NOTICE OF
PROTECTION PROVIDED BY
WYOMING LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Wyoming Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Wyoming law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Wyoming law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values

- Health Insurance
  - $300,000 in hospital, medical and surgical insurance benefits or major medical insurance
  - $300,000 in disability insurance benefits
  - $300,000 in disability income insurance
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits

- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of polices or contracts, is $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Wyoming law.

EXCLUSIONS FROM COVERAGE

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 stipulated premium insurance company, a local mutual burial association, a mutual assessment company, or similar plan in which the policy-holder 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 pursuant to the reinsurance policy or contract);
- interest rate yields that exceed an average rate or interest earned on an equity indexed policy;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- annuity contracts issued by a nonprofit insurance company exclusively for the benefit of nonprofit educational institutions and their employees;
- unallocated annuity contracts (which give rights to group contract holders, not individuals);
- any plan or program of an employer or association that provides life, health or annuity benefits to its employees or members to the extent the plan is self-funded or uninsured;
- an obligation that does not arise under the express written terms of the policy or contract;
- any policy providing Medicare Part C and Part D coverage.

To learn more about the above protections, protections relating to group contracts or retirement plans, and all exclusions from coverage, please visit the Association's website at www.wylifega.org or contact:

Wyoming Life and Health
Insurance Guaranty Association
6700 N. Linder Rd, Suite 156, Box 139
Meridian, ID 83646

Toll Free: (800) 362-0944
Fax: (208) 968-0206
Website: www.wylifega.org
Email: administrator@wylifega.org

Wyoming Department of Insurance
106 East 6th Avenue
Cheyenne, Wyoming 82002

Phone: (307) 777-7401
Toll Free: (800) 438-5768
Fax: (307) 777-2446
Website: doi.wyo.gov
Email: wyinsdep@wyo.gov

Insurance companies and agents are not allowed by Wyoming law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Wyoming law, then Wyoming law will control.

STANDARD INSURANCE COMPANY

A Stock Life Insurance Company
900 SW Fifth Avenue
Portland, Oregon 97204-1282
(503) 321-7000

GROUP CRITICAL ILLNESS INSURANCE CERTIFICATE

Policyholder:	Memorial Hospital of Laramie County dba Cheyenne Regional Medical Center
Group Policy Number:	171750-D
Group Policy Effective Date:	January 1, 2024
State of Issue:	Wyoming

The Group Policy has been issued to the Policyholder. We certify that you will be insured as provided by the terms of the Group Policy. If your insurance is changed by an amendment to the Group Policy, we will provide the Policyholder or Employer with a revised Certificate or other notice that will be available to you.

Possession of this Certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this Certificate.

"You" and "your" mean the Member. "We", "us" and "our" mean Standard Insurance Company. Other defined terms appear with the initial letters capitalized. Section and provision headings, and references to them, appear in boldface type.

Your Certificate describes the insurance under the Group Policy. Please read your Certificate carefully.

THIS CERTIFICATE IS ISSUED UNDER A LIMITED BENEFIT POLICY THAT PROVIDES CRITICAL ILLNESS INSURANCE BENEFITS. THE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED DOES NOT PROVIDE COMPREHENSIVE HEALTH INSURANCE COVERAGE. THIS CERTIFICATE IS NOT INTENDED TO SATISFY THE INDIVIDUAL MANDATE OF THE AFFORDABLE CARE ACT (ACA) OR PROVIDE THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE ACA (OFTEN REFERRED TO AS "MAJOR MEDICAL COVERAGE"). IT DOES NOT PROVIDE COVERAGE FOR HOSPITAL, SURGICAL OR MAJOR MEDICAL EXPENSES.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT POLICY. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE "GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE" AVAILABLE FROM US.

THIS CERTIFICATE DOES NOT CONTAIN COMPREHENSIVE ADULT WELLNESS BENEFITS AS DEFINED BY LAW.

STANDARD INSURANCE COMPANY
By

President and CEO

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COVERAGE FEATURES

Employer(s)

Memorial Hospital of Laramie County dba Cheyenne Regional Medical Center

Member

You are a Member if you are all of the following:

- A regular employee of the Employer working in the United States.
- Actively At Work at least 16 hours each week.
- A citizen or resident of the United States.

You are not a Member if you are:

- A temporary or seasonal employee.
- A full time member of the armed forces of any country.
- A leased employee.
- An independent contractor.

Class(es)

All Members

Eligibility Waiting Period

If you are a Member on the Group Policy Effective Date, you are eligible on the first day of the calendar month following the date you become a Member.

If you become a Member after the Group Policy Effective Date, you are eligible on the first day of the calendar month following the date you become a Member.

Premium Contributions

For you and your Child:	Contributory
For your Spouse:	Contributory

Contributory means you pay all or part of the premium for insurance.

Coverage Amount

The Coverage Amount is the amount of insurance under the Group Policy.

For Member:	The amount you elect and we approve in increments of $5,000 from $5,000 - $30,000.
For Child(ren):	50% of your Coverage Amount.
For Spouse:	The amount you elect for your Spouse and we approve in increments of $2,500 from $2,500 - $15,000, not to exceed 50% of your Coverage Amount.

Amount Payable

Table of Critical Illness Benefits

The amount payable is the percentage of the Coverage Amount in effect on the date of the Critical Illness. Subject to the Reoccurrence Benefit, only one Critical Illness is payable unless a previous diagnosis or recommendation, as required, for a different and subsequent Critical Illness is made at least 0 days after the preceding Critical Illness.

Advanced Alzheimer's Disease	100% of Coverage Amount
Advanced Multiple Sclerosis	100% of Coverage Amount
Advanced Parkinson's Disease	100% of Coverage Amount
Amyotrophic Lateral Sclerosis (ALS)	100% of Coverage Amount
Benign Brain Tumor	100% of Coverage Amount
Bone Marrow Transplant	100% of Coverage Amount
Cancer	100% of Coverage Amount
Carcinoma in Situ	25% of Coverage Amount
Coma	100% of Coverage Amount
End-Stage Renal (Kidney) Failure	100% of Coverage Amount
Loss of Hearing	100% of Coverage Amount
Loss of Sight	100% of Coverage Amount
Loss of Speech	100% of Coverage Amount
Major Organ Failure	100% of Coverage Amount
Myocardial Infarction (Heart Attack)	100% of Coverage Amount
Occupational Hepatitis	100% of Coverage Amount
Occupational Human Immunodeficiency Virus (HIV)	100% of Coverage Amount
Severe Coronary Artery Disease With a Recommendation of Bypass Surgery	25% of Coverage Amount
Stroke	100% of Coverage Amount
Child Diseases	100% of Coverage Amount for Child
Reoccurrence Benefit	100% of Coverage Amount

If a Critical Illness Benefit is payable and there is a subsequent diagnosis or recommendation for the same Critical Illness, a Reoccurrence Benefit is payable if you and your Dependents meet both of the following:

- You and your Dependents have been continuously insured under the Group Policy between the previous and subsequent diagnosis or recommendation.
- You and your Dependents have served a 12 month Treatment Free Period during such continuous insurance.

A Reoccurrence Benefit is payable only once per each Critical Illness during your or your Dependent's lifetime.

Treatment Free Period means you or your Dependent have not done any of the following in connection with the Critical Illness:

- Consulted a physician or other licensed medical professional.
- Received medical treatment, services or advice.
- Undergone diagnostic procedures, including self-administered procedures.
- Taken prescribed drugs or medications.

Treatment Free Period does not include:

- Maintenance drug therapy (such as: ongoing antiplatelet regimens and statins; ongoing hormonal therapy, immunotherapy or chemoprevention therapy) that is intended to decrease the risk of Critical Illness reoccurrence.
- Routine follow-up visits with a Physician, including necessary tests (such as a stress treadmill) to verify whether or not a Critical Illness has reoccurred.

Additional Benefits

Health Maintenance Screening Benefit	$50

Additional Features

Reinstatement

Continuity of Coverage

Continuation of Insurance (Portability) for the Member

Continuation of Insurance (Portability) for the Spouse

Other Services

Standard Insurance Company (The Standard) has negotiated with service providers to offer the following other service. The service provided are negotiated between The Standard and each service provider. Please note that occasionally our agreement with a service provider may require that the services provided be modified or terminated.

Health Advocacy	Health Advocacy assists you in navigating the healthcare system. Health Advocacy services will assist you with healthcare issues.

ELIGIBILITY AND ENROLLMENT

Becoming Insured

To become insured you must:

- Be a Member.
- Complete your Eligibility Waiting Period.
- Meet the requirements shown in **When Your Insurance Becomes Effective** and **Active Work Requirement**.

When Your Insurance Becomes Effective

The **Coverage Features** states whether insurance is Contributory or Noncontributory. Subject to the **Active Work Requirement,** your insurance becomes effective as follows:

Contributory insurance

You must apply in writing for Contributory insurance and agree to pay premiums. Contributory insurance becomes effective on:

- The date you become eligible if you apply on or before that date.
- The date you apply if you apply within 31 day(s) after you become eligible.
- The beginning of the next plan year following the Annual Enrollment Period if you apply during the Annual Enrollment Period.
- If you have a Family Status Change the later of:
  - The date of the Family Status Change if you apply on or before the date of the Family Status Change.
  - The date you apply if you apply within 31 day(s) of the Family Status Change.
  - The beginning of the next plan year following the Annual Enrollment Period, if you apply for the Family Status Change during the Annual Enrollment Period.

Annual Enrollment Period means the period designated each year by your Employer when you may apply for insurance or change insurance elections.

Changes in Your Insurance

You may apply in writing for any increase in your insurance.

Subject to the **Active Work Requirement,** increases in your insurance become effective as follows:

Increases becomes effective on the later of:

- The date you apply for the increase.
- The beginning of the next plan year following the Annual Enrollment Period during which you apply for the increase.
- The first day of the calendar month following the date of your Family Status Change.

Decreases in insurance due to a plan change or Coverage Amounts become effective on:

- The date of change in your Class.
- The date of change in your age.

- The beginning of the next plan year following the Annual Enrollment Period during which you requested the decrease.
- The first day of the calendar month coinciding with or next following the date the Policyholder or Employer receives your written request for the decrease.

Active Work Requirement

If you are incapable of Active Work because of sickness, injury, or pregnancy on the day before the scheduled effective date of your insurance or increase in Coverage Amount under the Group Policy, such insurance will not become effective until the day after you complete 1 full day(s) of Active Work as an eligible Member.

Active Work and Actively At Work mean performing the material duties of your own occupation at your Employer's usual place of business.

You will also meet the **Active Work Requirement** if you meet all of the requirements shown below:

- You were absent from Active Work because of a regularly scheduled day off, holiday, or vacation day.
- You were Actively At Work on your last scheduled work day before the date of your absence.
- You were capable of Active Work on the day before the scheduled effective date of your insurance.

When Your Insurance Ends

Insurance ends automatically on the earliest of the following:

- For Contributory insurance, the date you notify the Policyholder or your Employer in writing that coverage is to be terminated.
- The date the last period ends for which the premium was paid for your insurance.
- The date the Group Policy terminates unless you continue your insurance under the **Continuation of Insurance (Portability) for the Member** provision.
- The first day of the calendar month following the date your employment terminates unless you continue your insurance under the **Continuation of Insurance (Portability) for the Member** provision.
- The date you cease to be a Member. However, if you cease to be a Member because you are not working the required minimum number of hours, your insurance will be continued with payment of premium:
  - During the first 60 day(s) of a temporary or indefinite administrative leave of absence.
  - During any other scheduled leave of absence approved by your Employer in advance and in writing and lasting not more than 60 day(s).
  - During a leave of absence which is required by the federal or a state-mandated family or medical leave act or law.

CHILD INSURANCE

When Child Insurance Becomes Effective

Insurance for your Child becomes effective as follows:

- The date your insurance becomes effective if you have a Child on that date.
- The date you first acquire a Child, if you are insured on that date.

If you have more than one Child on the effective date, all are insured as of that date. While your insurance is in effect, each new Child becomes insured immediately.

A Member may not be insured as both a Member and a Child. A Child may not be insured by more than one Member.

Changes in Child Insurance

Increases or decreases resulting from changes in your Coverage Amounts will become effective for a Child on the effective date of your change.

When Child Insurance Ends

Your insurance for a Child ends automatically on the earliest of:

- The date your insurance ends unless the Child insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision or **Continuation of Insurance (Portability) for the Spouse** provision.
- The date the Child insurance terminates under the Group Policy unless the Child insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision or **Continuation of Insurance (Portability) for the Spouse** provision.
- The date a Child ceases to meet the definition of Child.
- The date the Group Policy terminates or your Employer's coverage under the Group Policy terminates unless Child insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision.

SPOUSE INSURANCE

Eligibility for Spouse Insurance

You become eligible to insure your Spouse on the later of:

- The date you become eligible for insurance if you have a Spouse on that date.
- The date you acquire a Spouse, if you are insured on that date.

A Member may not be insured as both a Member and a Spouse.

When Spouse Insurance Becomes Effective

The **Coverage Features** states whether your Spouse insurance is Contributory or Noncontributory. You must apply in writing for Contributory Spouse insurance and agree to pay premiums.

Contributory Spouse insurance becomes effective on:

- The date your insurance becomes effective if you apply on or before that date to insure your Spouse.
- The date you apply to insure your Spouse.
- The beginning of the next plan year following the Annual Enrollment Period.
- If you have a Family Status Change, the later of:
  - The date of the Family Status Change if you apply on or before the date of the Family Status Change.
  - The date you apply if you apply within 31 days of the Family Status Change.
  - The beginning of the next plan year following the Annual Enrollment Period if you apply for the Family Status Change during the Annual Enrollment Period.

Changes in Spouse Insurance

You may apply in writing for any increase in your Spouse insurance.

Increases in your Spouse's insurance becomes effective on the latest of:

- The date you apply for the increase.

- The beginning of the next plan year following the Annual Enrollment Period during which you apply for the increase.
- The first day of the calendar month following the date of your Family Status Change.

Decreases in your Spouse's Coverage Amounts become effective on:

- The first day of the calendar month coinciding with or next following the date the Policyholder or Employer receives your written request for the decrease.

When Spouse Insurance Ends

Your insurance for a Spouse ends automatically on the earliest of:

- The date your insurance ends unless Spouse insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision or **Continuation of Insurance (Portability) for the Spouse** provision.
- The date Spouse insurance terminates under the Group Policy unless Spouse insurance is continued under the **Continuation of Insurance (Portability) Portability of Insurance for the Member** provision or **Continuation of Insurance (Portability) Portability of Insurance for the Spouse** provision.
- The date a Spouse ceases to meet the definition of Spouse.
- The date the last period ends for which the premium was paid for your Spouse insurance.
- The date the Group Policy terminates unless Spouse insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision.

CRITICAL ILLNESS BENEFITS

Insuring Clause

If you or your Dependent incur a Critical Illness or meet the requirements for the Additional Benefits while insured under the Group Policy, we will pay benefits according to the terms of the Group Policy after we receive Proof Of Loss satisfactory to us.

Critical Illness Definitions

Advanced Alzheimer's Disease means a diagnosis of Alzheimer's Disease which has advanced to a permanent clinical loss of the ability to do all of the following: remember, reason, perceive, understand, express and give ideas.

The diagnosis of Advanced Alzheimer's Disease as defined above must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as a neurologist and has performed the appropriate neurological examination and cognitive testing including: Functional Assessment Staging Test (FAST) with a Stage 6 (moderately severe) or greater classification requiring substantial assistance in performing at least two or more Activities Of Daily Living (ADL's).

The diagnosis must eliminate other causes of dementia, including: mental health disorders, dementing organic brain disorders, vitamin deficiency or infection. Dementia due to the root cause of vascular dementia (including stroke), drug or alcohol are not included.

Advanced Multiple Sclerosis means a diagnosis of Multiple Sclerosis (MS) which has advanced to the inability to safely and completely perform two or more Activities Of Daily Living without Hands-on Assistance or Standby Assistance due to loss of functional capacity that has persisted for a continuous period of at least 6 months.

The diagnosis of Advanced MS as defined above must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as a neurologist.
- Be based on at least two episodes of well-defined neurological abnormalities with objective evidence of lesions at more than one site within the central nervous system as documented by Magnetic Resonance Imaging (MRI).
- Supported by modern investigative techniques including, but not limited to, a lumbar puncture.

Advanced Parkinson's Disease means a diagnosis of Parkinson's Disease which has advanced to a classification of Stage 4 or greater on the Hoehn and Yahr scale.

The diagnosis of Advanced Parkinson's Disease as defined above must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as a neurologist.
- Be based on neurological examination, cognitive testing, and the results of imaging studies.

Parkinson's disease secondary and other Parkinsonism Syndromes, such as: Progressive Supranuclear Palsy, Corticobasal Degeneration, Multiple System Atrophy, Vascular Parkinsonism, and Dementia with Lewy bodies are not included.

Amyotrophic Lateral Sclerosis (ALS) also known as Lou Gehrig's Disease, means a diagnosis of ALS.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as a neurologist.
- Be based according to the diagnostic criteria for ALS.

All other motor neuron diseases are not included.

Benign Brain Tumor means a diagnosis of a non-malignant tumor or cyst in the brain, cranial nerves, or meninges within the skull, resulting in permanent neurological deficit with persisting clinical symptoms.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as a neurologist.
- Be evidenced on Magnetic Resonance Imaging (MRI) of the brain (with or without contrast) or by pathological diagnosis. If you are unable to undergo a MRI, due to safety or mechanical reasons, a CT scan of the head may evidence the diagnosis of the tumor.

Tumors in the pituitary gland or angiomas are not included.

Bone Marrow Transplant means a diagnosis and recommendation that a bone marrow transplant is necessary due to the compromise of the bone marrow's ability to produce blood cells as a result of cancer.

The diagnosis and recommendation must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as a hematologist or oncologist.

Cancer means a diagnosis of any malignant tumor or neoplasm with histological confirmation, characterized by the uncontrolled growth of malignant cells and invasion of tissue beyond the initial tissue (invasive).

The diagnosis must:

- Be made while insured under the Group Policy.

- Be made by a Physician who is board certified as a pathologist or oncologist.
- Be based on pathological or clinical evidence.

Cancer includes:

- Leukemia
- Lymphoma
- Sarcoma
- Malignant melanoma
- Other skin malignancies that have been histologically classified as having caused invasion beyond the epidermis with a Clark's level III or greater, Breslow's depth of 0.75mm or greater, or AJCC TNM stage II or greater are included.

Conditions that are not invasive cancer are not included. Such conditions include, but are not limited to:

- All cancers which are histologically classified as pre-malignant, non-invasive, carcinoma in situ, having borderline malignancy, or having low malignant potential.
- Benign tumors or polyps.
- Early prostate cancer that is histologically classified as T1N0M0 or equivalent staging.
- Chronic lymphocytic leukemia that is histologically classified as Rai Stage 0 or Binet Stage A.
- Any skin cancer not previously incorporated in this definition, including:
    - Cutaneous lymphoma.
    - Melanoma that is histologically classified as Clark's level I or II; Breslow's depth of less than 0.75mm; or AJCC TNM stage 0 or I.

Carcinoma in Situ means a diagnosis of cancer in which the tumor or cells still lie within the tissue of origin without invading neighboring tissue or regional lymph nodes.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as a pathologist or oncologist.
- Be based on pathological or clinical evidence.

Carcinoma in Situ includes, but is not limited to:

- Early prostate cancer that is histologically classified as T1N0M0 or equivalent staging.
- Chronic lymphocytic leukemia that is histologically classified as Rai Stage 0 or Binet Stage A.
- Cutaneous lymphoma.
- Melanoma not invading the reticular (lower) dermis that is histologically classified as one of the following:
    - Clark's level I or II.
    - Breslow's depth of less than 0.75mm.
    - AJCC TNM stage 0 or I.

Carcinoma in Situ does not include: lesser skin malignancies (such as basal cell and squamous cell carcinomas, pre-malignant lesions), intraepithelial neoplasia, benign tumors or polyps.

Coma means an initial profound state of mental unconsciousness from which one cannot be aroused and there is no evidence of appropriate response to external stimulation, other than primitive avoidance reflexes, due to an accident or disease.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as a neurologist.
- Must last for at least 14 consecutive days resulting in neurological deficit with persisting clinical symptoms.

Coma which is medically induced or Coma as a result of drug or alcohol use is not included.

End-Stage Renal Failure means a diagnosis of chronic and end-stage irreversible failure of both kidneys to function, as a result of which the need for regular, at least weekly and for longer than 6 months, kidney dialysis or kidney transplant is recommended to sustain life.

The diagnosis and recommendation must:

- Be made while insured under the Group Policy.
- Be made by a board certified nephrologist.

Loss of Hearing means an initial diagnosis of entire, uncorrectable, and irrecoverable loss of hearing in both ears that results in one not being able to hear sounds at or below 70 decibels due to an accident or a disease.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as an otolaryngologist.
- Be based on audiometric testing.
- For a Child, occur after age 3.

Loss of Hearing does not include loss of hearing that can be corrected to hear sounds above 70 decibels by the use of any hearing aid or device.

Loss of Sight means an initial diagnosis of entire, uncorrectable, and irrecoverable loss of sight due to an accident or a disease.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as an ophthalmologist.
- Be based on evidence of sight in the better eye being reduced to a best-corrected visual acuity of 20/200 (Snellen or E-Chart Acuity) and visual field restriction to 20° or less in both eyes.
- For a Child, occur after age 3.

Loss of Speech means an initial diagnosis of entire, uncorrectable, and irrecoverable loss of the ability to speak due to an accident or a disease.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as a neurologist or otolaryngologist. The date of diagnosis for complete loss of speech is the date of certification of total and permanent loss of speech.
- Not be due to coma, psychiatric impairment, or stroke.
- For a Child, occur after age 3.

Major Organ Failure means a diagnosis of irreversible failure of the heart, liver, lung, small intestine, or pancreas as a result of a disease and, for which a transplantation of the organ(s) or tissue from a suitable human donor is required.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician.
- Be based on clinical evidence of major organ failure of an organ(s) or tissue and requires that your or your Dependent's condition meet the criteria for placement on the registry with the Organ Procurement and Transplantation Network/United Network for Organ Sharing (OPTN/UNOS) or its medically recognized successor organization.

If you or your Dependent do not meet the criteria for placement on the registry because your or your Dependent's condition is too far advanced or you or your Dependent are too ill to proceed with a transplant, this requirement will not apply.

Myocardial Infarction is commonly known as a heart attack and means an episode of rapid onset of chest pain that required immediate medical attention and with a diagnosis of death of a portion of the heart muscle as a result of inadequate blood supply to the heart.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician.
- Be based on new changes consistent with an evolving infarction on electrocardiogram (EKG) and concurrent with elevation of infarction specific enzymes, troponins or other biochemical markers accepted to be indicative of an acute Myocardial Infarction. In the event of death, an autopsy or death certificate indicating Myocardial Infarction as the cause will apply.

Myocardial Infarction does not include a heart attack that occurred during a medical procedure or due to alcohol or drug abuse. Other acute coronary syndromes, including but not limited to angina, are not included.

Occupational Hepatitis means a diagnosis of hepatitis, other than hepatitis A, that occurs as a result of a documented accidental exposure in the workplace to blood or other bodily fluids.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician.
- Be based on blood testing. A blood test is required within 72 hours of the accidental exposure with the results showing as negative for hepatitis. A follow up blood test with the results showing as positive for hepatitis must occur 6 to 12 months after the accidental exposure.
- Be documented by an appropriate accident report at the workplace.

Occupational Hepatitis does not include hepatitis that occurs as a result of accidental intravenous drug use, sexual transmission, or is determined not to be an accident.

Occupational Human Immunodeficiency Virus (HIV) means a diagnosis of HIV that occurs as a result of a documented accidental exposure in the workplace to blood or other bodily fluids.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician.
- Be based on blood testing. A blood test is required within 72 hours of the accidental exposure with the results showing as negative for HIV. A follow up blood test with the results showing positive for HIV must occur 6 to 12 months after the accidental exposure.
- Be documented by an appropriate accident report at the workplace.

Occupational HIV does not include HIV that occurs as a result of intravenous drug use, sexual transmission, or is determined not to be an accident.

Severe Coronary Artery Disease with a Recommendation of Bypass Surgery means a narrowing or blockage of the arteries and vessels that provide oxygen and nutrients to the heart that result in a diagnosis of severe coronary artery disease which results in a Physician's recommendation of bypass surgery. Severe Coronary Artery Disease with a Recommendation of Bypass Surgery includes but is not limited to: open heart surgery to increase the flow of blood through the coronary arteries.

The diagnosis and recommendation must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as a cardiologist or cardiac surgeon.
- Be based on a clinical diagnosis.

Severe Coronary Artery Disease does not include: angioplasty, stenting, percutaneous coronary intervention, or laser procedures.

If a Physician has recommended bypass surgery but you are too ill to proceed with the recommended surgery, the requirement that bypass surgery be recommended will not apply.

Stroke means a diagnosis of: a cerebrovascular accident or infarction (death) of brain tissue caused by hemorrhage, embolism or thrombosis producing measurable, neurological deficit, which is expected to be permanent.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician assigning a Modified Rankin Scale score of 4 (moderately severe disability) or greater.
- Be based on objective clinical evidence of brain tissue damage using current neuroimaging tests, including but not limited to: Computed Tomography scan (CT); Magnetic Resonance Imaging (MRI); Positron Emission Tomography scan (PET); arteriography; or angiography.

Stroke does not include Transient Ischemic Attack (TIA) and traumatic injury to brain tissue or blood vessels.

Child Diseases

Means any of the following Critical Illnesses where an initial diagnosis is made while the Child is insured under the Group Policy or the an initial diagnosis was made prior to birth and you were insured under the Group Policy and the Child became insured at birth.

Anal Atresia means a malformation of the anus and rectum.

The diagnosis must:

- Be made at birth with a physical examination, abdominal x-ray, ultrasound or Magnetic Resonance Imaging (MRI); or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero.
- Be made by a board certified pediatrician, neonatologist, pediatric surgeon or other board certified physician who specializes in treating this congenital defect.
- Include a recommendation for surgical intervention.

Anencephaly means an incomplete development of the brain, skull and scalp (neural tube defects).

The diagnosis must:

- Be made at birth with a physical examination; or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero via ultrasound, amniocentesis, or a serum folic acid test.

- Be made by a board certified pediatrician, neonatologist, pediatric surgeon or other board certified Physician who specializes in treating the congenital defect.

Biliary Atresia means a blockage in the bile duct tubes inhibiting bile flow from the liver to the gallbladder.

The diagnosis must:

- Be made by a diagnostic test, including but not limited to: abdominal x-ray; ultrasound; blood tests (to check total and direct bilirubin levels); Hepatobiliary iminodiacetic acid (HIDA) scan; cholescintigraphy; liver biopsy; and x-ray of the bile ducts (cholangiogram); or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero.
- Be made by a board certified pediatrician, neonatologist, pediatric surgeon or other board certified physician who specializes in treating the congenital defect.
- Include a recommendation for surgical intervention.

Cerebral Palsy means a group of disorders affecting development of movement, muscle tone and posture causing activity limitation, attributed to an insult to the immature, developing brain, most often before birth.

The diagnosis must:

- Be made during Childhood.
- Be made by a Physician who is board certified as a neurologist.

Cerebral Palsy does not include other similar conditions such as: degenerative nervous disorders, genetic diseases, muscle diseases, metabolic disorders, nervous system tumors, coagulation disorders, or other injuries or disorders which delay early development, but can be outgrown.

Cleft Lip means a physical split or separation of the two sides of the upper lip appearing as a narrow opening or gap in the skin of the upper lip where the separation often extends beyond the base of the nose and includes the bones of the upper jaw and/or upper gum.

The diagnosis must:

- Be made at birth with a physical examination; or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero via ultrasound or a sample of amniotic fluid (amniocentesis).
- Be made by a board certified pediatrician, neonatologist or other board certified physician who specializes in treating the congenital defect.
- Include a recommendation for surgery to ensure the Child's ability to eat, speak, hear and breathe and to achieve a normal facial appearance.

A Critical Illness Benefit is not payable for a Cleft Lip if a Cleft Palate is payable.

Cleft Palate means a split or opening in the roof of the mouth. A cleft palate can involve the hard palate (the bony front portion of the roof of the mouth), and/or the soft palate (the soft back portion of the roof of the mouth).

The diagnosis must:

- Be made at birth with a physical examination; or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero via ultrasound or a sample of amniotic fluid (amniocentesis).
- Be made by a board certified pediatrician, neonatologist or other board certified physician who specializes in treating the congenital defect.
- Include a recommendation for surgery to ensure the Child's ability to eat, speak, hear and breathe and to achieve a normal facial appearance.

Club Foot means a range of foot abnormalities in which the foot is twisted out of shape or position. The tissues connecting the muscles to the bone (tendons) are shorter than usual.

The diagnosis must:

- Be made at birth with a physical examination; or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero via ultrasound or a sample of amniotic fluid (amniocentesis).
- Be made by a board certified pediatrician, neonatologist or other board certified physician who specializes in treating the congenital defect.
- Include a recommendation of corrective techniques such as the Ponseti method and French/Functional method, or corrective surgery.

Coarctation of the Aorta means the severe narrowing of the aorta, causing a decrease in blood flow to the lower part of the body.

The diagnosis must:

- Be made at birth with a physical examination and diagnostic testing, including but not limited to: chest radiography; barium esophagography; cardiac catheterization or electrocardiography (ECG); or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero via a fetal echocardiography.
- Be made by a board certified pediatrician, neonatologist, pediatric cardiac surgeon or other board certified physician who specializes in treating the congenital defect.

Cystic Fibrosis means an inherited, life-threatening disorder that affects the cells that produce mucus, sweat and digestive juices that causes severe damage to the lungs and digestive system.

The diagnosis must:

- Be made during Childhood based on appropriate diagnostic measures, including but not limited to, a sweat test with results of chloride concentrations greater than 60 mmol/L; or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero via diagnostic amniocentesis, chorionic villus biopsy or a blood or saliva sample.
- Be made by a Physician who is board certified as a pediatrician or pulmonologist.

Diaphragmatic Hernia means an abnormal opening in the diaphragm allowing the abdominal organs (stomach, spleen, liver, and intestines) to appear in the chest cavity, impeding the lung tissue on the affected side to completely develop.

The diagnosis must:

- Be made at birth by physical examination with symptoms including, but not limited to: irregular chest movements; absent breath sounds on affected side; bowel sounds heard in the chest or abdomen feels less full on examination by touch (palpation); respirations distress (retractions, cyanosis, grunting respirations); rapid heart rate (tachycardia); and chest x- ray; or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero via a fetal echocardiography.
- Be made by a board certified pediatrician, neonatologist, pediatric surgeon or other board certified physician who specializes in treating this congenital defect.
- Include a recommendation for surgical repair.

Down's Syndrome means an extra full or partial copy of chromosome 21.

The diagnosis must:

- Be made during Childhood.
- Be made by a Physician who is board certified as a pediatrician.

Gastroschisis means a defect in the anterior abdominal wall through which the abdominal contents protrude (abdominal herniation).

The diagnosis must:

- Be made at birth with a physical examination; or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero via ultrasound or a sample of amniotic fluid (amniocentesis).
- Be made by a board certified pediatrician, neonatologist, pediatric surgeon or other board certified physician who specializes in treating the congenital defect.
- Include a recommendation for surgical intervention.

Hirschsprung's Disease means a disorder of the abdomen where part or all of the large intestine (colon) or antecedent parts of the gastrointestinal tract have no nerves and cannot function which creates an obstruction.

The diagnosis must:

- Be made at birth with a physical examination or diagnostic testing including but not limited to: abdominal x-ray using a contrast dye (barium or other); anal manometry test; rectal biopsy; or barium enema; or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero via ultrasound.
- Be made by a board certified pediatrician, neonatologist, pediatric surgeon or other board certified physician who specializes in treating the congenital defect.
- Include a recommendation for surgical intervention.

Hypoplastic Left Heart System means severely underdeveloped structures on the left side of the heart unable to support the circulation needed by the body's organs.

The diagnosis must:

- Be made at birth with a physical examination or shortly thereafter with symptoms including, but not limited to: blue or purple tint to lips, skin and nails (cyanosis), difficulty breathing, difficulty feeding, and lethargy (sleepy or unresponsive) or via diagnostic testing including but not limited to: electrocardiogram; chest X-ray; pulse, cardiac catheterization; or cardiac Magnetic Resonance Imaging (MRI); or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero via a fetal echocardiography.
- Include a recommendation of a heart transplantation with reconstruction via the Norwood (Stage I), Glenn (Stage II) and Fontan (Stage III) procedures or a hybrid procedure (combination of surgery and catheter-based treatment).
- Be made by a board certified pediatrician, neonatologist, pediatric cardiac surgeon or other board certified physician who specializes in treating this congenital defect.

Infantile Hypertrophic Pyloric Stenosis means a narrowing (stenosis) of the opening from the stomach to the first part of the small intestine (duodenum) due to enlargement (hypertrophy) of the muscle surrounding this opening (pylorus) resulting in violent projectile vomiting.

The diagnosis must:

- Be made at birth with a physical examination or diagnostic testing including, but not limited to: upper gastrointestinal series, abdominal ultrasound and/or blood tests; or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero via ultrasound or a sample of amniotic fluid (amniocentesis).
- Be made by a board certified pediatrician, neonatologist, pediatric surgeon or other board certified physician who specializes in treating the congenital defect.
- Include a recommendation for the surgical intervention of pyloromyotomy.

Muscular Dystrophy means a group of genetic diseases characterized by progressive weakness and degeneration of the skeletal or voluntary muscles that control movement.

The diagnosis must:

- Be made by a Physician who is board certified as a neurologist.
- Be based on testing methods, including but not limited to: Electromyography; muscle biopsy; nerve conduction tests; or blood enzyme tests.

Omphalocele means the organs remained enclosed in visceral peritoneum (membrane) and protrude out of the navel.

The diagnosis must:

- Be made at birth with a physical examination; or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero via ultrasound.
- Be made by a board certified pediatrician, neonatologist, pediatric surgeon or other board certified physician who specializes in treating this congenital defect.
- Include a recommendation of surgical intervention.

Patent Ductus Arteriosis (PDA) means a persistent opening between two major blood vessels leading from the heart.

The diagnosis must:

- Be made at birth with a physical examination or diagnostic testing, including but not limited to: echocardiogram; chest x-ray; electrocardiogram; cardiac catheterization; cardiac Computerized Tomography (CT); or Magnetic Resonance Imaging (MRI).
- Be made by a board certified pediatrician, neonatologist, pediatric cardiac surgeon or other board certified physician who specializes in treating the congenital defect.

Spina Bifida Cystica with Myelomeningocele means a malformation of the vertebrae around the Spinal cord.

The diagnosis must:

- Be made at birth with a physical examination or a diagnostic test (Magnetic Resonance Image (MRI) or Computed Tomography (CT) scan); or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero via diagnostic prenatal tests: blood test (maternal serum quadruple or triple screen), high resolution fetal ultrasound, or amniocentesis.
- Be made by a board certified pediatrician, neonatologist, pediatric surgeon or other board certified physician who specializes in treating the congenital defect.
- Include a recommendation for surgical intervention.

Tetralogy of Fallot means four heart defects (a large ventricular septal defect (VSD), pulmonary infundibular stenosis, right ventricular hypertrophy and an overriding aorta) with a recommendation of surgical repair.

The diagnosis must:

- Be made at birth with a physical examination or shortly thereafter with symptoms including, but not limited to: heart murmur; blue or purple tint to lips, skin and nails (cyanosis); difficulty in feeding; failure to gain weight; retarded growth and physical development; dyspnea on exertion; clubbing of the fingers and toes; polycythemia; or “tet spells"; or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero.
- Be made by a board certified pediatrician, neonatologist, pediatric cardiac surgeon or other board certified physician who specializes in treating the congenital defect.

Transposition of the Great Arteries means a transposition of the pulmonary artery and aorta resulting in a cyanotic heart defect (decreased oxygen in the blood being pumped to the rest of the body).

The diagnosis must:

- Be made at birth with a physical examination or shortly thereafter with symptoms including, but not limited to: blue or purple tint to lips, skin and nails (cyanosis), shortness of breath, clubbing of the fingers or toes and poor feeding or via diagnostic testing of at least one of the following: cardiac catheterization; chest x-ray; electrocardiography (ECG); echocardiogram and Pulse oximetry (to check blood oxygen level); or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero via a fetal echocardiography.
- Be made by a board certified pediatrician, neonatologist, pediatric cardiac surgeon or other board certified physician who specializes in treating the congenital defect.

Additional Benefits

Health Maintenance Screening Benefit

We will pay a Health Maintenance Screening Benefit if you or your Dependent meet all of the following requirements:

- A Health Maintenance Screening Procedure is performed.

Health Maintenance Screening Procedures are limited to the following:

- Abdominal aortic aneurysm ultrasound.
- Ankle Brachial Index (ABI) screening for peripheral vascular disease.
- Biopsies for cancer.
- Bone density screening.
- Breast ultrasound.
- Cancer antigen 125 blood test for ovarian cancer (CA 125).
- Cancer antigen 15-3 blood test for breast cancer (CA 15-3).
- Carcinoembryonic antigen blood test for colon cancer (CEA).
- Colonoscopy.
- Complete Blood Count (CBC).
- Comprehensive Metabolic Panel (CMP).
- Electrocardiogram (EKG).
- Hemocult stool analysis.
- Hemoglobin A1C.
- Human Papillomavirus (HPV) vaccination.
- Lipid panel.
- Mammography.
- Pap smears or thin prep pap test.
- Prostate specific antigen (PSA) test.
- Stress test on a bicycle or treadmill.
- Mental health assessments, including but not limited to, PHQ-9, Beck's Depression Inventory, Hamilton's Depression Rating Scale.

- Novel infectious disease testing, including testing for antibodies related to novel infectious diseases.

We will pay a Health Maintenance Screening Benefit for 1 day(s) per insured person per Calendar Year.

Calendar Year means the period from January 1 through December 31 of the same year.

EXCLUSIONS

General Exclusions

Benefits are not payable if Critical Illness is caused or contributed to by any of the following:

- War or act of War. War means declared or undeclared war, whether civil or international, insurrection, and any substantial armed conflict between organized forces of a military nature.
- Attempted suicide or other intentionally self-inflicted injury, while sane or insane.
- Committing or attempting to commit an assault, felony, or act of terrorism, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing official duties.
- The voluntary use or consumption of any poison, chemical compound, drug, or alcohol in excess of the legal limit in the state in which the Critical Illness occurred, unless used or consumed according to the directions of a Physician.
- Elective surgery or other procedure which:
  - Does not promote the proper function of your or your Dependent's body or prevent or treat sickness or injury.
  - Is directed at improving your or your Dependent's appearance, unless such surgery or procedure is necessary to correct a deformity resulting from a congenital abnormality or disfigurement.

  This exclusion will not apply to a Critical Illness caused or contributed to by your or your Dependent's donation of an organ or tissue.

ADDITIONAL FEATURES

Reinstatement

If your insurance ends, you may become insured again as a new Member. However, the following will apply:

- If your insurance ends because you cease to be a Member and if you become a Member again within 90 days, the Eligibility Waiting Period will be waived.
- If you ceased to be a Member under the Group Policy and continued insurance under the **Continuation of Insurance (Portability) for the Member** provision and you become a Member again within 90 days, your insurance will be for the coverage and amount which you continued under the **Continuation of Insurance (Portability) for the Member** provision the day before you become a new Member.

In no event will insurance be retroactive.

Continuity of Coverage

Waiver of **Active Work Requirement**

If you were insured under the Prior Plan on the day before the effective date of the Employer's coverage under the Group Policy, you can become insured on the effective date of your Employer's coverage without meeting the **Active Work Requirement**. See the **Active Work Requirement**.

Continuation of Insurance (Portability) for the Member

Eligibility for the Member

You become eligible to continue your or your Dependent's insurance on the date one of the following events occur:

- Your employment terminates with your Employer.
- The Group Policy terminates unless termination is to replace the Group Policy with another group policy underwritten by us.
- Your insurance ends because you are no longer a Member.

You are not eligible to continue insurance under this provision if:

- You are disabled.
- You are age 80 or older.

Application, Amount of Insurance, and Premium Payment

You must apply in writing and pay the first premium to us within 31 days after the date you become eligible. Your and your Dependent's continued insurance will be the same insurance provided under the Group Policy on the day before you become eligible under this **Continuation of Insurance (Portability) for the Member** provision. You may decrease the insurance, but cannot increase the insurance.

You will be directly billed for all premiums due if you have applied for and been approved for continuation of coverage under this provision. If premium is not paid on or before the Premium Due Date stated below it may be paid during the Grace Period as stated below. Your or your Dependent's insurance will remain in force during the Grace Period. You are liable for premium for insurance during the Grace Period.

The Premium Due Date is the first day of each calendar month.

The Grace Period is 60 days from the Premium Due Date.

When Insurance Ends

Insurance continued under this provision ends automatically on the earliest of:

- The date the last period ends for which you made the premium payment.
- The date you die, however your Spouse may apply to continue insurance under the **Continuation of Insurance (Portability) for the Spouse** provision below.
- The date you become a full-time member of the armed forces of any country.
- With respect to your Child's insurance, the date the Child ceases to meet the definition of Child.
- The date you are sentenced by a court for any reason to a penal or correctional institution, however your Spouse may apply to continue insurance under the **Continuation of Insurance (Portability) for the Spouse** provision below.
- With respect to your Spouse's insurance, the date the Spouse ceases to meet the definition of Spouse.
- With respect to coverage for your Dependent, the date your Dependent is sentenced by a court for any reason to a penal or correctional institution.
- The date you become insured again as a Member under the Group Policy.

Once insurance continued under this provision ends it cannot be reinstated. Except as provided above, insurance continued under this provision is subject to all other terms of the Group Policy.

Continuation of Insurance (Portability) for the Spouse

Eligibility for Your Spouse:

Your Spouse becomes eligible to continue insurance on the date one of the following events occur:

- Your insurance terminates due to your death and your Spouse has not reached age 80.
- You are legally divorced from your Spouse or your partnership with your Domestic Partner or Civil Union Partner is legally dissolved.
- Your continued insurance under the provision above ends because you reach age 80 and your Spouse has not reached age 80.
- Dependent insurance is no longer provided under the Group Policy.
- Your continued insurance under the provision above ends because you are sentenced by a court for any reason to a penal or correctional institution.

Except as provided below, all provisions and terms of the Group Policy apply to insurance continued under this **Continuation of Insurance (Portability) for the Spouse** provision. In the event your Spouse continues insurance under this **Continuation of Insurance (Portability) for the Spouse** provision, "you" and "your" will refer to your Spouse in **Exclusions, Claims and Benefit Payment,** and **General Provisions**.

Your Spouse is not eligible to continue insurance for your Child under this provision if the Child is insured under your insurance. Spouse is not eligible to continue insurance under this provision if your Spouse is 80 or older.

Application, Amount of Insurance, and Premium Payment

Your Spouse must apply in writing and pay the first premium to us within 60 days after the date your Spouse becomes eligible.

Your Dependent's continued insurance will be the same insurance provided under the Group Policy or your continued insurance on the day before your Spouse became eligible for continued insurance. Your Spouse may decrease the insurance, but cannot increase the insurance.

Your Spouse will be directly billed for all premiums due if your Spouse has applied and been approved for continuation of insurance under this provision. If premium is not paid on or before the Premium Due Date stated below it may be paid during the Grace Period as stated below. Dependent insurance will remain in force during the Grace Period. Your Spouse is liable for premium for insurance during the Grace Period.

The Premium Due Date is the first day of each calendar month.

The Grace Period is 60 days from the Premium Due Date.

When Insurance Ends

Insurance continued under this provision ends automatically on the earliest of:

- The date the last period ends for which your Spouse made a premium payment.
- The date your Spouse dies.
- The date your Spouse becomes a full-time member of the armed forces of any country.
- With respect to a Child's insurance, the date the Child ceases to meet the definition of Child.
- With respect to a Dependent's insurance, the date your Dependent is sentenced by a court for any reason to a penal or correctional institution.
- The date your Spouse is insured as a Member under the Group Policy.

Once insurance continued under this provision ends it cannot be reinstated.

CLAIMS AND BENEFIT PAYMENT

Filing a Claim

Claims should be filed on our forms. If we do not provide our forms within 15 days after they are requested, the claim may be submitted in a letter to us.

Time Limits on Filing Proof Of Loss

Proof Of Loss must be provided within 90 days after the date of the Critical Illness. For Additional Benefits, Proof Of Loss must be provided within 90 days after meeting the requirements for the Additional Benefits. If that is not possible, it must be provided as soon as reasonably possible, but not later than one year after that 90-day period.

If Proof Of Loss is filed outside these time limits, the claim will be denied. These limits will not apply while the claimant lacks legal capacity.

Proof Of Loss

Proof Of Loss means written proof that a Critical Illness or entitlement to an Additional Benefit occurred:

- For which the Group Policy provides benefits.
- Which is not subject to any exclusions.
- Which meets all other conditions for benefits.

Proof Of Loss includes any other information we may reasonably require in support of a claim. Proof Of Loss must be in writing and must be provided at the expense of the claimant. No benefits will be paid until we receive Proof of Loss satisfactory to us.

Investigation of Claim

We reserve the right to investigate a claim at any time at our expense, including an examination conducted by specialists of our choice. In case of death, we have the right and opportunity to request an autopsy, except where prohibited by law.

Notice of Decision on Claim

We will evaluate a claim for benefits promptly after we receive it. Within 60 days after we receive the claim, we will send the claimant: (a) a written decision on the claim; or (b) a notice that we are extending the period to decide the claim for an additional 60 days.

If we extend the period to decide the claim, we will notify the claimant of the following: (a) the reasons for the extension; and (b) when we expect to decide the claim.

If we deny any part of the claim, we will send the claimant a written notice of denial containing:

- The reasons for our decision.
- Reference to the parts of the Group Policy on which our decision is based.
- A description of any additional information needed to support the claim.
- Information concerning the claimant's right to a review of our decision.

Review Procedure

If all or part of a claim is denied, the claimant may request a review. The claimant must request a review in writing within 60 days after receiving notice of the denial of the claim.

The claimant may send us written comments or other items to support the claim. The claimant may review and receive copies of any non-privileged information that is relevant to the request for review. There will be no charge for such copies. Our review will include any written comments or other items the claimant submits to support the claim.

We will review the claim promptly after we receive the request. With respect to all claims, within 45 days after we receive the request for review we will send the claimant: (a) a written decision on review; or (b) a notice that we are extending the review period for 45 days.

If an extension is due to the claimant's failure to provide information necessary to decide the claim on review, the extended time period for review of the claim will not begin until the claimant provides the information or otherwise responds.

If we extend the review period, we will notify the claimant of the following: (a) the reasons for the extension; and (b) when we expect to decide the claim on review.

If we request additional information, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, we may conclude our review of the claim based on the information we have received.

If we deny any part of the claim on review, the claimant will receive a written notice of denial containing:

- The reasons for our decision.
- Reference to the parts of the Group Policy on which our decision is based.
- Information concerning the claimant's right to receive, free of charge, copies of non-privileged documents and records relevant to the claim.

Time of Payment

We will pay benefits within 30 days after Proof Of Loss is satisfied.

Payment of Benefits

Benefits will be paid to you. Any benefits remaining unpaid at your death will be paid as shown below.

Benefits will be paid in equal shares to the first surviving class of the classes below.

- Your Spouse.
- Your children.
- Your parents.
- Your brothers and sisters.
- Your estate.

Reimbursement

We reserve the right to recover any benefits that you or your Dependent or a claimant were paid but not entitled to under the terms of the Group Policy, state or federal law.

You or your Dependent, or a claimant or beneficiary must reimburse us in full. We will determine the method by which repayment is to be paid.

Unpaid Premium

Any unpaid premium due for your or your Dependent’s Critical Illness Insurance under the Group Policy may be recovered by us. Any Critical Illness Benefits payable to you or your Dependent, a claimant, a beneficiary or legal representative will be applied to reduce the amount of any unpaid premiums prior to paying you or your Dependent, a claimant, a beneficiary or a legal representative.

GENERAL PROVISIONS

Assignment

The rights and benefits under the Group Policy may not be assigned.

Time Limits on Legal Actions

No action at law or in equity may be brought until 60 days after we have been given Proof Of Loss. No such action may be brought more than three years after the earlier of:

- The date we receive Proof Of Loss.
- The time within which Proof Of Loss is required to be given.

Incontestability of Insurance

Any statement made to obtain insurance or to increase insurance is a representation and not a warranty. No misrepresentation will be used to reduce or deny a claim or contest the validity of insurance unless:

- The insurance would not have been approved if we had known the truth.
- We have given you or any other person claiming benefits a copy of the signed written instrument which contains the misrepresentation.

After insurance has been in effect for two years during the lifetime of the insured, we will not use a misrepresentation to reduce or deny the claim, unless it was a fraudulent misrepresentation.

Clerical Error

Clerical error by the Policyholder, your Employer, or their respective employees or representatives will not:

- Cause a person to become insured.
- Invalidate insurance under the Group Policy otherwise validly in force.
- Continue insurance under the Group Policy otherwise validly terminated.

Agency

The Policyholder and your Employer act on their own behalf as your agent, and not as our agent. Individuals selected by the Policyholder or by any Employer to secure coverage under the Group Policy or to perform their administrative function under it, represent and act on behalf of the person selecting them, and do not represent or act on behalf of us. The Policyholder and your Employer have no authority to alter, expand or extend our liability or to waive, modify or compromise any defense or right we may have under the Group Policy.

Misstatement of Age

If a person's age has been misstated, we will make an equitable adjustment of premiums, benefits, or both. The adjustment will be based on the following:

- The amount of insurance based on the correct age.
- The difference between the premiums paid and the premiums which would have been paid if the age had been correctly stated.

Misstatement of Tobacco Use

If a person’s use of tobacco has been misstated, we have the right to make an equitable adjustment of premiums, benefits, or both. The adjustment will be based on the following:

- The amount of insurance based on the correct tobacco use status.
- The difference between the premiums paid and the premiums which would have been paid if the tobacco use status had been correctly stated.

DEFINITIONS

Activities of Daily Living

- Bathing means washing oneself, whether in the tub or shower or by sponge bath, with or without the help of adaptive devices.
- Continence means voluntarily controlling bowel and bladder function, or, if incontinent, maintaining a reasonable level of personal hygiene.
- Dressing means putting on and removing all items of clothing, footwear, and medically necessary braces and artificial limbs.
- Eating means getting food and fluid into the body, whether manually, intravenously, or by feeding tube.
- Toileting means getting to and from and on and off the toilet, and performing related personal hygiene.
- Transferring means moving into or out of a bed, chair or wheelchair, with or without adaptive devices.

Child

Child means one of the following:

- Your child from live birth until age 26.
- Your adopted child until age 26.
- Your stepchild, foster child, dependent grandchild, and the child of your Spouse if living in your home until age 26.
- A child living in your home for whom you are the court appointed legal guardian until age 26.
- Your child, stepchild, foster child, dependent grandchild, and the child of your Spouse who is continuously incapable of self-sustaining employment because of mental or physical handicap; and chiefly dependent upon you for support and maintenance or institutionalized because of mental or physical handicap.

Child does not include a person who is eligible for insurance as a Member. A Child does not include a fulltime member of the armed forces of any country.

Childhood

From birth through age 12.

Dependent(s)

Your Spouse, your Child, or your Spouse or Child, or your Spouse and Child.

Eligibility Waiting Period

The period you must be a Member before you become eligible for insurance. Your Eligibility Waiting Period is shown in the **Coverage Features.**

Employer

An employer (including approved affiliates and subsidiaries) for which coverage under the Group Policy is approved in writing by us.

Evidence Of Insurability

You or your Spouse must:

- Complete and sign our medical history statement.
- If required by us, sign our form authorizing us to obtain information about the applicant's health.

- Undergo a physical examination, if required by us, which may include blood testing.
- Provide any additional information about the applicant's insurability that we may reasonably require.

Family Status Change

Family Status Change means any of the following events:

- Your marriage or divorce or dissolution of your Civil Union or Domestic Partner relationship.
- The birth of your Child.
- The adoption of a Child by you.
- The death of your Dependent.
- The commencement or termination of your Spouse's employment.
- A change in employment from full-time to part-time by your Spouse.
- A loss of critical illness insurance through your Spouse’s employment.

Group Policy

The group critical illness insurance policy issued by us to the Policyholder and identified by the Group Policy Number, the Policyholder's attached application, group critical illness insurance certificates with the same Group Policy Number, and any amendments to the policy or certificates.

Hands-on Assistance

The physical assistance of another person without which the insured would be unable to perform the Activity Of Daily Living.

Limb

The entire arm from shoulder to fingers, or the entire leg from hip to toes.

Physician

An individual who is licensed by the state as an M.D. or D.O. and acting within the scope of the license. Physician does not include you or your Spouse, or the brother, sister, parent or child of either you or your Spouse.

Prior Plan

A critical illness insurance plan which is replaced by coverage under the Group Policy and which is the Policyholder’s group critical illness insurance plan in effect on the day before the effective date of the Group Policy.

Spouse

Spouse means:

- A person to whom you are legally married.
- A person who is party to a Civil Union with you. A Civil Union means a civil union established according to applicable law.
- Your Domestic Partner. Domestic Partner means an individual with whom you have established a domestic partnership in accordance with the laws or regulations of a jurisdiction that recognizes domestic partnerships; or an individual you have identified as a domestic partner under your Employer’s domestic partnership policy.

Spouse does not include a full-time member of the armed forces of any country.

Standby Assistance

The presence of another person within arm's reach of the insured that is necessary to prevent, by physical intervention, injury to the insured while the insured is performing the Activity Of Daily Living (such as being ready to catch the insured if the insured falls while getting into or out of the bathtub or shower as part of Bathing, or being ready to remove food from the insured's throat if the insured chokes while Eating).