Group Accidental Death and Dismemberment (AD&D) Certificate of Insurance

Securian Life Insurance Company • A Stock Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

SECURIAN®

Effective January 1, 2023

POLICYHOLDER: Syneos Health, LLC

POLICY NUMBER: 70321

Read Your Certificate Carefully

If you meet the eligibility and enrollment requirements herein, you are insured under the group policy shown on the specifications page. This certificate summarizes the principal provisions of the group policy that affect you. The provisions summarized in this certificate are subject in every respect to the group policy. You may examine the group policy at the principal office of the policyholder during regular working hours.

Legal Actions

No legal action may be brought to recover on this certificate within the first sixty days after written proof of loss has been given as required by this certificate. No such action may be brought after three years from the time written proof of loss is required to be given.

Renée D. Montz

Secretary

President

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SECURIAN®

GENERAL INFORMATION

POLICYHOLDER	Syneos Health, LLC
POLICY NUMBER:	70321
ASSOCIATED COMPANIES:	All subsidiaries and affiliates reported to Securian Life by the policyholder for inclusion in the policy.
POLICY SITUS:	The policy was issued and delivered in North Carolina.
POLICY EFFECTIVE DATE:	January 1, 2018. This specifications page represents the plan in effect as of January 1, 2023.

This certificate and/or certificate specifications page replaces any and all certificates and/or certificate specifications pages previously issued to you under the group policy. Please replace any certificate and/or certificate specifications page previously issued to you with this new certificate and/or specifications page.

GROUP:	The group is composed of all active full-time employees of the policyholder and its associated companies working in the United States and designated expatriates. The employer agrees to report, in writing, exposure of any designated expatriates working outside of the United States. The report must include the name of each insured person, his or her location, and anticipated duration of domicile outside of the United States.
NO DOUBLE COVERAGE:	A person cannot be covered under more than one class. A person cannot be covered as both an active employee and a retiree. Any person who is eligible as an employee or retiree under the policy, or insured under the portability provisions, is not eligible as a dependent. Only one person can insure an eligible dependent child.
WAITING PERIOD:	None
MINIMUM HOURS PER WEEK REQUIRED:	30 hours per week

PLAN OF INSURANCE

EMPLOYEE BENEFIT SCHEDULE

EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE:

Eligible Class	Amount of AD&D Insurance
All employees	An amount elected by the employee in increments of $10,000, subject to a maximum of $1,000,000.

GENERAL PROVISIONS FOR EMPLOYEE INSURANCE

SPECIAL ENROLLMENT PERIOD

Employees are required to re-elect coverage to remain in the voluntary AD&D plan. If an employee does not re-elect voluntary AD&D coverage, an insured will no longer be covered under the voluntary AD&D plan.

DOMESTIC PARTNER DEFINITION

Domestic Partner means a person of the same or opposite sex who meets all of the following criteria:

a) shares the employee's permanent residence; and
b) has resided with the employee for at least one year and is expected to continue to reside with the employee indefinitely; and
c) is financially interdependent with the employee in each of the following ways:
   i. by holding one or more credit or bank accounts, including a checking account, as joint owners; and
   ii. by owning or leasing their permanent residence as joint tenants; and
   iii. by naming or being named by the employee as a beneficiary of life insurance or under a will.
d) has signed a domestic partner declaration with the employee, if the employee resides in a jurisdiction that provides for domestic partner declarations; and
e) has not signed a domestic partner declaration with any other person within the last 12 months; and
f) is not less than 18 years of age; and
g) is not currently legally married to any other person; and
h) is not a blood relative any closer than would prohibit legal marriage.

AGE REDUCTIONS:

The amount of insurance on an employee age 65 or older shall be a percentage of the amount otherwise provided by the plan of insurance applicable to such employee in accordance with the following table:

Age of Employee	Amount of Insurance
65 - 69	65%
70 and over	50%

Age reductions will apply the date of an insured employee's 65th and 70th birthdays.

RETIREMENT REDUCTIONS:

All insurance terminates at retirement, except as provided for under the portability provision.

CONTRIBUTORY/NONCONTRIBUTORY:

All AD&D insurance is contributory insurance.

INCREASES AND DECREASES:

Requests for increases and decreases may be made only at annual enrollment or within 31 days of a qualified status change (as defined by the employer). Requests made due to a status change shall be effective on the date of the request. Requests made during an annual enrollment shall be effective on the general effective date of the annual enrollment. All increases are subject to the actively at work requirement.

DEPENDENTS BENEFIT SCHEDULE

DEPENDENTS AD&D INSURANCE:

An employee must notify the employer when a dependent is no longer eligible for coverage under this certificate so that premiums may be discontinued. All premiums paid for dependents who are no longer eligible for coverage under this certificate will be refunded without any payment of claim.

An employee must be insured for AD&D insurance in order to be insured for dependents AD&D insurance.

Spouse/Domestic Partner AD&D Insurance

Eligible Class	Amount of Spouse/Domestic Partner AD&D Insurance
All employees	An amount elected by the employee, in an increment of $5,000, subject to a maximum of $260,000 or 100% of the employee's amount of insurance.

Child AD&D Insurance

Eligible Class	Amount of Child AD&D Insurance
All employees	An amount elected by the employee, in an increment of $2,000, subject to a maximum of $10,000.

GENERAL PROVISIONS FOR DEPENDENTS INSURANCE

CONTRIBUTORY/NONCONTRIBUTORY: Dependents insurance is contributory insurance.

INCREASES AND DECREASES: Requests for increases and decreases may be made only at annual enrollment or within 31 days of a qualified status change (as defined by the employer). Requests made due to a status change shall be effective on the date of the request. Requests made during an annual enrollment shall be effective on the general effective date of the annual enrollment. All increases are subject to the actively at work requirement for employees and the hospitalization/confinement clause for dependents.

Definitions

associated company

Any company which is a subsidiary or affiliate of the policyholder which is designated by the policyholder and agreed to by us to participate under the group policy.

contributory insurance

Insurance for which the employee is required to make premium contributions.

earnings

An employee's basic rate of compensation not including commissions, overtime or premium pay, bonuses, or any other additional compensation.

employee

An individual who is employed by the policyholder or by an associated company. A sole proprietor will be considered the employee of the proprietorship. A partner in a partnership will be considered an employee so long as the partner's principal work is the conduct of the partnership's business. The term employee does not include temporary employees nor corporate directors who are not otherwise employees.

employer

The policyholder or any designated associated company.

insured

A person who is eligible for and becomes insured under the terms of this certificate.

licensed physician

An individual who is licensed to practice medicine or treat illness in the state in which treatment is received. The physician cannot be you or your spouse, children, parents, grandparents, grandchildren, brothers or sisters, or the spouse of any such individuals.

non-work day

A day on which the employee is not regularly scheduled to work, including scheduled time off for vacations, personal holidays, weekends and holidays, and approved leaves of absence for non-medical reasons.

Non-work day does not include time off for medical leave of absence, temporary layoff, employer suspension of operations in total or in part, strike, and any time off due to sickness or injury including sick days, short-term disability, or long-term disability.

noncontributory insurance

Insurance for which the employee is not required to make premium contributions.

policyholder

The owner of the group policy as shown on the specifications page.

specifications page

The outline which summarizes your coverage under the policyholder's plan of insurance.

waiting period

The period, if any, of continuous employment with the employer that the employee must satisfy prior to becoming eligible for coverage under this certificate. You are not eligible to become insured until the first day following the waiting period. Any such waiting period is shown on the specifications page .

we, our, us

Securian Life Insurance Company.

you, your, certificate holder

An insured employee.

General Information

What is your agreement with us?

If you meet the eligibility and enrollment requirements, you are insured under the group policy shown on the specifications page. Your application as defined under this certificate is a part of this certificate. This certificate summarizes the principal provisions of the group policy that affect your insurance coverage. The provisions summarized in this certificate are subject in every respect to the group policy.

Any statements made in your application as defined in this certificate will, in the absence of fraud, be considered representations and not warranties. Also, any statement made will not be used to void your insurance nor defend against a claim unless the statement is contained in the application.

Can this certificate be amended?

Yes. We retain the right to amend this certificate at any time without your consent. Any amendment will be without prejudice to any claim incurred for benefits prior to the date of the amendment.

What employees are eligible for Accidental Death and Dismemberment (AD&D) insurance?

An employee is eligible for AD&D insurance if he or she:

(1) is a member of the eligible group and of an eligible class identified in the group policy; and
(2) works for the employer for at least the number of hours per week shown as the minimum hours per week requirement on the specifications page ; and

(3) has satisfied the waiting period, if any; and
(4) meets the actively at work requirement described in the "What is the actively at work requirement?" provision of this section.

What dependents are eligible for AD&D insurance under this certificate?

The following members of your family are eligible for AD&D insurance under this certificate:

(1) your lawful spouse who is not legally separated from you; or
(2) your domestic partner of the same or opposite sex who meets the requirements of the policyholder's affidavit of domestic partnership and have properly executed and filed such affidavit with the policyholder; and
(3) your or your spouse/domestic partner's natural, legally adopted, foster, stepchildren or any child that you have been required by a court or administrative order to provide health plan coverage for who are between the ages of birth and 26 years old. An adopted child includes a child from the moment of placement in the adoptive home regardless of whether or not the adoption has become final. A foster child includes a child from the moment of placement in the foster home. Eligibility begins at the moment of birth (stillborn or unborn children are not eligible).

After age 26, coverage for an unmarried child who is incapable of sustaining employment by reason of mental retardation or physical handicap, who became so incapacitated prior to the attainment of age 26 years of age and who is chiefly dependent upon you for support and maintenance, shall not terminate but coverage shall continue so long as your coverage remains in force and so long as the child remains in such condition.

A person who is eligible as an employee or retiree under the policy, or insured under the portability provisions, is not eligible as a dependent. Only one person can insure an eligible dependent child.

Any dependent who, subsequent to the effective date of your dependents AD&D insurance, meets the eligibility requirements of this certificate will become insured on the date he or she so qualifies, provided no additional premium is required and the dependent is not hospitalized or confined because of illness or disease (except in the case of a newborn). If additional premium is required, the insurance for that dependent will be effective under the same conditions which would apply if you were newly becoming eligible for dependents AD&D under this certificate. If the dependent is hospitalized or confined because of illness or disease on the date his or her insurance would otherwise become effective, his or her effective date shall be delayed until he or she is released from such hospitalization or confinement (except in the case of a newborn).

Are employees of associated companies eligible for insurance under the group policy?

Yes. Employees of associated companies may be eligible for insurance under the group policy. The policyholder represents any associated company in all transactions pertaining to the group policy. The policyholder's acts or omissions and every notice given by us to the policyholder shall be binding on every associated company. When an associated company ceases its participation under the policy, the policy shall be considered to be terminated for all employees of the associated company. All provisions related to the policy terminating will apply to such employees.

Are retired employees eligible for insurance?

If the policyholder's plan of insurance, as shown on the specifications page, does not specifically provide insurance for retired employees, a retired employee shall not be eligible to become insured, nor to have his or her insurance continued. If the policyholder's plan of insurance specifically provides insurance for retired employees, the minimum hours per week and actively at work requirements will not apply to such persons.

What is the actively at work requirement?

To be eligible to become insured or to receive an increase in the amount of insurance, an employee must be actively at work performing his or her customary duties at the employer's normal place of business, or at other places the employer's business requires him or her to travel.

Employees not working due to illness or injury do not meet the actively at work requirement nor do employees receiving sick pay, short-term disability benefits or long-term disability benefits.

If the employee is not actively at work on the date coverage would otherwise begin, or on the date an increase in his or her amount of insurance would otherwise be effective, he or she will not be eligible for the coverage or increase until he or she returns to active work. However, if the absence is on a non-work day, coverage will not be delayed provided the employee was actively at work on the work day immediately preceding the non-work day.

Except as otherwise provided for in this certificate, an employee is eligible to continue to be insured only while he or she remains actively at work.

Any insurance or increase in insurance which is elected or put in force while you are not actively at work will not be eligible for claim payment. You or your beneficiary will receive a refund of premium for any contributory insurance for which you were not eligible.

What is the delayed effective date provision for dependents?

If a dependent is hospitalized or confined because of illness or disease on the date his or her insurance would otherwise become effective, his or her effective date shall be delayed until he or she is released from such hospitalization or confinement. This does not apply to a newborn child. However, in no event will insurance on a dependent be effective before your insurance is effective.

When does your insurance become effective?

Your insurance becomes effective on the date that all of the following conditions have been met:

(1) you meet all eligibility requirements; and
(2) for contributory coverage, you apply for coverage in accordance with the application methods agreed upon by the policyholder and us.

When does a dependent's insurance become effective?

Insurance on a dependent becomes effective on the date that all of the following conditions have been met:

(1) your insurance becomes effective;
(2) the dependent meets all eligibility requirements; and
(3) for contributory coverage, you apply for dependents coverage in accordance with the application methods agreed upon by the policyholder and us.

Can your coverage be continued during sickness, injury, leave of absence or temporary layoff?

Yes. Insurance may be continued on an insured employee who is not actively at work due to sickness, injury, leave of absence or temporary layoff, subject to the employer's practices and procedures, including the employer's limits on the length of continuation allowed for the type of absence. Continuation is contingent upon continued premium payment and is subject to the following maximum time frames:

(1) if you are on non-medical leave of absence or temporary layoff, insurance cannot be continued beyond 90 days from the last day you were actively at work.
(2) if you are on a medical leave of absence, insurance cannot be continued beyond the later of 12 months from the last day you were actively at work.

Coverage during a leave of absence and upon return from a leave of absence shall meet all state and federal requirements. The above limits will be expanded if necessary in order to meet such requirements.

Premiums

When and how often are your premium contributions due?

Unless the policyholder and we have agreed to some other premium payment procedure, any premium contributions you are required to make for contributory insurance are to be paid by you to the policyholder on a regular periodic basis. We apply premiums consecutively to keep the insurance in force.

How is the premium determined?

The premium will be the applicable premium rate multiplied by the number of $1,000 units of insurance in force on the date premiums are due. The premium may also be computed by any other method on which the policyholder and we agree.

Premium rates are subject to change according to the provisions of the group policy.

Accidental Death and Dismemberment Benefit

What does accidental death or dismemberment by accidental injury mean?

AD&D coverage is limited coverage. This means this coverage will provide benefits only when an insured's loss, death or dismemberment results, directly and independently from all other causes, from an accidental bodily injury which was unintended, unexpected and unforeseen. The bodily injury must be evidenced by a visible contusion or wound, except in the case of accidental drowning. The bodily injury must be the sole cause of an insured's loss, death or dismemberment. The injury and accidental loss, death or dismemberment must occur while an insured's coverage is in force. An insured's loss, death or dismemberment must occur within 365 days after the date of the accidental injury. In no event will we pay the accidental death or dismemberment benefit where an insured's accident, injury, loss, death or dismemberment is caused directly or indirectly by, results in whole or in part from or during, or there is contribution from, any of the following:

(1) self-inflicted injury, self-destruction, or autoeroticism, whether sane or insane; or
(2) suicide or attempted suicide, whether sane or insane; or
(3) an insured's participation in, or attempt to commit, a crime, assault, felony, or any illegal activity, regardless of any legal proceedings thereto; or
(4) bodily or mental infirmity, illness or disease; or
(5) the use of alcohol; or
(6) the use of prescription drugs, non-prescription drugs, illegal drugs, medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected; or

(7) motor vehicle collision or accident where an insured is the operator of the motor vehicle and an insured's blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or
(8) infection, other than infection occurring simultaneously with, and as a direct and independent result of, the accidental injury; or
(9) medical or surgical treatment or diagnostic procedures or any resulting complications, including complications from medical misadventure; or
(10) travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; or
(11) war or any act of war, whether declared or undeclared.

What is the amount of the AD&D benefit?

The amount of the benefit shall be a percentage of the amount of insurance shown on the specifications page . The percentage is determined by the type of loss as shown in the following table:

TYPE OF LOSS	PERCENT OF AMOUNT OF INSURANCE
Life	100%
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
Speech and Hearing in Both Ears	100%
One Hand and One Foot	100%
One Foot and Sight of One Eye	100%
One Hand and Sight of One Eye	100%
Quadriplegia	100%
Paraplegia	75%
Sight of One Eye	50%
Speech or Hearing in Both Ears	50%
One Hand or One Foot	50%
Hemiplegia	50%
All Four Fingers of One Hand	50%
Thumb and Index Finger of One Hand	25%
Uniplegia	25%
Loss of Four Toes of One Foot	20%

Loss of hands or feet means complete severance at or above the wrist or ankle joints. Loss of sight, speech, or hearing means the entire and irrecoverable loss of sight, speech, or hearing which cannot be corrected by medical or surgical treatment or by artificial means. Loss of thumb or finger means complete severance at or above the metacarpophalangeal joints. Loss of toes means the complete severance at or above the metatarsophalangeal joints.

Quadriplegia means total and permanent paralysis of both upper limbs (from the shoulder down including total paralysis of both hands) and both lower limbs (from the waist down including total paralysis of both feet). Paraplegia means total and permanent paralysis of both lower limbs (from the waist down including total paralysis of both feet). Hemiplegia means total and permanent paralysis of both the upper limb (from the shoulder down including total paralysis of the hand) and lower limb (from the waist down including total paralysis of the foot) on one side of the body. Uniplegia means total and permanent paralysis of one limb (from the shoulder down including total paralysis of the hand if claiming an upper limb and from the waist down including total paralysis of the foot if claiming a lower limb).

A benefit is not payable for both loss of one hand and the loss of thumb and index finger of one hand or the loss of four fingers of one hand for injury to the same hand as a result of any one accident (the largest benefit of these overlapping losses only will be paid). Under no circumstance will more than one payment be made for the loss or paralysis of the same limb, eye, finger, thumb, hand, foot, sight, speech, or hearing if one payment has already been made for that loss.

Benefits may be paid for more than one accidental loss but the total amount of AD&D insurance payable under this certificate for any one accident, not including any amount paid according to the terms of the Additional Benefits section of this certificate, will never exceed the full amount of the insured's AD&D insurance.

Can you request a change in the amount of your contributory insurance?

Yes. The specifications page describes when changes can be requested, when evidence of insurability will be required for such changes, and when the changes will become effective.

What are the notice of claim and proof of loss requirements?

Written notice of injury on which a claim may be based must be given to us within 30 days after the accident. Proof of loss must be furnished to us within 90 days after the date of loss. However, failure to give such notice and proof within the time provided will not invalidate the claim if it is shown that notice and proof were given as soon as reasonably possible.

When we receive written notice of claim, we will send the claimant our claim forms if he or she needs them. If the claimant does not receive the forms within 15 days, we will accept his or her written description as proof of loss.

When will the accidental death or dismemberment benefit be payable?

We will pay the accidental death or dismemberment benefit upon receipt at our home office of written proof satisfactory to us as to both substance and form that you died or suffered a covered dismemberment as a result of a covered accidental injury. All payments by us are payable from our home office. The benefit will be paid in a single sum.

To whom will we pay the accidental death or dismemberment benefit?

In the case of your accidental death, we will pay the accidental death benefit to the beneficiary or beneficiaries. All other benefits,including any accidental death or dismemberment payable due to a dependent's loss, will be payable to you, if living, otherwise to your estate.

You name a beneficiary to receive the death benefit to be paid at your death. You may name one or more beneficiaries. You can change the beneficiary designation at any time, provided all of the following are true:

(1) your coverage is in force; and
(2) we have written consent of all irrevocable beneficiaries; and
(3) you have not assigned the ownership of your insurance.

A beneficiary designation must be made in writing or by any other method made available under the plan. Any beneficiary designation shall take effect as of the date it is signed, but will not affect any payment we make or action we take before receiving the designation.

You may also choose to name a beneficiary that you cannot change without the beneficiary's consent. This is called an irrevocable beneficiary.

If there is more than one beneficiary, each will receive an equal share, unless you have requested another method in your beneficiary designation. To receive the death benefit, a beneficiary must be living at the time of your death. In the event a beneficiary is not living at the time of your death, that beneficiary's portion of the death benefit shall be equally distributed to the remaining surviving beneficiaries. In the event of the simultaneous deaths of you and a beneficiary, the death benefit will be paid as if you survived the beneficiary.

If there is no eligible beneficiary, or if you do not name one, we will pay the death benefit to:

(1) your lawful spouse if living; otherwise
(2) your natural or legally adopted child (children) in equal shares, if living; otherwise
(3) your parents in equal shares, if living; otherwise
(4) your natural or legally adopted siblings in equal shares, if living; otherwise
(5) the personal representative of your estate.

Additional Benefits

Unless stated otherwise, additional benefits are payable to the same person or persons who receive the AD&D benefits. Additional benefits are paid in addition to any AD&D benefits described in the Accidental Death and Dismemberment section, unless otherwise stated. All provisions of this certificate, including but not limited to the exclusions and requirements listed under the "What does accidental death or dismemberment by accidental injury mean?" section, shall apply to these additional benefits**.**

Air Bag Benefit

What is the air bag benefit?

If an insured dies or suffers a covered dismemberment as a result of a covered accident which occurs while he or she is driving or riding in a private passenger car, we will pay an additional AD&D benefit equal to the lesser of $5,000 or 5% of the insured's amount of AD&D insurance.

In order to be eligible for this benefit, the following must apply:

(1) the seat in which the insured was seated was equipped with a properly installed airbag at the time of the accident; and
(2) the private passenger car is equipped with seatbelts; and
(3) a seatbelt was in proper use by the insured at the time of the accident as certified in the official accident report or by the investigating officer; and
(4) at the time of the accident, the driver of the private passenger car was a licensed driver and was not intoxicated, impaired, or under the influence of alcohol or drugs.

Airbag means a passive restraint device in a vehicle which inflates upon collision to protect an individual from injury or death.

Seatbelt means a properly installed seatbelt (or child restraint if the insured is a child), lap and shoulder restraint, or other restraint approved by the National Highway Traffic Safety Administration or any successor governmental agency. A private passenger car means a validly registered four-wheeled private passenger car or policyholder-owned car, jeep, pickup truck or van, including a sport utility vehicle (SUV), that is not licensed commercially or being used for racing, or acrobatic or stunt driving.

Child Care Benefit

What is the child care benefit?

If you die as a result of a covered accident and you are survived by one or more insured dependent children under age 13, we will pay additional benefits to reimburse for child care expenses incurred for your dependent children while under age 13.

The benefit for each child per year will be the lesser of:

(1) 3% of your amount of AD&D insurance; or
(2) $3,000; or
(3) actual incurred child care expenses.

Child care expenses are those expenses which are for a service or supply furnished by a licensed child care provider or facility for a dependent child's care. No

payment will be made for expenses incurred more than six years after the date of your death or for expenses incurred for dependent children over age 13. Proof of incurred child care expenses shall be required before any benefit payment is made. The child care benefit will be paid to the surviving parent, to the child's guardian, the custodian under the Uniform Transfers to Minors Act or to an adult caretaker when permitted under state law.

Coma Benefit

What is the coma benefit?

If an insured lapses into a coma as a result of and within 365 days of a covered accidental injury, and such coma has lasted for a minimum of 31 days, we will pay a monthly benefit equal to the lesser of:

(1) 1% of the insured's amount of AD&D insurance; or
(2) 1% of the difference between the insured's amount of AD&D insurance and the amount of any benefits paid under the loss schedule for the same accident. (if the full amount of AD&D insurance has been paid, no benefit is payable under this section).

This benefit will be paid monthly until the earliest of the following:

(1) the date the insured recovers such that he or she is no longer in a coma as defined herein; or
(2) the date of the insured's death. If an accidental death payment is due under this certificate, the amount of such payment will be reduced by the amount of AD&D insurance paid under this coma provision; or
(3) 12 monthly benefits have been paid. The 12th month will be a lump sum equal to 100% of the amount of AD&D insurance minus the amount already paid under this coma provision.

Coma means a state of profound unconsciousness with no evidence of appropriate responses to stimulation. The insured must be confined in a medical facility and diagnosed as comatose by a licensed physician.

Dependent Child Education Benefit

What is the dependent child education benefit?

We will pay an education benefit on behalf of your dependent children if you die as a result of a covered accident and are survived by one or more insured dependent children, provided that:

(1) at the time of your death, the dependent child is enrolled as a full-time student at an accredited post-secondary educational institution (however, no benefit will be payable for the current school year); or
(2) the dependent child enrolls on a full-time basis in an accredited post-secondary educational institution within one year of your death.

The benefit payable will be the lesser of:

(1) the actual tuition charged, exclusive of room and board; or
(2) 3% of your amount of insurance; or
(3) $3,000.

The benefit will be payable at the beginning of each school year for a maximum of four consecutive years, but not beyond the date the child attains age 25. The benefit will be paid to the insured dependent child if he or she is of legal age. If the insured dependent child is not of legal age the benefit will be paid to the person who provides proof they have paid or will pay the tuition bill for that school year. Proof of enrollment and tuition costs are required for each school year.

Disappearance Benefit

What is the disappearance benefit?

If an insured's body has not been found after one year from the date the conveyance in which he or she was traveling disappeared, exploded, sank, became stranded, made a forced landing or was wrecked, it shall be presumed, subject to all other terms of the policy and proof satisfactory to us that the accident occurred and the insured was a passenger on the conveyance, that the insured has died as a result of an accidental injury which was unintended, unexpected and unforeseen. Such death shall be considered a covered loss under this certificate.

Exposure Benefit

What is the exposure benefit?

If an insured suffers a loss under the Type of Loss schedule due to exposure to the elements, it will be covered as if it were due to injury, provided such loss results from unavoidable exposure to the elements by reason of a covered accident.

Medical Evacuation Benefit

What is the medical evacuation benefit?

If an insured requires air transport to a medical facility as a result of a covered accident, we will pay an additional benefit equal to the lesser of:

(1) incurred costs for such air transport; or
(2) $25,000.

Seatbelt Benefit

What is the seatbelt benefit?

If an insured dies or suffers a covered dismemberment as a result of a covered accident which occurs while he or

she is driving or riding in a private passenger car, we will pay an additional AD&D benefit equal to the lesser of:

(1) $25,000; or
(2) 10% of the insured's amount of AD&D insurance.

In order to be eligible for this benefit, the following must apply:

(1) the private passenger car was equipped with seatbelts; and
(2) a seatbelt was in proper use by the insured at the time of the accident as certified in the official accident report or by the investigating officer; and
(3) at the time of the accident, the driver of the private passenger car was a licensed driver and was not intoxicated, impaired, or under the influence of alcohol or drugs.

Seatbelt means a properly installed seatbelt (or child restraint if the insured is a child), lap and shoulder restraint, or other restraint approved by the National Highway Traffic Safety Administration or any successor governmental agency. A private passenger car means a validly registered four-wheeled private passenger car or policyholder-owned car, jeep, pickup truck or van, including a sport utility vehicle (SUV), that is not licensed commercially or being used for racing, or acrobatic or stunt driving.

Spouse Education Benefit

What is the spouse education benefit?

We will pay an education benefit on behalf of your spouse if you die as a result of a covered accident and are survived by your insured spouse, provided that your spouse enrolls in a program of higher education within 12 months after your death.

The benefit payable will be the least of:

(1) the actual tuition charged for all such education; or
(2) 5% of your amount of AD&D insurance; or
(3) $5,000.

Only expenses occurring within 30 months after the date of your death will be eligible for reimbursement.

Portability Benefit

What is the portability benefit?

The portability benefit provides for continuation of your group AD&D insurance if you no longer meet the eligibility requirements of this certificate, except as provided for herein.

To continue coverage under the provisions of this benefit, you must make a written request and make the first premium contribution within 31 days after insurance provided by the group policy would otherwise terminate. Coverage provided by this benefit will be effective the date we receive the completed application. This date is considered to be the insured's portability date and the insured is then considered to have portability status.

Who is eligible to continue insurance under this benefit?

An insured employee is eligible to continue insurance under the terms of this benefit if he or she, except as provided by this benefit, no longer meets the eligibility requirements of the certificate due to any of the following:

(1) the employee terminates employment, including retirement; or
(2) the employee is no longer in a class eligible for insurance or is on a leave or layoff; or
(3) a class or group of employees insured under the policy is no longer considered eligible and there is no successor plan for that class or group. Successor plan means an insurance policy or policies provided by us or another insurer that replaces insurance provided under this policy.

An insured will not be eligible to request coverage under this benefit if he or she:

(1) has attained the age of 70; or
(2) is an employee and was not actively at work due to sickness or injury on the date immediately preceding his or her portability date; or
(3) loses eligibility due to termination of the group policy.

What insurance can be continued under this benefit?

Both contributory and non-contributory insurance may be continued under this benefit. If an employee elects to continue his or her own coverage according to the provisions of this benefit, he or she may also elect to continue insurance for any other dependent insured under his or her certificate.

An insured may also continue coverage under all certificate benefits which apply to his or her insurance and by which he or she was insured immediately preceding his or her portability date, except the waiver of premium benefit, which shall terminate upon porting.

What is the minimum amount of insurance that can be continued under this benefit?

The minimum amount of AD&D insurance that can be continued on an employee under this benefit is $10,000. The minimum for dependents is $1,000.

What is the maximum amount of insurance that can be continued under this benefit?

The maximum amount of AD&D insurance that can be continued under this benefit is the amount of insurance that was in force on the insured's portability date, but not

more than $1,000,000 for an employee or $150,000 for a spouse. However, for an insured age 65 or older on his or her portability date, the amount will not be more than $325,000 for an employee or $97,500 for a spouse.

Will the amount of insurance continued under this benefit change?

Yes. On the first day of the month following the date an insured attains age 65, the amount of AD&D insurance on his or her life continued under this benefit will reduce to 65% of the amount of insurance in force on the day prior to attainment of age 65. Insurance terminates at age 70.

Can an insured request a change in the amount of insurance continued under this benefit?

Yes. An insured may elect to reduce the amount of AD&D insurance, subject to the minimum amount. The amount of insurance continued under this benefit will never increase.

How will premium contributions be paid?

Premium contributions will be paid directly to us on a monthly, quarterly, semi-annual, or annual basis and will be subject to an administrative charge per billing period. We may adjust the amount of the charge, but not more often than once per year.

Can the premium rate change?

Yes. The premium rate may increase on the portability date. The premium rate may also increase in the future.

What happens if an insured again becomes eligible under the certificate?

If an insured is continuing coverage under the terms of this benefit, and again meets the eligibility requirements of the certificate, not including the terms of this benefit, the insured shall no longer be considered to have portability status and ported coverage will terminate. Insurance may be continued only under the terms of the certificate, not including this benefit unless and until the insured no longer meets the eligibility requirements of the certificate and again return to portability status as provided for herein.

What happens to insurance provided under this benefit when the group policy terminates?

Anything in the group policy notwithstanding, termination of the group policy will not terminate AD&D insurance then in force for any person under the terms of this benefit. The group policy will be deemed to remain in force solely for the purpose of continuing such insurance, but without further obligation of the policyholder.

Any insurance continued under the terms of this benefit will remain in force until terminated by the provisions of the section entitled “When will insurance continued under this benefit terminate?”.

No individual may elect coverage under this benefit on or after the date of termination of the group policy.

When will insurance continued under this benefit terminate?

Insurance being continued under this benefit will terminate on the earliest of the following:

(1) the insured’s 70th birthday; or
(2) the date the insured again meets the eligibility requirements of the certificate, not including the terms of this benefit; or
(3) in the case of a dependent child or a spouse who is insured under the employee’s certificate, the date the employee’s coverage is no longer being continued or the date the spouse or child ceases to be eligible as defined under the terms of the certificate; or
(4) 31 days after the due date of any premium contribution which is not made; or
(5) the date you request to terminate this coverage.

Termination

When does an insured’s insurance end?

An insured’s insurance ends on the earliest of the following:

(1) the date the group policy ends; or
(2) the date the insured no longer meets the eligibility requirements, unless the insurance can be continued under the portability provisions; or
(3) the date the group policy is amended so the insured is no longer eligible, unless the insurance can be continued under the portability provisions; or
(4) 31 days (the grace period) after the due date of any unpaid premium if the premium remains unpaid at that time; or
(5) the last day for which premium contributions have been paid following your written request to cease participation under this certificate.

When does the group policy terminate?

The policyholder may terminate the group policy by giving us 31 days prior written notice. We reserve the right to terminate the group policy on the earlier of the following to occur:

(1) 31 days (the grace period) after the due date of any premiums which are not paid; or
(2) 31 days after we provide the policyholder with notice of our intent to terminate the group policy.

Additional Information

Do we have the right to obtain independent medical verification?

Yes. After you have provided proof of loss at your expense, we retain the right to have an insured medically examined at our expense whenever a claim is pending.

What if an insured's age has been misstated?

If an insured's age has been misstated, the accidental death or dismemberment benefit payable will be that amount to which the insured is entitled based on his or her correct age.

A premium adjustment will be made to the premium you pay for the insured's noncontributory insurance and to the premium an insured pays for contributory insurance, if any, so that the actual premium required at the insured's correct age is paid. If the insured's correct age is such that no benefit is payable, only a refund of premium will be made for the period the insured was not eligible.

Who is the owner of this coverage?

Unless assigned otherwise, you, the insured employee, are the owner of all coverage provided under your certificate. Only the owner has the right to exercise ownership rights under the certificate, including but not limited to naming or changing a beneficiary, changing the amount of insurance, assigning any or all ownership rights, and terminating the coverage.

Can your insurance be assigned?

Yes. However, we will not be bound by an assignment of the certificate or of any interest in it unless it is made as a written instrument, and you file the original instrument or a certified copy with us at our home office, and we send you an acknowledged copy.

We are not responsible for the validity of any assignment. You are responsible for ensuring that the assignment is legal in your state and that it accomplishes your intended goals. If a claim is based on an assignment, we may require proof of interest of the claimant. A valid assignment will take precedence over any claim of a beneficiary.

Can a change in ownership for a certificate be requested?

Yes. A change in ownership is a type of assignment. All provisions for assignments apply to ownership changes.

Is the policyholder required to maintain records?

Yes. The policyholder is required to maintain adequate records of any information necessary for us to administer the group policy, and shall provide access to such records when required for us to administer the policy.

If an administrative or clerical error is made in keeping records on or administering the insurance under the group policy, it will not affect otherwise valid insurance. A clerical or administrative error, however, does not continue insurance which is otherwise stopped, make insurance effective when it should not have been or change the amount of insurance provided by the provisions of the policy and no claim shall be paid on amounts put into effect as a result of a past clerical or administrative error. If an error causes a change in premium payment, a fair adjustment will be made.

Can insurance coverage be contested?

Yes. If an insured dies or sustains a covered loss under this certificate within two years of his or her original effective date of coverage or increase in coverage, we will verify the accuracy of the information provided by the insured during the application process. If we discover a material misrepresentation, the coverage will be rescinded and an otherwise valid claim will be denied. This two year period can be extended for fraud or as otherwise allowed by law.

Any statements the insured makes in his or her application will, in the absence of fraud, be considered representations and not warranties. Also, any statement an insured makes will not be used to void his or her insurance, or defend against a claim, unless the statement is contained in the application.

Will the provisions of this certificate conform with state law?

Yes. If any provision in this certificate or in the group policy is in conflict with the laws of the state governing the group policy or the certificates, the provision will be deemed to be amended to conform to such laws.

What is the policy interpretation right and authority?

The following applies only when the administration of the policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

Securian Life has the exclusive right and authority, in its sole discretion, to interpret the group policy and decide all matters arising thereunder. Securian Life's exercise of that authority shall be conclusive and binding on all persons unless it can be shown that the determination was arbitrary and capricious.

Group Accidental Death & Dismemberment Insurance Certificate Endorsement

Securian Life Insurance Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

SECURIAN®

This Certificate Endorsement is a part of the certificate of insurance describing the benefits available to you under Group Policy No. 70321, issued by Securian Life Insurance Company to Syneos Health, LLC. This endorsement is subject to every term, condition, exclusion and provision of the certificate unless otherwise expressly provided for herein.

The following applies to all employees at the time your coverage under this certificate became effective:

1. The cover page of the certificate is amended to include the following:

   THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the company.

Important Cancellation Information — Please Read The Provision Entitled, "When does the group policy terminate?," Found On Page 9. Benefits are reduced at age 65 and age 70.

2. The provision entitled "**What is your agreement with us?**" under the **General Information** section is amended in its entirety and replaced with the following:

   What is your agreement with us?

   If you meet the eligibility and enrollment requirements, you are insured under the group policy shown on the specifications page. Your application as defined under this certificate is a part of this certificate. This certificate summarizes the principal provisions of the group policy that affect your insurance coverage. The provisions summarized in this certificate are subject in every respect to the group policy.

   Any statements made in your application as defined in this certificate will be considered representations and not warranties. After two years from the date of issue of this certificate, no misstatements made by you in the application for such insurance shall be used to void the certificate or deny a claim for loss incurred commencing after the expiration of such two-year period.

3. The provision entitled "**What dependents are eligible for AD&D insurance under this certificate?**" under the **General Information** section is amended in its entirety and replaced with the following:

   What dependents are eligible for AD&D insurance under this certificate?

   The following members of your family are eligible for AD&D insurance under this certificate:

   (1) your lawful spouse who is not legally separated from you, or your domestic partner; and
   (2) your or your spouse/domestic partner's natural, legally adopted, foster, stepchildren or any child that you have been required by a court or administrative order to provide health plan coverage for who are between the ages of birth and 26 years old. An adopted child includes a child from the moment of placement in the adoptive home regardless of whether or not the adoption has become final. A foster child includes a child from the moment of placement in the foster home. Eligibility begins at the moment of birth (stillborn or unborn children are not eligible).

   After age 26, coverage for an unmarried child who is incapable of sustaining employment by reason of mental retardation or physical handicap, who became so incapacitated prior to the attainment of age 26 years of age and who is chiefly dependent upon you for support and maintenance, shall not terminate but coverage shall continue so long as your coverage remains in force and so long as the child remains in such condition.

A person who is eligible as an employee or retiree under the policy, or insured under the portability provisions, is not eligible as a dependent. Only one person can insure an eligible dependent child.

Any dependent who, subsequent to the effective date of your dependents AD&D insurance, meets the eligibility requirements of this certificate will become insured on the date he or she so qualifies, provided no additional premium is required and the dependent is not hospitalized or confined because of illness or disease (except in the case of a newborn). If additional premium is required, the insurance for that dependent will be effective under the same conditions which would apply if you were newly becoming eligible for dependents AD&D under this certificate. If the dependent is hospitalized or confined because of illness or disease on the date his or her insurance would otherwise become effective, his or her effective date shall be delayed until he or she is released from such hospitalization or confinement (except in the case of a newborn).

4. The provision entitled "**What does accidental death or dismemberment by accidental injury mean?**" under the **Accidental Death and Dismemberment Benefit** section is amended in its entirety and replaced with the following:

What does accidental death or dismemberment by accidental injury mean?

AD&D coverage is limited coverage. This means this coverage will provide benefits only when an insured's loss, death or dismemberment results directly and independently from all other causes, from an accidental bodily injury which was unintended, unexpected and unforeseen. The bodily injury must be evidenced by a contusion or wound, except in the case of accidental drowning. The bodily injury must be the sole cause of an insured's loss, death or dismemberment. The injury and accidental loss, death or dismemberment must occur while your coverage is in force. An insured's loss, death or dismemberment must occur within 365 days after the date of the accidental injury. In no event will we pay the accidental death or dismemberment benefit where an insured's accident, injury, loss, death or dismemberment is caused directly from any of the following:

(1) intentionally self-inflicted injury, self-destruction, or autoeroticism, whether sane or insane; or
(2) suicide or attempted suicide, whether sane or insane; or
(3) an insured's participation in, or attempt to commit, a felony, or your being engaged in an illegal occupation, regardless of any legal proceedings thereto; or
(4) bodily or mental infirmity, illness or disease, except for accidental ptomaine poisoning; or
(5) the use of alcohol; or
(6) the use of prescription drugs, non-prescription drugs, illegal drugs, medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected. This does not include involuntary inhalation of gases and fumes, or the involuntary taking of poison; or
(7) motor vehicle collision or accident where an insured is the operator of the motor vehicle and an insured's blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or
(8) infection, other than bacterial infection occurring simultaneously with, and as a direct and independent result of, the accidental injury; or
(9) medical or surgical treatment or diagnostic procedures or any resulting complications, including complications from medical misadventure; or
(10) travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; or
(11) war or any act of war (not including acts of terrorism), whether declared or undeclared. This exclusion does not apply when the insured is a known service member at the time of sale; or
(12) exposure to nuclear explosion, nuclear energy or nuclear elements, hazardous waste and other toxins, except as the result of involuntary exposure to such.

5. The provision entitled "**What are the notice of claim and proof of loss requirements?**" under the **Accidental Death and Dismemberment Benefit** section is amended in its entirety and replaced with the following:

What are the notice of claim and proof of loss requirements?

Written notice of injury on which a claim may be based must be given to us within 30 days after the accident.

Proof of loss must be furnished to us or our authorized agent within 180 days after the date of loss. However, failure to give such notice and proof within the time provided will not invalidate or reduce the claim if it was not reasonably possible to provide proof within this 180 day period. However, proof must be provided within 1 year of the loss, except in the absence of legal capacity.

When we receive written notice of claim, we will send the claimant our claim forms if he or she needs them. If the claimant does not receive the forms within 15 days, we will accept his or her written description as proof of loss.

6. The provision entitled "**When will the accidental death or dismemberment benefit be payable?**" under the **Accidental Death and Dismemberment Benefit** section is amended in its entirety and replaced with the following:

   When will the accidental death or dismemberment benefit be payable?

   We will pay the accidental death or dismemberment benefit immediately upon receipt at our home office of written proof satisfactory to us as to both substance and form that you died or suffered a covered dismemberment as a result of a covered accidental injury. All payments by us are payable from our home office. The benefit will be paid in a single sum.

7. The provision entitled "**How will premium contributions be paid?**" under the **Portability Benefit** section is amended in its entirety and replaced with the following:

   How will premium contributions be paid?

   Premium contributions will be paid directly to us on a monthly, quarterly, semi-annual, or annual basis. We may adjust the amount of the charge, but not prior to the end of the first year, nor more frequently than once every six months. You will receive written notice of any change at least 45 days prior to the effective date of the change.

8. The following provision is added to the **Termination** section:

   Can insurance be reinstated?

   If any renewal premium be not paid within the time granted for payment, a subsequent acceptance of premium by us or by any agent duly authorized by us to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate your coverage. The reinstated coverage shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement. In all other respects you and we shall have the same rights thereunder as we had under the certificate immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement.

9. The provision entitled "**Do we have the right to obtain independent medical verification?**" under the **Additional Information** section is amended in its entirety and replaced with the following:

   Do we have the right to obtain independent medical verification?"

   Yes. After you have provided proof of loss at your expense, we retain the right to have an insured medically examined at our expense whenever a claim is pending, and to make an autopsy in the case of death where it is not forbidden by law.

10. The provision entitled "**Can insurance coverage be contested?**" under the **Additional Information** section is amended in its entirety and replaced with the following:

    Can insurance coverage be contested?

    After this certificate has been in force for a period of two years during your lifetime, it shall become incontestable as to the statements contained in the application.

Renée D. Montz

Secretary

President

Important Notice

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies and Health Maintenance Organizations (HMOs) licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer or HMO becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted **in the box** below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty Association may or may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The North Carolina Life and Health Insurance Guaranty Association
4441 Six Forks RD STE 106-153
Raleigh, North Carolina 27609-5729
https://www.nclifega.org/

North Carolina Department of Insurance, Consumer Division
1201 Mail Service Center
Raleigh, North Carolina 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. **On the back of this page** is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer or HMO. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange;

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed the average rate specified in the law;
- dividends;
- experience or other credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals) unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered;
- a policy or contract commonly known as Medicare Part C, Medicare Part D, Medicaid, or any regulations issued pursuant thereto.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Association is obligated to pay out as follows:

(1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.

(2) Except as provided in (3), (4) and (5) below, the guaranty association will pay a maximum of $300,000 per individual, per insolvency, no matter the number of policies or types of policies issued by the insolvent company.

(3) The guaranty association will pay a maximum of $500,000 with respect to a health benefit plan.

(4) The guaranty association will pay a maximum of $1,000,000 with respect to the payee of a structured settlement annuity.

(5) The guaranty association will pay a maximum of $5,000,000 to any one unallocated annuity contract holder.

Your Rights Under ERISA

The following section contains information provided to you by the Plan Administrator of your Plan to meet the requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It does not constitute a part of the insurance policy issued in connection with the Plan. All inquiries relating to the following material should be referred directly to your Plan Administrator. This information should be attached to your certificate of insurance. Together they comprise your Summary Plan Description (SPD).

Summary Plan Description

General Information

Name of Plan	Syneos Health Employee Welfare Plan
Plan Sponsor	Name: Syneos Health, LLC Address: 1030 Sync Street, Morrisville, NC 27560
Employer ID	Employer Identification Number (EIN): 33-0723120
Plan Number	Plan Number: 501
Type of Plan	Welfare Plan providing life insurance and associated benefits for employees.
Administration of Plan	The Plan is administered by the Plan Administrator through an insurance policy(ies) purchased from Securian Life Insurance Company, 400 Robert Street North, St. Paul, MN 55101. Generally, the Plan Administrator oversees the operation and records of a plan.
Plan Administrator	Name: Syneos Health, LLC Address: Attention: Human Resources Department 1030Sync Street, Morrisville, NC 27560
Agent for Service of Legal Process	Name: Syneos Health, LLC Address: Attention: Human Resources Department 1030 Sync Street, Morrisville, NC 27560
Plan Year	January 1 – December 31
Plan Funding	The Plan has an insurance policy(ies) with Securian Life Insurance Company. The premiums for the policy(ies) are paid by employer and employee contributions.
Interpretation, Amendment and Termination	The plan sponsor reserves the right to interpret, change or terminate the Plan's operation in the future. In the event of termination, benefits would be discontinued as described in the certificate.

Claim Procedures

Under Department of Labor (DOL) regulations, claimants are entitled to full and fair review of any claims made under the Plan. The procedures described in this section are intended to comply with DOL regulations by providing reasonable procedures governing the filing of benefit claims, notification of benefit decisions, and appeal of adverse benefit decisions.

A. Presenting Claims for Benefits

Claim forms may be obtained from the Employer.

Contact your Plan Administrator if you have any questions or need claim forms. Read the instructions on those forms carefully, and be sure all the questions are answered and that you include any required attachments when the completed forms are returned. After your claim has been processed by Securian Life, you will be notified in writing if any benefits are denied in whole or in part, or if any additional information is required.

During all steps of the claims appeal procedure, you can write or call the appropriate Plan Administrator and ask to see all plan documents affecting your claim. In addition you may have an attorney or other representative write letters or otherwise act on your behalf, but the Plan Administrator reserves the right to require written authorization from you.

B. Claims Denial Procedure

If all or part of your claim for benefits is denied, Securian Life will notify you in writing within 90 days (45 days for any disability claims) of receiving your claim. If special circumstances require more time, the review period may be extended up to an additional 90 days (30 days for disability claims). You will be notified in writing of this extension within the original review period.

The notice of extension will include a description of the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the information needed to resolve those issues, and it shall specify a timeframe, no less than 45 days, in which the necessary information must be provided. Where the timeframe to process a claim is extended because the claim was incomplete, the extension time is calculated from the date the extension notice is sent to the claimant to the date the person responds to the request for additional information. If the person does not provide needed information to the Plan within 45 days of the date on the notice the Plan may close the claim and no further consideration will take place.

Any denial of a claim for benefits will be provided by Securian Life and consist of a written explanation which will include (i) the specific reasons for the denial, (ii) reference to the pertinent Plan provisions upon which the denial is based, (iii) a description of any additional information you might be required to provide and explanation of why it is needed, and (iv) an explanation of the Plan's claim review procedure.

Disability Claims Only – The following will also be included:

- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision.

- Explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant’s medical circumstances, if applicable.

C. Appealing the Denial of a Claim

You, your beneficiary (when an appropriate claimant), or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request for a full and fair review to Securian Life. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed, and comments and issues outlining the basis of the appeal may be submitted in writing. You may have representation throughout the review procedure. A request for a review must be filed by 60 days (180 days for any disability claims) after receipt of the written notice of denial of a claim. The full and fair review will be held and a decision rendered by Securian Life, no later than 60 days (45 days for disability claims) after receipt of the request for

review.

If special circumstances require more time, the review period may be extended up to an additional 60 days (45 days for disability claims). You will be notified in writing of this extension within the original appeal period.

The notice of extension will include a description of the missing information and shall specify a timeframe, no less than 60 days (180 days for disability claims), in which the necessary information must be provided. Where the timeframe to process an appeal is extended because the claim was incomplete, the time for the benefit determination is put on hold from the date the extension notice is sent to the claimant until the date the person responds to the request for additional information. If the person does not provide needed information to the Plan within the 60 days (180 days for disability claims) of the date on the notice the Plan will close the appeal and no further consideration will take place.

A decision on appeal is adverse if it is a denial, reduction or termination of a benefit, or a failure to provide or make payment, in whole or part, for a benefit. It also includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination that the claimant is no longer eligible to participate in a plan.

Written notification of the Plan's decision on a disability or non-disability appeal shall be provided to the claimant and will include the following:

- Explanation of the specific reasons for the denial
- A specific reference to pertinent Plan provisions on which the denial was based
- A statement regarding your right, upon request and free of charge, to reasonable access to review or copy pertinent documents
- A statement of the right to sue in federal court.

Disability Claims Only

- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision
- Explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances, if applicable.

D. Legal Action Following Appeals

After completing all mandatory appeal procedures, you have the right to further appeal adverse benefit determinations by bringing a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the Statement of ERISA Rights section for more details. No such action may be filed against the Plan after two years from the date the Plan gives you a final determination on your appeal. Also, no legal action may be brought if you do not file a claim for a benefit and seek timely review of a denial of that claim.

Statement of ERISA Rights

The Statement of ERISA rights is required by federal law and regulation.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents, including the insurance contract, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

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

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.

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials for the Plan and do not receive them within 30 days, you may file a suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance 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 the cost 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.

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 (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, EBSA, 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 EBSA.

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