YOUR BENEFIT PLAN

STEVENS AEROSPACE AND DEFENSE SYSTEMS, LLC.

Basic Term Life, Supplemental Dependent Life, Supplemental Term Life

Maryland

The group insurance policy providing coverage under this certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

State Notices

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: There are state-specific requirements that may change the provisions described in the group insurance certificate. If you live in a state that has such requirements, those requirements will apply to your coverage. State-specific requirements that may apply to your coverage are summarized below. In addition, updated state-specific requirements are published on our website. You may access the website at www.thehartford.com. If you are unable to access this website, want to receive a printed copy of these requirements, or have any questions or complaints regarding any of these requirements or any aspect of your coverage, please contact your Employee Benefits Manager; or you may contact us as follows:

The Hartford
Group Benefits Division, Customer Service
P.O. Box 2999
Hartford, CT 06104-2999
1-800-523-2233
https://www.thehartford.com/

If you have a complaint and contacts between you, us, your agent, or another representative have failed to produce a satisfactory solution to the problem, some states require we provide you with additional contact information. If your state requires such disclosure, the contact information is listed below with the other state requirements and notices.

We are providing notice that Hartford Life and Accident Insurance Company is subject to economic and trade sanctions laws and regulations. These laws and regulations, including the laws and regulations administered and enforced by the United States Department of the Treasury's Office of Foreign Assets Control ("OFAC"), prevent Hartford Life and Accident from providing coverage to, and from paying benefits to, entities and individuals where prohibited by applicable law. In addition, these laws and regulations prohibit certain activities with respect to certain countries.

We have included this information to make you aware of the existence and potential impact of these economic and trade sanctions programs on your benefit program.

The Hartford complies with applicable Federal civil rights laws and does not unlawfully discriminate on the basis of race, color, national origin, age, disability, or sex. The Hartford does not exclude or treat people differently for any reason prohibited by law with respect to their race, color, national origin, age, disability, or sex.

If your policy is governed under the laws of Maryland, any of the benefits, provisions or terms that apply to the state you reside in as shown below will apply only to the extent that such state requirements are more beneficial to you.

Alaska:

1. If notice of Your **Conversion Right** is not received by You on the date Your or Your Dependent's coverage terminates, You have 15 days from the date You receive the notice.
2. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
3. The **Spouse** definition will always include domestic partners, civil unions, and any other legal union recognized by state law.

Arizona:

1. **NOTICE:** The Certificate may not provide all benefits and protections provided by law in Arizona. Please read the Certificate carefully.

Arkansas:

1. **NOTICE:** You have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:
   Arkansas Insurance Department
   1 Commerce Way, Suite 102
   Little Rock, AR 72202

California:

1. The **Policy Interpretation** provision, if shown in the General Provisions section of the Certificate, does not apply to you. The following requirement applies to you:

Eligibility Determination: *How will We determine Your or Your Dependent's eligibility for benefits?*
We, and not Your Employer or plan administrator, have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine Your or Your Dependent's eligibility for benefits for any claim You or Your beneficiaries make on The Policy. We will:

1) obtain with Your or Your beneficiaries' cooperation and authorization if required by law, only such information that is necessary to evaluate Your or Your beneficiaries' claim and decide whether to accept or deny Your or Your beneficiaries' claim for benefits. We may obtain this information from Your or Your beneficiaries' Notice of Claim, submitted proofs of loss, statements, or other materials provided by You or others on Your behalf; or, at Our expense We may obtain necessary information, or have You or Your Dependent's physically examined when and as often as We may reasonably require while the claim is pending. In addition, and at Your or Your beneficiaries' option and at Your or Your beneficiaries' expense, You or Your beneficiaries may provide Us and We will consider any other information, including but not limited to, reports from a Physician or other expert of Your or Your beneficiaries' choice. You or Your beneficiaries should provide Us with all information that You or Your beneficiaries want Us to consider regarding Your or Your beneficiaries' claim;
2) As part of Our routine operations, We will apply the terms of The Policy for making decisions, including decisions on eligibility, receipt of benefits and claims or explaining policies, procedures and processes;
3) if We approve Your claim, We will review Our decision to approve Your or Your beneficiaries claim for benefits as often as is reasonably necessary to determine Your or Your Dependent's continued eligibility for benefits;
4) if We deny Your or Your beneficiaries' claim, We will explain in writing to You or Your beneficiaries the basis for an adverse determination in accordance with The Policy as described in the provision entitled **Claim Denial.**

In the event We deny Your or Your beneficiaries' claim for benefits, in whole or in part, You or Your beneficiaries can appeal the decision to Us. If You or Your beneficiaries choose to appeal Our decision, the process You or Your beneficiaries must follow is set forth in The Policy provision entitled **Claim Appeal.** If You or Your beneficiaries do not appeal the decision to Us, then the decision will be Our final decision.

2. **For Your Questions and Complaints:**
State of California Insurance Department
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
Toll Free: 1(800) 927-HELP
TDD Number: 1(800) 482-4833
Web Address: www.insurance.ca.gov

Colorado:

1. The **Suicide** provision will only exclude amounts of life insurance in effect within the first year of coverage or within the first year following an increase in coverage.
2. The **Dependent Child(ren)** definition will always include children related to You by civil union.
3. The **Spouse** definition will always include civil unions.
4. Entering a civil union, terminating a civil union, the death of a party to a civil union or a party to a civil union losing employment, which results in a loss of group insurance, will all constitute as a **Change in Family Status**.
5. The **Claim Appeal** provision will always include the following:

   In addition, if a claim for benefits is wholly or partially denied and all administrative remedies have been exhausted, You are entitled to pursue such claim anew, from the beginning, in a court with jurisdiction and entitled to a trial by jury.

Florida:

1. **Legal Actions** cannot be taken against Us more than 5 years after the date Proof of Loss is required to be furnished according to the terms of The Policy.
2. **NOTICE: The benefits of the policy providing you coverage may be governed primarily by the laws of a state other than Florida.**

Georgia:

1. **NOTICE:** The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based

upon his or her status as a victim of family abuse.

Idaho:

1. **For Your Questions and Complaints:**
   Idaho Department of Insurance
   Consumer Affairs
   700 W State Street, 3rd Floor
   PO Box 83720
   Boise, ID 83720-0043
   Toll Free: 1-800-721-3272
   Web Address: www.DOI.Idaho.gov

Illinois:

1. **For Your Questions and Complaints:**
   Illinois Department of Insurance
   Consumer Services Station
   Springfield, Illinois 62767
   Consumer Assistance: 1(866) 445-5364
   Officer of Consumer Health Insurance: 1(877) 527-9431
   Web Address: http://insurance.illinois.gov/
2. In accordance with Illinois law, insurers are required to provide the following **NOTICE** to applicants of insurance policies issued in Illinois.

STATE OF ILLINOIS
The Religious Freedom Protection and Civil Union Act
Effective June 1, 2011

The Religious Freedom Protection and Civil Union Act ("the Act") creates a legal relationship between two persons of the same or opposite sex who form a civil union. The Act provides that the parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Illinois to spouses. The law further provides that a party to a civil union shall be included in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms "marriage" or "married," or variations thereon. Insurance policies are required to provide identical benefits and protections to both civil unions and marriages. If policies of insurance provide coverage for children, the children of civil unions must also be provided coverage. The Act also requires recognition of civil unions or same sex civil unions or marriages legally entered into in other jurisdictions.

For more information regarding the Act, refer to 750 ILCS 75/1 *et seq*. Examples of the interaction between the Act and existing law can be found in the Illinois Insurance Facts, Civil Unions and Insurance Benefits document available on the Illinois Department of Insurance's website at http://insurance.illinois.gov/.

Indiana:

1. **For Your Questions and Complaints:**
   Public Information/Market Conduct
   Indiana Department of Insurance
   311 W. Washington St. Suite 300
   Indianapolis, IN 46204-2787
   1(317) 232-2395

Louisiana:

1. The age limit stated in the **Continuation for Dependent Child(ren)** with Disabilities provision is increased to 21, if less than 21.
2. The following requirement applies to you:

   Reinstatement after Military Service: *Can coverage be reinstated after return from active military service?*

If Your or Your Dependents' coverage ends because You or Your Dependents enter active military service, coverage may be reinstated, provided You request such reinstatement upon Your or Your Dependents' release from active military service.

The reinstated coverage will:

1) be the same coverage amounts in force on the date coverage ended;
2) not be subject to any Eligibility Waiting Period for Coverage or Evidence of Insurability; and
3) be subject to all the terms and provisions of The Policy.

Maine:

1. **NOTICE:** The laws of the State of Maine require notification of the right to designate a third party to receive notice of cancellation, to change such a designation and, to have the Policy reinstated if the insured suffers from cognitive impairment or functional incapacity and the ground for cancellation was the insured's nonpayment of premium or other lapse or default on the part of the insured.

   Within 10 days after a request by an insured, a Third Party Notice Request Form shall be mailed or personally delivered to the insured.

Massachusetts:

1. The definition of **Terminal Illness or Terminally Ill** shown in the **Accelerated Benefit** cannot exceed 24 months.
2. **NOTICE: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).**

   This plan is not intended to provide comprehensive health care coverage and **does not meet Minimum Creditable Coverage standards**, even if it does include services that are not available in the insured's other health plans.

   If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

Michigan:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

Minnesota:

1. You or Your Dependents must be on a documented military leave of absence in order to qualify for the Military Leave of Absence continuation shown in the **Continuation Provisions**.
2. If there are 25 or more residents of Minnesota who are covered under The Policy, or there are fewer than 25 residents and those residents constitute 25% or more of the total number of people covered under The Policy, the Lay Off continuation shown in the **Continuation Provisions** shall not apply to you. The following requirement applies to you:

   Minnesota Coverage Continuation: If You are voluntarily or involuntarily terminated or Laid Off by the Employer, You may elect to continue Your Life Insurance coverage (including Dependent Life coverage) by making premium payments to the Employer for the cost of continued coverage. Continued coverage will take effect on the date Your coverage would otherwise have ended and must be elected within 60 days from:

   1) the date Your coverage would otherwise terminate; or
   2) the date You receive a written notice of Your right to continue coverage from the Employer;

   whichever is later.

   The amount of premium charged may not exceed 102% of the premium paid for other similarly situated employees who are Actively at Work. The Employer will inform You of:

   1) Your right to continue coverage;
   2) the amount of premium; and
   3) how, where and by when payment must be made.

Upon request, the Employer will provide You Our written verification of the cost of coverage.

Coverage will be continued until the earliest of:
1) the date You are covered under another group policy;
2) the date the required premium is due but not paid; or
3) the last day of the 18th month following the date of termination or Lay Off.

Upon the termination of continued coverage, You may:
1) exercise Your Conversion Right; or
2) continue coverage under a group Portability policy; and
3) qualify for Retiree coverage.

Minnesota law requires that if Your coverage ends because the Employer fails to notify You of Your right to continue coverage or fails to pay the premium after timely receipt, the Employer will be liable for benefit payments to the extent We would have been liable had You still been covered.

3. If the following paragraph appears in the **Accelerated Benefit** provision, it does not apply to you:

   In the event:
   1) You are required by law to accelerate benefits to meet the claims of creditors; or
   2) if a government agency requires You to apply for benefits to qualify for a government benefit or entitlement;

   You will still be required to satisfy all the terms and conditions herein in order to receive an Accelerated Benefit
4. If there are 25 or more residents of Minnesota who are covered under The Policy and those 25 residents constitute 25% or more of the total number of people covered under The Policy, You are not required to be insured under The Policy for a specified period of time in order to exercise the **Conversion Right**.

Missouri:
1. The period in which You must remain Disabled to qualify for **Waiver of Premium** cannot exceed 180 days.
2. If Waiver of Premium is approved and You have completed the elimination period, We will retroactively refund to You, or to Your estate if You have died, any premiums paid during the period You have been continuously Disabled.
3. The **Suicide** provision will only exclude amounts of life insurance in effect within the first year of coverage or within the first year following an increase in coverage.

Montana:
1. The time period in which You are required to be insured under The Policy in order to exercise the **Conversion Right** cannot exceed 3 years.
2. If You are eligible to receive the **Felonious Assault Benefit**, We will not exclude for losses that result from a Felonious Assault committed by a member of Your family or a member of the household in which You live.
3. **NOTICE:** Conformity with Montana statutes: The provisions of the certificate conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of the certificate.

New Hampshire:
1. Your Spouse may be eligible to continue his or her Life Insurance coverage in the event of divorce or separation as shown in the **Spouse Continuation** below:

   Spouse Continuation: *Can coverage for my Spouse be continued in the event of divorce or separation?*
   If:
   1) You are a resident of New Hampshire;
   2) You get a divorce or legal separation from a Spouse that is covered under The Policy; and
   3) the final decree of divorce or legal separation does not expressly prohibit it;

   Your former Spouse may continue his or her coverage.

   We must receive Your Spouse's written request and the required premium to continue his or her coverage within 30 days of the final decree of divorce or legal separation.

Solely for the purpose of continuing the coverage, Your Spouse will be considered the insured person. However, Your former Spouse's coverage will not continue beyond the earliest of:

1) the 3-year anniversary of the final decree of divorce or legal separation;
2) the remarriage of the former Spouse;
3) Your death;
4) an earlier time as provided by the final decree of divorce or legal separation; or
5) a date the coverage would otherwise have ended under the Dependent Termination Provision.

New Mexico:

1. **For Your Questions and Complaints:**
   Office of Superintendent of Insurance
   Consumer Assistance Bureau
   P.O. Box 1689
   Santa Fe, NM 87504-1689
   1(855) 427-5674

New York:

1. If the definition of **Spouse** requires the completion of a domestic partner affidavit, the requirement applies to you: The domestic partner affidavit must be notarized and requires that You and Your domestic partner meet all of the following criteria:
   1) you are both legally and mentally competent to consent to contract in the state in which you reside;
   2) you are not related by blood in a manner that would bar marriage under laws of the state in which you reside;
   3) you have been living together on a continuous basis prior to the date of the application;
   4) neither of you have been registered as a member of another domestic partnership within the last six months; and
   5) you provide proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof).

   The domestic partner affidavit further requires that You and Your domestic partner provide proof of financial interdependence in the form of at least two of the following:
   1) a joint bank account;
   2) a joint credit card or charge card;
   3) joint obligation on a loan;
   4) status as an authorized signatory on the partner's bank account, credit card or charge card;
   5) joint ownership of holdings or investments, residence, real estate other than residence, major items of personal property (e.g., appliances, furniture), or a motor vehicle;
   6) listing of both partners as tenants on the lease of the shared residence;
   7) shared rental payments of residence (need not be shared 50/50)
   8) listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
   9) a common household and shared household expenses (e.g., grocery bills, utility bills, telephone bills, etc. and need not be shared 50/50);
   10) shared household budget for purposes of receiving government benefits;
   11) status of one as representative payee for the other's government benefits;
   12) joint responsibility for child care (e.g., school documents, guardianship);
   13) shared child-care expenses (e.g., babysitting, day care, school bills, etc. and need not be shared 50/50);
   14) execution of wills naming each other as executor and/or beneficiary;
   15) designation as beneficiary under the other's life insurance policy;
   16) designation as beneficiary under the other's retirement benefits account;
   17) mutual grant of durable power of attorney;
   18) mutual grant of authority to make health care decisions (e.g., health care power of attorney);
   19) affidavit by creditor or other individual able to testify to partners' financial interdependence;

20) other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

North Carolina:

1. **NOTICE:** UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, FINANCIAL AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP LIFE INSURANCE, GROUP HEALTH OR GROUP HEALTH PLAN PREMIUMS, SHALL:
   1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP LIFE INSURANCE, GROUP HEALTH INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSON INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT; AND
   2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

IMPORTANT TERMINATION INFORMATION

YOUR INSURANCE MAY BE CANCELLED BY THE COMPANY. PLEASE READ THE TERMINATION PROVISION IN THE CERTIFICATE.

THE CERTIFICATE OF INSURANCE PROVIDES COVERAGE UNDER A GROUP MASTER POLICY. THE CERTIFICATE PROVIDES ALL OF THE BENEFITS MANDATED BY THE NORTH CAROLINA INSURANCE CODE, BUT YOU MAY NOT RECEIVE ALL OF THE PROTECTIONS PROVIDED BY A POLICY ISSUED IN NORTH CAROLINA AND GOVERNED BY ALL OF THE LAWS OF NORTH CAROLINA.

North Dakota:

1. The **Suicide** provision will only exclude amounts of life insurance in effect within the first year of coverage or within the first year following an increase in coverage.

Ohio:

1. Any references to the **Accelerated Benefit** shall be changed to the **Accelerated Death Benefit**.

Oregon:

1. The **Spouse** definition will include Your domestic partner provided You have registered as domestic partners with a government agency or office where such registration is available. You will not be required to provide proof of such registration.
2. The **Dependent Child(ren)** definition will include children related to You by domestic partnership.
3. The following Jury Duty continuation applies for Employers with 10 or more employees:

   Jury Duty: If You are scheduled to serve or are required to serve as a juror, Your coverage may be continued until the last day of Your Jury Duty, provided You:
   1) elected to have Your coverage continued; and
   2) provided notice of the election to Your Employer in accordance with Your Employer's notification policy.

Rhode Island:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

South Carolina:

1. The dollar amount stated in the third paragraph of the **Claims to be Paid** provision is changed to $2,000, if greater than $2,000.
2. If the **Continuity from a Prior Policy for Disability Extension** provision is included in the Certificate and You qualify for continued coverage, Your Amount of Insurance will be the greater of the amount of life insurance and

accidental death and dismemberment principal sum that You had under the Prior Policy or the amount shown in the Schedule of Insurance. This Amount of Insurance will be reduced by any coverage amount that is in force, paid or payable under the Prior Policy or that would have been payable under the Prior Policy had timely election been made.

3. If The Policy Terminates or Your Employer ceases to be a Participating Employer and You have been approved for the **Waiver of Premium**, Your coverage under the terms of this provision will not be affected. Your Dependent coverage will continue for a period of 12 months from the date of Policy termination and will be subject to the terms and conditions of The Policy.
4. If The Policy Terminates or Your Employer ceases to be a Participating Employer and You have been approved for the **Disability Extension**, Your and Your Dependent's coverage will be continued for a period of up to 12 months from the date The Policy terminated or Your Employer ceased to be a Participating Employer, as long as premiums are paid when due. Coverage during this period will be subject to the other terms and conditions of the **Disability Extension Ceases** provision. When this extension period is exhausted, You may be eligible to exercise the **Conversion Right** for You and Your Dependent's coverage. **Portability Benefits** will not be available

South Dakota:

1. The definition of **Physician** can include You or a person Related to You by blood or marriage in the event that the Physician is the only one in the area and is acting within the scope of their normal employment.

Texas:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
2. **NOTICE:**

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

Hartford Life and Accident Insurance Company
To get information or file a complaint with your insurance company:

Call: Customer Service at 860-547-5000

Toll-free: 1-800-523-2233

Online: https://www.thehartford.com/contact-the-hartford
Email: GBD.Customerservice@hartfordlife.com
Mail: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros. Si no lo hace, podría perder su derecho para apelar.

Hartford Life and Accident Insurance Company
Para obtener información o para presentar una queja ante su compañía de seguros:

Llame a: servicio al cliente al 860-547-5000

Teléfono gratuito: 1-800-523-2233

En línea: https://www.thehartford.com/contact-the-hartford
Correo electrónico: GBD.Customerservice@hartfordlife.com
Dirección postal: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

Utah:

1. We will send **Claim Forms** within 15 days of receiving a Notice of Claim. If We do not send the forms within 15 days, any other written proof which fully describes the nature and extent of the claim may be submitted.
2. If the **Sending Proof of Loss** provision provides a timeframe in which proof must be submitted before it affects Your claim, this time limitation shall not apply to You.
3. When We determine that benefits are payable, We will make **Claim Payments** within no more than 45 days after **Proof of Loss** is received.
4. Any reference to fraud within the **Incontestability** provision does not apply to You.
5. A Sickness or Injury continuation of at least 6 months must be included in the **Continuation Provisions**.

Vermont:

1. The following requirement applies:

Purpose: This requirement is intended to provide benefits for parties to a civil union. Vermont law requires that insurance contracts and policies offered to married persons and their families be made available to parties to a civil union and their families. In order to receive benefits in accordance with this requirement, the civil union must have been established in the state of Vermont according to Vermont law.

General Definitions, Terms, Conditions and Provisions: The general definitions, terms, conditions or any other provisions of the policy, contract, certificate and/or riders and endorsements are hereby superseded as follows:

1) Terms that mean or refer to a marital relationship or that may be construed to mean or refer to a marital relationship: such as "marriage", "spouse", "husband", "wife", "dependent", "next of kin", "relative", "beneficiary", "survivor", "immediate family" and any other such terms include the relationship created by a civil union.
2) Terms that mean or refer to a family relationship arising from a marriage such as "family", "immediate family", "dependent", "children", "next of kin", "relative", "beneficiary", "survivor" and any other such terms include the family relationship created by a civil union.
3) Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage", "divorce decree", "termination of marriage" and any other such terms include the inception or dissolution of a civil union.
4) "Dependent" means a spouse, a party to a civil union, and/or a child or children (natural, stepchild, legally adopted or a minor who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union.

5) "Child or covered child" means a child (natural, step-child, legally adopted or a minor who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union.

<u>Cautionary Disclosure:</u> THIS NOTICE IS ISSUED TO MEET THE REQUIREMENTS OF VERMONT LAW AS EXPLAINED IN THE "PURPOSE" PARAGRAPH OF THE NOTICE. THE FEDERAL GOVERNMENT OR ANOTHER STATE GOVERNMENT MAY NOT RECOGNIZE THE BENEFITS GRANTED UNDER THIS NOTICE. YOU ARE ADVISED TO SEEK EXPERT ADVICE TO DETERMINE YOUR RIGHTS UNDER THIS CONTRACT

2. Interest on a **Claim Payment** is payable from the date of death until the date payment is made at an interest rate of 6% annually or Our corporate interest rate, whichever is greater.

Virginia:

1. **For Your Questions and Complaints:**
   State Corporation Commission
   Life and Health Division
   Bureau of Insurance
   P.O. Box 1157
   Richmond, VA 23218
   1(804) 371-9691 (inside Virginia)
   1(877) 310-6560 (outside Virginia)

Washington:

1. The following **Disputed Diagnosis** requirement applies to You:

   Disputed Diagnosis: *What happens if a dispute occurs over whether I am Terminally Ill or my Dependent is Terminally Ill?*
   If Your or Your Dependent's attending Physician, and a Physician appointed by Us, disagree on whether You or Your Dependent are Terminally Ill, Our Physician's opinion will not be binding upon You or Your Dependent. The two parties shall attempt to resolve the matter promptly and amicably. If the disagreement is not resolved, You or Your Dependent have the right to mediation or binding arbitration conducted by a disinterested third party who has no ongoing relationship with either You or Your Dependent or Us. Any such arbitration shall be conducted in accordance with the laws of the State of Washington. As part of the final decision, the arbitrator or mediator shall award the costs of the arbitrator to one party or the other, or may divide the costs equally or otherwise.

2. A Labor Dispute continuation of at least 6 months must be included in the **Continuations Provisions**.
3. The **Dependent Child(ren)** definition will always include children related to You by domestic partnership.
4. The definition of **Spouse** will always include domestic partners.
5. The provision titled **Suicide** does not apply to you.

Wisconsin:

1. **For Your Questions and Complaints:**
   To request a Complaint Form:
   Office of the Commissioner of Insurance
   Complaints Department
   P.O. Box 7873
   Madison, WI 53707-7873
   1(800) 236-8517 (outside of Madison)
   1(608) 266-0103 (in Madison)

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

CERTIFICATE OF INSURANCE

Policyholder: STEVENS AEROSPACE AND DEFENSE SYSTEMS, LLC.
Policy Number: GL-034329
Policy Effective Date: January 1, 1995
Policy Anniversary Date: January 1, 2025

We have issued The Policy to the Policyholder. Our name, the Policyholder's name and the Policy Number are shown above. The provisions of The Policy, which are important to You, are summarized in this certificate consisting of this form and any additional forms which have been made a part of this certificate. This certificate replaces any other certificate We may have given to You earlier under The Policy. The Policy alone is the only contract under which payment will be made. Any difference between The Policy and this certificate will be settled according to the provisions of The Policy on file with Us at Our home office. The Policy may be inspected at the office of the Policyholder.

Signed for the Company

Kevin Barnett, *Secretary*

Jonathan Bennett, *President*

A note on capitalization in this Certificate:
Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in The Policy or refers to a specific provision contained herein.

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SCHEDULE OF INSURANCE

The benefits described herein are those in effect as of August 1, 2024.

Cost of Coverage:
Non-Contributory Coverage: Basic Life Insurance

Contributory Coverage: Supplemental Life Insurance
Supplemental Dependent Life Insurance

Disclosure of Fees:
We may reduce or adjust premiums, rates, fees and/or other expenses for programs under The Policy.

Disclosure of Services:
In addition to the insurance coverage, We may offer noninsurance benefits and services to Active Employees.

Eligible Class(es) For Coverage: All Full-time Active Employees who are citizens or legal residents of the United States, its territories and protectorates; excluding Aircraft Sales Employees temporary, leased or seasonal employees.

Full-time Employment: at least 32 hours weekly

Annual Enrollment Period: November 1st through November 30th

Eligibility Waiting Period for Coverage:
1) None - if You are working for the Employer on the Policy Effective Date; or
2) The first day of the month following 1 month(s) of employment - if You start working for the Employer after the Policy Effective Date.

The time period(s) referenced above are continuous.

Life Insurance Benefit

Amount of Life Insurance:

Basic Amount of Life Insurance

Maximum Amount

1 times Your annual Earnings, subject to a maximum of $250,000 rounded to the next higher $1,000 if not already a multiple of $1,000.

Supplemental Amount of Life Insurance

Option 1:

Maximum Amount

$25,000

Option 2:

Maximum Amount

$50,000

Option 3:

Maximum Amount

$100,000

Option 4:

Maximum Amount

$200,000

Option 5:

Maximum Amount

$300,000

Option 6:

Guaranteed Issue Amount	**Maximum Amount**
$300,000	$500,000

Dependent Life Insurance Benefit

Supplemental Amount of Dependent Life Insurance

	Maximum Amount
Spouse	$50,000
Dependent Children: Age 15 day(s) but under age 6 month(s)	$10,000
Dependent Children: Age 6 month(s) but under age 19 year(s)	$10,000

Reduction in Amount of Life Insurance

We will reduce the Amount of Life Insurance for You and Your Dependents by any Amount of Life Insurance in force, paid or payable:

1) in accordance with the Conversion Right; or
2) under the Prior Policy.

Reduction in Coverage Due to Age

We will reduce the Life Insurance Benefit for You by the percentage indicated in the table below. This reduction will be effective on the Policy Anniversary Date following the date You attain the ages shown below. The reduction will apply to the Amount of Life Insurance in force immediately prior to that Anniversary Date.

Reductions also apply if:

1) You become covered under The Policy; or
2) Your coverage increases;

on or after the date You attain age 65.

Percentage by which current amount of coverage (after all previous reductions) will be reduced.	**Your Age**	**Your % Reduction**
	65	65%
	70	42%
	75	27%
	80	20%
	85	15%

90	11%
95	8%

The reduced amount of coverage will be rounded to the next higher multiple of $500, if not already a multiple of $500. An appropriate adjustment in premium will be made.

ELIGIBILITY AND ENROLLMENT

Eligible Persons: *Who is eligible for coverage?*
All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

Eligibility for Coverage: *When will I become eligible?*
You will become eligible for coverage on the latest of:
1) the Policy Effective Date;
2) the date You become a member of an Eligible Class; or
3) the date You complete the Eligibility Waiting Period for Coverage shown in the Schedule of Insurance, if applicable.

Eligibility for Dependent Coverage: *When will I become eligible for Dependent Coverage?*
You will become eligible for Dependent coverage on the later of:
1) the date You become insured for employee coverage; or
2) the date You acquire Your first Dependent.

No person may be insured:
1) as a Dependent and an Active Employee; or
2) as a Dependent of more than one Active Employee;

under The Policy.

Enrollment: *How do I enroll for coverage?*
For Non-Contributory Coverage, Your Employer will automatically enroll You for coverage. However, You will be required to complete a beneficiary designation form.

To enroll for Contributory Coverage, You must:
1) complete and sign a group insurance enrollment form which is satisfactory to Us, for Your and Your Dependent's coverage; and
2) deliver it to Your Employer.

If You do not enroll for Your coverage and/or Your Dependent's coverage within 31 days after becoming eligible under The Policy, or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll You may enroll for Your coverage and/or Your Dependent's coverage only:
1) during an Annual Enrollment Period designated by the Policyholder; or
2) within 31 days of the date You have a Change in Family Status.

Enrollment may be subject to the Evidence of Insurability Requirements provision.

Evidence of Insurability Requirements: *When will I first be required to provide Evidence of Insurability?*
We require Evidence of Insurability for initial coverage, if You:
1) enroll more than 31 days after the date You are first eligible to enroll, including electing initial coverage after a Change in Family Status;
2) enroll for an Amount of Life Insurance greater than the Supplemental Guaranteed Issue Amount, regardless of when You enroll for coverage; or
3) were eligible for any coverage under the Prior Policy, but did not enroll and later choose to enroll for that coverage under The Policy.

If Your Evidence of Insurability is not satisfactory to Us:
1) Your Amount of Life Insurance will equal the amount for which You were eligible without providing Evidence of Insurability, provided You enrolled within 31 days of the date You were first eligible to enroll; and

2) You will not be covered under The Policy if You enrolled more than 31 days after the date You were first eligible to enroll.

Dependent Evidence of Insurability Requirements: *When will my Dependents first be required to provide Evidence of Insurability?*
We require Evidence of Insurability, satisfactory to Us, for initial coverage, if You:
1) enroll for Your Dependents' coverage more than 31 days after the date You are first eligible to enroll, including electing initial coverage after a Change in Family Status; or
2) were eligible for any coverage under the Prior Policy, but did not enroll and later choose to enroll for that coverage under The Policy.

However, no Evidence of Insurability will be required if the Amount of Life Insurance for Your Dependent Child(ren) is $15,000 or less.

If Your Dependents' Evidence of Insurability is not satisfactory to Us:
1) Your Dependents' Amount of Life Insurance will equal the amount for which Your Dependents were eligible without providing Evidence of Insurability, provided You enrolled Your Dependents within 31 days of the date You were first eligible to enroll;
2) Your Dependents will not be covered under The Policy if You enrolled Your Dependents more than 31 days after the date You were first eligible to enroll.

Evidence of Insurability: *What is Evidence of Insurability?*
Evidence of Insurability must be satisfactory to Us and may include, but will not be limited to:
1) a completed and signed application approved by Us;
2) a medical examination;
3) an attending Physician's statement; and
4) any additional information We may require.

Evidence of Insurability will be furnished at Our expense except for Evidence of Insurability due to late enrollment. We will then determine if You or Your Dependents are insurable for initial coverage or an increase in coverage under The Policy.

You will be notified in writing of Our determination of any Evidence of Insurability submission.

Change in Family Status: *What constitutes a Change in Family Status?*
A Change in Family Status occurs when:
1) You get married;
2) You and Your spouse divorce;
3) Your child is born or You adopt or become the legal guardian of a child;
4) Your spouse dies;
5) Your child is no longer financially dependent on You or dies;
6) Your spouse is no longer employed, which results in a loss of group insurance; or
7) You have a change in classification from part-time to full-time or from full-time to part-time.

PERIOD OF COVERAGE

Effective Date: *When does my coverage start?*
Non-Contributory Coverage will start on the date You become eligible.

Contributory Coverage, for which Evidence of Insurability is not required, will start on the latest to occur of:
1) the date You become eligible, if You enroll on or before that date;
2) the January 1st on or next following the last day of the Annual Enrollment Period, if You enroll during an Annual Enrollment Period; or
3) the date You enroll, if You do so within 31 days from the date You are eligible.

Any coverage for which Evidence of Insurability is required, will become effective on the later of:
1) the date You become eligible; or
2) the date We approve Your Evidence of Insurability.

All Effective Dates of coverage are subject to the Deferred Effective Date provision.

Deferred Effective Date: *When will my effective date for coverage or a change in my coverage be deferred?*
If, on the date You are to become covered:
1) under The Policy;
2) for increased benefits; or
3) for a new benefit;

You are not Actively at Work due to a physical or mental condition, such coverage will not start until the date You are Actively at Work.

Continuity from a Prior Policy: *Is there continuity of coverage from a Prior Policy?*
Your initial coverage under The Policy will begin, and will not be deferred if, on the day before the Policy Effective Date, You were:
1) insured under the Prior Policy; and
2) Actively at Work or on an authorized family and medical leave;

but on the Policy Effective Date, You were not Actively at Work, and would otherwise meet the Eligibility requirements of The Policy. However, Your Amount of Insurance will be the lesser of the amount of life insurance:
1) You had under the Prior Policy; or
2) shown in the Schedule of Insurance;

reduced by any coverage amount:
1) that is in force, paid or payable under the Prior Policy; or
2) that would have been so payable under the Prior Policy had timely election been made.

Such amount of insurance under this provision is subject to any reductions in The Policy and will not increase.

Coverage provided through this provision ends on the first to occur of:
1) the last day of a period of 12 consecutive months after the Policy Effective Date;
2) the date Your insurance terminates for any reason shown under the Termination provision;
3) the last day You would have been covered under the Prior Policy, had the Prior Policy not terminated; or
4) the date You are Actively at Work.

However, if the coverage provided through this provision ends because You are Actively at Work, You may be covered as an Active Employee under The Policy.

Dependent Effective Date: *When does Dependent coverage start?*
Coverage will start on the latest to occur of:
1) the date You become eligible for Dependent coverage, if You have enrolled on or before that date; or
2) the January 1st on or next following the last day of the Annual Enrollment Period, if You enroll during an Annual Enrollment Period; or
3) the date You enroll, if You do so within 31 days from the date You are eligible for Dependent coverage.

Coverage for which Evidence of Insurability is required, will become effective on the later of:
1) the date You become eligible for Dependent coverage; or
2) the date We approve Your Dependents' Evidence of Insurability.

In no event will Dependent coverage become effective before You become insured.

Dependent Deferred Effective Date: *When will the effective date for Dependent coverage or a change in coverage be deferred?*
If, on the date Your Dependent is to become covered:
1) under The Policy;
2) for increased benefits; or
3) for a new benefit; and

he or she is:
1) confined in a hospital; or
2) Confined Elsewhere;

such coverage will not start until he or she:
1) is discharged from the hospital; or
2) is no longer Confined Elsewhere;

and has engaged in all the normal and customary activities of a person of like age and gender, in good health, for at least 15 consecutive days.

This Deferred Effective Date provision will not apply to disabled children who qualify under the definition of Dependent Child(ren).

Confined Elsewhere means Your Dependent is unable to perform, unaided, the normal functions of daily living, or leave home or other place of residence without assistance.

Dependent Continuity from a Prior Policy: *Is there continuity of coverage from a Prior Policy for my Dependents?*
If on the day before the Policy Effective Date, You were covered with respect to Your Dependents under the Prior Policy, the Deferred Effective Date provision will not apply to initial coverage under The Policy for such Dependents. However, the Dependent Amount of Insurance will be the lesser of the amount of life insurance:

1) Your Dependents had under the Prior Policy; or
2) shown in the Schedule of Insurance;

reduced by any coverage amount:

1) that is in force, paid or payable under the Prior Policy; or
2) that would have been so payable under the Prior Policy had timely election been made.

Change in Coverage: *When may I change my coverage or coverage for my Dependents?*
After Your initial enrollment You may increase or decrease coverage for You or Your Dependents, or add a new Dependent to Your existing Dependent coverage:

1) during any Annual Enrollment Period designated by the Policyholder; or
2) within 31 days of the date of a Change in Family Status.

Effective Date for Changes in Coverage: *When will changes in coverage become effective?*
Any decrease in coverage will take effect on the date of the change.

Any increase in coverage will take effect on the latest of:

1) the date of the change;
2) the date requirements of the Deferred Effective Date provision are met;
3) the date Evidence of Insurability is approved, if required; or
4) the January 1st on or next following the last day of the Annual Enrollment Period, except for an increase as a result of a Change in Family Status.

Increase in Amount of Life Insurance: *If I request an increase in the Amount of Life Insurance, must I provide Evidence of Insurability?*
If You or Your Dependents are:

1) already enrolled for an Amount of Supplemental Life Insurance under The Policy, then You and Your Dependents must provide Evidence of Insurability for an increase of more than one level; or
2) not already enrolled for an Amount of Supplemental Life Insurance under The Policy, You and Your Dependents must provide Evidence of Insurability for any amount of Supplemental Life Insurance coverage including an initial amount.

In any event, if the Amount of Life Insurance You request is greater than the Guaranteed Issue Amount, You must provide Evidence of Insurability.

If Your Evidence of Insurability is not satisfactory to Us, the Amount of Life Insurance You had in effect on the date immediately prior to the date You requested the increase will not change.

Termination: *When will my coverage end?*
Your coverage will end on the earliest of the following:

1) the date The Policy terminates;
2) the date You are no longer in a class eligible for coverage, or The Policy no longer insures Your class;
3) the date the premium payment is due but not paid;
4) the last day of the pay period coincident with or next following the date Your Employer terminates Your employment; or
5) the date You are no longer Actively at Work;

unless continued in accordance with any one of the Continuation Provisions.

Dependent Termination: *When does coverage for my Dependent end?*
Coverage for Your Dependent will end on the earliest to occur of:

1) the date Your coverage ends;
2) the date the required premium is due but not paid;
3) the date You are no longer eligible for Dependent coverage;
4) the date We or the Employer terminate Dependent coverage; or
5) the date the Dependent no longer meets the definition of Dependent;

unless continued in accordance with the Continuation Provisions.

Continuation Provisions: *Can my coverage and coverage for my Dependents be continued beyond the date it would otherwise terminate?*
Coverage can be continued by Your Employer beyond a date shown in the Termination provision, if Your Employer provides a plan of continuation which applies to all employees the same way.

The amount of continued coverage applicable to You or Your Dependents will be the amount of coverage in effect on the date immediately before coverage would otherwise have ended. Continued coverage:
1) is subject to any reductions in The Policy;
2) is subject to payment of premium;
3) may be continued up to the maximum time shown in the provisions; and
4) terminates if The Policy terminates.

In no event will the amount of insurance increase while coverage is continued in accordance with the following provisions. The Continuation Provisions shown below may not be applied consecutively.

In all other respects, the terms of Your coverage and coverage for Your Dependents remain unchanged.

Leave of Absence: If You are on a documented leave of absence, other than Family and Medical Leave or Military Leave of Absence, Your coverage (including Dependent Life coverage) may be continued for 5 month(s) after the month in which the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Military Leave of Absence: If You enter active full-time military service and are granted a military leave of absence in writing, Your coverage (including Dependent Life coverage) may be continued for up to 12 weeks. If the leave ends prior to the agreed upon date, this continuation will cease immediately.

Disability Insurance: If You are working for the Policyholder and:
1) are covered by; and
2) meet the definition of disabled under;

a group long term disability insurance policy, issued by Us to Your Employer, Your coverage (including Dependent Life coverage) may be continued for a period of 12 consecutive month(s) from the date You were last Actively at Work while You remain disabled.

Sickness or Injury: If You are not Actively at Work due to sickness or injury, all of Your coverages (including Dependent Life coverage) may be continued:
1) for a period of 12 consecutive month(s) from the date You were last Actively at Work; or
2) if such absence results in a leave of absence in accordance with state or federal family and medical leave laws, then the combined continuation period will not exceed 12 consecutive month(s).

Family and Medical Leave: If You are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your coverage(s) (including Dependent Life coverage) may be continued for up to 12 weeks, or 26 weeks if You qualify for Family Military Leave, or longer if required by other applicable law, following the date Your leave commenced. If the leave of absence ends prior to the agreed upon date, this continuation will cease immediately.

Severance: If Your employment terminates and continuation of life insurance is available to You and Your Dependents in a severance plan sponsored by the Employer, all of Your coverage (including Dependent Life coverage) may be continued. Your coverage will continue until the earliest of:
1) the date The Policy terminates;
2) the date You become covered under another group life insurance policy; or
3) the date specified in Your severance plan.

Coverage for Your Dependents will continue until the earliest of:
1) the date Your Dependents no longer meet the definition of Dependents;
2) the date We or Your Employer terminate Dependent coverage; or

3) the date Your coverage terminates.

Continuation for Dependent Child(ren) with Disabilities: *Will coverage for Dependent Child(ren) with disabilities be continued?*
If Your Dependent Child(ren) reach the age at which they would otherwise cease to be a Dependent as defined, and they are:
1) age 19 or older; and
2) disabled; and
3) primarily dependent upon You for financial support;

then Dependent Child(ren) coverage will not terminate solely due to age. However:
1) You must submit proof satisfactory to Us of such Dependent Child(ren)'s disability within 31 days of the date he or she reaches such age; and
2) such Dependent Child(ren) must have become disabled before attaining age 19.

Coverage under The Policy will continue as long as:
1) You remain insured;
2) the child continues to meet the required conditions; and
3) any required premium is paid when due.

However, no increase in the Amount of Life Insurance for such Dependent Child(ren) will be available.

We have the right to require proof, satisfactory to Us, as often as necessary during the first two years of continuation, that the child continues to meet these conditions. We will not require proof more often than once a year after that.

Waiver of Premium: *Does coverage continue if I am Disabled?*
Waiver of Premium is a provision which allows You to continue Your and Your Dependents' coverage without paying premium, while You are Disabled and qualify for Waiver of Premium.

If You qualify for Waiver of Premium, the amount of continued coverage:
1) will be the amount in force on the date You cease to be an Active Employee;
2) will be subject to any reductions provided by The Policy; and
3) will not increase.

Only Your Dependents who were covered under The Policy when You were last Actively at Work will be covered under Waiver of Premium.

Eligible Coverages: *What coverages are eligible under this provision?*
This provision applies only to:
1) Your Basic Life Insurance;
2) Your Supplemental Life Insurance; and
3) Dependent Life Insurance.

Disabled: *What does Disabled mean?*
Disabled means You are prevented by injury or sickness from doing any work for which You are, or could become, qualified by:
1) education;
2) training; or
3) experience.

Conditions for Qualification: *What conditions must I satisfy before I qualify for this provision?*
To qualify for Waiver of Premium You must:
1) be covered under The Policy and be under age 60 when you become Disabled;
2) be Disabled and provide Proof of Loss that You have been Disabled for 9 consecutive months, starting on the date You were last Actively at Work; and
3) provide such proof within one year of Your last day of work as an Active Employee.

In any event, You must have been Actively at Work under The Policy to qualify for Waiver of Premium.

When Premiums are Waived: *When will premiums be waived?*
If We approve Waiver of Premium, We will notify You of the date We will begin to waive premium. In any case, We will not waive premiums for the first 9 month(s) You are Disabled. We have the right to:

1) require Proof of Loss that You are Disabled; and
2) have You examined at reasonable intervals during the first 2 years after receiving initial Proof of Loss, but not more than once a year after that.

If You fail to submit any required Proof of Loss or refuse to be examined as required by Us, then Waiver of Premium ceases.

However, if We deny Waiver of Premium, You may be eligible to convert coverage in accordance with the Conversion Right for You and Your Dependents.

If You cease to be Disabled and return to work for a total of 5 days or less during the first 9 month(s) that You are Disabled, the 9 month waiting period will not be interrupted. Except for the 5 days or less that You worked, You must be Disabled by the same condition for the total 9 month period. If You return to work for more than 5 days, You must satisfy a new waiting period.

Benefit Payable before Approval of Waiver of Premium: *What if I die or my Dependent dies before I qualify for Waiver of Premium?*

If You or Your Dependent die within one year of Your last day of work as an Active Employee, but before You qualify for Waiver of Premium, We will pay the Amount of Life Insurance which is in force for the deceased person provided:

1) You were continuously Disabled;
2) the Disability lasted or would have lasted 9 months or more; and
3) premiums had been paid for coverage.

Waiver Ceases: *When will Waiver of Premium cease?*

We will waive premium payments and continue Your coverage, while You remain Disabled, until the date You attain age 65 if Disabled prior to age 60.

We will waive premium payments for Your Dependent Life Insurance and continue such coverage, while You remain Disabled, until the earliest of the date:

1) You die;
2) You no longer qualify for Waiver of Premium;
3) Your Dependents are no longer in an Eligible Class, or Dependent coverage is no longer offered; or
4) Your Dependent no longer meets the definition of Dependent.

What happens when Waiver of Premium ceases?

When the Waiver of Premium ceases:

1) if You return to work in an Eligible Class, as an Active Employee, then You may again be eligible for coverage for Yourself and Your Dependents as long as premiums are paid when due; or
2) if You do not return to work in an Eligible Class, coverage will end and You may be eligible to exercise the Conversion Right for You and Your Dependents if You do so within the time limits described in such provision. The Amount of Life Insurance that may be converted will be subject to the terms and conditions of the Conversion Right.

Effect of Policy Termination: *What happens to the Waiver of Premium if The Policy terminates?*

If The Policy terminates before You qualify for Waiver of Premium:

1) You may be eligible to exercise the Conversion Right, provided You do so within the time limits described in such provision; and
2) You may still be approved for Waiver of Premium if You qualify.

If The Policy terminates after You qualify for Waiver of Premium:

1) Your Dependent coverage will continue for a period of 12 months from the date of Policy termination and will be subject to the terms and conditions of this provision; and
2) Your coverage under the terms of this provision will not be affected.

BENEFITS

Life Insurance Benefit: *When is the Life Insurance Benefit payable?*

If You or Your Dependents die while covered under The Policy, We will pay the deceased person's Life Insurance Benefit after We receive Proof of Loss, in accordance with the Proof of Loss provision.

The Life Insurance Benefit will be paid according to the General Provisions of The Policy.

Suicide: *What benefit is payable if death is a result of suicide?*
If You or Your Dependent commit suicide while sane or insane, We will not pay any Supplemental Amount of Life Insurance or Supplemental Amount of Dependent Life Insurance for the deceased person which was elected within the 2 year period immediately prior to the date of death. This applies to initial coverage and elected increases in coverage.

This 2 year period includes the time group life insurance coverage was in force under the Prior Policy.

Any premium paid by You during this 2 year period for initial amounts of Supplemental Life Insurance or elected increases in Supplemental Life Insurance, will be returned to Your beneficiary.

Conversion Right: *If coverage under The Policy ends, do I have a right to convert?*
If Life Insurance coverage or any portion of it under The Policy ends for any reason, except nonpayment of premium, You and Your Dependents have the right to convert the coverage that terminated to an individual conversion policy without providing Evidence of Insurability. Conversion is not available for any Amount of Life Insurance for which You or Your Dependents were not eligible and covered under The Policy.

If coverage under The Policy ends because:
1) The Policy is terminated; or,
2) coverage for an Eligible Class is terminated;

then You or Your Dependent must have been insured under The Policy for 5 years or more, in order to be eligible to convert coverage. The amount which may be converted under these circumstances is limited to the lesser of:
1) $10,000; or
2) the Life Insurance Benefit under The Policy less any Amount of Life Insurance for which You or Your Dependent may become eligible under any group life insurance policy issued or reinstated within 31 days of termination of group life coverage.

If coverage under The Policy ends for any other reason, except nonpayment of premium, the full amount of coverage which ended may be converted.

Insurer, as used in this provision, means Us or another insurance company which has agreed to issue conversion policies according to this Conversion Right.

Conversion: *How do I convert my coverage or my Dependents' coverage?*
To convert Your coverage or coverage for Your Dependents, You must:
1) complete a Notice of Conversion Right form; and
2) have Your Employer sign the form.

The Insurer must receive this within:
1) 31 days after Life Insurance terminates; or
2) 15 days from the date Your Employer signs the form;

whichever is later. However, We will not accept requests for Conversion if they are received more than 91 days after Life Insurance terminates.

After the Insurer verifies eligibility for coverage, the Insurer will send You a Conversion Policy proposal. You must:
1) complete and return the request form in the proposal; and
2) pay the required premium for coverage;

within the time period specified in the proposal.

Any individual policy issued to You or Your Dependents under the Conversion Right:
1) will be effective as of the 32nd day after the date coverage ends; and
2) will be in lieu of coverage for this amount under The Policy.

Conversion Policy Provisions: *What are the Conversion Policy provisions?*
The Conversion Policy will:
1) be issued on any one of the Life Insurance policy forms the Insurer is issuing for this purpose at the time of conversion; and
2) base premiums on the Insurer's rates in effect for new applicants of Your class and age at the time of conversion.

The Conversion Policy will not provide:
1) the same terms and conditions of coverage as The Policy;

2) any benefit other than the Life Insurance Benefit; and
3) term insurance.

However, Conversion is not available for any Amount of Life Insurance which was, or is being, continued:
1) in accordance with the Waiver of Premium provision; or
2) in accordance with the Continuation Provisions;
until such coverage ends.

Death within the Conversion Period: *What if I or my Dependents die before coverage is converted?*
We will pay the deceased person's Amount of Life Insurance You would have had the right to apply for under this provision if:
1) coverage under The Policy terminates; and
2) You or Your Dependent die within 31 days of the date coverage terminates; and
3) We receive Proof of Loss.

If the Conversion Policy has already taken effect, no Life Insurance Benefit will be payable under The Policy for the amount converted.

Effect of Waiver of Premium on Conversion: *What happens to the Conversion Policy if Waiver of Premium is later approved?*
If You apply and are approved for Waiver of Premium after an individual Conversion Policy has been issued, any benefit payable at Your or Your Dependent's death under The Policy will be paid only if the individual Conversion Policy is surrendered. The Insurer will refund the premium paid for such Conversion Policy.

GENERAL PROVISIONS

Notice of Claim: *When should I notify the Company of a claim?*
You, or the person who has the right to claim benefits, must give Us, written notice of a claim within 30 days after the date of death.

If notice cannot be given within that time, it must be given as soon as reasonably possible after that. Such notice must include the claimant's name, address, and the Policy Number.

Claim Forms: *Are special forms required to file a claim?*
We will send forms to the claimant to provide Proof of Loss, within 15 days of receiving a Notice of Claim. If We do not send the forms within 15 days, the claimant may submit any other written proof which fully describes the nature and extent of the claim.

Proof of Loss: *What is Proof of Loss?*
Proof of Loss may include, but is not limited to, the following:
1) a completed claim form;
2) a certified copy of the death certificate (if applicable);
3) Your Enrollment form;
4) Your Beneficiary Designation (if applicable);
5) documentation of:
   a) the date Your disability began;
   b) the cause of Your disability; and
   c) the prognosis of Your disability;
6) any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
7) the names and addresses of all:
   a) Physicians or other qualified medical professionals You have consulted;
   b) hospitals or other medical facilities in which You have been treated; and
   c) pharmacies which have filled Your prescriptions within the past three years;
8) Your signed authorization for Us to obtain and release medical, employment and financial information (if applicable); or
9) any additional information required by Us to adjudicate the claim.

All proof submitted must be satisfactory to Us.

Sending Proof of Loss: *When must Proof of Loss be given?*
Written Proof of Loss should be sent to Us or Our representative within 365 day(s) after the loss. However, all claims should be submitted to Us within 90 days of the date coverage ends.

If proof is not given by the time it is due, it will not affect the claim if:
1) it was not reasonably possible to give proof within the required time; and
2) proof is given as soon as reasonably possible; but
3) not later than 1 year after it is due unless You, or the person who has the right to claim benefits, are not legally competent.

Physical Examination and Autopsy: *Can We have a claimant examined or request an autopsy?*
While a claim is pending We have the right at Our expense:
1) to have the person who has a loss examined by a Physician when and as often as We reasonably require; and
2) to have an autopsy performed in case of death where it is not forbidden by law.

Claim Payment: *When are benefit payments issued?*
When We determine that benefits are payable, We will pay the benefits in accordance with the Claims to be Paid provision, but not more than 30 days after such Proof of Loss is received.

Benefits may be subject to interest payments as required by applicable law.

Claims to be Paid: *To whom will benefits for my claim be paid?*
Life Insurance Benefits will be paid in accordance with the life insurance Beneficiary Designation provided it does not contradict the Claim Payment provision.

If no beneficiary is named, or if no named beneficiary survives You, We may, at Our option, pay:
1) the executors or administrators of Your estate;
2) all to Your surviving spouse;
3) if Your spouse does not survive You, in equal shares to Your surviving children; or
4) if no child survives You, in equal shares to Your surviving parents.

In addition, We may, at Our option, pay a portion of Your Life Insurance Benefit up to $500 to any person equitably entitled to payment by reason of having incurred expenses on Your behalf or because of expenses from Your burial. Payment to any person, as shown above, will release Us from liability for the amount paid.

If any beneficiary is a minor, We may pay his or her share, until a legal guardian of the minor's estate is appointed, to a person who at Our option and in Our opinion is providing financial support and maintenance for the minor. We will pay:
1) $200 at Your death; and
2) monthly installments of not more than $200.

Payment to any person as shown above will release Us from all further liability for the amount paid.

We will pay the Life Insurance Benefit at Your Dependent's death to You, if living. Otherwise, it will be paid, at Our option, to Your surviving spouse or the executor or administrator of Your estate.

If benefits are payable and meet Our guidelines, then You, or your Beneficiary, may elect to receive benefits in a lump sum payment or may elect to receive benefits through a draft book account. The draft book account will be owned by:
1) You, if living; or
2) Your beneficiary, in the event of Your death.

However, an account will not be established for:
1) a benefit payable to Your estate; or
2) an amount that is less than $10,000.

We will make any payments, other than for loss of life, to You. We may make any such payments owed at Your death to Your estate. If any payment is owed to:
1) Your estate;
2) a person who is a minor; or
3) a person who is not legally competent,

then We may pay up to $1,000 to a person who is related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.

Beneficiary Designation: *How do I designate or change my beneficiary?*
You may designate or change a beneficiary by doing so in writing on a form satisfactory to Us and filing the form with the Employer. Only satisfactory forms sent to the Employer prior to Your death will be accepted.

Beneficiary designations will become effective as of the date You signed and dated the form, even if You have since died. We will not be liable for any amounts paid before receiving notice of a beneficiary change from the Employer.

In no event may a beneficiary be changed by a power of attorney.

Claim Denial: *What notification will my beneficiary or I receive if a claim is denied?*
If a claim for benefits is wholly or partly denied, You or Your beneficiary will be furnished with written notification of the decision. This written notification will:

1) give the specific reason(s) for the denial;
2) make specific reference to the provisions upon which the denial is based;
3) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
4) provide an explanation of the review procedure.

Claim Appeal: *What recourse do my beneficiary or I have if a claim is denied?*
On any claim, the claimant or his or her representative may appeal to Us for a full and fair review. To do so, he or she:

1) must request a review upon written application within:
   a) 180 days of receipt of claim denial if the claim requires Us to make a determination of disability; or
   b) 60 days of receipt of claim denial if the claim does not require Us to make a determination of disability; and
2) may request copies of all documents, records, and other information relevant to the claim; and
3) may submit written comments, documents, records and other information relating to the claim.

We will respond in writing with Our final decision on the claim.

Policy Interpretation: *Who interprets the terms and conditions of The Policy?*
We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. This provision applies where the interpretation of The Policy is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Incontestability: *When can the Life Insurance Benefit of The Policy be contested?*
Except for non-payment of premiums, Your or Your Dependent's Life Insurance Benefit cannot be contested after two years from its effective date.

In the absence of fraud, no statement made by You or Your Spouse relating to Your or Your Spouse's insurability will be used to contest Your insurance for which the statement was made after Your insurance has been in force for two years. In order to be used, the statement must be in writing and signed by You and Your Spouse.

No statement made relating to Your Dependents being insurable will be used to contest their insurance for which the statement was made after their insurance has been in force for two years. In order to be used, the statement must be in writing and signed by You or Your representative.

All statements made by the Policyholder, the Employer or You or Your Spouse under The Policy will be deemed representations and not warranties. No statement made to affect this insurance will be used in any contest unless it is in writing and a copy of it is given to the person who made it, or to his or her beneficiary or Your representative.

Assignment: *Are there any rights of assignment?*
You have the right to absolutely assign all of Your rights and interest under The Policy including, but not limited to the following:

1) the right to make any contributions required to keep the insurance in force;
2) the right to convert; and
3) the right to name and change a beneficiary.

We will recognize any absolute assignment made by You under The Policy, provided:

1) it is duly executed; and
2) a copy is acknowledged and on file with Us.

We and the Policyholder assume no responsibility:
1) for the validity or effect of any assignment; or
2) to provide any assignee with notices which We may be obligated to provide to You.

You do not have the right to collaterally assign Your rights and interest under The Policy.

Legal Actions: *When can legal action be taken against Us?*
Legal action cannot be taken against Us:
1) sooner than 60 days after the date written Proof of Loss is furnished; or
2) more than 6 years after the date Proof of Loss is required to be furnished according to the terms of The Policy.

Workers' Compensation: *How does The Policy affect Workers' Compensation coverage?*
The Policy does not replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

Insurance Fraud: *How does the Company deal with fraud?*
Insurance fraud occurs when You, Your Dependents and/or the Employer provide Us with false information or file a claim for benefits that contains any false, incomplete or misleading information with the intent to injure, defraud or deceive Us. It is a crime if You, Your Dependents and/or the Employer commit insurance fraud. We will use all means available to Us to detect, investigate, deter and prosecute those who commit insurance fraud. We will pursue all available legal remedies if You, Your Dependents and/or the Employer perpetrate insurance fraud.

Misstatements: *What happens if facts are misstated?*
If material facts about You or Your Dependents were not stated accurately:
1) the premium may be adjusted; and
2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

DEFINITIONS

Active Employee means an employee who works for the Employer on a regular basis in the usual course of the Employer's business. This must be at least the number of hours shown in the Schedule of Insurance.

Actively at Work means at work with Your Employer on a day that is one of Your Employer's scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your job:
1) in the usual way; and
2) for Your usual number of hours.

We will also consider You to be Actively At Work on any regularly scheduled vacation day, paid time off day, personal day or holiday, only if You were Actively At Work on the preceding scheduled work day.

Contributory Coverage means coverage for which You are required to contribute toward the cost. Contributory Coverage is shown in the Schedule of Insurance.

Dependent Child(ren) means:
Your unmarried children, stepchildren, legally adopted children, or any other children related to You by blood or marriage who:
1) live with You in a regular parent-child relationship; and/or
2) You claimed as a dependent on Your last filed federal income tax return;

provided such children are primarily dependent upon You for financial support and maintenance and are:
1) at least 15 days old but not yet age 19;
2) age 19, but not yet age 25, and in full-time attendance (at least 12 course credit hours per semester) at an accredited institution of learning. If the institution establishes full-time status in any other manner, We reserve the right to determine whether the student continues to qualify as a Dependent; or
3) age 19 or older and disabled. Such children must have become disabled before attaining age 19. You must submit proof, satisfactory to Us, of such children's disability.

Dependents means Your Spouse and Your Dependent Child(ren). A dependent must be a citizen or legal resident of the United States of America, its territories and protectorates.

Earnings means, Your gross annual rate of pay, not counting commissions, bonuses, tips and tokens, overtime pay or any other fringe benefits or extra compensation, in effect on the date You were last Actively at Work.

However, if You are an hourly paid Active Employee, Earnings means the product of:

1) the average number of hours You worked per year, not including overtime, over the most recent 1 year period immediately prior to the date You were last Actively at Work, multiplied by:

2) Your hourly wage in effect on the date You were last Actively at Work.

Employer means the Policyholder.

Guaranteed Issue Amount means the Amount of Life Insurance for which We do not require Evidence of Insurability. The Guaranteed Issue Amount is shown in the Schedule of Insurance.

Non-Contributory Coverage means coverage for which You are not required to contribute toward the cost. Non-Contributory Coverage is shown in the Schedule of Insurance.

Physician means a person who is:

1) a doctor of medicine, Osteopathy, Psychology or other legally qualified practitioner of a healing art that We recognize or are required by law to recognize;
2) licensed to practice in the jurisdiction where care is being given;
3) practicing within the scope of that license; and
4) not You or Related to You by blood or marriage.

Prior Policy means the group life insurance policy carried by the Employer on the day before the Policy Effective Date and will only include the coverage which is transferred to Us.

Related means Your Spouse, or other adult living with You, or Your sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild.

Spouse means Your spouse who:

1) is not legally separated or divorced from You; and
2) is not in active full-time military service.

The Policy means the Policy which We issued to the Policyholder under the Policy Number shown on the face page.

We, Us, or Our means the insurance company named on the face page of The Policy.

You or Your means the person to whom this Certificate of Insurance is issued.

Certificate of Insurance
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
Hartford, Connecticut

Policyholder: STEVENS AEROSPACE AND DEFENSE SYSTEMS, LLC.
Policy Number: ADD-8141
Policy Effective Date: January 1, 1995
Certificate Effective Date: July 1, 2024

We have issued a policy to the Policyholder. Our name, the Policyholder name and the Policy Number are shown above. The provisions of the policy which are important to you are summarized in this Certificate; consisting of this Certificate and any additional forms which have been made a part of this Certificate. This Certificate replaces all certificates which may have been given to you earlier for the policy. The policy alone is the only contract under which payment will be made. Any difference between the policy and this Certificate will be settled according to the provisions of the policy.

Christine Hayer Repasy, *Secretary*

Thomas M. Marra, *President*

SCHEDULE

Eligible Persons:

All Full-time Active Employees.

Full-time Employee means a person who:
a) is regularly employed by the Policyholder in the usual course of their business; and
b) works at least 40 hours per work week.

Basic Benefits:

Principal Sum
1 times Salary, rounded to the next higher increment of $1,000, to a maximum amount of $250,000

Salary means you base annual salary on the date of the accident, excluding overtime pay, bonuses, commissions and any other type of incentives.

Eligible Dependents: None

Policy Age Limit: None

Accidental Death and Dismemberment Reduction on and after Age 65: On the Premium Due Date on or next following your attainment of ages 65, 70, 75, 80, 85, 90 and 95, your amount of Principal Sum will reduce. The reduced amount will be determined by multiplying the Amount of Principal Sum determined in the Enrollment Form on file with the Policyholder and applicable to you by the percentage shown below for your attained age:

Insured Person's Age	Percentage of Principal Sum
Age 65-69	65%
Age 70-74	42%
Age 75-79	27%
Age 80-84	20%
Age 85-89	15%
Age 90-94	11%
Age 95 or over	8%

If you are age 65 or over you will not be eligible for a Principal Sum Amount that is more than the Percentage of Principal Sum shown above for your attained age.

Waiver of Premium Benefit

DEFINITIONS

We, us or **ou**r means the insurance company named on the face page.

You, your or **Insured Person** means an Eligible Person while he or she is covered under the policy.

Injury means bodily injury resulting directly from accident and independently of all other causes which occurs while you are covered under the policy. Loss resulting from:

a) sickness or disease, except a pus-forming infection which occurs through an accidental wound; or
b) medical or surgical treatment of a sickness or disease;

is not considered as resulting from Injury.

On, when used with reference to any conveyance (land, water or air), means in or on, boarding or alighting from the conveyance.

Civil or Public Aircraft means an aircraft which:

a) has a current and valid Airworthiness Certificate;
b) is piloted by a person who has a valid and current certificate of competency of a rating which authorizes him or her to pilot the aircraft; and
c) is not operated by the militia or armed forces of any state, national government or international authority.

Airworthiness Certificate means:

a) the "Standard" Airworthiness Certificate issued by the United States Federal Aviation Administration; or
b) a foreign equivalent issued by the governmental authority with jurisdiction over civil aviation in the country of its registry.

Military Transport Aircraft means a transport aircraft operated by:

a) the United States Air Mobility Command (AMC); or
b) a national military air transport service of any country.

Written Request means any form provided by us for the particular request.

INSURED PERSONS PERIOD OF COVERAGE

Each Eligible Person who is eligible for Basic Benefits and who gives us a Written Request for these benefits within 31 days of becoming eligible becomes covered for those benefits on the later of:

a) the Policy Effective Date; or
b) the date we receive the Written Request.

Termination: Your coverage terminates on the earlier of:

a) the date the policy is terminated; or
b) the date you:
   1) cease to be an Eligible Person, or
   2) attain the Policy Age Limit, if any, shown in the Schedule.

Request For Change In Coverage: If you give us a Written Request for a change in your coverage, and if you:

a) are not eligible for the coverage requested, the change will not become effective;
b) are eligible for the coverage requested, the change will become effective on date we receive the request.

EXCLUSIONS

The policy does not cover any loss resulting from:

1. intentionally self-inflicted Injury, suicide or attempted suicide, whether sane or insane;
2. war or act of war, whether declared or undeclared;
3. Injury sustained while full-time in the armed forces of any country or international authority; or
4. Injury sustained while riding On any aircraft except a Civil or Public Aircraft, or Military Transport Aircraft.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If your Injury results in any of the following losses within 365 days after the date of accident, we will pay the sum shown opposite the loss. We will not pay more than the Principal Sum for all losses due to the same accident. Your amount of the Principal Sum is determined in the Enrollment Form on file with the Policyholder.

For Loss of:	
Life	The Principal Sum
Both Hands or Both Feet or Sight of Both Eyes	The Principal Sum
One Hand and One Foot	The Principal Sum
Speech and Hearing	The Principal Sum
Either Hand or Foot and Sight of One Eye	The Principal Sum
Either Hand or Foot	One-Half The Principal Sum
Sight of One Eye	One-Half The Principal Sum
Speech or Hearing	One-Half The Principal Sum
Thumb and Index Finger of Either Hand	One-Quarter The Principal Sum

Loss means with regard to:

a) hands and feet, actual severance through or above wrist or ankle joints;
b) sight, speech or hearing, entire and irrecoverable loss thereof;
c) thumb and index finger, actual severance through or above the metacarpophalangeal joints.

EXPOSURE

Exposure to the elements will be presumed to be Injury if:

a) it results from the forced landing, stranding, sinking or wrecking of a conveyance in which you were an occupant at the time of the accident; and
b) the policy would have covered Injury resulting from the accident.

DISAPPEARANCE

You will be presumed to have suffered loss of life if:

a) your body has not been found within one year after the disappearance of a conveyance in which you were an occupant at the time of its disappearance;
b) the disappearance of the conveyance was due to its accidental forced landing, stranding, sinking or wrecking; and
c) the policy would have covered Injury resulting from the accident.

WAIVER OF PREMIUM BENEFIT

Waiver of Premium: We will waive your payment of premium and continue your coverage and your Covered Dependent's coverage, if any, during a period of Total Disability as defined.

Total Disability means a disability which:

a) begins while you are covered under the policy;
b) is caused by bodily Injury or disease which continuously prevents you from performing the material and substantial duties of your occupation for a period of 9 months after the date of Injury or sickness, and which thereafter continuously prevents you from performing the material and substantial duties of any occupation for which you are suited by education, training and experience; and
c) has existed continuously for a period of at least nine months.

Proof of Disability must be sent to us at least nine months but not later than twelve months from the beginning of total disability (or within one year of death if proof was not furnished during your lifetime). We have the right to:

a) require satisfactory proof of continuous Total Disability; or
b) examine you at any time during the first two years after receiving initial proof of disability, but not more than once a year after that.

Refund of Premium: When proof of disability is received, we will refund to you or to your estate, if you have died, any premium paid during the period of continuous disability.

Waiver Ceases: The Waiver of Premium will cease on the Premium Due Date on or next following the first to occur of:

a) the date you cease to be totally disabled;
b) the date you fail to submit the required proof of continuous disability;
c) the date you fail to submit to any physical examination;
d) the date you attain age 65, if totally disabled before age 60;
e) five years after the date your Total Disability began, if disabled on or after age 60; or
f) the date the policy terminates.

CLAIMS

Notice of Claim: The person who has the right to claim benefits (the claimant or beneficiary) must give us written notice of a claim within 20 days after a covered loss begins. If notice cannot be given within that time, it must be given as soon as reasonably possible.

The notice should include your name and the policy number. Send it to our office in Hartford, Connecticut, or give it to our agent.

Claim Forms: When we receive the notice of claim, we will send forms to the claimant for giving us proof of loss. The forms will be sent within 15 days after we receive the notice of claim.

If the forms are not received, the claimant will satisfy the proof of loss requirement if a written notice of the occurrence, character and nature of the loss is sent to us.

Proof of Loss: Proof of loss must be sent to us in writing within 90 days after:

a) the end of a period of our liability for periodic payment claims; or
b) the date of the loss for all other claims.

If the claimant is not able to send it within that time, it may be sent as soon as reasonably possible without affecting the claim. The additional time allowed cannot exceed one year unless the claimant is legally incapacitated.

Time of Claim Payment: We will pay any daily, weekly or monthly benefit due:

a) on a monthly basis, after we receive the proof of loss, while the loss and our liability continue; or
b) immediately after we receive the proof of loss following the end of our liability.

We will pay any other benefit due immediately after we receive the proof of loss.

Payment of Claims: We will pay any benefit due for loss of your life:

a) according to the beneficiary designation in effect under the policy at the time of your death; or
b) if no beneficiary is designated, according to the beneficiary designation under the Group Life Insurance Policy issued to the Policyholder and in effect at time of death; otherwise
c) to the survivors, in equal shares, in the first of the following classes to have a survivor at your death:
    1) spouse,
    2) children,
    3) parents,
    4) brothers and sisters.

If there is no survivor in these classes, payment will be made to your estate.

All other benefits due and not assigned will be paid to you, if living. Otherwise, the benefits will be paid according to the preceding paragraph.

If a benefit due is payable to:

a) your estate; or
b) you or any person who is either a minor or not competent to give a valid release for the payment;

we may pay up to $1,000 of the benefit due to some other person.

The other person will be someone related to the minor or incompetent person by blood or marriage who we believe is entitled to the payment. We will be relieved of further responsibility to the extent of any payment made in good faith.

Appealing Denial of Claims: If a claim for benefits is wholly or partially denied, notice of the decision shall be furnished to you. The written decision will:

a) give the specific reason or reasons for denial;
b) make specific reference to the policy provision on which the denial is based;
c) provide a description of any additional information necessary to prepare the claim and an explanation of why it is necessary; and
d) provide an explanation of the review procedure.

On any denied claim, you or your representative may appeal to us for a full and fair review. The claimant may:

a) request a review upon written application within 60 days of the receipt of claim denial;
b) review pertinent documents;
c) submit issues and comments in writing.

We will make a decision no more than 60 days after the receipt of the request for review, except in special circumstances (such as the need to hold a hearing), but in no case more than 120 days after we receive the request for review. The written decision will include specific reasons on which the decision is based.

Physical Examinations: While a claim is pending we have the right at our expense to have the person who has a loss examined by a physician when and as often as we feel is necessary.

Legal Actions: You cannot take legal action against us:

a) before 60 days following the date proof of loss is sent to us;
b) after 6 years following the date proof of loss is due.

Naming a Beneficiary: You may name a beneficiary or change a revocably named beneficiary by giving your Written Request to the Policyholder. Your request takes effect on the date you execute it, regardless of whether you are living when the Policyholder receives it. We will be relieved of further responsibility to the extent of any payment we made in good faith before the Policyholder received your request.

Assignment: We will recognize any assignment you make under the policy, provided:

a) it is duly executed; and
b) a copy is on file with us.

We and the Policyholder assume no responsibility for the validity or effect of an assignment.

POLICY TRANSITION PROVISIONS

Prior Policy means Policy No. GSR 7395 issued by Commercial Insurance Company.

The Policy means Policy No. ADD-8141 issued by Hartford Life and Accident Insurance Company.

A designation of beneficiary in effect on December 31, 1994 for the Prior Policy is considered to be a designation of beneficiary under The Policy which shall take effect on the effective date of The Policy. However, any designation of beneficiary made on or before the effective date of the policy in connection with the insurance provided by The Policy, in lieu of the designation of beneficiary made under the Prior Policy, takes effect on the effective date of The Policy.

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

CERTIFICATE OF INSURANCE

Policyholder: Stevens Aviation, Inc.
Policy Number: ADD-8142
Policy Effective Date: January 1, 1995
Certificate Effective Date: November 1, 2018

We have issued a policy to the Policyholder. Our name, the Policyholder name and the Policy Number are shown above. The provisions of the policy which are important to you are summarized in this Certificate; consisting of this Certificate and any additional forms which have been made a part of this Certificate. This Certificate replaces all certificates which may have been given to you earlier for the policy. The policy alone is the only contract under which payment will be made. Any difference between the policy and this Certificate will be settled according to the provisions of the policy.

Lisa Levin, *Secretary*

Michael Concannon, *President*

SCHEDULE

Eligible Persons:

All employees of the Policyholder who are enrolled in the Group Supplemental Life Program

Voluntary Benefits:

Principal Sum

The Principal Sum applicable to you is the amount for which:
a) you are eligible to request as determined below;
b) you have given us a Written Request; and
c) the required premium is paid.

Principal Sum Amount:

An amount equal to $25,000, $50,000, $100,000, $200,000, $300,000 or $500,000

The Principal Sum requested can not exceed the lesser of four (4) times Salary, rounded down to the nearest Principal Sum selection or $300,000.

The Principal Sum requested cannot be equal to $500,000 unless:
a) the Insured Person is an Executive of the Policyholder; and
b) the Insured Person's Salary is greater than or equal to $125,000 per year.

Salary means your base annual salary on the date of the accident, including commissions**.**

Eligible Dependents: Eligible Person's Spouse and Child(ren)

Policy Age Limit: Insured Person - None
Spouse - 70

Accidental Death and Dismemberment Reduction on and after Age 65: On the Premium Due Date on or next following your attainment of ages 65, 70, 75, 80 , 85, 90 and 95 your amount of Principal Sum will reduce. The reduced amount will be determined by multiplying the Amount of Principal Sum determined in the Enrollment Form on file with the Policyholder and applicable to you by the percentage shown below for your attained age:

Insured Person's Age	Percentage of Principal Sum
Age 65-69	65%
Age 70-74	42%
Age 75-79	27%
Age 80-84	20%
Age 85-89	15%
Age 90-94	11%
Age 95 or over	8%

If you are age 65 or over you will not be eligible for a Principal Sum Amount that is more than the Percentage of Principal Sum shown above for your attained age.

Principal Sum for Each of Your Eligible Dependents
(Please see Accidental Death and Dismemberment Benefit)

Seat Belt Coverage
Seat Belt Benefit Amount: 10% of Principal Sum to a maximum amount of $25,000

Conversion Privilege Benefit
Conversion Limit: $100,000

Waiver of Premium Benefit

DEFINITIONS

We, **us** or **our** means the insurance company named on the face page.

You, your or **Insured Person** means an Eligible Person while he or she is covered under the policy.

Covered Person means you or your Eligible Dependent while you, he or she is covered under the policy.

Injury means bodily injury resulting directly from accident and independently of all other causes which occurs while the Covered Person is covered under the policy. Loss resulting from:
a) sickness or disease, except a pus-forming infection which occurs through an accidental wound; or
b) medical or surgical treatment of a sickness or disease;
is not considered as resulting from Injury.

On, when used with reference to any conveyance (land, water or air), means in or on, boarding or alighting from the conveyance.

Civil or **Public Aircraft** means an aircraft which:

a) has a current and valid Airworthiness Certificate;
b) is piloted by a person who has a valid and current certificate of competency of a rating which authorizes him or her to pilot the aircraft; and
c) is not operated by the militia or armed forces of any state, national government or international authority.

Airworthiness Certificate means:

a) the "Standard" Airworthiness Certificate issued by the United States Federal Aviation Administration; or
b) a foreign equivalent issued by the governmental authority with jurisdiction over civil aviation in the country of its registry.

Military Transport Aircraft means a transport aircraft operated by:

a) the United States Air Mobility Command (AMC); or
b) a national military air transport service of any country.

Written Request means any form provided by us for the particular request.

INSURED PERSONS PERIOD OF COVERAGE

Effective Date:
Each Eligible Person who is eligible for Voluntary Benefits and who gives us a Written Request for these benefits within 31 days of becoming eligible becomes covered for those benefits on the later of:

a) the Policy Effective Date; or
b) the date we receive the Written Request.

Termination: Your coverage terminates on the earlier of:

a) the date you request that your Voluntary Benefits be terminated;
b) the date you cease to be eligible for Voluntary Benefits; or
c) the date on which you fail to pay any required premium for Voluntary Benefits.

Request For Change In Coverage: If you give us a Written Request for a change in your coverage, and if you:

a) are not eligible for the coverage requested, the change will not become effective;
b) are eligible for the coverage requested, the change will become effective on date we receive the request.

DEPENDENTS PERIOD OF COVERAGE

You are insured with Dependents Coverage if it is indicated in the Enrollment Form on file with the Policyholder.

Eligibility: Eligible Dependents are defined below. In any event, you are not an Eligible Dependent.

Eligible Dependents:

1. **Spouse** means your spouse unless:
   a) you and your spouse are legally separated or divorced; or
   b) your spouse has attained the Policy Age Limit, if any, shown in the Schedule.
2. **Child** or **Children** means your unmarried child, stepchild, legally adopted child, or foster child:
   a) who is less than age 19 and primarily dependent on you for support and maintenance; or
   b) who is at least age 19 but less than age 25 who:
      1) regularly attends an institution of learning; and
      2) is primarily dependent on you for support and maintenance.

Effective Date: If you give us a Written Request for Dependents coverage within 31 days of the date your Dependents become eligible for coverage under the policy, your Eligible Dependents will become covered under the policy on the later of:

a) the date you become an Insured Person;
b) the date we receive your Written Request for coverage of Dependents; or
c) the date the person qualifies as an Eligible Dependent.

Termination: Coverage of each Eligible Dependent terminates on the Premium Due Date on or next following the earlier of:

a) the date you cease to be an Insured Person; or
b) the date he or she ceases to qualify as an Eligible Dependent.

Incapacitated Child: Coverage of a child who, on the date he or she reaches age 19 or 25, is:

a) covered under the policy;
b) mentally or physically incapable of earning his or her own living; and
c) unmarried and primarily dependent on you for support and maintenance;

will not terminate solely due to age.

However, you must give us written notice of the incapacity within 31 days of the termination date.

Coverage will continue as long as:

a) the incapacity continues; and
b) the required premium is paid.

We may, from time to time, require proof of continued incapacity and dependency. After the first two years, we cannot require proof more than once each year.

Request For Change In Coverage: If you give us a Written Request for a change in the coverage of your Eligible Dependents, and if they:

a) is not eligible for the coverage requested, it will not become effective; or
b) is eligible for the coverage requested, the change will become effective on date we receive the request.

EXCLUSIONS

The policy does not cover any loss resulting from:

1. intentionally self-inflicted Injury, suicide or attempted suicide, whether sane or insane;
2. war or act of war, whether declared or undeclared;
3. Injury sustained while full-time in the armed forces of any country or international authority; or
4. Injury sustained while riding On any aircraft except a Civil or Public Aircraft, or Military Transport Aircraft.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The amount of Spouse Supplemental Coverage may never exceed 50% or $50,000 of Supplemental Amount of Life Insurance in force for the employee.

Principal Sum for Your Eligible Children:

Principal Sum Amount:
$10,000

The Principal Sum for any one Child age 6 months or older cannot exceed $10,000. The Principal Sum for any one Child age 15 days or older, but less than age 6 months, is $1,000. No Principal Sum is provided for any child less than 15 days of age.

For Loss of:	
Life	The Principal Sum
Both Hands or Both Feet or Sight of Both Eyes	The Principal Sum
One Hand and One Foot	The Principal Sum

Speech and Hearing .....The Principal Sum
Either Hand or Foot
and Sight of One Eye .....….....The Principal Sum
Movement of Both Upper
and Lower Limbs
(Quadriplegia).....The Principal Sum
Movement of Both
Lower Limbs (Paraplegia) .....Three-Quarters The Principal Sum
Movement of Both Upper
and Lower Limbs of
One Side of Body (Hemiplegia) .....One-Half The Principal Sum
Either Hand or Foot .....One-Half The Principal Sum
Sight of One Eye .....One-Half The Principal Sum
Speech or Hearing .....One-Half The Principal Sum
Thumb and Index
Finger of Either Hand..... One-Quarter The Principal Sum

Loss means with regard to:

a) hands and feet, actual severance through or above wrist or ankle joints;
b) sight, speech or hearing, entire and irrecoverable loss thereof;
c) thumb and index finger, actual severance through or above the metacarpophalangeal joints;
d) movement of limbs, complete and irreversible paralysis of such limbs.

EXPOSURE

Exposure to the elements will be presumed to be Injury if:

a) it results from the forced landing, stranding, sinking or wrecking of a conveyance in which the Covered Person was an occupant at the time of the accident; and
b) the policy would have covered Injury resulting from the accident.

DISAPPEARANCE

A Covered Person will be presumed to have suffered loss of life if:

a) his or her body has not been found within one year after the disappearance of a conveyance in which he or she was an occupant at the time of its disappearance;
b) the disappearance of the conveyance was due to its accidental forced landing, stranding, sinking or wrecking; and
c) the policy would have covered Injury resulting from the accident.

SEAT BELT BENEFIT

If a Covered Person's Injury results in a covered Loss while:

a) a passenger riding in; or
b) the licensed operator of;

a duly registered Automobile, and while wearing a Seat Belt at the time of Accident as verified on the police report, then the amount of the Principal Sum will be increased by the Seat Belt Benefit Amount stated in the Schedule.

Accident, for the purposes of Seat Belt Coverage, means the unintentional collision of an Automobile during which the Covered Person is wearing a Seat Belt.

Automobile means a four-wheeled, private passenger car, station wagon, van or jeep-type vehicle which is not being used as a Common Carrier.

Common Carrier means a conveyance operated by a concern, other than the Policyholder, organized and licensed for the transportation of passengers for hire and operated by an employee of that concern.

Seat Belt means:

a) a belt, lap restraint, or shoulder restraint installed by the manufacturer of the Automobile; or
b) a child's car seat properly placed in the Automobile.

Exclusions: This Seat Belt Coverage does not cover any loss if the Covered Person:

a) is under the influence of any intoxicant, excitant, hallucinogen, or any narcotic or other drug, or similar substance as verified in the police accident report (unless administered under the advice of a physician); and
b) is operating the Automobile.

CONVERSION PRIVILEGE

If you cease to be covered under the policy because you cease to be eligible for coverage and:

a) the policy has not terminated; and
b) you have not failed to pay any required premium;

you have a conversion privilege as provided below.

If your Covered Dependent Spouse ceases to be covered under the policy because you and your Spouse obtain a valid decree of divorce and:

a) the policy has not terminated
b) your coverage has not terminated when his or her coverage ceases;
c) he or she has not attained age 70 when his or her coverage ceases; and
d) you have not failed to pay any required premium for his or her coverage;

he or she has a conversion privilege as provided below.

The conversion right allows you to request coverage under a conversion policy from the Insurer within 31 days of the date your coverage ceases under the policy, without giving evidence of insurability, to cover yourself and your Eligible Dependents who are covered under the policy on the date your coverage ceases. Dependents who continue to be covered under the policy in the same or a different class cannot be covered under your converted policy. The conversion right allows your divorced Spouse to request coverage under a conversion policy from the Insurer, without giving evidence of insurability, within 60 days of obtaining a valid decree of divorce, to cover himself or herself.

Insurer, as used on this page, means us or another insurance company which has agreed with us to issue converted policies according to this conversion privilege.

You must:

a) give the Insurer a Written Request for the converted policy; and
b) pay the Insurer the initial premium;

within 31 days after you cease to be covered under the policy.

Your former Covered Dependent Spouse must:

a) give the Insurer a Written Request for the converted policyl; and
b) pay the Insurer the initial premium;

within 60 days after obtaining a valid decree of divorce.

The converted policy:

a) will have the provisions, limitations and exclusions on the form the Insurer is issuing for this purpose at conversion;
b) will provide coverage on a twenty-four hour-a-day basis;
c) will provide benefits for accidental death and dismemberment alone;
d) will take effect on the date the eligible person under this Benefit ceases to be covered under the policy;
e) may exclude any condition excluded by the policy;
f) will not pay for any loss covered by the policy;
g) will provide a Principal Sum for yourself which will be:
    1) the amount of your Principal Sum under the policy on the date of conversion, rounded to the nearest $1,000, subject to a minimum of $25,000.00 and a maximum amount of $100,000, if you are under age 70;
    2) $25,000.00, if you are age 70 or older but less than age 75; or
    3) $12,500.00, if you are age 75 or older;
h) will have premiums based on the Insurer's rates in effect for new applicants of your class and age at conversion.

WAIVER OF PREMIUM BENEFIT

Waiver of Premium: We will waive your payment of premium and continue your coverage and your Covered Dependent's coverage, if any, during a period of Total Disability as defined.

Total Disability means a disability which:

a) begins while you are covered under the policy;
b) is caused by bodily Injury or disease which continuously prevents you from performing the material and substantial duties of your occupation for a period of 9 months after the date of Injury or sickness, and which thereafter continuously prevents you from performing the material and substantial duties of any occupation for which you are suited by education, training and experience; and
c) has existed continuously for a period of at least nine months.

Proof of Disability must be sent to us at least nine months but not later than twelve months from the beginning of total disability (or within one year of death if proof was not furnished during your lifetime). We have the right to:

a) require satisfactory proof of continuous Total Disability; or
b) examine you at any time during the first two years after receiving initial proof of disability, but not more than once a year after that.

Refund of Premium: When proof of disability is received, we will refund to you or to your estate, if you have died, any premium paid during the period of continuous disability.

Waiver Ceases: The Waiver of Premium will cease on the Premium Due Date on or next following the first to occur of:

a) the date you cease to be totally disabled;
b) the date you fail to submit the required proof of continuous disability;
c) the date you fail to submit to any physical examination;
d) the date you attain age 65, if totally disabled before age 60;
e) five years after the date your Total Disability began, if disabled on or after age 60; or
f) the date the policy terminates.

CLAIMS

Notice of Claim: The person who has the right to claim benefits (the claimant or beneficiary) must give us written notice of a claim within 20 days after a covered loss begins. If notice cannot be given within that time, it must be given as soon as reasonably possible.

The notice should include your name and the policy number. Send it to our office in Hartford, Connecticut, or give it to our agent.

Claim Forms: When we receive the notice of claim, we will send forms to the claimant for giving us proof of loss. The forms will be sent within 15 days after we receive the notice of claim.

If the forms are not received, the claimant will satisfy the proof of loss requirement if a written notice of the occurrence, character and nature of the loss is sent to us.

Proof of Loss: Proof of loss must be sent to us in writing within 90 days after:

a) the end of a period of our liability for periodic payment claims; or
b) the date of the loss for all other claims.

If the claimant is not able to send it within that time, it may be sent as soon as reasonably possible without affecting the claim. The additional time allowed cannot exceed one year unless the claimant is legally incapacitated.

Time of Claim Payment: We will pay any daily, weekly or monthly benefit due:

a) on a monthly basis, after we receive the proof of loss, while the loss and our liability continue; or
b) immediately after we receive the proof of loss following the end of our liability.

We will pay any other benefit due immediately after we receive the proof of loss.

Payment of Claims: We will pay any benefit due for loss of your life:

a) according to the beneficiary designation in effect under the policy at the time of your death; or
b) if no beneficiary is designated, according to the beneficiary designation under the Group Life Insurance Policy issued to the Policyholder and in effect at time of death; otherwise
c) to the survivors, in equal shares, in the first of the following classes to have a survivor at your death:
    1) spouse,

2) children,
3) parents,
4) brothers and sisters.

If there is no survivor in these classes, payment will be made to your estate.

All other benefits due and not assigned will be paid to you, if living. Otherwise, the benefits will be paid according to the preceding paragraph.

If a benefit due is payable to:
a) your estate; or
b) you or any person who is either a minor or not competent to give a valid release for the payment;
we may pay up to $1,000 of the benefit due to some other person.

The other person will be someone related to the minor or incompetent person by blood or marriage who we believe is entitled to the payment. We will be relieved of further responsibility to the extent of any payment made in good faith.

Appealing Denial of Claims: If a claim for benefits is wholly or partially denied, notice of the decision shall be furnished to you. The written decision will:
a) give the specific reason or reasons for denial;
b) make specific reference to the policy provision on which the denial is based;
c) provide a description of any additional information necessary to prepare the claim and an explanation of why it is necessary; and
d) provide an explanation of the review procedure.

On any denied claim, you or your representative may appeal to us for a full and fair review. The claimant may:
a) request a review upon written application within 60 days of the receipt of claim denial;
b) review pertinent documents;
c) submit issues and comments in writing.

We will make a decision no more than 60 days after the receipt of the request for review, except in special circumstances (such as the need to hold a hearing), but in no case more than 120 days after we receive the request for review. The written decision will include specific reasons on which the decision is based.

Physical Examinations: While a claim is pending we have the right at our expense to have the person who has a loss examined by a physician when and as often as we feel is necessary.

Legal Actions: You cannot take legal action against us:
a) before 60 days following the date proof of loss is sent to us;
b) after 6 years following the date proof of loss is due.

Naming a Beneficiary: You may name a beneficiary or change a revocably named beneficiary by giving your Written Request to the Policyholder. Your request takes effect on the date you execute it, regardless of whether you are living when the Policyholder receives it. We will be relieved of further responsibility to the extent of any payment we made in good faith before the Policyholder received your request.

Assignment: We will recognize any assignment you make under the policy, provided:
a) it is duly executed; and
b) a copy is on file with us.

We and the Policyholder assume no responsibility for the validity or effect of an assignment.

POLICY TRANSITION PROVISIONS

Prior Policy means Policy No. GSR 7395 issued by Commercial Insurance Company.

The Policy means Policy No. ADD-8142 issued by Hartford Life and Accident Insurance Company.

A designation of beneficiary in effect on December 31, 1994 for the Prior Policy is considered to be a designation of beneficiary under The Policy which shall take effect on the effective date of The Policy. However, any designation of beneficiary made on or before the effective date of the policy in connection with the insurance provided by The Policy, in lieu of the designation of beneficiary made under the Prior Policy, takes effect on the effective date of The Policy.

ERISA INFORMATION
THE FOLLOWING NOTICE
CONTAINS IMPORTANT INFORMATION

This employee welfare benefit plan (Plan) is subject to certain requirements of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA requires that you receive a Statement of ERISA Rights, a description of Claim Procedures, and other specific information about the Plan. This document serves to meet ERISA requirements and provides important information about the Plan.

The benefits described in your booklet-certificate (Booklet) are provided under a group insurance policy (Policy) issued by the Hartford Life and Accident Insurance Company (Insurance Company) and are subject to the Policy's terms and conditions. The Policy is incorporated into, and forms a part of, the Plan. The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

A copy of the Plan is available for your review during normal working hours in the office of the Plan Administrator.

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1. **Plan Name**

   Group Basic Term Life, Supplemental Dependent Life, Supplemental Term Life Plan for employees of STEVENS AEROSPACE AND DEFENSE SYSTEMS, LLC..

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2. **Plan Number**

   LIFE - 501

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3. **Employer/Plan Sponsor**

   STEVENS AEROSPACE AND DEFENSE SYSTEMS, LLC.
   600 Delaware Street
   Greenville, SC 29605

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4. **Employer Identification Number**

   57-0885551

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5. **Type of Plan**

   Welfare Benefit Plan providing Group Basic Term Life, Supplemental Dependent Life, Supplemental Term Life.

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6. **Plan Administrator**

   STEVENS AEROSPACE AND DEFENSE SYSTEMS, LLC.
   600 Delaware Street
   Greenville, SC 29605

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7. **Agent for Service of Legal Process**

   For the Plan

   STEVENS AEROSPACE AND DEFENSE SYSTEMS, LLC.

600 Delaware Street
Greenville, SC 29605

For the Policy:

Hartford Life and Accident Insurance Company
One Hartford Plaza
Hartford, Connecticut 06155

In addition to the above, Service of Legal Process may be made on a plan trustee or the plan administrator.

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8. **Sources of Contributions (Life)** Basic and supplemental coverage are being offered under a single ERISA plan. The Employer may pay some or all of the premium for the basic coverage. Coverages described in the certificate/policy as noncontributory or as being paid by the Employer, if any, are those paid for directly by the Employer such that you may have no direct out of pocket expense for such coverage. However, employees who elect supplemental coverage will be required to contribute specified amounts to the plan. Any amounts paid by employees may be used to pay any benefit or expense under the plan and may be used to reduce what the Employer pays for basic coverage.

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9. **Type of Administration** The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable group plan.

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10. The Plan and its records are kept on a Policy Year basis.

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11. **Labor Organizations**

    None

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12. **Names and Addresses of Trustees**

    None

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13. **Plan Amendment Procedure**

    The Plan Administrator reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice.

    The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

STATEMENT OF ERISA RIGHTS

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

1. Receive Information About Your Plan and Benefits

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

2. 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.

3. 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 the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. 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.

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

CLAIM PROCEDURES

The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy, to the extent permitted by applicable state law.

Claim Procedures for Claims Requiring a Determination of Disability

Claims and appeals for disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

If the Insurance Company fails to strictly adhere to all the requirements of ERISA with respect to a claim, you are deemed to have exhausted the administrative remedies available under the Plan, with certain exceptions. Accordingly, you are entitled to bring a civil action to pursue any available remedies under section 502(a) of ERISA on the basis that the Insurance Company has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If you choose to bring a civil action to pursue remedies under section 502(a) of ERISA under such circumstances, your claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary. However, the administrative remedies available under the Plan will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the Insurance Company demonstrates that the violation was for good cause or due to matters beyond the control of the Insurance Company and that the violation occurred in the context of an ongoing, good faith exchange of information between the Insurance Company and you. This exception is not available if the violation is part of a pattern or practice of violations by the Insurance Company. Before filing a civil action, you may request a written explanation of the violation from the Insurance Company, and the Insurance Company must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects your request for immediate review on the basis that the Insurance Company met the standards for the exception, your claim shall be considered as re-filed on appeal upon the Insurance Company's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Insurance Company shall provide you with notice of the resubmission.

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, the Insurance Company notifies you in writing that an extension is necessary due to matters beyond the control of the Insurance Company, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to our request. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and include: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the Insurance Company's review procedures and time limits applicable to such procedures; 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal the decision and after you receive a written denial on appeal; 6) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c*)* a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 7) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 8) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Insurance Company do not exist; 9) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and

10) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court, with the exception of an action under the deemed exhausted process described above. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 180 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Before the Insurance Company can issue an adverse benefit determination on review, the Insurance Company shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Insurance Company (or at the direction of the Insurance Company) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Before the Insurance Company can issue an adverse benefit determination on review based on a new or additional rationale, the Insurance Company shall provide you, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

The Insurance Company will make a final decision no more than 45 days after it receives your timely appeal. The time for final decision may be extended for one additional 45 day period provided that, prior to the extension, the Insurance Company notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to the request. The Insurance Company may also toll the time for a decision to allow you a reasonable opportunity to respond to new or additional evidence or a new or additional rationale. Tolling will begin on the date that the Insurance Company provides you with new or additional evidence or a new or additional rationale, and end when the Insurance Company receives the response or on the date by which the Insurance Company has requested a response, whichever comes first.

The individual reviewing your appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on 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 and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a statement that you are entitled to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim; 4) a statement (a) that you have the right to bring a civil action under section 502(a) of ERISA, and (b) describing any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim; 5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c) a

disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; 8) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company; and 9) any other notice(s), statement(s) or information required by applicable law.

Claim Procedures for Claims Not Requiring a Determination of Disability

Claims and appeals for benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 90 days after receipt of your properly filed claim. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 180 days after your claim was received. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination will be in writing and include: 1) specific reasons for the decision; 2) specific references to Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the review procedures and time limits applicable to such, and 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 60 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 60 days after it receives your timely appeal. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 120 days after your appeal was received. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision and specific references to the Policy provisions on which the decision is based, 2) a statement that you are 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, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.

The Plan Described in this Booklet is Insured by the

Hartford Life and Accident Insurance Company
Hartford, Connecticut
Member of The Hartford Insurance Group