Plan
The Prior Plan refers to the plan of insurance providing similar benefits sponsored by the Employer in effect directly prior to the Policy Effective Date. A Prior Plan will include the plan of an employer in effect on the day prior to that employer's addition to this policy.

To be covered under the Policy, required premium must be paid for all covered Employees.

Sickness
Any physical or mental illness.

Spouse
The current lawful Spouse of an Employee.

Subscriber
Any participating organization that subscribes to the trust to which this Policy is issued, and which is insured under this Policy.

TL-004708-1 as modified by TL-010150a

LIFE INSURANCE COMPANY OF NORTH AMERICA
1601 CHESTNUT STREET
PHILADELPHIA, PA 19192-2235

STATE MODIFYING PROVISIONS AMENDMENT RIDER

Subscriber: The Reinalt-Thomas Corporation, a Michigan corporation, dba Discount Tire/America's Tire/Discount Tire Direct
Policy No.: FLX-980462
Amendment Effective Date: January 1, 2020

This amendment is attached to and made part of the Policy/Certificate specified above. Its provisions are intended to conform this Policy/Certificate to the laws of the state in which the insured resides.

The Policy delivered under the Group Policy are amended as follows:

APPLICABLE TO CALIFORNIA RESIDENTS:

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

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

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

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

APPLICABLE TO FLORIDA RESIDENTS:

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

APPLICABLE TO MARYLAND RESIDENTS:

The Group Insurance Policy was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

APPLICABLE TO MISSOURI RESIDENTS:

Applicable to Voluntary Life Insurance Benefits

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

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

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

APPLICABLE TO NORTH DAKOTA RESIDENTS:

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

APPLICABLE TO OREGON RESIDENTS:

NOTICE: MUST PROVIDE DOMESTIC PARTNER COVERAGE FOR OREGON RESIDENTS

APPLICABLE TO VERMONT RESIDENTS:

To the extent the Policy provides insurance coverage to a spouse, the identical consideration must be applied to same sex marriages and civil unions. The language is as follows:

1. Civil Union Partner means:
   a. A person with whom the Employee has a registered civil union under Vermont law which imposes obligations on the parties substantially similar to marriage. Such person will continue to be recognized as a Civil Union Partner unless and until:
      (1) the civil union is dissolved under applicable law; or
      (2) either the Employee or the Civil Union Partner marries another person.

2. Spouse means:
   a. "Lawful spouse" and includes a lawful spouse of the same sex.
   b. This also includes a partner to a civil union recognized under Vermont Law.

APPLICABLE TO WASHINGTON RESIDENTS:

1. The following *Continuation of Insurance* provision is added to the Policy:

   Continuation of Life Coverage During Labor Disputes
   If an Employee's Active Service ends because of a Labor Dispute and his or her premium for Life Insurance Benefits under the Policy is paid either by the Employer, in whole or in part, or by the Employee through payroll deductions, then the Employee may continue his or her Life Insurance Benefits. The Employer will send written notice of the right to continue coverage to each insured Employee at his or her most recent address as on file with the Employer.

   To continue coverage, the Employee must pay premiums directly to the Employer, who will remit the premiums to the Insurance Company. Premiums must be paid by the date they are due, subject to the 31 day grace period. Policy coverages and premiums will stay the same during a Labor Dispute; however, the Insurance Company may make normal changes in premium rates when the Policy is renewed, under the terms set forth in the Policy.

   Coverage continued in this manner will end on the earliest of the following dates.
   a. The date the Labor Dispute has ended.
   b. The date coverage has been continued for 6 months.

   If the Labor Dispute continues beyond 6 months, the Employee may apply for an individual insurance policy, as set forth in detail under "Conversion Privilege for Life Insurance."

   "Labor Dispute," as used here, means a strike, lockout, or other labor dispute between the Employer and its Employees, during which time the Employee is not paid by the Employer.

2. If the Policy provides coverage to dependents, benefits for a Spouse or Dependent Child are limited to 100% of the insured Employee's coverage amount . Stand-alone Spouse and Dependent Child coverage (when Employee is not insured) is not permitted.

3. The *Suicide* Exclusion, if any, does not apply.

4. To the extent the policy includes *Accelerated Benefits,* the following resolution of disputes requirements are added to the Policy.

   - For Terminal Illness – *Determination of Terminal Illness*

     In the event the Physician representing the Insurance Company disputes the existence of a Terminal Illness, and the dispute cannot be resolved, the Insured has the right to mediation and binding arbitration in accordance with Washington Administrative Code 284-23-730.

5. The *Incontestability Provision* is replaced as follows:

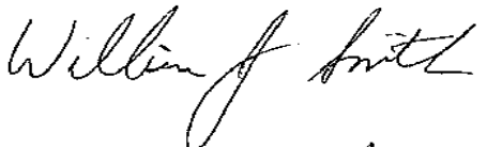
   Incontestability
   All statements made by the Employer or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement has been furnished to the claimant. In the event of death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

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

6. If the term "*Accident*" is defined in the Policy, it is replaced by the following:

Accident
An Accident is a sudden, unforeseeable event that causes bodily Injury to an Insured while coverage is in force under the Policy.

Signed for the
Life Insurance Company of North America



William J. Smith, President

TL-00-3000.00

RECEIPT ACKNOWLEDGEMENT FORM
LIFE INSURANCE COMPANY OF NORTH AMERICA
PHILADELPHIA, PA 19192-2235

We, The Reinalt-Thomas Corporation, a Michigan corporation, dba Discount Tire/America's Tire/Discount Tire Direct, whose main office address is Scottsdale, AZ, hereby approve and accept the terms of Group Policy Number FLX-980462 issued by the LIFE INSURANCE COMPANY OF NORTH AMERICA to the TRUSTEE OF THE GROUP INSURANCE TRUST FOR EMPLOYERS IN THE RETAIL TRADE INDUSTRY.

This application is to be signed.

The Reinalt-Thomas Corporation, a Michigan corporation,
dba Discount Tire/America's Tire/Discount Tire Direct

Signature: _____ Date: _____

Title: _____

Group Life
Insurance Certificate

The Reinalt-Thomas Corporation, a Michigan corporation, dba Discount Tire/America's Tire/Discount Tire Direct

IMPORTANT NOTICES

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

Arizona, Florida and Maryland residents:

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

Washington Residents:

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

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

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

NOTICE

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

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

TL-004788

FOREWORD

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

The need for life insurance protection depends on individual circumstances and financial situations. Your Employer is offering you the opportunity to purchase this insurance to make your benefit program more comprehensive and responsive to your needs.

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

Any insurance benefit described in the following pages will apply to you only if you have elected that benefit and have authorized payroll deduction for the required premium.

LIFE INSURANCE COMPANY OF NORTH AMERICA
1601 CHESTNUT STREET
PHILADELPHIA, PA 19192-2235
(800) 732-1603 TDD (800) 336-2485
A STOCK INSURANCE COMPANY

GROUP INSURANCE CERTIFICATE

We, the LIFE INSURANCE COMPANY OF NORTH AMERICA, have issued a Group Policy, FLX-980462, to TRUSTEE OF THE GROUP INSURANCE TRUST FOR EMPLOYERS IN THE RETAIL TRADE INDUSTRY on behalf of The Reinalt-Thomas Corporation, a Michigan corporation, dba Discount Tire/America's Tire/Discount Tire Direct.

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

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

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

William J. Smith, President

TL-004704

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

Policy Effective Date: January 1, 2020

Policy Anniversary Date: January 1

Policy Number: FLX-980462

Class Definition

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

All active, Full-time Employees of the Employer classified as Special Management regularly working the required number of hours to qualify for benefits according to the Employer's company policy, working in the United States who are citizens or permanentresident aliens of the United States, excluding temporary and seasaonal Employees.

Your Eligibility Waiting Period

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

If you were hired on or before the Policy Effective Date:
After 90 days of continuous Active Service

If you were hired after the Policy Effective Date:
After 90 days of continuous Active Service

The *Eligibility Waiting Period* does not apply if you are a former Employee rehired within 12 months after your termination date and you had satisfied the *Eligibility Waiting Period* prior to your termination date. If you did not fully satisfy the *Eligibility Waiting Period* prior to your termination date, credit will be given for any time that was satisfied.

LIFE INSURANCE BENEFITS

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

Employee Benefits

Basic Benefit	1.5 times your Annual Compensation
Guaranteed Issue Amount:	the lesser of 1.5 times Annual Compensation or $50,000
Maximum Benefit:	the lesser of 1.5 times Annual Compensation or $50,000

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

Basic Terminal Illness Benefit	You can elect up to 75% of Basic Life Insurance Benefits in force on the date you are determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $37,500.

Voluntary Benefit	An amount elected in units of $10,000
Guaranteed Issue Amount:	the greater of a) or b) below: a) the lesser of 7 times Annual Compensation or $400,000, or b) an amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan
Maximum Benefit:	$500,000

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

Voluntary Terminal Illness Benefit	You can elect up to 75% of Voluntary Life Insurance Benefits in force on the date you are determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $250,000.
Age Based Reductions	When you are age 65 or older, your Life Insurance Benefit will reduce to the percentage shown below: 65% of the Life Insurance Benefit at age 65 40% of the Life Insurance Benefit at age 70 25% of the Life Insurance Benefit at age 75

Benefit reductions will be effective on your attainment of age as specified in schedule above.

Automatic Increase Feature for Life Insurance

An increase in your Life Insurance resulting from an increase in Annual Compensation will not be subject to the Insurability Requirement, even if the increase causes the Life Insurance to exceed the Guaranteed Issue Amount.

If you are not in Active Service on the date the increase would go into effect, your benefit will not increase until you return to Active Service.

Premiums must be paid on the basis of any increased amount of Life Insurance resulting from increases in Annual Compensation.

Spouse Benefits

Voluntary Benefit	An amount elected in units of $5,000
Guaranteed Issue Amount:	the greater of a) or b) below: a) $30,000, or b) an amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan
Maximum Benefit:	$100,000

Your Spouse's Life Insurance Benefits cannot exceed 50% of your Life Insurance Benefits.

Age Based Reductions	When you are age 65 or older, your Spouse’s Life Insurance Benefit will reduce to the percentage shown below: 65% of the Life Insurance Benefit at age 65 40% of the Life Insurance Benefit at age 70 25% of the Life Insurance Benefit at age 75

Benefit reductions will be effective on your attainment of age as specified in schedule above.

Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Dependent Child Benefits

Voluntary Benefit	An amount elected in units of $5,000
Maximum Benefit:	$10,000 The Maximum Benefit for a Dependent Child who is less than 6 months old is $5,000.

All Dependent Child benefits are Guaranteed Issue.

Annual Enrollment Period

For Employees
During an Annual Enrollment Period, if you are currently insured under the Voluntary Life Insurance portion of this Policy, you may increase your Voluntary Life Insurance Benefit, or if you are eligible for the Voluntary Life Insurance portion of this Policy but have not previously enrolled, you may become insured under the Policy, as long as the total Benefit does not exceed the Maximum Benefit by satisfying the Insurability Requirement. Insurance will be effective on the later of January 1st following the Annual Enrollment Period or the date the Insurance Company agrees in writing to insure you.

For Spouses
During an Annual Enrollment Period, if you are an eligible Employee, you may elect coverage for your eligible Spouse. If your Spouse is currently insured under the Voluntary Life Insurance portion of this Policy, his or her Voluntary Life Insurance Benefit may be increased, or if your Spouse is eligible for the Voluntary Life Insurance portion of this Policy but has not previously enrolled, he or she may become insured under the Policy, as long as the total Benefit does not exceed the Maximum Benefit, by satisfying the Insurability Requirement. Insurance will be effective on the later of January 1st following the Annual Enrollment Period or the date the Insurance Company agrees in writing to insure him or her.

Insurance Benefits for you, your Spouse and Dependent Children may be reduced at any time. A request for a Benefit reduction received during an Annual Enrollment Period will become effective on January 1st following the Annual Enrollment Period. Any other Benefit reduction will be effective on the date the Insurance Company receives the completed change form.

TL-008025-1

Life Status Change

For Employees
Within 31 days after a Life Status Change, if you are currently insured under the Voluntary Life Insurance portion of this Policy, you may increase your Voluntary Life Insurance Benefit, or if you are eligible for the Voluntary Life Insurance portion of this Policy but have not previously enrolled, you may become insured under the Policy, as long as the total Benefit does not exceed the Maximum Benefit by satisfying the Insurability Requirement. Insurance will be effective on the later of the first of the month following the Life Status Change or the date the Insurance Company agrees in writing to insure you.

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

TL-008030-1

Former Employee Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Life Insurance Benefits allowable to you, less any amount of conversion insurance issued under the Conversion Privilege for Life Insurance. Any amount elected in excess of the Life Insurance Benefits in effect on the date you no longer qualify as an Employee will be effective on the date the Insurance Company agrees in writing to insure you. The Maximum Benefit for Basic Life Insurance Benefits is $50,000.
Maximum Benefit Period	To Age 70
Terminal Illness Benefit	You can elect up to 75% of Life Insurance Benefits in force on the date you are determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $287,500.

Spouse of Former Employee Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Voluntary Life Insurance Benefits available to a Spouse. Any amount elected in excess of the Voluntary Life Insurance Benefits in effect on the date your employment with the Employer ends will be effective on the date we agree in writing to insure him or her.
Maximum Benefit Period	To Age 70
Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Former Spouse Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Voluntary Life Insurance Benefits available to a Spouse. Any amount elected in excess of the Voluntary Life Insurance Benefits in effect on the date he or she no longer qualifies as a Spouse will be effective on the date we agree in writing to insure him or her.
Maximum Benefit Period	To Age 70
Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Former Dependent Child Benefits

Amount of Insurance	Units of $25,000
Guaranteed Issue Amount:	$25,000
Maximum Benefit:	$50,000
Maximum Benefit Period	To Age 70

TL-004774

WHO IS ELIGIBLE

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

An Employee who is the Spouse of another Employee may not be insured for Voluntary Life Insurance as both an Employee and as a Spouse at the same time.

Any Employee, who is eligible for Voluntary Life Insurance, will not be eligible to be insured as a Dependent Child of another Employee.

If an Employee is eligible and has enrolled as the Spouse of another Employee, but ceases to be eligible to maintain the amount of insurance for which he or she has enrolled as a Spouse, that Employee may, within 31 days, enroll for coverage as an Employee, in an amount equal to the lesser of (1) the amount of Spouse Voluntary Life Insurance terminating, or (2) the maximum amount of Employee Voluntary Life Insurance for which the Employee is eligible. The Insurability Requirement does not apply. If this amount is not equal to a Voluntary Life Insurance coverage option, it will be adjusted to the next higher available Voluntary Life Insurance coverage option. This provision shall be in lieu of the Policy's provisions, if any, regarding coverage changes following Life Status Changes.

If a Spouse is eligible and has enrolled for Voluntary Life Insurance as an Employee, but ceases to be eligible to maintain the amount of insurance for which he or she has enrolled as an Employee, the Spouse may, within 31 days, instead become enrolled as a Spouse of another Employee, in an amount equal to the lesser of (1) the amount of Employee Voluntary Life Insurance terminating, or (2) the Maximum Benefit Amount of Spouse Voluntary Life Insurance for which the Spouse is eligible. The Insurability Requirement does not apply. If this amount is not equal to a Voluntary Life Insurance coverage option, it will be adjusted to the next higher available Voluntary Life Insurance coverage option.

A Dependent Child of two or more Employees may only be insured once under the Policy. If an Employee who has elected to insure Dependent Children ceases to be eligible to do so, then the Employee's Spouse may, within 31 days, elect to insure Dependent Children, provided he or she is insured as an Employee. In all cases, "Dependent Child" shall be defined with respect to the Employee who has enrolled dependent children.

In all cases, amounts of insurance referred to in these provisions shall be determined before the application of any reductions in benefits due to age.

Any amount of Voluntary Life Insurance Coverage which cannot be continued under the above provisions may be subject to the Conversion Privilege.

Employee
If you qualify under the Class Definition shown in the Schedule of Benefits, you are eligible to be insured on the Policy Effective Date or the day after you complete the Eligibility Waiting Period, if later. The Eligibility Waiting Period will not apply if you are in Active Service on the Policy Effective Date and you satisfied the Eligibility Waiting Period, if any, of the Prior Plan. Credit will be given for any time you satisfied.

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

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

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

For eligibility purposes, your Spouse must be a lawful Spouse and not legally separated from, divorced from, or widowed by you.

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

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

TL-004710-1

WHEN COVERAGE BEGINS

If you are required to contribute to the cost of this insurance, you may elect insurance for yourself, your Spouse and Dependent Children only by authorizing payroll deduction in a form approved by the Employer and us. The effective date of this insurance depends on the date and amount of insurance elected.

If you elect coverage within 31 days after you become eligible to enroll or increase coverage, the Guaranteed Issue Amount will be effective on the latest of the following dates:
1. The Policy Effective Date.
2. The date you authorize payroll deduction for this insurance.
3. The date the Employer or Insurance Company receives the completed enrollment form.

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

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

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

If an eligible Spouse or Dependent Child is:

1. an inpatient in a hospital, hospice, rehabilitation or convalescence center, or custodial care facility; or
2. confined to his or her home under the care of a Physician

on the date insurance would otherwise be effective, it will be effective on the date he or she is no longer an inpatient in these facilities or confined at home. If such Spouse or Dependent Child was covered by the Prior Plan immediately prior to the Policy Effective Date, this provision will not apply to the amount of coverage in effect as of the Policy Effective Date, but will apply to any increase in coverage. This does not apply to a Dependent Child who is age 6 months or less.

TL-004712

Takeover Provision

Special Terms Applicable to Previously Insured Employees Not in Active Service and Their Dependents

Coverage will not go into effect for you, or your Spouse and Dependent Children unless you are in Active Service on the date you would have first become eligible to be insured under this Policy.

However:

1. if you, and your Spouse or Dependent Children were insured under a Prior Plan on the date immediately prior to the date you would have first become eligible to be insured under this Policy and had satisfied the Active Service requirement, and
2. if you, your Spouse or Dependent Child die, we agree to provide a Death Benefit only equal to the lesser of:

a. the amount due under this Policy (had you satisfied the Active Service requirement), or
b. the amount that would have been due under the Prior Plan had it remained in force.

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

These special terms will end on the earliest of the following dates:

1. the date you meet the Active Service requirements;
2. the date insurance terminates for one of the reasons stated in the Termination of Insurance provision;
3. 12 months after the date you first become eligible under this Policy; or
4. the last day you, your Spouse or Dependent Children would have been covered under the Prior Plan if coverage under that plan for you, your Spouse or Dependent Children was still in force.

TL-009020-1

WHEN COVERAGE ENDS

Coverage will end on the earliest of the following dates:

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

TL-004714-1

WHEN COVERAGE CONTINUES

Continuation for Temporary Leave of Absence, Layoff, Leave for Military Service or Family Medical Leave

If you are an Employee and your Active Service ends due to an Employer approved unpaid leave of absence, layoff, leave for military service or family medical leave, your insurance will continue if the required premium is paid.

In these circumstances, your insurance may continue as follows.

1. For an Employer approved unpaid leave of absence, up to 18 months following the date coverage would otherwise end due to exhaustion of Family and Medical Leave Act (FMLA), state leave of absence laws, or termination of Short Term Disability benefits under the Employer's Short Term Disability Plan.
2. For layoff, up to 3 months.
3. For leave for military service, up to 24 months.
4. For an Employer approved family medical leave, up to the later of the period of the approved FMLA leave or the leave period required by the laws of the state in which the Employee is employed.

Continuation for Disability

If you become Disabled, the Life Insurance Benefits shown in the Schedule of Benefits will be continued, provided premiums are paid, until the earlier of the following dates:

1. The date you are no longer Disabled.
2. The date you are Disabled for up to 18 months following the date coverage would otherwise end due to exhaustion of Family and Medical Leave Act (FMLA), state leave of absence laws or termination of Short Term Disability benefits under the Employer's Short Term Disability Plan.
3. The date coinciding with the end of the last period for which premiums are paid.
4. The date the Policy is terminated.

Amount of Insurance

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

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

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

Extended Death Benefit with Waiver of Premium

Extended Death Benefit

If you become Disabled and are less than age 60, the Life Insurance Benefits shown in the Schedule of Benefits will be extended without premium payment until the earlier of the following dates:

1. The date you are no longer Disabled; or
2. 9 months after the end of your Active Service.

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

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

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

Waiver of Premium
If you submit satisfactory proof that you have been continuously Disabled for 6 months, coverage will be extended up to age 65.

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

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

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

Termination of Waiver
Your insurance will end on the earliest of the following dates.
1. The date you are no longer Disabled;
2. The date you refuse to submit to any physical examination required by us;
3. The date you refuse to participate in a Rehabilitation Plan for which the Insurance Company determines you to be eligible;
4. The last day of the 12-month period of Disability during which you fail to submit satisfactory proof of continued Disability;
5. To Age 65.

"Disability/Disabled" means because of Injury or Sickness you are unable to perform the material duties of your Regular Occupation, or are receiving disability benefits under the Employer's plan, during the initial 6 months of Disability. Thereafter, you must be unable to perform all of the material duties of any occupation which you may reasonably become qualified based on education, training or experience, or are subject to the terms of a Rehabilitation Plan approved by the Insurance Company.

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

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

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

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

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

TL-009745 as modified by TL-009745-1

Portability Options
For Employees

If your coverage under the Policy ends prior to age 70, for any of the following reasons:
a. termination of employment; or
b. termination of membership in an eligible class under the Policy;
Life Insurance Benefits may be continued up to the Maximum Benefit shown in the Schedule of Benefits for this option.

You must apply to the Insurance Company and pay the required premium. If you continue coverage, coverage for your Spouse or Dependent Child may also be continued by you. Your Spouse or Dependent Child must be covered under the Policy on the date coverage would otherwise end. The application must be submitted:
a. within 31 days of your termination of employment or membership in an eligible class under the Policy; or
b. during the time that you have to exercise the Conversion Privilege.
Coverage under this option may not be elected at a later date.

When applying for this option, you must name a beneficiary. Any beneficiary named previously under the Policy is no longer in effect. If there is no named or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives:
a. spouse;
b. child or children;
c. mother or father;
d. brothers or sisters; or
e. the executors or administrators of your estate.

When coverage is continued under this option, you become a Former Employee. Your Spouse becomes a Spouse of a Former Employee. Your Dependent Child becomes a Dependent Child of a Former Employee.

If you, as a Former Employee, later acquire a Spouse or Dependent Child, you may elect coverage for them. You must apply to the Insurance Company and pay the required premium. Coverage for your Spouse or Dependent Child will be effective on the date we agree in writing to insure them. We may require that your Spouse or Dependent Child satisfy the Insurability Requirement before we agree to insure them.

Coverage will end on the earliest of the following dates.
a. The date we cancel coverage for all Former Employees.
b. The end of the period for which premiums are paid.
c. The date an Insured reaches age 70.
d. The date the Maximum Benefit Period shown in the Schedule of Benefits for this option ends.

Also, coverage for any Dependent Child will end on any of the dates listed above or when he or she no longer qualifies as a Dependent Child, if earlier.

For Spouses

If prior to age 70, a Spouse is:
a. legally separated, divorced; or
b. widowed
from an insured Employee or Former Employee, Life Insurance Benefits may be continued. Coverage may be continued up to the Maximum Benefit shown in the Schedule of Benefits for this option. The Spouse must apply to the Insurance Company and pay the required premium.

A Spouse who continues coverage may also continue coverage for a Dependent Child. The Dependent Child must be covered under the Policy on the date coverage would otherwise end. A Spouse must elect to continue insurance under this option within 31 days after coverage ends. Coverage may not be elected at a later date.

When applying for this option, a Spouse must name a beneficiary. Any beneficiary named previously under the Policy is no longer in effect. If there is no named or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives:
a. spouse;
b. child or children;
c. mother or father;
d. brothers or sisters; or
e. the executors or administrators of the Spouse’s estate.

When coverage is continued under this option, the Spouse becomes a Former Spouse. A separate certificate of insurance will be issued to the Former Spouse. Coverage will be effective on the date after coverage as a Spouse ends if the required premium is paid.

Coverage will end on the earliest of the following dates.
a. The date we cancel coverage for all Former Spouses.
b. The end of the period for which premiums are paid.
c. The date the Former Spouse reaches age 70.
d. The date the Maximum Benefit Period shown in the Schedule of Benefits for this option ends.

Also, coverage for a Dependent Child will end on any of the dates listed above or when he or she no longer qualifies as a Dependent Child, if earlier.

For Dependent Children

If a Dependent Child is insured under the Policy and is at least 19 years of age, Life Insurance Benefits may be continued under this option. Coverage may be continued up to the Maximum Benefit shown in the Schedule of Benefits for this option.

The Dependent Child must apply to the Insurance Company and pay the required premium. If a Dependent Child does not elect to continue insurance within 31 days after reaching age 19; or the date he or she no longer qualifies as a Dependent Child, if later, coverage under this option may not be elected at a later date.

When applying for this option, a Dependent Child must name a beneficiary. Any beneficiary named previously under the Policy is no longer in effect. If there is no named or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives:

a. spouse;
b. child or children;
c. mother or father;
d. brothers or sisters; or
e. the executors or administrators of the Dependent Child's estate.

When a Dependent Child continues coverage under this option, he or she becomes a Former Dependent Child. A separate certificate of insurance will be issued to the Former Dependent Child. Coverage for a Former Dependent Child will be effective on the following dates.

a. For any Guaranteed Issue Amount, immediately following the date his or her coverage as a Dependent Child ends, provided the Insurance Company receives the required premium.
b. For any amount of insurance that exceeds the Guaranteed Issue Amount, the date the Insurance Company agrees in writing to insure him or her. The Insurance Company will require the Former Dependent Child to satisfy the Insurability Requirement before it agrees to insure him or her.

Coverage will end on the earliest of the following dates.

a. The date we cancel coverage for all Former Dependent Children.
b. The end of the period for which premiums are paid.
c. The date the Former Dependent Child is age 70.
d. The date the Maximum Benefit Period shown in the Schedule of Benefits for this option ends.

TL-004716 as modified by TL-009330

WHAT IS COVERED

LIFE INSURANCE BENEFITS

Death Benefit

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

TL-004730

Accelerated Benefits

Any benefits payable under this and under any similar Accelerated Benefits provision accelerated under a Prior Plan will reduce the Death Benefit payable for Life Insurance. We will deduct from any Death Benefit payable under this Policy, the amount of any similar accelerated benefit paid under a Prior Plan.

Any automatic increases in Life Insurance Benefits will end when benefits are payable under this provision, unless the Insured is determined by the Insurance Company not to be eligible for Accelerated Benefits.

Terminal Illness Benefit
We will pay a Terminal Illness Benefit to an Insured who has incurred a Terminal Illness while insured under this provision.

The Terminal Illness Benefit is shown on the Schedule of Benefits.

A claim for a similar terminal illness benefit under a Prior Plan or group policy intended to replace this Policy shall be deemed payable until such time as it is finally determined not to be payable.

Determination of Terminal Illness
For the purpose of determining the existence of a Terminal Illness, we will require the Insured submit the following proof:
1. A written diagnosis and prognosis by a licensed Physician; and
2. Supportive evidence satisfactory to us, including but not limited to, radiological, histological or laboratory reports documenting the Terminal Illness.

We may require, at our expense, an examination of the Insured and a review of the documented evidence by a Physician of our choice.

Such proofs must be submitted to us within the period of time provided in the *Proof of Loss* section of the Policy. For purposes of this Benefit, the date of loss shall be the date of first prognosis of Terminal Illness.

"Terminal Illness" means that, due to an Injury or Sickness, the Insured has a prognosis of 12 months or less to live without reasonable prospect of recovery, as determined by us.

Payment of Terminal Illness Benefit
The Terminal Illness Benefit will be payable in accordance with the provisions of the *To Whom Payable* section of the Policy.

The Terminal Illness Benefit is payable only once under the Policy in an Insured's lifetime.

Conditions Applicable to Coverage
Unless the Insured qualifies for waiver of premium, premium payments must continue to be paid on the full amount of group life insurance, including during any Continuation of Insurance under the Policy, in accordance with the *Premium* section in the *Administrative Provisions*.

The amount of Life Insurance which may be converted under the *Conversion Privilege* cannot exceed the amount of the reduced death benefit payable under the Policy.

Before a Terminal Illness Benefit is paid in a Community Property state, we may require the written consent of the Insured’s Spouse.

Exclusions Applicable to Terminal Illness Benefit
A Terminal Illness Benefit will not be payable:
1. when the Insured has irrevocably assigned group life insurance under this Policy;
2. when all or a portion of group life insurance benefits under this Policy are to be paid to a former spouse as part of a qualified domestic relations order;
3. for any intentionally self-inflicted Injury or Sickness, or suicide attempt;
4. if the Insured’s coverage ends under the *When Coverage Ends* provision prior to the prognosis of Terminal Illness;
5. if the required premium is due and unpaid;
6. if this Policy terminates prior to the prognosis of Terminal Illness;

7. if you or the Insured is only provided coverage under the Takeover provision of the Policy (Employees Not in Active Service on the Policy Effective Date); or
8. if the date of first prognosis of Terminal Illness occurs more than 12 months before the submission of the Terminal Illness claim.

TL-004748a

Conversion Privilege for Life Insurance

Each Insured may convert all or any portion of his or her Life Insurance that would end under the Policy due to:

1. termination of employment;
2. termination of membership in an eligible class under the Policy;
3. termination of the Policy.

The Insured may apply for any type of life insurance we offer to persons of the same age in the amount applied for, except you may not:

1. choose term insurance;
2. apply for an amount of insurance greater than the coverage amount terminating under the Policy (also, the conversion policy will not provide accident, disability or other benefits); or
3. apply for more than $10,000 of insurance if the Policy is terminated or amended to terminate the insurance for any class of Insureds, or the Employer cancels participation under the Policy. Conversion in these cases is only permitted if you have been covered by the Policy or, any group life insurance policy issued to the Employer which the Policy replaced, for at least 3 years.

If the Insured becomes eligible for coverage under any group life policy within 31 days of termination of coverage under this Policy, the Insured may not convert an amount of insurance greater than the amount of coverage terminating under the Policy less the amount for which he or she may be covered under the other policy.

To apply for conversion insurance, the Insured must, within 31 days after coverage under the Policy ends:

1. submit an application to us; and
2. pay the required premium.

Evidence of insurability is not required.

Premium for the conversion insurance will be based on the age and class of risk of the Insured and the type and amount of coverage issued.

If the Insured has assigned ownership of his group coverage, the owner/assignee must apply for the individual policy.

Conversion insurance will become effective on the 31st day after the date coverage under the Policy ends provided the application is received by us and the required premium has been paid.

If the Insured dies during the 31-day conversion period, the Life Insurance benefits will be paid under the Policy regardless of whether he or she applied for conversion insurance. If a conversion policy is issued, it will be in exchange for any further benefits for that type and amount of insurance from this Policy.

Extension of Conversion Period

If an Insured is eligible for conversion insurance and is not notified of this right at least 15 days prior to the end of the 31-day conversion period, the conversion period will be extended. The Insured will have 15 days from the date notice is given to apply for conversion insurance. In no event will the conversion period be extended beyond 90 days. Notice, for the purpose of this section, means written notice presented to the Insured by the Employer or mailed to the Insured's last known address as reported by the Employer.

If the Insured dies during the extended conversion period, but more than 31 days after his or her coverage under the Policy terminates, Life Insurance benefits:

1. will not be paid under the Policy; and
2. will be payable under the conversion insurance; provided:
    a. the Insured's application for conversion insurance has been received by us; and
    b. the required premium has been paid.

Prior Conversion Limitation
If an Insured is covered under a life insurance conversion policy previously issued by us, he or she will not be eligible for this Conversion Privilege unless the prior coverage has ended.

TL-009740

LIFE INSURANCE EXCLUSIONS

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

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

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

TL-004752

CLAIM PROVISIONS

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

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

Claim Forms
When we receive notice of claim, we will send claim forms for filing proof of loss. If we do not send claim forms within 15 days after notice is received by us, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof, or proof by any other electronic/telephonic means authorized by us, of the nature and extent of the loss.

Claimant Cooperation Provision
If you fail to cooperate with us in our administration of your claim, we may terminate the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

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

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

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

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

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

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

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

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

To Whom Payable
Death Benefits will be paid to the Insured's named beneficiary, if any, on file at the time of payment or to the certificate owner if alive. If there is no named beneficiary or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives: spouse; child or children; mother or father; brothers or sisters; or to the executors or administrators of the Insured's estate. We may reduce the amount payable by any indebtedness due.

All benefits payable under the Accelerated Benefits section are payable to the Insured, if living. If the Insured dies prior to the payment of an eligible claim for an Accelerated Benefit, benefits will be paid in accordance with the provisions applicable to the payment of Life Insurance proceeds, unless the Insured has directed us otherwise in writing. However, any payment made by us prior to notice of the Insured's death shall discharge us of any benefit that was paid.

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

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

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

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

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

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

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

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

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

TL-004724

ADMINISTRATIVE PROVISIONS

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

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

Your Grace Period
If your required premium is not paid on the Premium Due Date, there is a 60 day grace period after each premium due date after the first. If the required premium is not paid during the grace period, insurance will end on the last day for which premium was paid.

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

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

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

TL-004722

GENERAL PROVISIONS

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

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

Misstatement of Age
If an Insured's age has been misstated, we will adjust all benefits to the amounts that would have been purchased for the correct age.

Workers' Compensation Insurance
The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance Law.

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

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

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

TL-004728

DEFINITIONS

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

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

Active Service
If you are an Employee, you are in Active Service with the Employer on a day which is one of the Employer's scheduled work days if either of the following conditions are met.

1. You are actively at work. This means you are performing your regular occupation for the Employer on a Full-time basis, either at one of the Employer's usual places of business or at some location to which the Employer's business requires you to travel.
2. The day is a scheduled holiday, vacation day or period of Employer approved paid leave of absence, other than disability or sick leave after 7 days.

You are considered in Active Service on a day which is not one of the Employer's scheduled work days only if you were in Active Service on the preceding scheduled work day.

Annual Compensation
Annual Compensation means your annual wage or salary as reported by the Employer for work performed for the Employer as of the date the covered loss occurs. It includes earnings received as bonuses and overtime pay, but not other extra compensation. Annual Compensation is determined initially on the date you apply for coverage. A change in the amount of Annual Compensation is effective on the date of the change, if the Employer gives us written notice of the change and the required premium is paid.

Bonuses and overtime pay will be averaged for the 12 months just prior to the date the covered loss occurs, or the months employed, if less than 12 months.

Dependent Child
An unmarried child who meets the following requirements.

1. A child from live birth but less than 26 years old;
2. A child who is 26 or more years old, primarily supported by you and incapable of self-sustaining employment by reason of mental or physical incapacity.
3. A child stillborn during the third trimester.

The term "child" means:

a. your natural child;
b. your legally adopted child, beginning with any waiting period pending finalization of the child’s adoption. It also means the legally adopted child of your Spouse provided the child is living with, and is financially dependent upon you;
c. a stepchild born to your Spouse and who is living with and financially dependent upon you;
d. a child for whom you are the court-appointed legal guardian and who resides with, and is financially dependent upon you.

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

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

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

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

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

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

Insured
You are an Insured if you are eligible for insurance under the Policy, insurance is elected for you, the required premium is paid and your coverage is in force under the Policy.

Life Status Change
A Life Status Change is an event recognized by the Employer's Flexible Benefits Plan as qualifying you to make changes in benefit selections at a time other than an Annual Enrollment Period.

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

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

Policy Anniversary
A Policy Anniversary is the date stated on the policy cover and the same date that follows every 12 months for as long the Policy is in effect.

Policy Effective Date
The Policy Effective Date is the date stated on the policy cover.

Prior Plan
The Prior Plan refers to the plan of insurance providing similar benefits to you, sponsored by the Employer and in effect directly prior to the Policy Effective Date. A Prior Plan will include the plan of an employer in effect on the day prior to that employer's addition to this policy.

To be covered under the Policy, required premium must be paid for all covered Employees.

Sickness
The term Sickness means a physical or mental illness.

Spouse
Your current lawful spouse.

Subscriber
Any participating organization that subscribes to the trust to which this Policy is issued, and which is insured under this Policy.

TL-004708-1 as modified by TL-010150a

LIFE INSURANCE COMPANY OF NORTH AMERICA
1601 CHESTNUT STREET
PHILADELPHIA, PA 19192-2235

STATE MODIFYING PROVISIONS AMENDMENT RIDER

Subscriber: The Reinalt-Thomas Corporation, a Michigan corporation, dba Discount Tire/America's Tire/Discount Tire Direct
Policy No.: FLX-980462
Amendment Effective Date: January 1, 2020

This amendment is attached to and made part of the Policy/Certificate specified above. Its provisions are intended to conform this Policy/Certificate to the laws of the state in which the insured resides.

The Policy delivered under the Group Policy are amended as follows:

APPLICABLE TO CALIFORNIA RESIDENTS:

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

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

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

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

APPLICABLE TO FLORIDA RESIDENTS:

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

APPLICABLE TO MARYLAND RESIDENTS:

The Group Insurance Policy was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

APPLICABLE TO MISSOURI RESIDENTS:

Applicable to Voluntary Life Insurance Benefits

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

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

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

APPLICABLE TO NORTH DAKOTA RESIDENTS:

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

APPLICABLE TO OREGON RESIDENTS:

NOTICE: MUST PROVIDE DOMESTIC PARTNER COVERAGE FOR OREGON RESIDENTS

APPLICABLE TO VERMONT RESIDENTS:

To the extent the Policy provides insurance coverage to a spouse, the identical consideration must be applied to same sex marriages and civil unions. The language is as follows:

1. Civil Union Partner means:
   a. A person with whom the Employee has a registered civil union under Vermont law which imposes obligations on the parties substantially similar to marriage. Such person will continue to be recognized as a Civil Union Partner unless and until:
      (1) the civil union is dissolved under applicable law; or
      (2) either the Employee or the Civil Union Partner marries another person.

2. Spouse means:
   a. "Lawful spouse" and includes a lawful spouse of the same sex.
   b. This also includes a partner to a civil union recognized under Vermont Law.

APPLICABLE TO WASHINGTON RESIDENTS:

1. The following *Continuation of Insurance* provision is added to the Policy:

   Continuation of Life Coverage During Labor Disputes
   If an Employee's Active Service ends because of a Labor Dispute and his or her premium for Life Insurance Benefits under the Policy is paid either by the Employer, in whole or in part, or by the Employee through payroll deductions, then the Employee may continue his or her Life Insurance Benefits. The Employer will send written notice of the right to continue coverage to each insured Employee at his or her most recent address as on file with the Employer.

   To continue coverage, the Employee must pay premiums directly to the Employer, who will remit the premiums to the Insurance Company. Premiums must be paid by the date they are due, subject to the 31 day grace period. Policy coverages and premiums will stay the same during a Labor Dispute; however, the Insurance Company may make normal changes in premium rates when the Policy is renewed, under the terms set forth in the Policy.

   Coverage continued in this manner will end on the earliest of the following dates.
   a. The date the Labor Dispute has ended.
   b. The date coverage has been continued for 6 months.

   If the Labor Dispute continues beyond 6 months, the Employee may apply for an individual insurance policy, as set forth in detail under "Conversion Privilege for Life Insurance."

   "Labor Dispute," as used here, means a strike, lockout, or other labor dispute between the Employer and its Employees, during which time the Employee is not paid by the Employer.

2. If the Policy provides coverage to dependents, benefits for a Spouse or Dependent Child are limited to 100% of the insured Employee's coverage amount. Stand-alone Spouse and Dependent Child coverage (when Employee is not insured) is not permitted.

3. The *Suicide* Exclusion, if any, does not apply.

4. To the extent the policy includes *Accelerated Benefits,* the following resolution of disputes requirements are added to the Policy.

   - For Terminal Illness – *Determination of Terminal Illness*

     In the event the Physician representing the Insurance Company disputes the existence of a Terminal Illness, and the dispute cannot be resolved, the Insured has the right to mediation and binding arbitration in accordance with Washington Administrative Code 284-23-730.

5. The *Incontestability Provision* is replaced as follows:

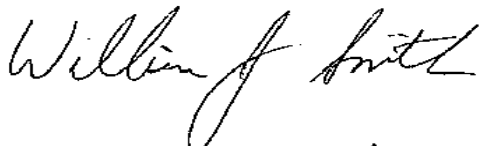
   Incontestability
   All statements made by the Employer or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement has been furnished to the claimant. In the event of death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

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

6. If the term "*Accident*" is defined in the Policy, it is replaced by the following:

Accident
An Accident is a sudden, unforeseeable event that causes bodily Injury to an Insured while coverage is in force under the Policy.

Signed for the
Life Insurance Company of North America



William J. Smith, President

TL-00-3000.00

SUPPLEMENTAL INFORMATION
for

Reinalt-Thomas Corporation Fully Insured Life, AD&D, LTD and STD Welfare Benefit Plan ("Plan")

required by the Employee Retirement Income Security Act of 1974

As a Plan participant in The Reinalt-Thomas Corporation, a Michigan corporation, dba Discount Tire/America's Tire/Discount Tire Direct's Plan, you are entitled to certain information, rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

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

IMPORTANT INFORMATION ABOUT THE PLAN

- The Plan is established and maintained by The Reinalt-Thomas Corporation, a Michigan corporation, dba Discount Tire/America's Tire/Discount Tire Direct, the Plan Sponsor.
- The Employer Identification Number (EIN) is 38-1889682.
- The Plan Number is 526.
- The Insurance Plan is administered directly by the Plan Administrator with benefits provided, in accordance with the provisions of the group insurance contract, FLX-980462 ("Policy"), issued by LIFE INSURANCE COMPANY OF NORTH AMERICA ("Insurance Company").
- The Plan Administrator is: Reinalt-Thomas Corporation
  20225 North Scottsdale Road
  Scottsdale, AZ 85255
  480-606-6000
- The Plan Administrator has authority to control and manage the operation and administration of the Plan.
- The Plan Sponsor may terminate, suspend, withdraw or amend the Plan, in whole or in part, at any time, subject to the applicable provisions of the Policy. (Your rights upon termination or amendment of the Plan are set forth in your Certificate.)
- The agent for service of legal process is the Plan Administrator.
- The Plan of benefits is financed by the Employees.
- The date of the end of the Plan Year is December 31.

YOUR RIGHTS AS SET FORTH BY ERISA

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

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

WHAT YOU SHOULD DO AND EXPECT IF YOU HAVE A CLAIM

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

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

A disability "claim" is any claim which requires a determination of disability by the Insurance Company regardless of the type of policy under which it arises (for example, short/long term disability, waiver of premium, etc.). A disability claim is "filed" as of the date the Insurance Company first receives, in writing (including electronically) or by telephone (through the Insurance Company's intake department), notice that a claimant is seeking disability benefits under the Policy. The notice of claim received should provide the date of disability/loss, the claimant's name and address, and the group Policy holder's name and address. Properly filed claims will be decided with independence and impartiality.

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

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

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

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

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

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

A written request for appeal must be received by the Insurance Company within 180 days from the date the claimant received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived. The Insurance Company has 45 days from the date it receives a request for appeal to provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim and can extend the time for decision, once, by an additional 45 days. If this should happen, the Insurance Company must provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Insurance Company's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Insurance Company receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

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

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

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

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

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

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

A non-disability "claim" is any claim which does not require a determination of disability by the Insurance Company regardless of the type of policy under which it arises (for example, a death claim, an accident claim, etc.). A non-disability claim is "filed" as of the date the Insurance Company first receives, in writing or by telephone (through the Insurance Company's intake department), notice that a claimant is seeking benefits under the Policy. The notice of claim should include the group Policy holder's name, the Policy and Certificate number and the claimant's name and address.

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

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

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

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

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

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

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

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

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

ER-03-2

UNDERWRITTEN BY:
LIFE INSURANCE COMPANY OF NORTH AMERICA
a Cigna company

Class 1
12/2019

Group Life
Insurance Certificate

The Reinalt-Thomas Corporation, a Michigan corporation, dba Discount Tire/America's Tire/Discount Tire Direct

IMPORTANT NOTICES

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

Arizona, Florida and Maryland residents:

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

Washington Residents:

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

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

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

NOTICE

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

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

TL-004788

FOREWORD

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

The need for life insurance protection depends on individual circumstances and financial situations. Your Employer is offering you the opportunity to purchase this insurance to make your benefit program more comprehensive and responsive to your needs.

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

Any insurance benefit described in the following pages will apply to you only if you have elected that benefit and have authorized payroll deduction for the required premium.

LIFE INSURANCE COMPANY OF NORTH AMERICA
1601 CHESTNUT STREET
PHILADELPHIA, PA 19192-2235
(800) 732-1603 TDD (800) 336-2485
A STOCK INSURANCE COMPANY

GROUP INSURANCE
CERTIFICATE

We, the LIFE INSURANCE COMPANY OF NORTH AMERICA, have issued a Group Policy, FLX-980462, to TRUSTEE OF THE GROUP INSURANCE TRUST FOR EMPLOYERS IN THE RETAIL TRADE INDUSTRY on behalf of The Reinalt-Thomas Corporation, a Michigan corporation, dba Discount Tire/America's Tire/Discount Tire Direct.

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

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

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

William J. Smith, President

TL-004704

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SCHEDULE OF BENEFITS

Policy Effective Date: January 1, 2020

Certificate Effective Date: July 1, 2021

Policy Anniversary Date: January 1

Policy Number: FLX-980462

Class Definition

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

All active Full-time Employees of the Employer classified as Executives, Corporate Directors, Corporate Managers, Corporate Assistant Managers, Corporate Process Managers, Business Relationship Owners, Project Managers, Risk Litigation Coordinators, Systems Engineers - IT Omni Channel, Regional Office Managers, Store Managers, Store Maintenance Managers, Regional Facilities Managers, Warehouse Managers, Pilots, Flight Department Directors, Flight Department Managers, Aircraft Quality Control Inspectors, Discount Tire Direct (DTD) Directors, DTD Managers, DTD Supervisors, DTD DC Managers, DTD Senior DC Assistant Managers regularly working the required number of hours to qualify for benefits according to the Employer's company policy, working in the United States who are citizens or permanent resident aliens of the United States, excluding temporary and seasonal workers.

Your Eligibility Waiting Period

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

If you were hired on or before the Policy Effective Date:
After 90 days of continuous Active Service

If you were hired after the Policy Effective Date:
After 90 days of continuous Active Service

The *Eligibility Waiting Period* does not apply if you are a former Employee rehired within 12 months after your termination date and you had satisfied the *Eligibility Waiting Period* prior to your termination date. If you did not fully satisfy the *Eligibility Waiting Period* prior to your termination date, credit will be given for any time that was satisfied.

LIFE INSURANCE BENEFITS

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

Employee Benefits

Basic Benefit	1.5 times your Annual Compensation
Guaranteed Issue Amount:	the lesser of 1.5 times Annual Compensation or $50,000
Maximum Benefit:	the lesser of 1.5 times Annual Compensation or $50,000

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

Basic Terminal Illness Benefit	You can elect up to 75% of Basic Life Insurance Benefits in force on the date you are determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $37,500.
Voluntary Benefit	An amount elected in units of $10,000
Guaranteed Issue Amount:	the greater of a) or b) below: a) the lesser of 7 times Annual Compensation or $400,000, or b) an amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan
Maximum Benefit:	$500,000

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

Voluntary Terminal Illness Benefit	You can elect up to 75% of Voluntary Life Insurance Benefits in force on the date you are determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $250,000.
Age Based Reductions	When you are age 65 or older, your Life Insurance Benefit will reduce to the percentage shown below: 65% of the Life Insurance Benefit at age 65 40% of the Life Insurance Benefit at age 70 25% of the Life Insurance Benefit at age 75

Benefit reductions will be effective on your attainment of age as specified in schedule above.

Automatic Increase Feature for Life Insurance

An increase in your Life Insurance resulting from an increase in Annual Compensation will not be subject to the Insurability Requirement, even if the increase causes the Life Insurance to exceed the Guaranteed Issue Amount.

If you are not in Active Service on the date the increase would go into effect, your benefit will not increase until you return to Active Service.

Premiums must be paid on the basis of any increased amount of Life Insurance resulting from increases in Annual Compensation.

Spouse Benefits

Voluntary Benefit	An amount elected in units of $5,000
Guaranteed Issue Amount:	the greater of a) or b) below: a) $30,000, or b) an amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan
Maximum Benefit:	$100,000

Your Spouse's Life Insurance Benefits cannot exceed 50% of your Life Insurance Benefits.

Age Based Reductions	When you are age 65 or older, your Spouse's Life Insurance Benefit will reduce to the percentage shown below: 65% of the Life Insurance Benefit at age 65 40% of the Life Insurance Benefit at age 70 25% of the Life Insurance Benefit at age 75

Benefit reductions will be effective on your attainment of age as specified in schedule above.

Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Dependent Child Benefits

Voluntary Benefit	An amount elected in units of $5,000
Maximum Benefit:	$10,000 The Maximum Benefit for a Dependent Child who is less than 6 months old is $5,000.

All Dependent Child benefits are Guaranteed Issue.

Annual Enrollment Period

For Employees
During an Annual Enrollment Period, if you are currently insured under the Voluntary Life Insurance portion of this Policy, you may increase your Voluntary Life Insurance Benefit, or if you are eligible for the Voluntary Life Insurance portion of this Policy but have not previously enrolled, you may become insured under the Policy, as long as the total Benefit does not exceed the Maximum Benefit by satisfying the Insurability Requirement. Insurance will be effective on the later of January 1st following the Annual Enrollment Period or the date the Insurance Company agrees in writing to insure you.

For Spouses
During an Annual Enrollment Period, if you are an eligible Employee, you may elect coverage for your eligible Spouse. If your Spouse is currently insured under the Voluntary Life Insurance portion of this Policy, his or her Voluntary Life Insurance Benefit may be increased, or if your Spouse is eligible for the Voluntary Life Insurance portion of this Policy but has not previously enrolled, he or she may become insured under the Policy, as long as the total Benefit does not exceed the Maximum Benefit, by satisfying the Insurability Requirement. Insurance will be effective on the later of January 1st following the Annual Enrollment Period or the date the Insurance Company agrees in writing to insure him or her.

Insurance Benefits for you, your Spouse and Dependent Children may be reduced at any time. A request for a Benefit reduction received during an Annual Enrollment Period will become effective on January 1st following the Annual Enrollment Period. Any other Benefit reduction will be effective on the date the Insurance Company receives the completed change form.

TL-008025-1

Life Status Change

For Employees
Within 31 days after a Life Status Change, if you are currently insured under the Voluntary Life Insurance portion of this Policy, you may increase your Voluntary Life Insurance Benefit, or if you are eligible for the Voluntary Life Insurance portion of this Policy but have not previously enrolled, you may become insured under the Policy, as long as the total Benefit does not exceed the Maximum Benefit by satisfying the Insurability Requirement. Insurance will be effective on the later of the first of the month following the Life Status Change or the date the Insurance Company agrees in writing to insure you.

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

TL-008030-1

Former Employee Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Life Insurance Benefits allowable to you, less any amount of conversion insurance issued under the Conversion Privilege for Life Insurance. Any amount elected in excess of the Life Insurance Benefits in effect on the date you no longer qualify as an Employee will be effective on the date the Insurance Company agrees in writing to insure you. The Maximum Benefit for Basic Life Insurance Benefits is $50,000.
Maximum Benefit Period	To Age 70
Terminal Illness Benefit	You can elect up to 75% of Life Insurance Benefits in force on the date you are determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $287,500.

Spouse of Former Employee Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Voluntary Life Insurance Benefits available to a Spouse. Any amount elected in excess of the Voluntary Life Insurance Benefits in effect on the date your employment with the Employer ends will be effective on the date we agree in writing to insure him or her.
Maximum Benefit Period	To Age 70
Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Former Spouse Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Voluntary Life Insurance Benefits available to a Spouse. Any amount elected in excess of the Voluntary Life Insurance Benefits in effect on the date he or she no longer qualifies as a Spouse will be effective on the date we agree in writing to insure him or her.
Maximum Benefit Period	To Age 70
Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Former Dependent Child Benefits

Amount of Insurance	Units of $25,000
Guaranteed Issue Amount:	$25,000
Maximum Benefit:	$50,000
Maximum Benefit Period	To Age 70

TL-004774

WHO IS ELIGIBLE

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

An Employee who is the Spouse of another Employee may not be insured for Voluntary Life Insurance as both an Employee and as a Spouse at the same time.

Any Employee, who is eligible for Voluntary Life Insurance, will not be eligible to be insured as a Dependent Child of another Employee.

If an Employee is eligible and has enrolled as the Spouse of another Employee, but ceases to be eligible to maintain the amount of insurance for which he or she has enrolled as a Spouse, that Employee may, within 31 days, enroll for coverage as an Employee, in an amount equal to the lesser of (1) the amount of Spouse Voluntary Life Insurance terminating, or (2) the maximum amount of Employee Voluntary Life Insurance for which the Employee is eligible. The Insurability Requirement does not apply. If this amount is not equal to a Voluntary Life Insurance coverage option, it will be adjusted to the next higher available Voluntary Life Insurance coverage option. This provision shall be in lieu of the Policy's provisions, if any, regarding coverage changes following Life Status Changes.

If a Spouse is eligible and has enrolled for Voluntary Life Insurance as an Employee, but ceases to be eligible to maintain the amount of insurance for which he or she has enrolled as an Employee, the Spouse may, within 31 days, instead become enrolled as a Spouse of another Employee, in an amount equal to the lesser of (1) the amount of Employee Voluntary Life Insurance terminating, or (2) the Maximum Benefit Amount of Spouse Voluntary Life Insurance for which the Spouse is eligible. The Insurability Requirement does not apply. If this amount is not equal to a Voluntary Life Insurance coverage option, it will be adjusted to the next higher available Voluntary Life Insurance coverage option.

A Dependent Child of two or more Employees may only be insured once under the Policy. If an Employee who has elected to insure Dependent Children ceases to be eligible to do so, then the Employee's Spouse may, within 31 days, elect to insure Dependent Children, provided he or she is insured as an Employee. In all cases, "Dependent Child" shall be defined with respect to the Employee who has enrolled dependent children.

In all cases, amounts of insurance referred to in these provisions shall be determined before the application of any reductions in benefits due to age.

Any amount of Voluntary Life Insurance Coverage which cannot be continued under the above provisions may be subject to the Conversion Privilege.

Employee
If you qualify under the Class Definition shown in the Schedule of Benefits, you are eligible to be insured on the Policy Effective Date or the day after you complete the Eligibility Waiting Period, if later. The Eligibility Waiting Period will not apply if you are in Active Service on the Policy Effective Date and you satisfied the Eligibility Waiting Period, if any, of the Prior Plan. Credit will be given for any time you satisfied.

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

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

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

For eligibility purposes, your Spouse must be a lawful Spouse and not legally separated from, divorced from, or widowed by you.

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

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

TL-004710-1

WHEN COVERAGE BEGINS

If you are required to contribute to the cost of this insurance, you may elect insurance for yourself, your Spouse and Dependent Children only by authorizing payroll deduction in a form approved by the Employer and us. The effective date of this insurance depends on the date and amount of insurance elected.

If you elect coverage within 31 days after you become eligible to enroll or increase coverage, the Guaranteed Issue Amount will be effective on the latest of the following dates:
1. The Policy Effective Date.
2. The date you authorize payroll deduction for this insurance.
3. The date the Employer or Insurance Company receives the completed enrollment form.

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

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

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

If an eligible Spouse or Dependent Child is:

1. an inpatient in a hospital, hospice, rehabilitation or convalescence center, or custodial care facility; or
2. confined to his or her home under the care of a Physician

on the date insurance would otherwise be effective, it will be effective on the date he or she is no longer an inpatient in these facilities or confined at home. If such Spouse or Dependent Child was covered by the Prior Plan immediately prior to the Policy Effective Date, this provision will not apply to the amount of coverage in effect as of the Policy Effective Date, but will apply to any increase in coverage. This does not apply to a Dependent Child who is age 6 months or less.

TL-004712

Takeover Provision

Special Terms Applicable to Previously Insured Employees Not in Active Service and Their Dependents

Coverage will not go into effect for you, or your Spouse and Dependent Children unless you are in Active Service on the date you would have first become eligible to be insured under this Policy.

However:

1. if you, and your Spouse or Dependent Children were insured under a Prior Plan on the date immediately prior to the date you would have first become eligible to be insured under this Policy and had satisfied the Active Service requirement, and
2. if you, your Spouse or Dependent Child die, we agree to provide a Death Benefit only equal to the lesser of:

a. the amount due under this Policy (had you satisfied the Active Service requirement), or
b. the amount that would have been due under the Prior Plan had it remained in force.

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

These special terms will end on the earliest of the following dates:

1. the date you meet the Active Service requirements;
2. the date insurance terminates for one of the reasons stated in the Termination of Insurance provision;
3. 12 months after the date you first become eligible under this Policy; or
4. the last day you, your Spouse or Dependent Children would have been covered under the Prior Plan if coverage under that plan for you, your Spouse or Dependent Children was still in force.

TL-009020-1

WHEN COVERAGE ENDS

Coverage will end on the earliest of the following dates:

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

TL-004714-1

WHEN COVERAGE CONTINUES

Continuation for Temporary Leave of Absence, Layoff, Leave for Military Service or Family Medical Leave

If you are an Employee and your Active Service ends due to an Employer approved unpaid leave of absence, layoff, leave for military service or family medical leave, your insurance will continue if the required premium is paid.

In these circumstances, your insurance may continue as follows.

1. For an Employer approved unpaid leave of absence, up to 18 months following the date coverage would otherwise end due to exhaustion of Family and Medical Leave Act (FMLA), state leave of absence laws, or termination of Short Term Disability benefits under the Employer's Short Term Disability Plan.
2. For layoff, up to 3 months.
3. For leave for military service, up to 24 months.
4. For an Employer approved family medical leave, up to the later of the period of the approved FMLA leave or the leave period required by the laws of the state in which the Employee is employed.

Continuation for Disability

If you become Disabled, the Life Insurance Benefits shown in the Schedule of Benefits will be continued, provided premiums are paid, until the earlier of the following dates:

1. The date you are no longer Disabled.
2. The date you are Disabled for up to 18 months following the date coverage would otherwise end due to exhaustion of Family and Medical Leave Act (FMLA), state leave of absence laws or termination of Short Term Disability benefits under the Employer's Short Term Disability Plan.
3. The date coinciding with the end of the last period for which premiums are paid.
4. The date the Policy is terminated.

Amount of Insurance

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

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

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

Extended Death Benefit with Waiver of Premium

Extended Death Benefit

If you become Disabled and are less than age 60, the Life Insurance Benefits shown in the Schedule of Benefits will be extended without premium payment until the earlier of the following dates:

1. The date you are no longer Disabled; or
2. 9 months after the end of your Active Service.

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

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

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

Waiver of Premium
If you submit satisfactory proof that you have been continuously Disabled for 6 months, coverage will be extended up to age 65.

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

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

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

Termination of Waiver
Your insurance will end on the earliest of the following dates.
1. The date you are no longer Disabled;
2. The date you refuse to submit to any physical examination required by us;
3. The date you refuse to participate in a Rehabilitation Plan for which the Insurance Company determines you to be eligible;
4. The last day of the 12-month period of Disability during which you fail to submit satisfactory proof of continued Disability;
5. To Age 65.

"Disability/Disabled" means because of Injury or Sickness you are unable to perform the material duties of your Regular Occupation, or are receiving disability benefits under the Employer's plan, during the initial 6 months of Disability. Thereafter, you must be unable to perform all of the material duties of any occupation which you may reasonably become qualified based on education, training or experience, or are subject to the terms of a Rehabilitation Plan approved by the Insurance Company.

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

Rehabilitation During a Period of Disability

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

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

"Rehabilitation Plan" means a written plan designed to enable the Employee to return to work. The Rehabilitation Plan will consist of one or more of the following phases:

1. Rehabilitation, under which the Insurance Company may provide, arrange or authorize educational, vocational or physical rehabilitation or other appropriate services;
2. Work, which may include modified work and work on a Part-time basis.

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

TL-009745 as modified by TL-009745-1

Portability Options

For Employees

If your coverage under the Policy ends prior to age 70, for any of the following reasons:

a. termination of employment; or
b. termination of membership in an eligible class under the Policy;

Life Insurance Benefits may be continued up to the Maximum Benefit shown in the Schedule of Benefits for this option.

You must apply to the Insurance Company and pay the required premium. If you continue coverage, coverage for your Spouse or Dependent Child may also be continued by you. Your Spouse or Dependent Child must be covered under the Policy on the date coverage would otherwise end. The application must be submitted:

a. within 31 days of your termination of employment or membership in an eligible class under the Policy; or
b. during the time that you have to exercise the Conversion Privilege.

Coverage under this option may not be elected at a later date.

When applying for this option, you must name a beneficiary. Any beneficiary named previously under the Policy is no longer in effect. If there is no named or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives:

a. spouse;
b. child or children;
c. mother or father;
d. brothers or sisters; or
e. the executors or administrators of your estate.

When coverage is continued under this option, you become a Former Employee. Your Spouse becomes a Spouse of a Former Employee. Your Dependent Child becomes a Dependent Child of a Former Employee.

If you, as a Former Employee, later acquire a Spouse or Dependent Child, you may elect coverage for them. You must apply to the Insurance Company and pay the required premium. Coverage for your Spouse or Dependent Child will be effective on the date we agree in writing to insure them. We may require that your Spouse or Dependent Child satisfy the Insurability Requirement before we agree to insure them.

Coverage will end on the earliest of the following dates.
a. The date we cancel coverage for all Former Employees.
b. The end of the period for which premiums are paid.
c. The date an Insured reaches age 70.
d. The date the Maximum Benefit Period shown in the Schedule of Benefits for this option ends.

Also, coverage for any Dependent Child will end on any of the dates listed above or when he or she no longer qualifies as a Dependent Child, if earlier.

For Spouses

If prior to age 70, a Spouse is:
a. legally separated, divorced; or
b. widowed
from an insured Employee or Former Employee, Life Insurance Benefits may be continued. Coverage may be continued up to the Maximum Benefit shown in the Schedule of Benefits for this option. The Spouse must apply to the Insurance Company and pay the required premium.

A Spouse who continues coverage may also continue coverage for a Dependent Child. The Dependent Child must be covered under the Policy on the date coverage would otherwise end. A Spouse must elect to continue insurance under this option within 31 days after coverage ends. Coverage may not be elected at a later date.

When applying for this option, a Spouse must name a beneficiary. Any beneficiary named previously under the Policy is no longer in effect. If there is no named or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives:
a. spouse;
b. child or children;
c. mother or father;
d. brothers or sisters; or
e. the executors or administrators of the Spouse's estate.

When coverage is continued under this option, the Spouse becomes a Former Spouse. A separate certificate of insurance will be issued to the Former Spouse. Coverage will be effective on the date after coverage as a Spouse ends if the required premium is paid.

Coverage will end on the earliest of the following dates.
a. The date we cancel coverage for all Former Spouses.
b. The end of the period for which premiums are paid.
c. The date the Former Spouse reaches age 70.
d. The date the Maximum Benefit Period shown in the Schedule of Benefits for this option ends.

Also, coverage for a Dependent Child will end on any of the dates listed above or when he or she no longer qualifies as a Dependent Child, if earlier.

For Dependent Children

If a Dependent Child is insured under the Policy and is at least 19 years of age, Life Insurance Benefits may be continued under this option. Coverage may be continued up to the Maximum Benefit shown in the Schedule of Benefits for this option.

The Dependent Child must apply to the Insurance Company and pay the required premium. If a Dependent Child does not elect to continue insurance within 31 days after reaching age 19; or the date he or she no longer qualifies as a Dependent Child, if later, coverage under this option may not be elected at a later date.

When applying for this option, a Dependent Child must name a beneficiary. Any beneficiary named previously under the Policy is no longer in effect. If there is no named or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives:

a. spouse;
b. child or children;
c. mother or father;
d. brothers or sisters; or
e. the executors or administrators of the Dependent Child's estate.

When a Dependent Child continues coverage under this option, he or she becomes a Former Dependent Child. A separate certificate of insurance will be issued to the Former Dependent Child. Coverage for a Former Dependent Child will be effective on the following dates.

a. For any Guaranteed Issue Amount, immediately following the date his or her coverage as a Dependent Child ends, provided the Insurance Company receives the required premium.
b. For any amount of insurance that exceeds the Guaranteed Issue Amount, the date the Insurance Company agrees in writing to insure him or her. The Insurance Company will require the Former Dependent Child to satisfy the Insurability Requirement before it agrees to insure him or her.

Coverage will end on the earliest of the following dates.

a. The date we cancel coverage for all Former Dependent Children.
b. The end of the period for which premiums are paid.
c. The date the Former Dependent Child is age 70.
d. The date the Maximum Benefit Period shown in the Schedule of Benefits for this option ends.

TL-004716 as modified by TL-009330

WHAT IS COVERED

LIFE INSURANCE BENEFITS

Death Benefit

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

TL-004730

Accelerated Benefits

Any benefits payable under this and under any similar Accelerated Benefits provision accelerated under a Prior Plan will reduce the Death Benefit payable for Life Insurance. We will deduct from any Death Benefit payable under this Policy, the amount of any similar accelerated benefit paid under a Prior Plan.

Any automatic increases in Life Insurance Benefits will end when benefits are payable under this provision, unless the Insured is determined by the Insurance Company not to be eligible for Accelerated Benefits.

Terminal Illness Benefit

We will pay a Terminal Illness Benefit to an Insured who has incurred a Terminal Illness while insured under this provision.

The Terminal Illness Benefit is shown on the Schedule of Benefits.

A claim for a similar terminal illness benefit under a Prior Plan or group policy intended to replace this Policy shall be deemed payable until such time as it is finally determined not to be payable.

Determination of Terminal Illness

For the purpose of determining the existence of a Terminal Illness, we will require the Insured submit the following proof:

1. A written diagnosis and prognosis by a licensed Physician; and
2. Supportive evidence satisfactory to us, including but not limited to, radiological, histological or laboratory reports documenting the Terminal Illness.

We may require, at our expense, an examination of the Insured and a review of the documented evidence by a Physician of our choice.

Such proofs must be submitted to us within the period of time provided in the *Proof of Loss* section of the Policy. For purposes of this Benefit, the date of loss shall be the date of first prognosis of Terminal Illness.

"Terminal Illness" means that, due to an Injury or Sickness, the Insured has a prognosis of 12 months or less to live without reasonable prospect of recovery, as determined by us.

Payment of Terminal Illness Benefit

The Terminal Illness Benefit will be payable in accordance with the provisions of the *To Whom Payable* section of the Policy.

The Terminal Illness Benefit is payable only once under the Policy in an Insured's lifetime.

Conditions Applicable to Coverage
Unless the Insured qualifies for waiver of premium, premium payments must continue to be paid on the full amount of group life insurance, including during any Continuation of Insurance under the Policy, in accordance with the *Premium* section in the *Administrative Provisions.*

The amount of Life Insurance which may be converted under the *Conversion Privilege* cannot exceed the amount of the reduced death benefit payable under the Policy.

Before a Terminal Illness Benefit is paid in a Community Property state, we may require the written consent of the Insured's Spouse.

Exclusions Applicable to Terminal Illness Benefit
A Terminal Illness Benefit will not be payable:
1. when the Insured has irrevocably assigned group life insurance under this Policy;
2. when all or a portion of group life insurance benefits under this Policy are to be paid to a former spouse as part of a qualified domestic relations order;
3. for any intentionally self-inflicted Injury or Sickness, or suicide attempt;
4. if the Insured's coverage ends under the *When Coverage Ends* provision prior to the prognosis of Terminal Illness;
5. if the required premium is due and unpaid;
6. if this Policy terminates prior to the prognosis of Terminal Illness;
7. if you or the Insured is only provided coverage under the Takeover provision of the Policy (Employees Not in Active Service on the Policy Effective Date); or
8. if the date of first prognosis of Terminal Illness occurs more than 12 months before the submission of the Terminal Illness claim.

TL-004748a

Conversion Privilege for Life Insurance
Each Insured may convert all or any portion of his or her Life Insurance that would end under the Policy due to:
1. termination of employment;
2. termination of membership in an eligible class under the Policy;
3. termination of the Policy.

The Insured may apply for any type of life insurance we offer to persons of the same age in the amount applied for, except you may not:
1. choose term insurance;
2. apply for an amount of insurance greater than the coverage amount terminating under the Policy (also, the conversion policy will not provide accident, disability or other benefits); or
3. apply for more than $10,000 of insurance if the Policy is terminated or amended to terminate the insurance for any class of Insureds, or the Employer cancels participation under the Policy. Conversion in these cases is only permitted if you have been covered by the Policy or, any group life insurance policy issued to the Employer which the Policy replaced, for at least 3 years.

If the Insured becomes eligible for coverage under any group life policy within 62 days of termination of coverage under this Policy, the Insured may not convert an amount of insurance greater than the amount of coverage terminating under the Policy less the amount for which he or she may be covered under the other policy.

To apply for conversion insurance, the Insured must, within 62 days after coverage under the Policy ends:
1. submit an application to us; and
2. pay the required premium.

Evidence of insurability is not required.

Premium for the conversion insurance will be based on the age and class of risk of the Insured and the type and amount of coverage issued.

If the Insured has assigned ownership of his group coverage, the owner/assignee must apply for the individual policy.

Conversion insurance will become effective on the 31st day after the date coverage under the Policy ends provided the application is received by us and the required premium has been paid.

If the Insured dies during the 31-day conversion period, the Life Insurance benefits will be paid under the Policy regardless of whether he or she applied for conversion insurance. If a conversion policy is issued, it will be in exchange for any further benefits for that type and amount of insurance from this Policy.

Extension of Conversion Period
If an Insured is eligible for conversion insurance and is not notified of this right at least 31 days prior to the end of the 62-day conversion period, the conversion period will be extended. The Insured will have 31 days from the date notice is given to apply for conversion insurance. In no event will the conversion period be extended beyond 105 days. Notice, for the purpose of this section, means written notice presented to the Insured by the Employer or mailed to the Insured's last known address as reported by the Employer.

If the Insured dies during the extended conversion period, but more than 31 days after his or her coverage under the Policy terminates, Life Insurance benefits:
1. will not be paid under the Policy; and
2. will be payable under the conversion insurance; provided:
    a. the Insured's application for conversion insurance has been received by us; and
    b. the required premium has been paid.

Prior Conversion Limitation
If an Insured is covered under a life insurance conversion policy previously issued by us, he or she will not be eligible for this Conversion Privilege unless the prior coverage has ended.

TL-009740

LIFE INSURANCE EXCLUSIONS

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

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

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

TL-004752

CLAIM PROVISIONS

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

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

Claim Forms
When we receive notice of claim, we will send claim forms for filing proof of loss. If we do not send claim forms within 15 days after notice is received by us, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof, or proof by any other electronic/telephonic means authorized by us, of the nature and extent of the loss.

Claimant Cooperation Provision
If you fail to cooperate with us in our administration of your claim, we may terminate the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

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

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

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

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

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

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

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

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

To Whom Payable
Death Benefits will be paid to the Insured's named beneficiary, if any, on file at the time of payment or to the certificate owner if alive. If there is no named beneficiary or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives: spouse; child or children; mother or father; brothers or sisters; or to the executors or administrators of the Insured's estate. We may reduce the amount payable by any indebtedness due.

All benefits payable under the Accelerated Benefits section are payable to the Insured, if living. If the Insured dies prior to the payment of an eligible claim for an Accelerated Benefit, benefits will be paid in accordance with the provisions applicable to the payment of Life Insurance proceeds, unless the Insured has directed us otherwise in writing. However, any payment made by us prior to notice of the Insured's death shall discharge us of any benefit that was paid.

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

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

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

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

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

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

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

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

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

TL-004724

ADMINISTRATIVE PROVISIONS

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

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

Your Grace Period
If your required premium is not paid on the Premium Due Date, there is a 60 day grace period after each premium due date after the first. If the required premium is not paid during the grace period, insurance will end on the last day for which premium was paid.

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

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

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

TL-004722

GENERAL PROVISIONS

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

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

Misstatement of Age
If an Insured's age has been misstated, we will adjust all benefits to the amounts that would have been purchased for the correct age.

Workers' Compensation Insurance
The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance Law.

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

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

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

TL-004728

DEFINITIONS

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

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

Active Service
If you are an Employee, you are in Active Service with the Employer on a day which is one of the Employer's scheduled work days if either of the following conditions are met.

1. You are actively at work. This means you are performing your regular occupation for the Employer on a Full-time basis, either at one of the Employer's usual places of business or at some location to which the Employer's business requires you to travel.
2. The day is a scheduled holiday, vacation day or period of Employer approved paid leave of absence, other than disability or sick leave after 7 days.

You are considered in Active Service on a day which is not one of the Employer's scheduled work days only if you were in Active Service on the preceding scheduled work day.

Annual Compensation
Annual Compensation means your annual wage or salary as reported by the Employer for work performed for the Employer as of the date the covered loss occurs. It includes earnings received as bonuses and overtime pay, but not other extra compensation. Annual Compensation is determined initially on the date you apply for coverage. A change in the amount of Annual Compensation is effective on the date of the change, if the Employer gives us written notice of the change and the required premium is paid.

Bonuses and overtime pay will be averaged for the 12 months just prior to the date the covered loss occurs, or the months employed, if less than 12 months.

Dependent Child
An unmarried child who meets the following requirements.

1. A child from live birth but less than 26 years old;
2. A child who is 26 or more years old, primarily supported by you and incapable of self-sustaining employment by reason of mental or physical incapacity.
3. A child stillborn during the third trimester.

The term "child" means:

a. your natural child;
b. your legally adopted child, beginning with any waiting period pending finalization of the child's adoption. It also means the legally adopted child of your Spouse provided the child is living with, and is financially dependent upon you;
c. a stepchild born to your Spouse and who is living with and financially dependent upon you;
d. a child for whom you are the court-appointed legal guardian and who resides with, and is financially dependent upon you.

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

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

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

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

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

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

Insured
You are an Insured if you are eligible for insurance under the Policy, insurance is elected for you, the required premium is paid and your coverage is in force under the Policy.

Life Status Change
A Life Status Change is an event recognized by the Employer's Flexible Benefits Plan as qualifying you to make changes in benefit selections at a time other than an Annual Enrollment Period.

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

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

Policy Anniversary
A Policy Anniversary is the date stated on the policy cover and the same date that follows every 12 months for as long the Policy is in effect.

Policy Effective Date
The Policy Effective Date is the date stated on the policy cover.

Prior Plan
The Prior Plan refers to the plan of insurance providing similar benefits to you, sponsored by the Employer and in effect directly prior to the Policy Effective Date. A Prior Plan will include the plan of an employer in effect on the day prior to that employer's addition to this policy.

To be covered under the Policy, required premium must be paid for all covered Employees.

Sickness
The term Sickness means a physical or mental illness.

Spouse
Your current lawful spouse.

Subscriber
Any participating organization that subscribes to the trust to which this Policy is issued, and which is insured under this Policy.

TL-004708-1 as modified by TL-010150a

STATE MODIFYING PROVISIONS AMENDMENT RIDER

Subscriber: The Reinalt-Thomas Corporation, a Michigan corporation, dba Discount Tire/America's Tire/Discount Tire Direct
Policy No.: FLX-980462
Amendment Effective Date: January 1, 2020

This amendment is attached to and made part of the Policy/Certificate specified above. Its provisions are intended to conform this Policy/Certificate to the laws of the state in which the insured resides.

The Policy delivered under the Group Policy are amended as follows:

APPLICABLE TO CALIFORNIA RESIDENTS:

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

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

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

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

APPLICABLE TO FLORIDA RESIDENTS:

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

APPLICABLE TO MARYLAND RESIDENTS:

The Group Insurance Policy was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

APPLICABLE TO MISSOURI RESIDENTS:

Applicable to Voluntary Life Insurance Benefits

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

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

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

APPLICABLE TO NORTH DAKOTA RESIDENTS:

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

APPLICABLE TO OREGON RESIDENTS:

NOTICE: MUST PROVIDE DOMESTIC PARTNER COVERAGE FOR OREGON RESIDENTS

APPLICABLE TO VERMONT RESIDENTS:

To the extent the Policy provides insurance coverage to a spouse, the identical consideration must be applied to same sex marriages and civil unions. The language is as follows:

1. Civil Union Partner means:
   a. A person with whom the Employee has a registered civil union under Vermont law which imposes obligations on the parties substantially similar to marriage. Such person will continue to be recognized as a Civil Union Partner unless and until:
      (1) the civil union is dissolved under applicable law; or
      (2) either the Employee or the Civil Union Partner marries another person.

2. Spouse means:
   a. "Lawful spouse" and includes a lawful spouse of the same sex.
   b. This also includes a partner to a civil union recognized under Vermont Law.

APPLICABLE TO WASHINGTON RESIDENTS:

1. The following *Continuation of Insurance* provision is added to the Policy:

   Continuation of Life Coverage During Labor Disputes
   If an Employee's Active Service ends because of a Labor Dispute and his or her premium for Life Insurance Benefits under the Policy is paid either by the Employer, in whole or in part, or by the Employee through payroll deductions, then the Employee may continue his or her Life Insurance Benefits. The Employer will send written notice of the right to continue coverage to each insured Employee at his or her most recent address as on file with the Employer.

   To continue coverage, the Employee must pay premiums directly to the Employer, who will remit the premiums to the Insurance Company. Premiums must be paid by the date they are due, subject to the 31 day grace period. Policy coverages and premiums will stay the same during a Labor Dispute; however, the Insurance Company may make normal changes in premium rates when the Policy is renewed, under the terms set forth in the Policy.

   Coverage continued in this manner will end on the earliest of the following dates.
   a. The date the Labor Dispute has ended.
   b. The date coverage has been continued for 6 months.

   If the Labor Dispute continues beyond 6 months, the Employee may apply for an individual insurance policy, as set forth in detail under "Conversion Privilege for Life Insurance."

   "Labor Dispute," as used here, means a strike, lockout, or other labor dispute between the Employer and its Employees, during which time the Employee is not paid by the Employer.

2. If the Policy provides coverage to dependents, benefits for a Spouse or Dependent Child are limited to 100% of the insured Employee's coverage amount. Stand-alone Spouse and Dependent Child coverage (when Employee is not insured) is not permitted.

3. The *Suicide* Exclusion, if any, does not apply.

4. To the extent the policy includes *Accelerated Benefits,* the following resolution of disputes requirements are added to the Policy.

   - For Terminal Illness – *Determination of Terminal Illness*

     In the event the Physician representing the Insurance Company disputes the existence of a Terminal Illness, and the dispute cannot be resolved, the Insured has the right to mediation and binding arbitration in accordance with Washington Administrative Code 284-23-730.

5. The *Incontestability Provision* is replaced as follows:

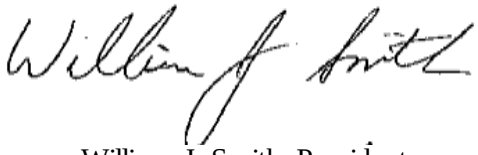
   Incontestability
   All statements made by the Employer or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement has been furnished to the claimant. In the event of death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

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

6. If the term "*Accident*" is defined in the Policy, it is replaced by the following:

Accident
An Accident is a sudden, unforeseeable event that causes bodily Injury to an Insured while coverage is in force under the Policy.

Signed for the
Life Insurance Company of North America



William J. Smith, President

TL-00-3000.00

SUPPLEMENTAL INFORMATION
for

Reinalt-Thomas Corporation Fully Insured Life, AD&D, LTD and STD Welfare Benefit Plan ("Plan")

required by the Employee Retirement Income Security Act of 1974

As a Plan participant in The Reinalt-Thomas Corporation, a Michigan corporation, dba Discount Tire/America's Tire/Discount Tire Direct's Plan, you are entitled to certain information, rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

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

IMPORTANT INFORMATION ABOUT THE PLAN

- The Plan is established and maintained by The Reinalt-Thomas Corporation, a Michigan corporation, dba Discount Tire/America's Tire/Discount Tire Direct, the Plan Sponsor.
- The Employer Identification Number (EIN) is 38-1889682.
- The Plan Number is 526.
- The Insurance Plan is administered directly by the Plan Administrator with benefits provided, in accordance with the provisions of the group insurance contract, FLX-980462 ("Policy"), issued by LIFE INSURANCE COMPANY OF NORTH AMERICA ("Insurance Company").
- The Plan Administrator is: Reinalt-Thomas Corporation
  20225 North Scottsdale Road
  Scottsdale, AZ 85255
  480-606-6000
- The Plan Administrator has authority to control and manage the operation and administration of the Plan.
- The Plan Sponsor may terminate, suspend, withdraw or amend the Plan, in whole or in part, at any time, subject to the applicable provisions of the Policy. (Your rights upon termination or amendment of the Plan are set forth in your Certificate.)
- The agent for service of legal process is the Plan Administrator.
- The Plan of benefits is financed by the Employees.
- The date of the end of the Plan Year is December 31.

YOUR RIGHTS AS SET FORTH BY ERISA

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

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

WHAT YOU SHOULD DO AND EXPECT IF YOU HAVE A CLAIM

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

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

A disability "claim" is any claim which requires a determination of disability by the Insurance Company regardless of the type of policy under which it arises (for example, short/long term disability, waiver of premium, etc.). A disability claim is "filed" as of the date the Insurance Company first receives, in writing (including electronically) or by telephone (through the Insurance Company's intake department), notice that a claimant is seeking disability benefits under the Policy. The notice of claim received should provide the date of disability/loss, the claimant's name and address, and the group Policy holder's name and address. Properly filed claims will be decided with independence and impartiality.

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

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

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

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

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

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

A written request for appeal must be received by the Insurance Company within 180 days from the date the claimant received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived. The Insurance Company has 45 days from the date it receives a request for appeal to provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim and can extend the time for decision, once, by an additional 45 days. If this should happen, the Insurance Company must provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Insurance Company's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Insurance Company receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

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

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

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

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

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

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

A non-disability "claim" is any claim which does not require a determination of disability by the Insurance Company regardless of the type of policy under which it arises (for example, a death claim, an accident claim, etc.). A non-disability claim is "filed" as of the date the Insurance Company first receives, in writing or by telephone (through the Insurance Company's intake department), notice that a claimant is seeking benefits under the Policy. The notice of claim should include the group Policy holder's name, the Policy and Certificate number and the claimant's name and address.

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

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

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

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

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

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

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

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

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

ER-03-2

UNDERWRITTEN BY:
LIFE INSURANCE COMPANY OF NORTH AMERICA
a Cigna company

Class 2
06/2021

Group Life
Insurance Certificate

The Reinalt-Thomas Corporation, a Michigan corporation, dba Discount Tire/America's Tire/Discount Tire Direct

IMPORTANT NOTICES

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

Arizona, Florida and Maryland residents:

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

Washington Residents:

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

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

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

NOTICE

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

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

TL-004788

FOREWORD

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

The need for life insurance protection depends on individual circumstances and financial situations. Your Employer is offering you the opportunity to purchase this insurance to make your benefit program more comprehensive and responsive to your needs.

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

Any insurance benefit described in the following pages will apply to you only if you have elected that benefit and have authorized payroll deduction for the required premium.

LIFE INSURANCE COMPANY OF NORTH AMERICA
1601 CHESTNUT STREET
PHILADELPHIA, PA 19192-2235
(800) 732-1603 TDD (800) 336-2485
A STOCK INSURANCE COMPANY

GROUP INSURANCE
CERTIFICATE

We, the LIFE INSURANCE COMPANY OF NORTH AMERICA, have issued a Group Policy, FLX-980462, to TRUSTEE OF THE GROUP INSURANCE TRUST FOR EMPLOYERS IN THE RETAIL TRADE INDUSTRY on behalf of The Reinalt-Thomas Corporation, a Michigan corporation, dba Discount Tire/America's Tire/Discount Tire Direct.

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

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

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

William J. Smith, President

TL-004704

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SCHEDULE OF BENEFITS

Policy Effective Date: January 1, 2020

Certificate Effective Date: July 1, 2021

Policy Anniversary Date: January 1

Policy Number: FLX-980462

Class Definition

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

All active, Full-time Employees of the Employer classified as Store, Warehouse or Maintenance regularly working the required number of hours to qualify for benefits according to the Employer's company policy, working in the United States who are citizensor permanent resident aliens of the United States excluding temporary and seasonal workers.

Your Eligibility Waiting Period

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

If you were hired on or before the Policy Effective Date:
After 90 days of continuous Active Service

If you were hired after the Policy Effective Date:
After 90 days of continuous Active Service

The *Eligibility Waiting Period* does not apply if you are a former Employee rehired within 12 months after your termination date and you had satisfied the *Eligibility Waiting Period* prior to your termination date. If you did not fully satisfy the *Eligibility Waiting Period* prior to your termination date, credit will be given for any time that was satisfied.

LIFE INSURANCE BENEFITS

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

Employee Benefits

Basic Benefit	1.5 times your Annual Compensation
Guaranteed Issue Amount:	the lesser of 1.5 times Annual Compensation or $50,000
Maximum Benefit:	the lesser of 1.5 times Annual Compensation or $50,000

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

Basic Terminal Illness Benefit	You can elect up to 75% of Basic Life Insurance Benefits in force on the date you are determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $37,500.
Voluntary Benefit	An amount elected in units of $10,000
Guaranteed Issue Amount:	the greater of a) or b) below: a) the lesser of 7 times Annual Compensation or $400,000, or b) an amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan
Maximum Benefit:	$500,000

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

Voluntary Terminal Illness Benefit	You can elect up to 75% of Voluntary Life Insurance Benefits in force on the date you are determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $250,000.
Age Based Reductions	When you are age 65 or older, your Life Insurance Benefit will reduce to the percentage shown below: 65% of the Life Insurance Benefit at age 65 40% of the Life Insurance Benefit at age 70 25% of the Life Insurance Benefit at age 75

Benefit reductions will be effective on your attainment of age as specified in schedule above.

Automatic Increase Feature for Life Insurance

An increase in your Life Insurance resulting from an increase in Annual Compensation will not be subject to the Insurability Requirement, even if the increase causes the Life Insurance to exceed the Guaranteed Issue Amount.

If you are not in Active Service on the date the increase would go into effect, your benefit will not increase until you return to Active Service.

Premiums must be paid on the basis of any increased amount of Life Insurance resulting from increases in Annual Compensation.

Spouse Benefits

Voluntary Benefit	An amount elected in units of $5,000
Guaranteed Issue Amount:	the greater of a) or b) below: a) $30,000, or b) an amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan
Maximum Benefit:	$100,000

Your Spouse's Life Insurance Benefits cannot exceed 50% of your Life Insurance Benefits.

Age Based Reductions	When you are age 65 or older, your Spouse's Life Insurance Benefit will reduce to the percentage shown below: 65% of the Life Insurance Benefit at age 65 40% of the Life Insurance Benefit at age 70 25% of the Life Insurance Benefit at age 75

Benefit reductions will be effective on your attainment of age as specified in schedule above.

Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Dependent Child Benefits

Voluntary Benefit	An amount elected in units of $5,000
Maximum Benefit:	$10,000 The Maximum Benefit for a Dependent Child who is less than 6 months old is $5,000.

All Dependent Child benefits are Guaranteed Issue.

Annual Enrollment Period

For Employees
During an Annual Enrollment Period, if you are currently insured under the Voluntary Life Insurance portion of this Policy, you may increase your Voluntary Life Insurance Benefit, or if you are eligible for the Voluntary Life Insurance portion of this Policy but have not previously enrolled, you may become insured under the Policy, as long as the total Benefit does not exceed the Maximum Benefit by satisfying the Insurability Requirement. Insurance will be effective on the later of January 1st following the Annual Enrollment Period or the date the Insurance Company agrees in writing to insure you.

For Spouses
During an Annual Enrollment Period, if you are an eligible Employee, you may elect coverage for your eligible Spouse. If your Spouse is currently insured under the Voluntary Life Insurance portion of this Policy, his or her Voluntary Life Insurance Benefit may be increased, or if your Spouse is eligible for the Voluntary Life Insurance portion of this Policy but has not previously enrolled, he or she may become insured under the Policy, as long as the total Benefit does not exceed the Maximum Benefit, by satisfying the Insurability Requirement. Insurance will be effective on the later of January 1st following the Annual Enrollment Period or the date the Insurance Company agrees in writing to insure him or her.

Insurance Benefits for you, your Spouse and Dependent Children may be reduced at any time. A request for a Benefit reduction received during an Annual Enrollment Period will become effective on January 1st following the Annual Enrollment Period. Any other Benefit reduction will be effective on the date the Insurance Company receives the completed change form.

TL-008025-1

Life Status Change

For Employees
Within 31 days after a Life Status Change, if you are currently insured under the Voluntary Life Insurance portion of this Policy, you may increase your Voluntary Life Insurance Benefit, or if you are eligible for the Voluntary Life Insurance portion of this Policy but have not previously enrolled, you may become insured under the Policy, as long as the total Benefit does not exceed the Maximum Benefit by satisfying the Insurability Requirement. Insurance will be effective on the later of the first of the month following the Life Status Change or the date the Insurance Company agrees in writing to insure you.

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

TL-008030-1

Former Employee Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Life Insurance Benefits allowable to you, less any amount of conversion insurance issued under the Conversion Privilege for Life Insurance. Any amount elected in excess of the Life Insurance Benefits in effect on the date you no longer qualify as an Employee will be effective on the date the Insurance Company agrees in writing to insure you. The Maximum Benefit for Basic Life Insurance Benefits is $50,000.
Maximum Benefit Period	To Age 70
Terminal Illness Benefit	You can elect up to 75% of Life Insurance Benefits in force on the date you are determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $287,500.

Spouse of Former Employee Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Voluntary Life Insurance Benefits available to a Spouse. Any amount elected in excess of the Voluntary Life Insurance Benefits in effect on the date your employment with the Employer ends will be effective on the date we agree in writing to insure him or her.
Maximum Benefit Period	To Age 70
Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Former Spouse Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Voluntary Life Insurance Benefits available to a Spouse. Any amount elected in excess of the Voluntary Life Insurance Benefits in effect on the date he or she no longer qualifies as a Spouse will be effective on the date we agree in writing to insure him or her.
Maximum Benefit Period	To Age 70
Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Former Dependent Child Benefits

Amount of Insurance	Units of $25,000
Guaranteed Issue Amount:	$25,000
Maximum Benefit:	$50,000
Maximum Benefit Period	To Age 70

TL-004774

WHO IS ELIGIBLE

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

An Employee who is the Spouse of another Employee may not be insured for Voluntary Life Insurance as both an Employee and as a Spouse at the same time.

Any Employee, who is eligible for Voluntary Life Insurance, will not be eligible to be insured as a Dependent Child of another Employee.

If an Employee is eligible and has enrolled as the Spouse of another Employee, but ceases to be eligible to maintain the amount of insurance for which he or she has enrolled as a Spouse, that Employee may, within 31 days, enroll for coverage as an Employee, in an amount equal to the lesser of (1) the amount of Spouse Voluntary Life Insurance terminating, or (2) the maximum amount of Employee Voluntary Life Insurance for which the Employee is eligible. The Insurability Requirement does not apply. If this amount is not equal to a Voluntary Life Insurance coverage option, it will be adjusted to the next higher available Voluntary Life Insurance coverage option. This provision shall be in lieu of the Policy's provisions, if any, regarding coverage changes following Life Status Changes.

If a Spouse is eligible and has enrolled for Voluntary Life Insurance as an Employee, but ceases to be eligible to maintain the amount of insurance for which he or she has enrolled as an Employee, the Spouse may, within 31 days, instead become enrolled as a Spouse of another Employee, in an amount equal to the lesser of (1) the amount of Employee Voluntary Life Insurance terminating, or (2) the Maximum Benefit Amount of Spouse Voluntary Life Insurance for which the Spouse is eligible. The Insurability Requirement does not apply. If this amount is not equal to a Voluntary Life Insurance coverage option, it will be adjusted to the next higher available Voluntary Life Insurance coverage option.

A Dependent Child of two or more Employees may only be insured once under the Policy. If an Employee who has elected to insure Dependent Children ceases to be eligible to do so, then the Employee's Spouse may, within 31 days, elect to insure Dependent Children, provided he or she is insured as an Employee. In all cases, "Dependent Child" shall be defined with respect to the Employee who has enrolled dependent children.

In all cases, amounts of insurance referred to in these provisions shall be determined before the application of any reductions in benefits due to age.

Any amount of Voluntary Life Insurance Coverage which cannot be continued under the above provisions may be subject to the Conversion Privilege.

Employee
If you qualify under the Class Definition shown in the Schedule of Benefits, you are eligible to be insured on the Policy Effective Date or the day after you complete the Eligibility Waiting Period, if later. The Eligibility Waiting Period will not apply if you are in Active Service on the Policy Effective Date and you satisfied the Eligibility Waiting Period, if any, of the Prior Plan. Credit will be given for any time you satisfied.

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

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

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

For eligibility purposes, your Spouse must be a lawful Spouse and not legally separated from, divorced from, or widowed by you.

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

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

TL-004710-1

WHEN COVERAGE BEGINS

If you are required to contribute to the cost of this insurance, you may elect insurance for yourself, your Spouse and Dependent Children only by authorizing payroll deduction in a form approved by the Employer and us. The effective date of this insurance depends on the date and amount of insurance elected.

If you elect coverage within 31 days after you become eligible to enroll or increase coverage, the Guaranteed Issue Amount will be effective on the latest of the following dates:
1. The Policy Effective Date.
2. The date you authorize payroll deduction for this insurance.
3. The date the Employer or Insurance Company receives the completed enrollment form.

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

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

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

If an eligible Spouse or Dependent Child is:

1. an inpatient in a hospital, hospice, rehabilitation or convalescence center, or custodial care facility; or
2. confined to his or her home under the care of a Physician

on the date insurance would otherwise be effective, it will be effective on the date he or she is no longer an inpatient in these facilities or confined at home. If such Spouse or Dependent Child was covered by the Prior Plan immediately prior to the Policy Effective Date, this provision will not apply to the amount of coverage in effect as of the Policy Effective Date, but will apply to any increase in coverage. This does not apply to a Dependent Child who is age 6 months or less.

TL-004712

Takeover Provision

Special Terms Applicable to Previously Insured Employees Not in Active Service and Their Dependents

Coverage will not go into effect for you, or your Spouse and Dependent Children unless you are in Active Service on the date you would have first become eligible to be insured under this Policy.

However:

1. if you, and your Spouse or Dependent Children were insured under a Prior Plan on the date immediately prior to the date you would have first become eligible to be insured under this Policy and had satisfied the Active Service requirement, and
2. if you, your Spouse or Dependent Child die, we agree to provide a Death Benefit only equal to the lesser of:

a. the amount due under this Policy (had you satisfied the Active Service requirement), or
b. the amount that would have been due under the Prior Plan had it remained in force.

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

These special terms will end on the earliest of the following dates:

1. the date you meet the Active Service requirements;
2. the date insurance terminates for one of the reasons stated in the Termination of Insurance provision;
3. 12 months after the date you first become eligible under this Policy; or
4. the last day you, your Spouse or Dependent Children would have been covered under the Prior Plan if coverage under that plan for you, your Spouse or Dependent Children was still in force.

TL-009020-1

WHEN COVERAGE ENDS

Coverage will end on the earliest of the following dates:

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

TL-004714-1

WHEN COVERAGE CONTINUES

Continuation for Temporary Leave of Absence, Layoff, Leave for Military Service or Family Medical Leave

If you are an Employee and your Active Service ends due to an Employer approved unpaid leave of absence, layoff, leave for military service or family medical leave, your insurance will continue if the required premium is paid.

In these circumstances, your insurance may continue as follows.

1. For an Employer approved unpaid leave of absence, up to 18 months following the date coverage would otherwise end due to exhaustion of Family and Medical Leave Act (FMLA), state leave of absence laws, or termination of Short Term Disability benefits under the Employer's Short Term Disability Plan.
2. For layoff, up to 3 months.
3. For leave for military service, up to 24 months.
4. For an Employer approved family medical leave, up to the later of the period of the approved FMLA leave or the leave period required by the laws of the state in which the Employee is employed.

Continuation for Disability

If you become Disabled, the Life Insurance Benefits shown in the Schedule of Benefits will be continued, provided premiums are paid, until the earlier of the following dates:

1. The date you are no longer Disabled.
2. The date you are Disabled for up to 18 months following the date coverage would otherwise end due to exhaustion of Family and Medical Leave Act (FMLA), state leave of absence laws or termination of Short Term Disability benefits under the Employer's Short Term Disability Plan.
3. The date coinciding with the end of the last period for which premiums are paid.
4. The date the Policy is terminated.

Amount of Insurance

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

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

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

Extended Death Benefit with Waiver of Premium

Extended Death Benefit

If you become Disabled and are less than age 60, the Life Insurance Benefits shown in the Schedule of Benefits will be extended without premium payment until the earlier of the following dates:

1. The date you are no longer Disabled; or
2. 9 months after the end of your Active Service.

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

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

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

Waiver of Premium
If you submit satisfactory proof that you have been continuously Disabled for 6 months, coverage will be extended up to age 65.

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

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

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

Termination of Waiver
Your insurance will end on the earliest of the following dates.
1. The date you are no longer Disabled;
2. The date you refuse to submit to any physical examination required by us;
3. The date you refuse to participate in a Rehabilitation Plan for which the Insurance Company determines you to be eligible;
4. The last day of the 12-month period of Disability during which you fail to submit satisfactory proof of continued Disability;
5. To Age 65.

"Disability/Disabled" means because of Injury or Sickness you are unable to perform the material duties of your Regular Occupation, or are receiving disability benefits under the Employer's plan, during the initial 6 months of Disability. Thereafter, you must be unable to perform all of the material duties of any occupation which you may reasonably become qualified based on education, training or experience, or are subject to the terms of a Rehabilitation Plan approved by the Insurance Company.

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

Rehabilitation During a Period of Disability

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

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

"Rehabilitation Plan" means a written plan designed to enable the Employee to return to work. The Rehabilitation Plan will consist of one or more of the following phases:

1. Rehabilitation, under which the Insurance Company may provide, arrange or authorize educational, vocational or physical rehabilitation or other appropriate services;
2. Work, which may include modified work and work on a Part-time basis.

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

TL-009745 as modified by TL-009745-1

Portability Options

For Employees

If your coverage under the Policy ends prior to age 70, for any of the following reasons:

a. termination of employment; or
b. termination of membership in an eligible class under the Policy;

Life Insurance Benefits may be continued up to the Maximum Benefit shown in the Schedule of Benefits for this option.

You must apply to the Insurance Company and pay the required premium. If you continue coverage, coverage for your Spouse or Dependent Child may also be continued by you. Your Spouse or Dependent Child must be covered under the Policy on the date coverage would otherwise end. The application must be submitted:

a. within 31 days of your termination of employment or membership in an eligible class under the Policy; or
b. during the time that you have to exercise the Conversion Privilege.

Coverage under this option may not be elected at a later date.

When applying for this option, you must name a beneficiary. Any beneficiary named previously under the Policy is no longer in effect. If there is no named or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives:

a. spouse;
b. child or children;
c. mother or father;
d. brothers or sisters; or
e. the executors or administrators of your estate.

When coverage is continued under this option, you become a Former Employee. Your Spouse becomes a Spouse of a Former Employee. Your Dependent Child becomes a Dependent Child of a Former Employee.

If you, as a Former Employee, later acquire a Spouse or Dependent Child, you may elect coverage for them. You must apply to the Insurance Company and pay the required premium. Coverage for your Spouse or Dependent Child will be effective on the date we agree in writing to insure them. We may require that your Spouse or Dependent Child satisfy the Insurability Requirement before we agree to insure them.

Coverage will end on the earliest of the following dates.
a. The date we cancel coverage for all Former Employees.
b. The end of the period for which premiums are paid.
c. The date an Insured reaches age 70.
d. The date the Maximum Benefit Period shown in the Schedule of Benefits for this option ends.

Also, coverage for any Dependent Child will end on any of the dates listed above or when he or she no longer qualifies as a Dependent Child, if earlier.

For Spouses

If prior to age 70, a Spouse is:
a. legally separated, divorced; or
b. widowed
from an insured Employee or Former Employee, Life Insurance Benefits may be continued. Coverage may be continued up to the Maximum Benefit shown in the Schedule of Benefits for this option. The Spouse must apply to the Insurance Company and pay the required premium.

A Spouse who continues coverage may also continue coverage for a Dependent Child. The Dependent Child must be covered under the Policy on the date coverage would otherwise end. A Spouse must elect to continue insurance under this option within 31 days after coverage ends. Coverage may not be elected at a later date.

When applying for this option, a Spouse must name a beneficiary. Any beneficiary named previously under the Policy is no longer in effect. If there is no named or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives:
a. spouse;
b. child or children;
c. mother or father;
d. brothers or sisters; or
e. the executors or administrators of the Spouse's estate.

When coverage is continued under this option, the Spouse becomes a Former Spouse. A separate certificate of insurance will be issued to the Former Spouse. Coverage will be effective on the date after coverage as a Spouse ends if the required premium is paid.

Coverage will end on the earliest of the following dates.
a. The date we cancel coverage for all Former Spouses.
b. The end of the period for which premiums are paid.
c. The date the Former Spouse reaches age 70.
d. The date the Maximum Benefit Period shown in the Schedule of Benefits for this option ends.

Also, coverage for a Dependent Child will end on any of the dates listed above or when he or she no longer qualifies as a Dependent Child, if earlier.

For Dependent Children

If a Dependent Child is insured under the Policy and is at least 19 years of age, Life Insurance Benefits may be continued under this option. Coverage may be continued up to the Maximum Benefit shown in the Schedule of Benefits for this option.

The Dependent Child must apply to the Insurance Company and pay the required premium. If a Dependent Child does not elect to continue insurance within 31 days after reaching age 19; or the date he or she no longer qualifies as a Dependent Child, if later, coverage under this option may not be elected at a later date.

When applying for this option, a Dependent Child must name a beneficiary. Any beneficiary named previously under the Policy is no longer in effect. If there is no named or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives:

a. spouse;
b. child or children;
c. mother or father;
d. brothers or sisters; or
e. the executors or administrators of the Dependent Child's estate.

When a Dependent Child continues coverage under this option, he or she becomes a Former Dependent Child. A separate certificate of insurance will be issued to the Former Dependent Child. Coverage for a Former Dependent Child will be effective on the following dates.

a. For any Guaranteed Issue Amount, immediately following the date his or her coverage as a Dependent Child ends, provided the Insurance Company receives the required premium.
b. For any amount of insurance that exceeds the Guaranteed Issue Amount, the date the Insurance Company agrees in writing to insure him or her. The Insurance Company will require the Former Dependent Child to satisfy the Insurability Requirement before it agrees to insure him or her.

Coverage will end on the earliest of the following dates.

a. The date we cancel coverage for all Former Dependent Children.
b. The end of the period for which premiums are paid.
c. The date the Former Dependent Child is age 70.
d. The date the Maximum Benefit Period shown in the Schedule of Benefits for this option ends.

TL-004716 as modified by TL-009330

WHAT IS COVERED

LIFE INSURANCE BENEFITS

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

TL-004730

Accelerated Benefits
Any benefits payable under this and under any similar Accelerated Benefits provision accelerated under a Prior Plan will reduce the Death Benefit payable for Life Insurance. We will deduct from any Death Benefit payable under this Policy, the amount of any similar accelerated benefit paid under a Prior Plan.

Any automatic increases in Life Insurance Benefits will end when benefits are payable under this provision, unless the Insured is determined by the Insurance Company not to be eligible for Accelerated Benefits.

Terminal Illness Benefit
We will pay a Terminal Illness Benefit to an Insured who has incurred a Terminal Illness while insured under this provision.

The Terminal Illness Benefit is shown on the Schedule of Benefits.

A claim for a similar terminal illness benefit under a Prior Plan or group policy intended to replace this Policy shall be deemed payable until such time as it is finally determined not to be payable.

Determination of Terminal Illness
For the purpose of determining the existence of a Terminal Illness, we will require the Insured submit the following proof:
1. A written diagnosis and prognosis by a licensed Physician; and
2. Supportive evidence satisfactory to us, including but not limited to, radiological, histological or laboratory reports documenting the Terminal Illness.

We may require, at our expense, an examination of the Insured and a review of the documented evidence by a Physician of our choice.

Such proofs must be submitted to us within the period of time provided in the *Proof of Loss* section of the Policy. For purposes of this Benefit, the date of loss shall be the date of first prognosis of Terminal Illness.

"Terminal Illness" means that, due to an Injury or Sickness, the Insured has a prognosis of 12 months or less to live without reasonable prospect of recovery, as determined by us.

Payment of Terminal Illness Benefit
The Terminal Illness Benefit will be payable in accordance with the provisions of the *To Whom Payable* section of the Policy.

The Terminal Illness Benefit is payable only once under the Policy in an Insured's lifetime.

Conditions Applicable to Coverage
Unless the Insured qualifies for waiver of premium, premium payments must continue to be paid on the full amount of group life insurance, including during any Continuation of Insurance under the Policy, in accordance with the *Premium* section in the *Administrative Provisions.*

The amount of Life Insurance which may be converted under the *Conversion Privilege* cannot exceed the amount of the reduced death benefit payable under the Policy.

Before a Terminal Illness Benefit is paid in a Community Property state, we may require the written consent of the Insured's Spouse.

Exclusions Applicable to Terminal Illness Benefit
A Terminal Illness Benefit will not be payable:
1. when the Insured has irrevocably assigned group life insurance under this Policy;
2. when all or a portion of group life insurance benefits under this Policy are to be paid to a former spouse as part of a qualified domestic relations order;
3. for any intentionally self-inflicted Injury or Sickness, or suicide attempt;
4. if the Insured's coverage ends under the *When Coverage Ends* provision prior to the prognosis of Terminal Illness;
5. if the required premium is due and unpaid;
6. if this Policy terminates prior to the prognosis of Terminal Illness;
7. if you or the Insured is only provided coverage under the Takeover provision of the Policy (Employees Not in Active Service on the Policy Effective Date); or
8. if the date of first prognosis of Terminal Illness occurs more than 12 months before the submission of the Terminal Illness claim.

TL-004748a

Conversion Privilege for Life Insurance
Each Insured may convert all or any portion of his or her Life Insurance that would end under the Policy due to:
1. termination of employment;
2. termination of membership in an eligible class under the Policy;
3. termination of the Policy.

The Insured may apply for any type of life insurance we offer to persons of the same age in the amount applied for, except you may not:
1. choose term insurance;
2. apply for an amount of insurance greater than the coverage amount terminating under the Policy (also, the conversion policy will not provide accident, disability or other benefits); or
3. apply for more than $10,000 of insurance if the Policy is terminated or amended to terminate the insurance for any class of Insureds, or the Employer cancels participation under the Policy. Conversion in these cases is only permitted if you have been covered by the Policy or, any group life insurance policy issued to the Employer which the Policy replaced, for at least 3 years.

If the Insured becomes eligible for coverage under any group life policy within 62 days of termination of coverage under this Policy, the Insured may not convert an amount of insurance greater than the amount of coverage terminating under the Policy less the amount for which he or she may be covered under the other policy.

To apply for conversion insurance, the Insured must, within 62 days after coverage under the Policy ends:
1. submit an application to us; and
2. pay the required premium.

Evidence of insurability is not required.

Premium for the conversion insurance will be based on the age and class of risk of the Insured and the type and amount of coverage issued.

If the Insured has assigned ownership of his group coverage, the owner/assignee must apply for the individual policy.

Conversion insurance will become effective on the 31st day after the date coverage under the Policy ends provided the application is received by us and the required premium has been paid.

If the Insured dies during the 31-day conversion period, the Life Insurance benefits will be paid under the Policy regardless of whether he or she applied for conversion insurance. If a conversion policy is issued, it will be in exchange for any further benefits for that type and amount of insurance from this Policy.

Extension of Conversion Period
If an Insured is eligible for conversion insurance and is not notified of this right at least 31 days prior to the end of the 62-day conversion period, the conversion period will be extended. The Insured will have 31 days from the date notice is given to apply for conversion insurance. In no event will the conversion period be extended beyond 105 days. Notice, for the purpose of this section, means written notice presented to the Insured by the Employer or mailed to the Insured's last known address as reported by the Employer.

If the Insured dies during the extended conversion period, but more than 31 days after his or her coverage under the Policy terminates, Life Insurance benefits:
1. will not be paid under the Policy; and
2. will be payable under the conversion insurance; provided:
    a. the Insured's application for conversion insurance has been received by us; and
    b. the required premium has been paid.

Prior Conversion Limitation
If an Insured is covered under a life insurance conversion policy previously issued by us, he or she will not be eligible for this Conversion Privilege unless the prior coverage has ended.

TL-009740

LIFE INSURANCE EXCLUSIONS

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

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

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

TL-004752

CLAIM PROVISIONS

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

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

Claim Forms
When we receive notice of claim, we will send claim forms for filing proof of loss. If we do not send claim forms within 15 days after notice is received by us, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof, or proof by any other electronic/telephonic means authorized by us, of the nature and extent of the loss.

Claimant Cooperation Provision
If you fail to cooperate with us in our administration of your claim, we may terminate the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

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

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

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

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

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

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

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

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

To Whom Payable
Death Benefits will be paid to the Insured's named beneficiary, if any, on file at the time of payment or to the certificate owner if alive. If there is no named beneficiary or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives: spouse; child or children; mother or father; brothers or sisters; or to the executors or administrators of the Insured's estate. We may reduce the amount payable by any indebtedness due.

All benefits payable under the Accelerated Benefits section are payable to the Insured, if living. If the Insured dies prior to the payment of an eligible claim for an Accelerated Benefit, benefits will be paid in accordance with the provisions applicable to the payment of Life Insurance proceeds, unless the Insured has directed us otherwise in writing. However, any payment made by us prior to notice of the Insured's death shall discharge us of any benefit that was paid.

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

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

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

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

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

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

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

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

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

TL-004724

ADMINISTRATIVE PROVISIONS

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

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

Your Grace Period
If your required premium is not paid on the Premium Due Date, there is a 60 day grace period after each premium due date after the first. If the required premium is not paid during the grace period, insurance will end on the last day for which premium was paid.

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

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

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

TL-004722

GENERAL PROVISIONS

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

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

Misstatement of Age
If an Insured's age has been misstated, we will adjust all benefits to the amounts that would have been purchased for the correct age.

Workers' Compensation Insurance
The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance Law.

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

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

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

TL-004728

DEFINITIONS

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

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

Active Service
If you are an Employee, you are in Active Service with the Employer on a day which is one of the Employer's scheduled work days if either of the following conditions are met.

1. You are actively at work. This means you are performing your regular occupation for the Employer on a Full-time basis, either at one of the Employer's usual places of business or at some location to which the Employer's business requires you to travel.
2. The day is a scheduled holiday, vacation day or period of Employer approved paid leave of absence, other than disability or sick leave after 7 days.

You are considered in Active Service on a day which is not one of the Employer's scheduled work days only if you were in Active Service on the preceding scheduled work day.

Annual Compensation
Annual Compensation means your annual wage or salary as reported by the Employer for work performed for the Employer as of the date the covered loss occurs. It includes earnings received as overtime pay, but not bonuses or other extra compensation. Annual Compensation is determined initially on the date you apply for coverage. A change in the amount of Annual Compensation is effective on the date of the change, if the Employer gives us written notice of the change and the required premium is paid.

Overtime pay will be averaged for the 12 months just prior to the date the covered loss occurs, or the months employed, if less than 12 months.

Dependent Child
An unmarried child who meets the following requirements.

1. A child from live birth but less than 26 years old;
2. A child who is 26 or more years old, primarily supported by you and incapable of self-sustaining employment by reason of mental or physical incapacity.
3. A child stillborn during the third trimester.

The term "child" means:

a. your natural child;
b. your legally adopted child, beginning with any waiting period pending finalization of the child's adoption. It also means the legally adopted child of your Spouse provided the child is living with, and is financially dependent upon you;
c. a stepchild born to your Spouse and who is living with and financially dependent upon you;
d. a child for whom you are the court-appointed legal guardian and who resides with, and is financially dependent upon you.

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

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

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

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

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

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

Insured
You are an Insured if you are eligible for insurance under the Policy, insurance is elected for you, the required premium is paid and your coverage is in force under the Policy.

Life Status Change
A Life Status Change is an event recognized by the Employer's Flexible Benefits Plan as qualifying you to make changes in benefit selections at a time other than an Annual Enrollment Period.

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

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

Policy Anniversary
A Policy Anniversary is the date stated on the policy cover and the same date that follows every 12 months for as long the Policy is in effect.

Policy Effective Date
The Policy Effective Date is the date stated on the policy cover.

Prior Plan
The Prior Plan refers to the plan of insurance providing similar benefits to you, sponsored by the Employer and in effect directly prior to the Policy Effective Date. A Prior Plan will include the plan of an employer in effect on the day prior to that employer's addition to this policy.

To be covered under the Policy, required premium must be paid for all covered Employees.

Sickness
The term Sickness means a physical or mental illness.

Spouse
Your current lawful spouse.

Subscriber
Any participating organization that subscribes to the trust to which this Policy is issued, and which is insured under this Policy.

TL-004708-1 as modified by TL-010150a

STATE MODIFYING PROVISIONS AMENDMENT RIDER

Subscriber: The Reinalt-Thomas Corporation, a Michigan corporation, dba Discount Tire/America's Tire/Discount Tire Direct
Policy No.: FLX-980462
Amendment Effective Date: January 1, 2020

This amendment is attached to and made part of the Policy/Certificate specified above. Its provisions are intended to conform this Policy/Certificate to the laws of the state in which the insured resides.

The Policy delivered under the Group Policy are amended as follows:

APPLICABLE TO CALIFORNIA RESIDENTS:

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

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

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

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

APPLICABLE TO FLORIDA RESIDENTS:

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

APPLICABLE TO MARYLAND RESIDENTS:

The Group Insurance Policy was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

APPLICABLE TO MISSOURI RESIDENTS:

Applicable to Voluntary Life Insurance Benefits

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

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

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

APPLICABLE TO NORTH DAKOTA RESIDENTS:

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

APPLICABLE TO OREGON RESIDENTS:

NOTICE: MUST PROVIDE DOMESTIC PARTNER COVERAGE FOR OREGON RESIDENTS

APPLICABLE TO VERMONT RESIDENTS:

To the extent the Policy provides insurance coverage to a spouse, the identical consideration must be applied to same sex marriages and civil unions. The language is as follows:

1. Civil Union Partner means:
   a. A person with whom the Employee has a registered civil union under Vermont law which imposes obligations on the parties substantially similar to marriage. Such person will continue to be recognized as a Civil Union Partner unless and until:
      (1) the civil union is dissolved under applicable law; or
      (2) either the Employee or the Civil Union Partner marries another person.

2. Spouse means:
   a. "Lawful spouse" and includes a lawful spouse of the same sex.
   b. This also includes a partner to a civil union recognized under Vermont Law.

APPLICABLE TO WASHINGTON RESIDENTS:

1. The following *Continuation of Insurance* provision is added to the Policy:

   Continuation of Life Coverage During Labor Disputes
   If an Employee's Active Service ends because of a Labor Dispute and his or her premium for Life Insurance Benefits under the Policy is paid either by the Employer, in whole or in part, or by the Employee through payroll deductions, then the Employee may continue his or her Life Insurance Benefits. The Employer will send written notice of the right to continue coverage to each insured Employee at his or her most recent address as on file with the Employer.

   To continue coverage, the Employee must pay premiums directly to the Employer, who will remit the premiums to the Insurance Company. Premiums must be paid by the date they are due, subject to the 31 day grace period. Policy coverages and premiums will stay the same during a Labor Dispute; however, the Insurance Company may make normal changes in premium rates when the Policy is renewed, under the terms set forth in the Policy.

   Coverage continued in this manner will end on the earliest of the following dates.
   a. The date the Labor Dispute has ended.
   b. The date coverage has been continued for 6 months.

   If the Labor Dispute continues beyond 6 months, the Employee may apply for an individual insurance policy, as set forth in detail under "Conversion Privilege for Life Insurance."

   "Labor Dispute," as used here, means a strike, lockout, or other labor dispute between the Employer and its Employees, during which time the Employee is not paid by the Employer.

2. If the Policy provides coverage to dependents, benefits for a Spouse or Dependent Child are limited to 100% of the insured Employee's coverage amount. Stand-alone Spouse and Dependent Child coverage (when Employee is not insured) is not permitted.

3. The *Suicide* Exclusion, if any, does not apply.

4. To the extent the policy includes *Accelerated Benefits,* the following resolution of disputes requirements are added to the Policy.

   - For Terminal Illness – *Determination of Terminal Illness*

     In the event the Physician representing the Insurance Company disputes the existence of a Terminal Illness, and the dispute cannot be resolved, the Insured has the right to mediation and binding arbitration in accordance with Washington Administrative Code 284-23-730.

5. The *Incontestability Provision* is replaced as follows:

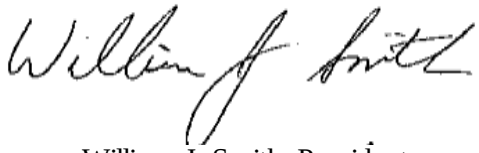
   Incontestability
   All statements made by the Employer or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement has been furnished to the claimant. In the event of death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

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

6. If the term "*Accident*" is defined in the Policy, it is replaced by the following:

Accident
An Accident is a sudden, unforeseeable event that causes bodily Injury to an Insured while coverage is in force under the Policy.

Signed for the
Life Insurance Company of North America



William J. Smith, President

TL-00-3000.00

SUPPLEMENTAL INFORMATION
for

Reinalt-Thomas Corporation Fully Insured Life, AD&D, LTD and STD Welfare Benefit Plan ("Plan")

required by the Employee Retirement Income Security Act of 1974

As a Plan participant in The Reinalt-Thomas Corporation, a Michigan corporation, dba Discount Tire/America's Tire/Discount Tire Direct's Plan, you are entitled to certain information, rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

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

IMPORTANT INFORMATION ABOUT THE PLAN

- The Plan is established and maintained by The Reinalt-Thomas Corporation, a Michigan corporation, dba Discount Tire/America's Tire/Discount Tire Direct, the Plan Sponsor.
- The Employer Identification Number (EIN) is 38-1889682.
- The Plan Number is 526.
- The Insurance Plan is administered directly by the Plan Administrator with benefits provided, in accordance with the provisions of the group insurance contract, FLX-980462 ("Policy"), issued by LIFE INSURANCE COMPANY OF NORTH AMERICA ("Insurance Company").
- The Plan Administrator is: Reinalt-Thomas Corporation
  20225 North Scottsdale Road
  Scottsdale, AZ 85255
  480-606-6000
- The Plan Administrator has authority to control and manage the operation and administration of the Plan.
- The Plan Sponsor may terminate, suspend, withdraw or amend the Plan, in whole or in part, at any time, subject to the applicable provisions of the Policy. (Your rights upon termination or amendment of the Plan are set forth in your Certificate.)
- The agent for service of legal process is the Plan Administrator.
- The Plan of benefits is financed by the Employees.
- The date of the end of the Plan Year is December 31.

YOUR RIGHTS AS SET FORTH BY ERISA

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

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

WHAT YOU SHOULD DO AND EXPECT IF YOU HAVE A CLAIM

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

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

A disability "claim" is any claim which requires a determination of disability by the Insurance Company regardless of the type of policy under which it arises (for example, short/long term disability, waiver of premium, etc.). A disability claim is "filed" as of the date the Insurance Company first receives, in writing (including electronically) or by telephone (through the Insurance Company's intake department), notice that a claimant is seeking disability benefits under the Policy. The notice of claim received should provide the date of disability/loss, the claimant's name and address, and the group Policy holder's name and address. Properly filed claims will be decided with independence and impartiality.

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

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

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

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

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

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

A written request for appeal must be received by the Insurance Company within 180 days from the date the claimant received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived. The Insurance Company has 45 days from the date it receives a request for appeal to provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim and can extend the time for decision, once, by an additional 45 days. If this should happen, the Insurance Company must provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Insurance Company's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Insurance Company receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

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

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

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

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

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

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

A non-disability "claim" is any claim which does not require a determination of disability by the Insurance Company regardless of the type of policy under which it arises (for example, a death claim, an accident claim, etc.). A non-disability claim is "filed" as of the date the Insurance Company first receives, in writing or by telephone (through the Insurance Company's intake department), notice that a claimant is seeking benefits under the Policy. The notice of claim should include the group Policy holder's name, the Policy and Certificate number and the claimant's name and address.

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

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

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

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

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

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

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

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

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

ER-03-2

UNDERWRITTEN BY:
LIFE INSURANCE COMPANY OF NORTH AMERICA
a Cigna company

Class 3
06/2021

Group Life
Insurance Certificate

The Reinalt-Thomas Corporation, a Michigan corporation, dba Discount Tire/America's Tire/Discount Tire Direct

IMPORTANT NOTICES

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

Arizona, Florida and Maryland residents:

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

Washington Residents:

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

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

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

NOTICE

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

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

TL-004788

FOREWORD

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

The need for life insurance protection depends on individual circumstances and financial situations. Your Employer is offering you the opportunity to purchase this insurance to make your benefit program more comprehensive and responsive to your needs.

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

Any insurance benefit described in the following pages will apply to you only if you have elected that benefit and have authorized payroll deduction for the required premium.

LIFE INSURANCE COMPANY OF NORTH AMERICA
1601 CHESTNUT STREET
PHILADELPHIA, PA 19192-2235
(800) 732-1603 TDD (800) 336-2485
A STOCK INSURANCE COMPANY

GROUP INSURANCE
CERTIFICATE

We, the LIFE INSURANCE COMPANY OF NORTH AMERICA, have issued a Group Policy, FLX-980462, to TRUSTEE OF THE GROUP INSURANCE TRUST FOR EMPLOYERS IN THE RETAIL TRADE INDUSTRY on behalf of The Reinalt-Thomas Corporation, a Michigan corporation, dba Discount Tire/America's Tire/Discount Tire Direct.

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

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

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

William J. Smith, President

TL-004704

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

Policy Effective Date: January 1, 2020

Certificate Effective Date: July 1, 2021

Policy Anniversary Date: January 1

Policy Number: FLX-980462

Class Definition

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

All active, Full-time Employees of the Employer classified as Office or Inside Sales Agents regularly working the required number of hours to qualify for benefits according to the Employer's company policy, working in the United States who are citizens or permanent resident aliens of the United States excluding temporary and seasonal workers.

Your Eligibility Waiting Period

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

If you were hired on or before the Policy Effective Date:
After 90 days of continuous Active Service

If you were hired after the Policy Effective Date:
After 90 days of continuous Active Service

The *Eligibility Waiting Period* does not apply if you are a former Employee rehired within 12 months after your termination date and you had satisfied the *Eligibility Waiting Period* prior to your termination date. If you did not fully satisfy the *Eligibility Waiting Period* prior to your termination date, credit will be given for any time that was satisfied.

LIFE INSURANCE BENEFITS

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

Employee Benefits

Basic Benefit	1.5 times your Annual Compensation
Guaranteed Issue Amount:	the lesser of 1.5 times Annual Compensation or $50,000
Maximum Benefit:	the lesser of 1.5 times Annual Compensation or $50,000

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

Basic Terminal Illness Benefit	You can elect up to 75% of Basic Life Insurance Benefits in force on the date you are determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $37,500.
Voluntary Benefit	An amount elected in units of $10,000
Guaranteed Issue Amount:	the greater of a) or b) below: a) the lesser of 7 times Annual Compensation or $400,000, or b) an amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan
Maximum Benefit:	$500,000

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

Voluntary Terminal Illness Benefit	You can elect up to 75% of Voluntary Life Insurance Benefits in force on the date you are determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $250,000.
Age Based Reductions	When you are age 65 or older, your Life Insurance Benefit will reduce to the percentage shown below: 65% of the Life Insurance Benefit at age 65 40% of the Life Insurance Benefit at age 70 25% of the Life Insurance Benefit at age 75

Benefit reductions will be effective on your attainment of age as specified in schedule above.

Automatic Increase Feature for Life Insurance

An increase in your Life Insurance resulting from an increase in Annual Compensation will not be subject to the Insurability Requirement, even if the increase causes the Life Insurance to exceed the Guaranteed Issue Amount.

If you are not in Active Service on the date the increase would go into effect, your benefit will not increase until you return to Active Service.

Premiums must be paid on the basis of any increased amount of Life Insurance resulting from increases in Annual Compensation.

Spouse Benefits

Voluntary Benefit	An amount elected in units of $5,000
Guaranteed Issue Amount:	the greater of a) or b) below: a) $30,000, or b) an amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan
Maximum Benefit:	$100,000

Your Spouse's Life Insurance Benefits cannot exceed 50% of your Life Insurance Benefits.

Age Based Reductions	When you are age 65 or older, your Spouse's Life Insurance Benefit will reduce to the percentage shown below: 65% of the Life Insurance Benefit at age 65 40% of the Life Insurance Benefit at age 70 25% of the Life Insurance Benefit at age 75

Benefit reductions will be effective on your attainment of age as specified in schedule above.

Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Dependent Child Benefits

Voluntary Benefit	An amount elected in units of $5,000
Maximum Benefit:	$10,000 The Maximum Benefit for a Dependent Child who is less than 6 months old is $5,000.

All Dependent Child benefits are Guaranteed Issue.

Annual Enrollment Period

For Employees
During an Annual Enrollment Period, if you are currently insured under the Voluntary Life Insurance portion of this Policy, you may increase your Voluntary Life Insurance Benefit, or if you are eligible for the Voluntary Life Insurance portion of this Policy but have not previously enrolled, you may become insured under the Policy, as long as the total Benefit does not exceed the Maximum Benefit by satisfying the Insurability Requirement. Insurance will be effective on the later of January 1st following the Annual Enrollment Period or the date the Insurance Company agrees in writing to insure you.

For Spouses
During an Annual Enrollment Period, if you are an eligible Employee, you may elect coverage for your eligible Spouse. If your Spouse is currently insured under the Voluntary Life Insurance portion of this Policy, his or her Voluntary Life Insurance Benefit may be increased, or if your Spouse is eligible for the Voluntary Life Insurance portion of this Policy but has not previously enrolled, he or she may become insured under the Policy, as long as the total Benefit does not exceed the Maximum Benefit, by satisfying the Insurability Requirement. Insurance will be effective on the later of January 1st following the Annual Enrollment Period or the date the Insurance Company agrees in writing to insure him or her.

Insurance Benefits for you, your Spouse and Dependent Children may be reduced at any time. A request for a Benefit reduction received during an Annual Enrollment Period will become effective on January 1st following the Annual Enrollment Period. Any other Benefit reduction will be effective on the date the Insurance Company receives the completed change form.

TL-008025-1

Life Status Change

For Employees
Within 31 days after a Life Status Change, if you are currently insured under the Voluntary Life Insurance portion of this Policy, you may increase your Voluntary Life Insurance Benefit, or if you are eligible for the Voluntary Life Insurance portion of this Policy but have not previously enrolled, you may become insured under the Policy, as long as the total Benefit does not exceed the Maximum Benefit by satisfying the Insurability Requirement. Insurance will be effective on the later of the first of the month following the Life Status Change or the date the Insurance Company agrees in writing to insure you.

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

TL-008030-1

Former Employee Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Life Insurance Benefits allowable to you, less any amount of conversion insurance issued under the Conversion Privilege for Life Insurance. Any amount elected in excess of the Life Insurance Benefits in effect on the date you no longer qualify as an Employee will be effective on the date the Insurance Company agrees in writing to insure you. The Maximum Benefit for Basic Life Insurance Benefits is $50,000.
Maximum Benefit Period	To Age 70
Terminal Illness Benefit	You can elect up to 75% of Life Insurance Benefits in force on the date you are determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $287,500.

Spouse of Former Employee Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Voluntary Life Insurance Benefits available to a Spouse. Any amount elected in excess of the Voluntary Life Insurance Benefits in effect on the date your employment with the Employer ends will be effective on the date we agree in writing to insure him or her.
Maximum Benefit Period	To Age 70
Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Former Spouse Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Voluntary Life Insurance Benefits available to a Spouse. Any amount elected in excess of the Voluntary Life Insurance Benefits in effect on the date he or she no longer qualifies as a Spouse will be effective on the date we agree in writing to insure him or her.
Maximum Benefit Period	To Age 70
Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Former Dependent Child Benefits

Amount of Insurance	Units of $25,000
Guaranteed Issue Amount:	$25,000
Maximum Benefit:	$50,000
Maximum Benefit Period	To Age 70

TL-004774

WHO IS ELIGIBLE

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

An Employee who is the Spouse of another Employee may not be insured for Voluntary Life Insurance as both an Employee and as a Spouse at the same time.

Any Employee, who is eligible for Voluntary Life Insurance, will not be eligible to be insured as a Dependent Child of another Employee.

If an Employee is eligible and has enrolled as the Spouse of another Employee, but ceases to be eligible to maintain the amount of insurance for which he or she has enrolled as a Spouse, that Employee may, within 31 days, enroll for coverage as an Employee, in an amount equal to the lesser of (1) the amount of Spouse Voluntary Life Insurance terminating, or (2) the maximum amount of Employee Voluntary Life Insurance for which the Employee is eligible. The Insurability Requirement does not apply. If this amount is not equal to a Voluntary Life Insurance coverage option, it will be adjusted to the next higher available Voluntary Life Insurance coverage option. This provision shall be in lieu of the Policy's provisions, if any, regarding coverage changes following Life Status Changes.

If a Spouse is eligible and has enrolled for Voluntary Life Insurance as an Employee, but ceases to be eligible to maintain the amount of insurance for which he or she has enrolled as an Employee, the Spouse may, within 31 days, instead become enrolled as a Spouse of another Employee, in an amount equal to the lesser of (1) the amount of Employee Voluntary Life Insurance terminating, or (2) the Maximum Benefit Amount of Spouse Voluntary Life Insurance for which the Spouse is eligible. The Insurability Requirement does not apply. If this amount is not equal to a Voluntary Life Insurance coverage option, it will be adjusted to the next higher available Voluntary Life Insurance coverage option.

A Dependent Child of two or more Employees may only be insured once under the Policy. If an Employee who has elected to insure Dependent Children ceases to be eligible to do so, then the Employee's Spouse may, within 31 days, elect to insure Dependent Children, provided he or she is insured as an Employee. In all cases, "Dependent Child" shall be defined with respect to the Employee who has enrolled dependent children.

In all cases, amounts of insurance referred to in these provisions shall be determined before the application of any reductions in benefits due to age.

Any amount of Voluntary Life Insurance Coverage which cannot be continued under the above provisions may be subject to the Conversion Privilege.

Employee
If you qualify under the Class Definition shown in the Schedule of Benefits, you are eligible to be insured on the Policy Effective Date or the day after you complete the Eligibility Waiting Period, if later. The Eligibility Waiting Period will not apply if you are in Active Service on the Policy Effective Date and you satisfied the Eligibility Waiting Period, if any, of the Prior Plan. Credit will be given for any time you satisfied.

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

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

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

For eligibility purposes, your Spouse must be a lawful Spouse and not legally separated from, divorced from, or widowed by you.

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

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

TL-004710-1

WHEN COVERAGE BEGINS

If you are required to contribute to the cost of this insurance, you may elect insurance for yourself, your Spouse and Dependent Children only by authorizing payroll deduction in a form approved by the Employer and us. The effective date of this insurance depends on the date and amount of insurance elected.

If you elect coverage within 31 days after you become eligible to enroll or increase coverage, the Guaranteed Issue Amount will be effective on the latest of the following dates:
1. The Policy Effective Date.
2. The date you authorize payroll deduction for this insurance.
3. The date the Employer or Insurance Company receives the completed enrollment form.

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

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

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

If an eligible Spouse or Dependent Child is:

1. an inpatient in a hospital, hospice, rehabilitation or convalescence center, or custodial care facility; or
2. confined to his or her home under the care of a Physician

on the date insurance would otherwise be effective, it will be effective on the date he or she is no longer an inpatient in these facilities or confined at home. If such Spouse or Dependent Child was covered by the Prior Plan immediately prior to the Policy Effective Date, this provision will not apply to the amount of coverage in effect as of the Policy Effective Date, but will apply to any increase in coverage. This does not apply to a Dependent Child who is age 6 months or less.

TL-004712

Takeover Provision

Special Terms Applicable to Previously Insured Employees Not in Active Service and Their Dependents

Coverage will not go into effect for you, or your Spouse and Dependent Children unless you are in Active Service on the date you would have first become eligible to be insured under this Policy.

However:

1. if you, and your Spouse or Dependent Children were insured under a Prior Plan on the date immediately prior to the date you would have first become eligible to be insured under this Policy and had satisfied the Active Service requirement, and
2. if you, your Spouse or Dependent Child die, we agree to provide a Death Benefit only equal to the lesser of:

a. the amount due under this Policy (had you satisfied the Active Service requirement), or
b. the amount that would have been due under the Prior Plan had it remained in force.

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

These special terms will end on the earliest of the following dates:

1. the date you meet the Active Service requirements;
2. the date insurance terminates for one of the reasons stated in the Termination of Insurance provision;
3. 12 months after the date you first become eligible under this Policy; or
4. the last day you, your Spouse or Dependent Children would have been covered under the Prior Plan if coverage under that plan for you, your Spouse or Dependent Children was still in force.

TL-009020-1

WHEN COVERAGE ENDS

Coverage will end on the earliest of the following dates:

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

TL-004714-1

WHEN COVERAGE CONTINUES

Continuation for Temporary Leave of Absence, Layoff, Leave for Military Service or Family Medical Leave

If you are an Employee and your Active Service ends due to an Employer approved unpaid leave of absence, layoff, leave for military service or family medical leave, your insurance will continue if the required premium is paid.

In these circumstances, your insurance may continue as follows.

1. For an Employer approved unpaid leave of absence, up to 18 months following the date coverage would otherwise end due to exhaustion of Family and Medical Leave Act (FMLA), state leave of absence laws, or termination of Short Term Disability benefits under the Employer's Short Term Disability Plan.
2. For layoff, up to 3 months.
3. For leave for military service, up to 24 months.
4. For an Employer approved family medical leave, up to the later of the period of the approved FMLA leave or the leave period required by the laws of the state in which the Employee is employed.

Continuation for Disability

If you become Disabled, the Life Insurance Benefits shown in the Schedule of Benefits will be continued, provided premiums are paid, until the earlier of the following dates:

1. The date you are no longer Disabled.
2. The date you are Disabled for up to 18 months following the date coverage would otherwise end due to exhaustion of Family and Medical Leave Act (FMLA), state leave of absence laws or termination of Short Term Disability benefits under the Employer's Short Term Disability Plan.
3. The date coinciding with the end of the last period for which premiums are paid.
4. The date the Policy is terminated.

Amount of Insurance

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

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

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

Extended Death Benefit with Waiver of Premium

Extended Death Benefit

If you become Disabled and are less than age 60, the Life Insurance Benefits shown in the Schedule of Benefits will be extended without premium payment until the earlier of the following dates:

1. The date you are no longer Disabled; or
2. 9 months after the end of your Active Service.

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

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

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

Waiver of Premium
If you submit satisfactory proof that you have been continuously Disabled for 6 months, coverage will be extended up to age 65.

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

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

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

Termination of Waiver
Your insurance will end on the earliest of the following dates.
1. The date you are no longer Disabled;
2. The date you refuse to submit to any physical examination required by us;
3. The date you refuse to participate in a Rehabilitation Plan for which the Insurance Company determines you to be eligible;
4. The last day of the 12-month period of Disability during which you fail to submit satisfactory proof of continued Disability;
5. To Age 65.

"Disability/Disabled" means because of Injury or Sickness you are unable to perform the material duties of your Regular Occupation, or are receiving disability benefits under the Employer's plan, during the initial 6 months of Disability. Thereafter, you must be unable to perform all of the material duties of any occupation which you may reasonably become qualified based on education, training or experience, or are subject to the terms of a Rehabilitation Plan approved by the Insurance Company.

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

Rehabilitation During a Period of Disability

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

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

"Rehabilitation Plan" means a written plan designed to enable the Employee to return to work. The Rehabilitation Plan will consist of one or more of the following phases:

1. Rehabilitation, under which the Insurance Company may provide, arrange or authorize educational, vocational or physical rehabilitation or other appropriate services;
2. Work, which may include modified work and work on a Part-time basis.

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

TL-009745 as modified by TL-009745-1

Portability Options

For Employees

If your coverage under the Policy ends prior to age 70, for any of the following reasons:

a. termination of employment; or
b. termination of membership in an eligible class under the Policy;

Life Insurance Benefits may be continued up to the Maximum Benefit shown in the Schedule of Benefits for this option.

You must apply to the Insurance Company and pay the required premium. If you continue coverage, coverage for your Spouse or Dependent Child may also be continued by you. Your Spouse or Dependent Child must be covered under the Policy on the date coverage would otherwise end. The application must be submitted:

a. within 31 days of your termination of employment or membership in an eligible class under the Policy; or
b. during the time that you have to exercise the Conversion Privilege.

Coverage under this option may not be elected at a later date.

When applying for this option, you must name a beneficiary. Any beneficiary named previously under the Policy is no longer in effect. If there is no named or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives:

a. spouse;
b. child or children;
c. mother or father;
d. brothers or sisters; or
e. the executors or administrators of your estate.

When coverage is continued under this option, you become a Former Employee. Your Spouse becomes a Spouse of a Former Employee. Your Dependent Child becomes a Dependent Child of a Former Employee.

If you, as a Former Employee, later acquire a Spouse or Dependent Child, you may elect coverage for them. You must apply to the Insurance Company and pay the required premium. Coverage for your Spouse or Dependent Child will be effective on the date we agree in writing to insure them. We may require that your Spouse or Dependent Child satisfy the Insurability Requirement before we agree to insure them.

Coverage will end on the earliest of the following dates.
a. The date we cancel coverage for all Former Employees.
b. The end of the period for which premiums are paid.
c. The date an Insured reaches age 70.
d. The date the Maximum Benefit Period shown in the Schedule of Benefits for this option ends.

Also, coverage for any Dependent Child will end on any of the dates listed above or when he or she no longer qualifies as a Dependent Child, if earlier.

For Spouses

If prior to age 70, a Spouse is:
a. legally separated, divorced; or
b. widowed
from an insured Employee or Former Employee, Life Insurance Benefits may be continued. Coverage may be continued up to the Maximum Benefit shown in the Schedule of Benefits for this option. The Spouse must apply to the Insurance Company and pay the required premium.

A Spouse who continues coverage may also continue coverage for a Dependent Child. The Dependent Child must be covered under the Policy on the date coverage would otherwise end. A Spouse must elect to continue insurance under this option within 31 days after coverage ends. Coverage may not be elected at a later date.

When applying for this option, a Spouse must name a beneficiary. Any beneficiary named previously under the Policy is no longer in effect. If there is no named or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives:
a. spouse;
b. child or children;
c. mother or father;
d. brothers or sisters; or
e. the executors or administrators of the Spouse's estate.

When coverage is continued under this option, the Spouse becomes a Former Spouse. A separate certificate of insurance will be issued to the Former Spouse. Coverage will be effective on the date after coverage as a Spouse ends if the required premium is paid.

Coverage will end on the earliest of the following dates.
a. The date we cancel coverage for all Former Spouses.
b. The end of the period for which premiums are paid.
c. The date the Former Spouse reaches age 70.
d. The date the Maximum Benefit Period shown in the Schedule of Benefits for this option ends.

Also, coverage for a Dependent Child will end on any of the dates listed above or when he or she no longer qualifies as a Dependent Child, if earlier.

For Dependent Children

If a Dependent Child is insured under the Policy and is at least 19 years of age, Life Insurance Benefits may be continued under this option. Coverage may be continued up to the Maximum Benefit shown in the Schedule of Benefits for this option.

The Dependent Child must apply to the Insurance Company and pay the required premium. If a Dependent Child does not elect to continue insurance within 31 days after reaching age 19; or the date he or she no longer qualifies as a Dependent Child, if later, coverage under this option may not be elected at a later date.

When applying for this option, a Dependent Child must name a beneficiary. Any beneficiary named previously under the Policy is no longer in effect. If there is no named or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives:

a. spouse;
b. child or children;
c. mother or father;
d. brothers or sisters; or
e. the executors or administrators of the Dependent Child's estate.

When a Dependent Child continues coverage under this option, he or she becomes a Former Dependent Child. A separate certificate of insurance will be issued to the Former Dependent Child. Coverage for a Former Dependent Child will be effective on the following dates.

a. For any Guaranteed Issue Amount, immediately following the date his or her coverage as a Dependent Child ends, provided the Insurance Company receives the required premium.
b. For any amount of insurance that exceeds the Guaranteed Issue Amount, the date the Insurance Company agrees in writing to insure him or her. The Insurance Company will require the Former Dependent Child to satisfy the Insurability Requirement before it agrees to insure him or her.

Coverage will end on the earliest of the following dates.

a. The date we cancel coverage for all Former Dependent Children.
b. The end of the period for which premiums are paid.
c. The date the Former Dependent Child is age 70.
d. The date the Maximum Benefit Period shown in the Schedule of Benefits for this option ends.

TL-004716 as modified by TL-009330

WHAT IS COVERED

LIFE INSURANCE BENEFITS

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

TL-004730

Accelerated Benefits
Any benefits payable under this and under any similar Accelerated Benefits provision accelerated under a Prior Plan will reduce the Death Benefit payable for Life Insurance. We will deduct from any Death Benefit payable under this Policy, the amount of any similar accelerated benefit paid under a Prior Plan.

Any automatic increases in Life Insurance Benefits will end when benefits are payable under this provision, unless the Insured is determined by the Insurance Company not to be eligible for Accelerated Benefits.

Terminal Illness Benefit
We will pay a Terminal Illness Benefit to an Insured who has incurred a Terminal Illness while insured under this provision.

The Terminal Illness Benefit is shown on the Schedule of Benefits.

A claim for a similar terminal illness benefit under a Prior Plan or group policy intended to replace this Policy shall be deemed payable until such time as it is finally determined not to be payable.

Determination of Terminal Illness
For the purpose of determining the existence of a Terminal Illness, we will require the Insured submit the following proof:
1. A written diagnosis and prognosis by a licensed Physician; and
2. Supportive evidence satisfactory to us, including but not limited to, radiological, histological or laboratory reports documenting the Terminal Illness.

We may require, at our expense, an examination of the Insured and a review of the documented evidence by a Physician of our choice.

Such proofs must be submitted to us within the period of time provided in the *Proof of Loss* section of the Policy. For purposes of this Benefit, the date of loss shall be the date of first prognosis of Terminal Illness.

"Terminal Illness" means that, due to an Injury or Sickness, the Insured has a prognosis of 12 months or less to live without reasonable prospect of recovery, as determined by us.

Payment of Terminal Illness Benefit
The Terminal Illness Benefit will be payable in accordance with the provisions of the *To Whom Payable* section of the Policy.

The Terminal Illness Benefit is payable only once under the Policy in an Insured's lifetime.

Conditions Applicable to Coverage
Unless the Insured qualifies for waiver of premium, premium payments must continue to be paid on the full amount of group life insurance, including during any Continuation of Insurance under the Policy, in accordance with the *Premium* section in the *Administrative Provisions.*

The amount of Life Insurance which may be converted under the *Conversion Privilege* cannot exceed the amount of the reduced death benefit payable under the Policy.

Before a Terminal Illness Benefit is paid in a Community Property state, we may require the written consent of the Insured's Spouse.

Exclusions Applicable to Terminal Illness Benefit
A Terminal Illness Benefit will not be payable:
1. when the Insured has irrevocably assigned group life insurance under this Policy;
2. when all or a portion of group life insurance benefits under this Policy are to be paid to a former spouse as part of a qualified domestic relations order;
3. for any intentionally self-inflicted Injury or Sickness, or suicide attempt;
4. if the Insured's coverage ends under the *When Coverage Ends* provision prior to the prognosis of Terminal Illness;
5. if the required premium is due and unpaid;
6. if this Policy terminates prior to the prognosis of Terminal Illness;
7. if you or the Insured is only provided coverage under the Takeover provision of the Policy (Employees Not in Active Service on the Policy Effective Date); or
8. if the date of first prognosis of Terminal Illness occurs more than 12 months before the submission of the Terminal Illness claim.

TL-004748a

Conversion Privilege for Life Insurance
Each Insured may convert all or any portion of his or her Life Insurance that would end under the Policy due to:
1. termination of employment;
2. termination of membership in an eligible class under the Policy;
3. termination of the Policy.

The Insured may apply for any type of life insurance we offer to persons of the same age in the amount applied for, except you may not:
1. choose term insurance;
2. apply for an amount of insurance greater than the coverage amount terminating under the Policy (also, the conversion policy will not provide accident, disability or other benefits); or
3. apply for more than $10,000 of insurance if the Policy is terminated or amended to terminate the insurance for any class of Insureds, or the Employer cancels participation under the Policy. Conversion in these cases is only permitted if you have been covered by the Policy or, any group life insurance policy issued to the Employer which the Policy replaced, for at least 3 years.

If the Insured becomes eligible for coverage under any group life policy within 62 days of termination of coverage under this Policy, the Insured may not convert an amount of insurance greater than the amount of coverage terminating under the Policy less the amount for which he or she may be covered under the other policy.

To apply for conversion insurance, the Insured must, within 62 days after coverage under the Policy ends:
1. submit an application to us; and
2. pay the required premium.

Evidence of insurability is not required.

Premium for the conversion insurance will be based on the age and class of risk of the Insured and the type and amount of coverage issued.

If the Insured has assigned ownership of his group coverage, the owner/assignee must apply for the individual policy.

Conversion insurance will become effective on the 31st day after the date coverage under the Policy ends provided the application is received by us and the required premium has been paid.

If the Insured dies during the 31-day conversion period, the Life Insurance benefits will be paid under the Policy regardless of whether he or she applied for conversion insurance. If a conversion policy is issued, it will be in exchange for any further benefits for that type and amount of insurance from this Policy.

Extension of Conversion Period
If an Insured is eligible for conversion insurance and is not notified of this right at least 31 days prior to the end of the 62-day conversion period, the conversion period will be extended. The Insured will have 31 days from the date notice is given to apply for conversion insurance. In no event will the conversion period be extended beyond 105 days. Notice, for the purpose of this section, means written notice presented to the Insured by the Employer or mailed to the Insured's last known address as reported by the Employer.

If the Insured dies during the extended conversion period, but more than 31 days after his or her coverage under the Policy terminates, Life Insurance benefits:
1. will not be paid under the Policy; and
2. will be payable under the conversion insurance; provided:
    a. the Insured's application for conversion insurance has been received by us; and
    b. the required premium has been paid.

Prior Conversion Limitation
If an Insured is covered under a life insurance conversion policy previously issued by us, he or she will not be eligible for this Conversion Privilege unless the prior coverage has ended.

TL-009740

LIFE INSURANCE EXCLUSIONS

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

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

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

TL-004752

CLAIM PROVISIONS

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

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

Claim Forms
When we receive notice of claim, we will send claim forms for filing proof of loss. If we do not send claim forms within 15 days after notice is received by us, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof, or proof by any other electronic/telephonic means authorized by us, of the nature and extent of the loss.

Claimant Cooperation Provision
If you fail to cooperate with us in our administration of your claim, we may terminate the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

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

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

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

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

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

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

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

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

To Whom Payable
Death Benefits will be paid to the Insured's named beneficiary, if any, on file at the time of payment or to the certificate owner if alive. If there is no named beneficiary or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives: spouse; child or children; mother or father; brothers or sisters; or to the executors or administrators of the Insured's estate. We may reduce the amount payable by any indebtedness due.

All benefits payable under the Accelerated Benefits section are payable to the Insured, if living. If the Insured dies prior to the payment of an eligible claim for an Accelerated Benefit, benefits will be paid in accordance with the provisions applicable to the payment of Life Insurance proceeds, unless the Insured has directed us otherwise in writing. However, any payment made by us prior to notice of the Insured's death shall discharge us of any benefit that was paid.

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

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

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

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

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

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

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

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

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

TL-004724

ADMINISTRATIVE PROVISIONS

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

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

Your Grace Period
If your required premium is not paid on the Premium Due Date, there is a 60 day grace period after each premium due date after the first. If the required premium is not paid during the grace period, insurance will end on the last day for which premium was paid.

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

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

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

TL-004722

GENERAL PROVISIONS

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

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

Misstatement of Age
If an Insured's age has been misstated, we will adjust all benefits to the amounts that would have been purchased for the correct age.

Workers' Compensation Insurance
The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance Law.

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

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

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

TL-004728

DEFINITIONS

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

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

Active Service
If you are an Employee, you are in Active Service with the Employer on a day which is one of the Employer's scheduled work days if either of the following conditions are met.

1. You are actively at work. This means you are performing your regular occupation for the Employer on a Full-time basis, either at one of the Employer's usual places of business or at some location to which the Employer's business requires you to travel.
2. The day is a scheduled holiday, vacation day or period of Employer approved paid leave of absence, other than disability or sick leave after 7 days.

You are considered in Active Service on a day which is not one of the Employer's scheduled work days only if you were in Active Service on the preceding scheduled work day.

Annual Compensation
Annual Compensation means your annual wage or salary as reported by the Employer for work performed for the Employer as of the date the covered loss occurs. It includes earnings received as overtime pay, but not bonuses or other extra compensation. Annual Compensation is determined initially on the date you apply for coverage. A change in the amount of Annual Compensation is effective on the date of the change, if the Employer gives us written notice of the change and the required premium is paid.

Overtime pay will be averaged for the 12 months just prior to the date the covered loss occurs, or the months employed, if less than 12 months.

Dependent Child
An unmarried child who meets the following requirements.

1. A child from live birth but less than 26 years old;
2. A child who is 26 or more years old, primarily supported by you and incapable of self-sustaining employment by reason of mental or physical incapacity.
3. A child stillborn during the third trimester.

The term "child" means:

a. your natural child;
b. your legally adopted child, beginning with any waiting period pending finalization of the child's adoption. It also means the legally adopted child of your Spouse provided the child is living with, and is financially dependent upon you;
c. a stepchild born to your Spouse and who is living with and financially dependent upon you;
d. a child for whom you are the court-appointed legal guardian and who resides with, and is financially dependent upon you.

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

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

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

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

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

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

Insured
You are an Insured if you are eligible for insurance under the Policy, insurance is elected for you, the required premium is paid and your coverage is in force under the Policy.

Life Status Change
A Life Status Change is an event recognized by the Employer's Flexible Benefits Plan as qualifying you to make changes in benefit selections at a time other than an Annual Enrollment Period.

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

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

Policy Anniversary
A Policy Anniversary is the date stated on the policy cover and the same date that follows every 12 months for as long the Policy is in effect.

Policy Effective Date
The Policy Effective Date is the date stated on the policy cover.

Prior Plan
The Prior Plan refers to the plan of insurance providing similar benefits to you, sponsored by the Employer and in effect directly prior to the Policy Effective Date. A Prior Plan will include the plan of an employer in effect on the day prior to that employer's addition to this policy.

To be covered under the Policy, required premium must be paid for all covered Employees.

Sickness
The term Sickness means a physical or mental illness.

Spouse
Your current lawful spouse.

Subscriber
Any participating organization that subscribes to the trust to which this Policy is issued, and which is insured under this Policy.

TL-004708-1 as modified by TL-010150a

STATE MODIFYING PROVISIONS AMENDMENT RIDER

Subscriber: The Reinalt-Thomas Corporation, a Michigan corporation, dba Discount Tire/America's Tire/Discount Tire Direct
Policy No.: FLX-980462
Amendment Effective Date: January 1, 2020

This amendment is attached to and made part of the Policy/Certificate specified above. Its provisions are intended to conform this Policy/Certificate to the laws of the state in which the insured resides.

The Policy delivered under the Group Policy are amended as follows:

APPLICABLE TO CALIFORNIA RESIDENTS:

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

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

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

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

APPLICABLE TO FLORIDA RESIDENTS:

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

APPLICABLE TO MARYLAND RESIDENTS:

The Group Insurance Policy was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

APPLICABLE TO MISSOURI RESIDENTS:

Applicable to Voluntary Life Insurance Benefits

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

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

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

APPLICABLE TO NORTH DAKOTA RESIDENTS:

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

APPLICABLE TO OREGON RESIDENTS:

NOTICE: MUST PROVIDE DOMESTIC PARTNER COVERAGE FOR OREGON RESIDENTS

APPLICABLE TO VERMONT RESIDENTS:

To the extent the Policy provides insurance coverage to a spouse, the identical consideration must be applied to same sex marriages and civil unions. The language is as follows:

1. Civil Union Partner means:
   a. A person with whom the Employee has a registered civil union under Vermont law which imposes obligations on the parties substantially similar to marriage. Such person will continue to be recognized as a Civil Union Partner unless and until:
      (1) the civil union is dissolved under applicable law; or
      (2) either the Employee or the Civil Union Partner marries another person.

2. Spouse means:
   a. "Lawful spouse" and includes a lawful spouse of the same sex.
   b. This also includes a partner to a civil union recognized under Vermont Law.

APPLICABLE TO WASHINGTON RESIDENTS:

1. The following *Continuation of Insurance* provision is added to the Policy:

   Continuation of Life Coverage During Labor Disputes
   If an Employee's Active Service ends because of a Labor Dispute and his or her premium for Life Insurance Benefits under the Policy is paid either by the Employer, in whole or in part, or by the Employee through payroll deductions, then the Employee may continue his or her Life Insurance Benefits. The Employer will send written notice of the right to continue coverage to each insured Employee at his or her most recent address as on file with the Employer.

   To continue coverage, the Employee must pay premiums directly to the Employer, who will remit the premiums to the Insurance Company. Premiums must be paid by the date they are due, subject to the 31 day grace period. Policy coverages and premiums will stay the same during a Labor Dispute; however, the Insurance Company may make normal changes in premium rates when the Policy is renewed, under the terms set forth in the Policy.

   Coverage continued in this manner will end on the earliest of the following dates.
   a. The date the Labor Dispute has ended.
   b. The date coverage has been continued for 6 months.

   If the Labor Dispute continues beyond 6 months, the Employee may apply for an individual insurance policy, as set forth in detail under "Conversion Privilege for Life Insurance."

   "Labor Dispute," as used here, means a strike, lockout, or other labor dispute between the Employer and its Employees, during which time the Employee is not paid by the Employer.

2. If the Policy provides coverage to dependents, benefits for a Spouse or Dependent Child are limited to 100% of the insured Employee's coverage amount. Stand-alone Spouse and Dependent Child coverage (when Employee is not insured) is not permitted.

3. The *Suicide* Exclusion, if any, does not apply.

4. To the extent the policy includes *Accelerated Benefits,* the following resolution of disputes requirements are added to the Policy.

   - For Terminal Illness – *Determination of Terminal Illness*

     In the event the Physician representing the Insurance Company disputes the existence of a Terminal Illness, and the dispute cannot be resolved, the Insured has the right to mediation and binding arbitration in accordance with Washington Administrative Code 284-23-730.

5. The *Incontestability Provision* is replaced as follows:

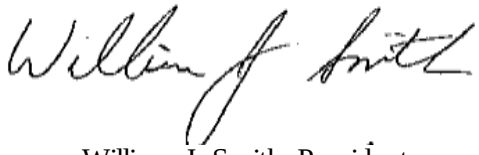
   Incontestability
   All statements made by the Employer or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement has been furnished to the claimant. In the event of death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

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

6. If the term "*Accident*" is defined in the Policy, it is replaced by the following:

Accident
An Accident is a sudden, unforeseeable event that causes bodily Injury to an Insured while coverage is in force under the Policy.

Signed for the
Life Insurance Company of North America



William J. Smith, President

TL-00-3000.00

SUPPLEMENTAL INFORMATION
for

Reinalt-Thomas Corporation Fully Insured Life, AD&D, LTD and STD Welfare Benefit Plan ("Plan")

required by the Employee Retirement Income Security Act of 1974

As a Plan participant in The Reinalt-Thomas Corporation, a Michigan corporation, dba Discount Tire/America's Tire/Discount Tire Direct's Plan, you are entitled to certain information, rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

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

IMPORTANT INFORMATION ABOUT THE PLAN

- The Plan is established and maintained by The Reinalt-Thomas Corporation, a Michigan corporation, dba Discount Tire/America's Tire/Discount Tire Direct, the Plan Sponsor.
- The Employer Identification Number (EIN) is 38-1889682.
- The Plan Number is 526.
- The Insurance Plan is administered directly by the Plan Administrator with benefits provided, in accordance with the provisions of the group insurance contract, FLX-980462 ("Policy"), issued by LIFE INSURANCE COMPANY OF NORTH AMERICA ("Insurance Company").
- The Plan Administrator is: Reinalt-Thomas Corporation
  20225 North Scottsdale Road
  Scottsdale, AZ 85255
  480-606-6000
- The Plan Administrator has authority to control and manage the operation and administration of the Plan.
- The Plan Sponsor may terminate, suspend, withdraw or amend the Plan, in whole or in part, at any time, subject to the applicable provisions of the Policy. (Your rights upon termination or amendment of the Plan are set forth in your Certificate.)
- The agent for service of legal process is the Plan Administrator.
- The Plan of benefits is financed by the Employees.
- The date of the end of the Plan Year is December 31.

YOUR RIGHTS AS SET FORTH BY ERISA

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

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

WHAT YOU SHOULD DO AND EXPECT IF YOU HAVE A CLAIM

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

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

A disability "claim" is any claim which requires a determination of disability by the Insurance Company regardless of the type of policy under which it arises (for example, short/long term disability, waiver of premium, etc.). A disability claim is "filed" as of the date the Insurance Company first receives, in writing (including electronically) or by telephone (through the Insurance Company's intake department), notice that a claimant is seeking disability benefits under the Policy. The notice of claim received should provide the date of disability/loss, the claimant's name and address, and the group Policy holder's name and address. Properly filed claims will be decided with independence and impartiality.

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

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

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

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

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

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

A written request for appeal must be received by the Insurance Company within 180 days from the date the claimant received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived. The Insurance Company has 45 days from the date it receives a request for appeal to provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim and can extend the time for decision, once, by an additional 45 days. If this should happen, the Insurance Company must provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Insurance Company's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Insurance Company receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

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

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

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

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

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

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

A non-disability "claim" is any claim which does not require a determination of disability by the Insurance Company regardless of the type of policy under which it arises (for example, a death claim, an accident claim, etc.). A non-disability claim is "filed" as of the date the Insurance Company first receives, in writing or by telephone (through the Insurance Company's intake department), notice that a claimant is seeking benefits under the Policy. The notice of claim should include the group Policy holder's name, the Policy and Certificate number and the claimant's name and address.

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

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

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

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

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

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

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

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

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

ER-03-2

UNDERWRITTEN BY:
LIFE INSURANCE COMPANY OF NORTH AMERICA
a Cigna company

Class 4
06/2021

Group Life
Insurance Certificate

The Reinalt-Thomas Corporation, a Michigan corporation, dba Discount Tire/America's Tire/Discount Tire Direct

IMPORTANT NOTICES

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

Arizona, Florida and Maryland residents:

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

Washington Residents:

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

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

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

NOTICE

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

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

TL-004788

FOREWORD

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

The need for life insurance protection depends on individual circumstances and financial situations. Your Employer is offering you the opportunity to purchase this insurance to make your benefit program more comprehensive and responsive to your needs.

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

Any insurance benefit described in the following pages will apply to you only if you have elected that benefit and have authorized payroll deduction for the required premium.

LIFE INSURANCE COMPANY OF NORTH AMERICA
1601 CHESTNUT STREET
PHILADELPHIA, PA 19192-2235
(800) 732-1603 TDD (800) 336-2485
A STOCK INSURANCE COMPANY

GROUP INSURANCE
CERTIFICATE

We, the LIFE INSURANCE COMPANY OF NORTH AMERICA, have issued a Group Policy, FLX-980462, to TRUSTEE OF THE GROUP INSURANCE TRUST FOR EMPLOYERS IN THE RETAIL TRADE INDUSTRY on behalf of The Reinalt-Thomas Corporation, a Michigan corporation, dba Discount Tire/America's Tire/Discount Tire Direct.

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

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

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

William J. Smith, President

TL-004704

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

Policy Effective Date: January 1, 2020

Certificate Effective Date: July 1, 2021

Policy Anniversary Date: January 1

Policy Number: FLX-980462

Class Definition

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

Employees who were insured under the Prior Plan on December 31, 2019, who were not actively at work on December 31, 2019, and who do not qualify for waiver of premium under the Prior Plan due to age. Employees eligible under this class will cease to be eligible as of January 1, 2021.

Your Eligibility Waiting Period

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

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

LIFE INSURANCE BENEFITS

Employee Benefits

Basic Benefit	An amount as on file with the Employer and Insurance Company.
Voluntary Benefit	An amount as on file with the Employer and Insurance Company.
Age Based Reductions	When you are age 65 or older, your Life Insurance Benefit will reduce to the percentage shown below: 65% of the Life Insurance Benefit at age 65 40% of the Life Insurance Benefit at age 70 25% of the Life Insurance Benefit at age 75

Benefit reductions will be effective on your attainment of age as specified in schedule above.

Terminal Illness Benefit	You can elect up to 75% of Life Insurance Benefits in force on the date you are determined by the Insurance Company to be Terminally Ill.

Spouse Benefits

Voluntary Benefit	An amount as on file with the Employer and Insurance Company.
Age Based Reductions	When you are age 65 or older, your Spouse's Life Insurance Benefit will reduce to the percentage shown below: 65% of the Life Insurance Benefit at age 65 40% of the Life Insurance Benefit at age 70 25% of the Life Insurance Benefit at age 75

Benefit reductions will be effective on your attainment of age as specified in schedule above.

Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Dependent Child Benefits

Voluntary Benefit	An amount as on file with the Employer and Insurance Company.

All Dependent Child benefits are Guaranteed Issue.

Former Employee Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Life Insurance Benefits allowable to you, less any amount of conversion insurance issued under the Conversion Privilege for Life Insurance. Any amount elected in excess of the Life Insurance Benefits in effect on the date you no longer qualify as an Employee will be effective on the date the Insurance Company agrees in writing to insure you. The Maximum Benefit for Basic Life Insurance Benefits is $50,000.
Maximum Benefit Period	To Age 70
Terminal Illness Benefit	You can elect up to 75% of Life Insurance Benefits in force on the date you are determined by the Insurance Company to be Terminally Ill.

TL-004774

WHO IS ELIGIBLE

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

An Employee who is the Spouse of another Employee may not be insured for Voluntary Life Insurance as both an Employee and as a Spouse at the same time.

Any Employee, who is eligible for Voluntary Life Insurance, will not be eligible to be insured as a Dependent Child of another Employee.

If an Employee is eligible and has enrolled as the Spouse of another Employee, but ceases to be eligible to maintain the amount of insurance for which he or she has enrolled as a Spouse, that Employee may, within 31 days, enroll for coverage as an Employee, in an amount equal to the lesser of (1) the amount of Spouse Voluntary Life Insurance terminating, or (2) the maximum amount of Employee Voluntary Life Insurance for which the Employee is eligible. The Insurability Requirement does not apply. If this amount is not equal to a Voluntary Life Insurance coverage option, it will be adjusted to the next higher available Voluntary Life Insurance coverage option. This provision shall be in lieu of the Policy's provisions, if any, regarding coverage changes following Life Status Changes.

If a Spouse is eligible and has enrolled for Voluntary Life Insurance as an Employee, but ceases to be eligible to maintain the amount of insurance for which he or she has enrolled as an Employee, the Spouse may, within 31 days, instead become enrolled as a Spouse of another Employee, in an amount equal to the lesser of (1) the amount of Employee Voluntary Life Insurance terminating, or (2) the Maximum Benefit Amount of Spouse Voluntary Life Insurance for which the Spouse is eligible. The Insurability Requirement does not apply. If this amount is not equal to a Voluntary Life Insurance coverage option, it will be adjusted to the next higher available Voluntary Life Insurance coverage option.

A Dependent Child of two or more Employees may only be insured once under the Policy. If an Employee who has elected to insure Dependent Children ceases to be eligible to do so, then the Employee's Spouse may, within 31 days, elect to insure Dependent Children, provided he or she is insured as an Employee. In all cases, "Dependent Child" shall be defined with respect to the Employee who has enrolled dependent children.

In all cases, amounts of insurance referred to in these provisions shall be determined before the application of any reductions in benefits due to age.

Any amount of Voluntary Life Insurance Coverage which cannot be continued under the above provisions may be subject to the Conversion Privilege.

Employee
If you qualify under the Class Definition shown in the Schedule of Benefits, you are eligible to be insured on the Policy Effective Date.

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

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

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

For eligibility purposes, your Spouse must be a lawful Spouse and not legally separated from, divorced from, or widowed by you.

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

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

TL-004710-1

WHEN COVERAGE BEGINS

If you are required to contribute to the cost of this insurance, you may elect insurance for yourself, your Spouse and Dependent Children only by authorizing payroll deduction in a form approved by the Employer and us. The effective date of this insurance depends on the date and amount of insurance elected.

If an eligible Spouse or Dependent Child is:
1. an inpatient in a hospital, hospice, rehabilitation or convalescence center, or custodial care facility; or
2. confined to his or her home under the care of a Physician

on the date insurance would otherwise be effective, it will be effective on the date he or she is no longer an inpatient in these facilities or confined at home. If such Spouse or Dependent Child was covered by the Prior Plan immediately prior to the Policy Effective Date, this provision will not apply to the amount of coverage in effect as of the Policy Effective Date, but will apply to any increase in coverage. This does not apply to a Dependent Child who is age 6 months or less.

TL-004712

Takeover Provision
Special Terms Applicable to Previously Insured Employees Not in Active Service and Their Dependents

Coverage will not go into effect for you, or your Spouse and Dependent Children unless you are in Active Service on the date you would have first become eligible to be insured under this Policy.

However:
1. if you, and your Spouse or Dependent Children were insured under a Prior Plan on the date immediately prior to the date you would have first become eligible to be insured under this Policy and had satisfied the Active Service requirement, and
2. if you, your Spouse or Dependent Child die, we agree to provide a Death Benefit only equal to the lesser of:

a. the amount due under this Policy (had you satisfied the Active Service requirement), or
b. the amount that would have been due under the Prior Plan had it remained in force.

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

These special terms will end on the earliest of the following dates:
1. the date you meet the Active Service requirements;
2. the date insurance terminates for one of the reasons stated in the Termination of Insurance provision;
3. 12 months after the date you first become eligible under this Policy; or
4. the last day you, your Spouse or Dependent Children would have been covered under the Prior Plan if coverage under that plan for you, your Spouse or Dependent Children was still in force.

TL-009020-1

WHEN COVERAGE ENDS

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

TL-004714-1

WHEN COVERAGE CONTINUES

Portability Options
For Employees

If your coverage under the Policy ends prior to age 70, for any of the following reasons:
a. termination of employment; or
b. termination of membership in an eligible class under the Policy;
Life Insurance Benefits may be continued up to the Maximum Benefit shown in the Schedule of Benefits for this option.

You must apply to the Insurance Company and pay the required premium. The application must be submitted:
a. within 31 days of your termination of employment or membership in an eligible class under the Policy; or
b. during the time that you have to exercise the Conversion Privilege.
Coverage under this option may not be elected at a later date.

When applying for this option, you must name a beneficiary. Any beneficiary named previously under the Policy is no longer in effect. If there is no named or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives:
a. spouse;
b. child or children;
c. mother or father;
d. brothers or sisters; or
e. the executors or administrators of your estate.

When coverage is continued under this option, you become a Former Employee.

Coverage will end on the earliest of the following dates.

a. The date we cancel coverage for all Former Employees.
b. The end of the period for which premiums are paid.
c. The date an Insured reaches age 70.
d. The date the Maximum Benefit Period shown in the Schedule of Benefits for this option ends.

TL-004716 as modified by TL-009330

WHAT IS COVERED

LIFE INSURANCE BENEFITS

Death Benefit

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

TL-004730

Accelerated Benefits

Any benefits payable under this and under any similar Accelerated Benefits provision accelerated under a Prior Plan will reduce the Death Benefit payable for Life Insurance. We will deduct from any Death Benefit payable under this Policy, the amount of any similar accelerated benefit paid under a Prior Plan.

Any automatic increases in Life Insurance Benefits will end when benefits are payable under this provision, unless the Insured is determined by the Insurance Company not to be eligible for Accelerated Benefits.

Terminal Illness Benefit

We will pay a Terminal Illness Benefit to an Insured who has incurred a Terminal Illness while insured under this provision.

The Terminal Illness Benefit is shown on the Schedule of Benefits.

A claim for a similar terminal illness benefit under a Prior Plan or group policy intended to replace this Policy shall be deemed payable until such time as it is finally determined not to be payable.

Determination of Terminal Illness

For the purpose of determining the existence of a Terminal Illness, we will require the Insured submit the following proof:

1. A written diagnosis and prognosis by a licensed Physician; and
2. Supportive evidence satisfactory to us, including but not limited to, radiological, histological or laboratory reports documenting the Terminal Illness.

We may require, at our expense, an examination of the Insured and a review of the documented evidence by a Physician of our choice.

Such proofs must be submitted to us within the period of time provided in the *Proof of Loss* section of the Policy. For purposes of this Benefit, the date of loss shall be the date of first prognosis of Terminal Illness.

"Terminal Illness" means that, due to an Injury or Sickness, the Insured has a prognosis of 12 months or less to live without reasonable prospect of recovery, as determined by us.

Payment of Terminal Illness Benefit
The Terminal Illness Benefit will be payable in accordance with the provisions of the *To Whom Payable* section of the Policy.

The Terminal Illness Benefit is payable only once under the Policy in an Insured's lifetime.

Conditions Applicable to Coverage
Unless the Insured qualifies for waiver of premium, premium payments must continue to be paid on the full amount of group life insurance, including during any Continuation of Insurance under the Policy, in accordance with the *Premium* section in the *Administrative Provisions.*

The amount of Life Insurance which may be converted under the *Conversion Privilege* cannot exceed the amount of the reduced death benefit payable under the Policy.

Before a Terminal Illness Benefit is paid in a Community Property state, we may require the written consent of the Insured's Spouse.

Exclusions Applicable to Terminal Illness Benefit
A Terminal Illness Benefit will not be payable:
1. when the Insured has irrevocably assigned group life insurance under this Policy;
2. when all or a portion of group life insurance benefits under this Policy are to be paid to a former spouse as part of a qualified domestic relations order;
3. for any intentionally self-inflicted Injury or Sickness, or suicide attempt;
4. if the Insured's coverage ends under the *When Coverage Ends* provision prior to the prognosis of Terminal Illness;
5. if the required premium is due and unpaid;
6. if this Policy terminates prior to the prognosis of Terminal Illness;
7. if you or the Insured is only provided coverage under the Takeover provision of the Policy (Employees Not in Active Service on the Policy Effective Date); or
8. if the date of first prognosis of Terminal Illness occurs more than 12 months before the submission of the Terminal Illness claim.

TL-004748a

Conversion Privilege for Life Insurance
Each Insured may convert all or any portion of his or her Life Insurance that would end under the Policy due to:
1. termination of employment;
2. termination of membership in an eligible class under the Policy;
3. termination of the Policy.

The Insured may apply for any type of life insurance we offer to persons of the same age in the amount applied for, except you may not:
1. choose term insurance;
2. apply for an amount of insurance greater than the coverage amount terminating under the Policy (also, the conversion policy will not provide accident, disability or other benefits); or
3. apply for more than $10,000 of insurance if the Policy is terminated or amended to terminate the insurance for any class of Insureds, or the Employer cancels participation under the Policy. Conversion in these cases is only permitted if you have been covered by the Policy or, any group life insurance policy issued to the Employer which the Policy replaced, for at least 3 years.

If the Insured becomes eligible for coverage under any group life policy within 62 days of termination of coverage under this Policy, the Insured may not convert an amount of insurance greater than the amount of coverage terminating under the Policy less the amount for which he or she may be covered under the other policy.

To apply for conversion insurance, the Insured must, within 62 days after coverage under the Policy ends:
1. submit an application to us; and
2. pay the required premium.

Evidence of insurability is not required.

Premium for the conversion insurance will be based on the age and class of risk of the Insured and the type and amount of coverage issued.

If the Insured has assigned ownership of his group coverage, the owner/assignee must apply for the individual policy.

Conversion insurance will become effective on the 31st day after the date coverage under the Policy ends provided the application is received by us and the required premium has been paid.

If the Insured dies during the 31-day conversion period, the Life Insurance benefits will be paid under the Policy regardless of whether he or she applied for conversion insurance. If a conversion policy is issued, it will be in exchange for any further benefits for that type and amount of insurance from this Policy.

Extension of Conversion Period
If an Insured is eligible for conversion insurance and is not notified of this right at least 31 days prior to the end of the 62-day conversion period, the conversion period will be extended. The Insured will have 31 days from the date notice is given to apply for conversion insurance. In no event will the conversion period be extended beyond 105 days. Notice, for the purpose of this section, means written notice presented to the Insured by the Employer or mailed to the Insured's last known address as reported by the Employer.

If the Insured dies during the extended conversion period, but more than 31 days after his or her coverage under the Policy terminates, Life Insurance benefits:
1. will not be paid under the Policy; and
2. will be payable under the conversion insurance; provided:
    a. the Insured's application for conversion insurance has been received by us; and
    b. the required premium has been paid.

Prior Conversion Limitation
If an Insured is covered under a life insurance conversion policy previously issued by us, he or she will not be eligible for this Conversion Privilege unless the prior coverage has ended.

TL-009740

LIFE INSURANCE EXCLUSIONS

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

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

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

TL-004752

CLAIM PROVISIONS

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

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

Claim Forms
When we receive notice of claim, we will send claim forms for filing proof of loss. If we do not send claim forms within 15 days after notice is received by us, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof, or proof by any other electronic/telephonic means authorized by us, of the nature and extent of the loss.

Claimant Cooperation Provision
If you fail to cooperate with us in our administration of your claim, we may terminate the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

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

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

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

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

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

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

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

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

To Whom Payable
Death Benefits will be paid to the Insured's named beneficiary, if any, on file at the time of payment or to the certificate owner if alive. If there is no named beneficiary or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives: spouse; child or children; mother or father; brothers or sisters; or to the executors or administrators of the Insured's estate. We may reduce the amount payable by any indebtedness due.

All benefits payable under the Accelerated Benefits section are payable to the Insured, if living. If the Insured dies prior to the payment of an eligible claim for an Accelerated Benefit, benefits will be paid in accordance with the provisions applicable to the payment of Life Insurance proceeds, unless the Insured has directed us otherwise in writing. However, any payment made by us prior to notice of the Insured's death shall discharge us of any benefit that was paid.

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

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

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

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

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

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

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

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

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

TL-004724

ADMINISTRATIVE PROVISIONS

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

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

Your Grace Period
If your required premium is not paid on the Premium Due Date, there is a 60 day grace period after each premium due date after the first. If the required premium is not paid during the grace period, insurance will end on the last day for which premium was paid.

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

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

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

TL-004722

PROVISIONS

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

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

Misstatement of Age
If an Insured's age has been misstated, we will adjust all benefits to the amounts that would have been purchased for the correct age.

Workers' Compensation Insurance
The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance Law.

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

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

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

TL-004728

DEFINITIONS

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

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

Active Service
If you are an Employee, you are in Active Service with the Employer on a day which is one of the Employer's scheduled work days if either of the following conditions are met.

1. You are actively at work. This means you are performing your regular occupation for the Employer on a Full-time basis, either at one of the Employer's usual places of business or at some location to which the Employer's business requires you to travel.
2. The day is a scheduled holiday, vacation day or period of Employer approved paid leave of absence, other than disability or sick leave after 7 days.

You are considered in Active Service on a day which is not one of the Employer's scheduled work days only if you were in Active Service on the preceding scheduled work day.

Dependent Child
An unmarried child who meets the following requirements.

1. A child from live birth but less than 26 years old;
2. A child who is 26 or more years old, primarily supported by you and incapable of self-sustaining employment by reason of mental or physical incapacity.
3. A child stillborn during the third trimester.

The term "child" means:

a. your natural child;
b. your legally adopted child, beginning with any waiting period pending finalization of the child's adoption. It also means the legally adopted child of your Spouse provided the child is living with, and is financially dependent upon you;
c. a stepchild born to your Spouse and who is living with and financially dependent upon you;
d. a child for whom you are the court-appointed legal guardian and who resides with, and is financially dependent upon you.

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

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

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

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

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

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

Insured
You are an Insured if you are eligible for insurance under the Policy, insurance is elected for you, the required premium is paid and your coverage is in force under the Policy.

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

Policy Anniversary
A Policy Anniversary is the date stated on the policy cover and the same date that follows every 12 months for as long the Policy is in effect.

Policy Effective Date
The Policy Effective Date is the date stated on the policy cover.

Prior Plan
The Prior Plan refers to the plan of insurance providing similar benefits to you, sponsored by the Employer and in effect directly prior to the Policy Effective Date. A Prior Plan will include the plan of an employer in effect on the day prior to that employer's addition to this policy.

To be covered under the Policy, required premium must be paid for all covered Employees.

Sickness
The term Sickness means a physical or mental illness.

Spouse
Your current lawful spouse.

Subscriber
Any participating organization that subscribes to the trust to which this Policy is issued, and which is insured under this Policy.

TL-004708-1 as modified by TL-010150a

LIFE INSURANCE COMPANY OF NORTH AMERICA
1601 CHESTNUT STREET
PHILADELPHIA, PA 19192-2235

STATE MODIFYING PROVISIONS AMENDMENT RIDER

Subscriber: The Reinalt-Thomas Corporation, a Michigan corporation, dba Discount Tire/America's Tire/Discount Tire Direct
Policy No.: FLX-980462
Amendment Effective Date: January 1, 2020

This amendment is attached to and made part of the Policy/Certificate specified above. Its provisions are intended to conform this Policy/Certificate to the laws of the state in which the insured resides.

The Policy delivered under the Group Policy are amended as follows:

APPLICABLE TO CALIFORNIA RESIDENTS:

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

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

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

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

APPLICABLE TO FLORIDA RESIDENTS:

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

APPLICABLE TO MARYLAND RESIDENTS:

The Group Insurance Policy was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

APPLICABLE TO MISSOURI RESIDENTS:

Applicable to Voluntary Life Insurance Benefits

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

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

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

APPLICABLE TO NORTH DAKOTA RESIDENTS:

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

APPLICABLE TO OREGON RESIDENTS:

NOTICE: MUST PROVIDE DOMESTIC PARTNER COVERAGE FOR OREGON RESIDENTS

APPLICABLE TO VERMONT RESIDENTS:

To the extent the Policy provides insurance coverage to a spouse, the identical consideration must be applied to same sex marriages and civil unions. The language is as follows:

1. Civil Union Partner means:
   a. A person with whom the Employee has a registered civil union under Vermont law which imposes obligations on the parties substantially similar to marriage. Such person will continue to be recognized as a Civil Union Partner unless and until:
      (1) the civil union is dissolved under applicable law; or
      (2) either the Employee or the Civil Union Partner marries another person.

2. Spouse means:
   a. "Lawful spouse" and includes a lawful spouse of the same sex.
   b. This also includes a partner to a civil union recognized under Vermont Law.

APPLICABLE TO WASHINGTON RESIDENTS:

1. The following *Continuation of Insurance* provision is added to the Policy:

   Continuation of Life Coverage During Labor Disputes
   If an Employee's Active Service ends because of a Labor Dispute and his or her premium for Life Insurance Benefits under the Policy is paid either by the Employer, in whole or in part, or by the Employee through payroll deductions, then the Employee may continue his or her Life Insurance Benefits. The Employer will send written notice of the right to continue coverage to each insured Employee at his or her most recent address as on file with the Employer.

   To continue coverage, the Employee must pay premiums directly to the Employer, who will remit the premiums to the Insurance Company. Premiums must be paid by the date they are due, subject to the 31 day grace period. Policy coverages and premiums will stay the same during a Labor Dispute; however, the Insurance Company may make normal changes in premium rates when the Policy is renewed, under the terms set forth in the Policy.

   Coverage continued in this manner will end on the earliest of the following dates.
   a. The date the Labor Dispute has ended.
   b. The date coverage has been continued for 6 months.

   If the Labor Dispute continues beyond 6 months, the Employee may apply for an individual insurance policy, as set forth in detail under "Conversion Privilege for Life Insurance."

   "Labor Dispute," as used here, means a strike, lockout, or other labor dispute between the Employer and its Employees, during which time the Employee is not paid by the Employer.

2. If the Policy provides coverage to dependents, benefits for a Spouse or Dependent Child are limited to 100% of the insured Employee's coverage amount. Stand-alone Spouse and Dependent Child coverage (when Employee is not insured) is not permitted.

3. The *Suicide* Exclusion, if any, does not apply.

4. To the extent the policy includes *Accelerated Benefits,* the following resolution of disputes requirements are added to the Policy.

   - For Terminal Illness – *Determination of Terminal Illness*

     In the event the Physician representing the Insurance Company disputes the existence of a Terminal Illness, and the dispute cannot be resolved, the Insured has the right to mediation and binding arbitration in accordance with Washington Administrative Code 284-23-730.

5. The *Incontestability Provision* is replaced as follows:

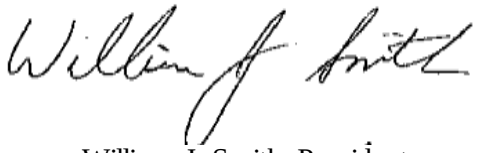
   Incontestability
   All statements made by the Employer or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement has been furnished to the claimant. In the event of death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

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

6. If the term "*Accident*" is defined in the Policy, it is replaced by the following:

Accident
An Accident is a sudden, unforeseeable event that causes bodily Injury to an Insured while coverage is in force under the Policy.

Signed for the
Life Insurance Company of North America



William J. Smith, President

TL-00-3000.00

SUPPLEMENTAL INFORMATION
for

Reinalt-Thomas Corporation Fully Insured Life, AD&D, LTD and STD Welfare Benefit Plan ("Plan")

required by the Employee Retirement Income Security Act of 1974

As a Plan participant in The Reinalt-Thomas Corporation, a Michigan corporation, dba Discount Tire/America's Tire/Discount Tire Direct's Plan, you are entitled to certain information, rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

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

IMPORTANT INFORMATION ABOUT THE PLAN

- The Plan is established and maintained by The Reinalt-Thomas Corporation, a Michigan corporation, dba Discount Tire/America's Tire/Discount Tire Direct, the Plan Sponsor.
- The Employer Identification Number (EIN) is 38-1889682.
- The Plan Number is 526.
- The Insurance Plan is administered directly by the Plan Administrator with benefits provided, in accordance with the provisions of the group insurance contract, FLX-980462 ("Policy"), issued by LIFE INSURANCE COMPANY OF NORTH AMERICA ("Insurance Company").
- The Plan Administrator is: Reinalt-Thomas Corporation
  20225 North Scottsdale Road
  Scottsdale, AZ 85255
  480-606-6000
- The Plan Administrator has authority to control and manage the operation and administration of the Plan.
- The Plan Sponsor may terminate, suspend, withdraw or amend the Plan, in whole or in part, at any time, subject to the applicable provisions of the Policy. (Your rights upon termination or amendment of the Plan are set forth in your Certificate.)
- The agent for service of legal process is the Plan Administrator.
- The Plan of benefits is financed by the Employees.
- The date of the end of the Plan Year is December 31.

YOUR RIGHTS AS SET FORTH BY ERISA

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

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

WHAT YOU SHOULD DO AND EXPECT IF YOU HAVE A CLAIM

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

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

A disability "claim" is any claim which requires a determination of disability by the Insurance Company regardless of the type of policy under which it arises (for example, short/long term disability, waiver of premium, etc.). A disability claim is "filed" as of the date the Insurance Company first receives, in writing (including electronically) or by telephone (through the Insurance Company's intake department), notice that a claimant is seeking disability benefits under the Policy. The notice of claim received should provide the date of disability/loss, the claimant's name and address, and the group Policy holder's name and address. Properly filed claims will be decided with independence and impartiality.

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

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

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

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

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

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

A written request for appeal must be received by the Insurance Company within 180 days from the date the claimant received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived. The Insurance Company has 45 days from the date it receives a request for appeal to provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim and can extend the time for decision, once, by an additional 45 days. If this should happen, the Insurance Company must provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Insurance Company's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Insurance Company receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

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

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

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

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

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

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

A non-disability "claim" is any claim which does not require a determination of disability by the Insurance Company regardless of the type of policy under which it arises (for example, a death claim, an accident claim, etc.). A non-disability claim is "filed" as of the date the Insurance Company first receives, in writing or by telephone (through the Insurance Company's intake department), notice that a claimant is seeking benefits under the Policy. The notice of claim should include the group Policy holder's name, the Policy and Certificate number and the claimant's name and address.

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

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

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

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

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

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

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

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

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

ER-03-2

UNDERWRITTEN BY:
LIFE INSURANCE COMPANY OF NORTH AMERICA
a Cigna company

Class 5
06/2021