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, 2025

POLICYHOLDER: Modine Manufacturing Company

POLICY NUMBER: 70315

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

TABLE OF CONTENTS

GROUP ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) CERTIFICATE OF INSURANCE

Certificate Specifications Page

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

SECURIAN®

GENERAL INFORMATION

POLICYHOLDER Modine Manufacturing Company

POLICY NUMBER: 70315

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 Wisconsin.

POLICY EFFECTIVE DATE: January 1, 2018. This specifications page represents the plan of insurance in effect as of January 1, 2025.

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 Modine manufacturing employees of the policyholder and its associated companies working in 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, is not eligible as a dependent. Only one person can insure an eligible dependent child.

WAITING PERIOD: The period commencing with the employee's date of employment and coinciding with the employee's completion of 30 days of continuous employment.

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	One, two, three, four, five, six, seven, or eight times annual earnings, multiplied and then rounded to the next higher $1,000 if not already a multiple thereof, subject to a maximum of $750,000.

GENERAL PROVISIONS FOR EMPLOYEE INSURANCE

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	65%

Age reductions will apply the date of an insured employee's 65th birthday.

RETIREMENT REDUCTIONS: All insurance terminates at retirement.

CONTRIBUTORY/NONCONTRIBUTORY: All AD&D insurance is contributory insurance.

INCREASES AND DECREASES: The effective date of increases and decreases due to a change in eligible class or earnings is the date of the change in eligible class or earnings. All increases are subject to the actively at work requirement.

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.

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.

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.

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 12 months 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 or attained age 65.

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 your 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 your loss, death or dismemberment. The injury and accidental loss, death or dismemberment must occur while your coverage is in force. Your 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 your 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) your 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 you are the operator of the motor vehicle and your 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%
One Arm or One Leg	25%
Hearing in One Hear	25%

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 arm or leg means complete severance at or above the elbow or knee. Loss with regard to an arm, leg hand or foot shall also mean the total and irrecoverable loss of its use.

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.

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,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
(1) we have written consent of all irrevocable beneficiaries; and
(2) 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) 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**.**

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) 100% of your amount of insurance; or
(3) $12,000.

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.

Public Transportation Benefit

What is the public transportation benefit?

If an insured dies or suffers a covered dismemberment as a result of a covered accident which occurs while the insured is a fare-paying passenger on a public transportation vehicle, we will pay an additional benefit equal to the lesser of:

(1) 100% of the insured's full amount of AD&D insurance; or
(2) $250,000.

Public transportation vehicle means any air, land or water vehicle operated under a license for the transportation of fare paying passengers.

Repatriation Benefit

What is the repatriation benefit?

If, as a result of a covered accident, an insured dies at least 100 miles from his or her principal residence, an additional accidental death benefit shall be paid for the preparation and transportation of the body to a mortuary. The additional benefit shall be the lesser of the actual cost of such preparation and transportation or $5,000. The benefit will be paid to the person who has or who will incur such cost, as evidenced to the satisfaction of us. This may or may not be the beneficiary for the rest of the accidental death proceeds. We may at our sole discretion pay benefits directly to the facility handling the preparation and/or transportation. All determinations and payments by us will be final and fully release and discharge us from any further liability under this repatriation benefit.

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) $10,000; or
(2) 100% 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.

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; or
(3) the date the group policy is amended so the insured is no longer eligible; or
(4) 60 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) 60 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. 70315, issued by Securian Life Insurance Company to Modine Manufacturing Company. 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:

1. 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:

   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 and within one year after the end of the 90 day period.

   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.

2. 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:

   We will pay the accidental death or dismemberment benefit within 30 days of 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. If the benefit is not paid within the 30 day period, then we shall also pay interest on the benefit from the date of death at a rate of 12% per annum to the date when the benefit is paid. All payments by us are payable from our home office. The benefit will be paid in a single sum.

3. Item (2) of the provision entitled "**When does the group policy terminate?**" under the **Termination** section is amended in its entirety and replaced with the following:

   (2) 60 days after we provide the policyholder with notice of our intent to terminate the group policy.

4. The **Additional Information** section is amended to add the following provision:

   GRIEVANCE PROCEDURES

   The following grievance procedures are available.

   INTERNAL GRIEVANCE

   You or your authorized representative may submit a grievance in writing to us at our home office. You also have the right to appear in person before our grievance panel to present written or oral information. We will mail a written acknowledgement of the grievance within 5 business days of its receipt in our home office. If the person requesting the review elects to appear in person, we will provide written notification of the time and place of the grievance meeting at least 7 calendar days before the meeting. We will also allow reasonable accommodations to allow the person to participate in the meeting. Our grievance panel will be made up of at least one person authorized to take corrective action on the grievance and may consult with the person who made the initial determination.

   We will resolve a grievance within 30 calendar days after its receipt in our home office. The grievance panel's decision will contain the disposition of the claim and any corrective action taken on the grievance. It will be signed by one voting member of the panel and include a written description of position titles of panel members involved

in making the decision. If we are unable to resolve the grievance, we may extend the time another 30 calendar days. If extended, we will provide you or your authorized representative with a notice explaining that we have not resolved the grievance, when the resolution of the grievance may be expected and the reason additional time is needed.

INDEPENDENT REVIEW

You or your authorized representative may request an independent review of any adverse determination. You must request an independent review within four (4) months after we have reviewed the internal grievance and determined no further benefits are payable. You must exhaust the internal grievance before he or she may request an independent review. You are not required to exhaust the internal grievance before requesting an independent review if we and you agree that the matter may proceed directly to independent review. This may also apply if, along with the request for the independent review, you submit to the independent review organization selected, a request to bypass the internal grievance. If the independent review organization determines that your health condition is such that requiring you to use the internal grievance before proceeding to independent review would jeopardize your life or health or your ability to regain maximum function, they may waive the internal grievance. When the denial is made, we will provide you with information on how to request a review and the time within which the review must be requested. This information will include a current listing of certified independent review organizations from which you or your representative may choose from. You must submit your choice to us in writing along with a $25.00 check made payable to the independent review organization. Once we have received this request, we have five (5) business days to notify the commissioner of insurance and the independent review organization chosen. We will also send the following information to the independent review organization: any information submitted to us by you or your authorized representative in support of your position under the internal grievance; the contract provisions of our Group Critical Illness insurance; and any other relevant documents or information used by us in the internal grievance determination. The independent review organization has five (5) business days after receiving our information to request additional information from us. If requested, we must provide them with the information requested or an explanation of why the information is not being submitted within five (5) business days. The independent review organization has thirty (30) days to make a decision. They will send a copy of their decision to us and their decision is binding on both you and us.

EXPEDITED REVIEW

If the independent review organization determines that your health condition is such that the above steps would jeopardize your life or health or your ability to regain maximum function, the above procedures would apply with the following exceptions:

1. Once we have received the request for an independent review, we have (1) business day to notify the commissioner of insurance and the independent review organization chosen.
2. The independent review organization has two (2) business days after receiving our information to request additional information from us. If requested, we must provide them with the information requested or an explanation of why the information is not being submitted within two (2) business days.

3. The independent review organization has seventy-two (72) hours to make a decision. They will send a copy of their decision to us. Their decision is binding on both you and us.

DEFINITIONS

For the purposes of the above provisions, the following definitions apply.

adverse determination

A determination by us based on the information provided, where we denied payment of the claim.

expedited grievance

A grievance where:

1. the duration of the standard grievance resolution process will result in serious jeopardy to your life or health or your ability to regain maximum function; and

2. in the opinion of a physician with knowledge of your medical condition, you are subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance; and

3. a physician with knowledge of your medical condition determines that the grievance shall be treated as an expedited grievance.

grievance

Any dissatisfaction with the provision of services or claims practices that is expressed in writing to us by, or on behalf of, you.

independent review

A review conducted by a certified independent review organization. The organization is certified by the Wisconsin Office of the Commissioner of Insurance.

Renée D. Montz

Secretary

President

Important Notice

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

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

SECURIAN LIFE INSURANCE COMPANY
400 ROBERT STREET NORTH
ST PAUL MN 55101-2098
651-665-3500

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE,** a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** at its website at https://oci.wi.gov/, or by contacting:

OFFICE OF THE COMMISSIONER OF INSURANCE
COMPLAINTS DEPARTMENT
PO BOX 7873
MADISON WI 53707-7873
1-800-236-8517
608-266-0103

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

Modine Manufacturing Company Health and Welfare Plan (f/k/a the Modine Manufacturing Company Group Insurance Plan)

Plan Sponsor

Name: Modine Manufacturing Company
Address: 1500 DeKoven Avenue
Racine, WI 53403

Employer ID

Employer Identification Number (EIN): 39-0482000

Plan Number

Plan Number: 501

Type of Plan

Welfare Plan. This Summary Plan Description describes certain life insurance and accidental death and dismemberment ("AD&D") benefits provided under the Plan. Other employee welfare benefits are also provided under the Plan and are described in other summaries.

Administration of Plan

The Plan Administrator is Modine Manufacturing Company. Benefits described in this Summary Plan Description, however, are provided under one or more insurance policies purchased from Securian Life Insurance Company, herein known as the "Insurer." The Insurer administers benefits, and claims for benefits, described under this Summary Plan Description. The Insurer's address is:

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

Plan Administrator

Name: Modine Manufacturing Company
Address: 1500 DeKoven Avenue
Racine, WI 53403

Agent for Service of Legal Process

Name: Modine Manufacturing Company
Address: 1500 DeKoven Avenue
Racine, WI 53403

Plan Year

April 1 to December 31. The benefit year for administration of benefits described in this Summary Plan Description is January 1 to December 31.

Plan Funding

The Plan has an insurance policy(ies) with the Insurer. The premiums for the policy(ies) are paid by contributions from the employer and employees.

Interpretation, Amendment and Termination

Modine Manufacturing Company, as Plan sponsor, reserves the right to amend, modify, or terminate the Plan at any time and from time to time.

Except as noted in the following paragraph, Modine Manufacturing Company, as the Plan Administrator, has the sole and absolute discretion to resolve all questions arising in the administration, interpretation, and application of the Plan, including, but not limited to, questions arising as to the right of any person to participate in or to receive any benefit from the Plan. The Plan Administrator's determination is binding on all parties.

The Insurer has the sole and absolute discretion to resolve all questions arising in the administration, interpretation, and application of any insurance contract it has issued under the Plan, including, but not limited to, questions arising as to the right of any person to receive benefits under such contract.

Plan Merger

Prior to April 1, 2018, benefits described in this Summary Plan Description were provided under the Modine Life Insurance and Long-Term Disability Plan (Plan Number 550). Effective April 1, 2018, Modine Manufacturing Company merged the Modine Life Insurance and Long-Term Disability Plan into this Plan. The merger of the plans did not affect the benefits described in this Summary Plan Description.

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 by contacting the Insurer.

Contact the plan administrator if you have any questions or to initiate a claim. You may also contact the Insurer directly to initiate a claim. Upon the receipt of notification of a claim the Insurer will provide claim forms. Read the instructions on those forms carefully, and be sure all the questions are answered and that you include any required attachments. Completed forms must be sent to Claims, PO Box 64114, St. Paul, MN 55164-0114. After your claim has been processed by the Insurer, you will be notified in writing if any benefits are denied in whole or in part, or if any additional information is required.

B. Claims Denial Procedure

If all or part of your claim for benefits is denied, the Insurer 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 explain the circumstances requiring the extension and indicate the date by which the plan expects to render the benefit determination. For disability claims, the review period may be extended up to an additional 30 days provided the written notice described above is sent to the claimant before the expiration of the first 30-day extension period.

For disability claims, the notice of extension will also include a description of the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, the information needed to resolve those issues, and the claimant will be given at least 45 days to provide the information. Where the timeframe to process a disability claim is extended because the claim was incomplete, the time for the claim 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 Insurer within 45 days of the date on the notice, the Insurer may deny the claim.

<u>Notification of Claim Denial</u>

Any denial of a claim for benefits will be provided by the Insurer and will include the content required by law.

C. Appealing the Denial of a Claim

You may appeal any denial of a claim for benefits by filing a written request for a full and fair review to the Insurer at Claims, PO Box 64114, St. Paul, MN, 55164-0114. In connection with such a request, documents relevant to the appeal 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, if you submit written proof of the representation to the Insurer. An appeal must be filed by 60 days (180 days for disability claims) after receipt of the written notice of denial of a claim. Before the Insurer can deny a claim on appeal, the Insurer shall provide the claimant with any new evidence considered, relied upon, or generated during the appeal, as well as any new rationale for the decision. Any new evidence or rationale will be provided to the claimant free of charge, as soon as possible before the date by which the appeal is to be decided, so that the claimant may respond to the evidence or rationale before that date. The full and fair review will be held and notification of a decision rendered by the Insurer will be provided no later than 60 days (45 days for disability claims) after receipt of the request for review.

If special circumstances beyond the control of the Insurer 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 explain the circumstances requiring the extension and indicate the date by which the Insurer expects to render the benefit determination.

The notice of extension will include a description of any missing information and shall specify a timeframe, no less than 180 days in which the necessary information must be provided. Where the timeframe to process an appeal is extended because additional information to render an appeal decision is needed, 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 Insurer within the 180 days of the date on the notice, the Insurer may close the appeal and no further consideration will take place.

During all steps of the claims appeal procedure, you can write or call the Insurer and ask to see all documents relevant to your claim. In addition, you may have an attorney or other representative write letters or otherwise act on your behalf, but you may need to provide written proof of designation of the representative.

Notification of Appeal Decision

Written notification of the Insurer's decision on an appeal shall be provided to the claimant and will include the information required by law.

D. Legal Action Following Appeals

After completing the claims and appeal procedures, you have the right to dispute the determination 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 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 exhaust these claims procedures, unless exhaustion is not required.

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.

Securian Life Insurance Company • A Stock Company

400 Robert Street North • St Paul, Minnesota 55101-2098

GROUP ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) CERTIFICATE OF INSURANCE