

**NOTICE OF PROTECTION PROVIDED BY  
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION**

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

**COVERAGE**

- **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

- **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- **Life Insurance**

80% of death benefits but not to exceed \$300,000

80% of cash surrender or withdrawal values but not to exceed \$100,000

- **Annuities and Structured Settlement Annuities**

80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed \$250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is \$300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is \$546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website [www.califega.org](http://www.califega.org).

## **COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE**

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- 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 certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

## **NOTICES**

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at [www.califega.org](http://www.califega.org), or contact either of the following:

California Life and Health Insurance  
Guarantee Association  
PO Box 16860  
Beverly Hills, CA 90209-3319  
(323) 782-0182

California Department of Insurance  
Consumer Communications Bureau  
300 South Spring Street  
Los Angeles CA 90013  
(800) 927-4357

**Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or 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 California law, then California law will control.**

**CALIFORNIA NOTICE OF COMPLAINT PROCEDURE**

**Should any dispute arise about your premium or about a claim that you have filed, write to the company that issued the group policy at:**

**Standard Insurance Company  
PO Box 711  
Portland, OR 97207  
(971) 321-7000**

**If the problem is not resolved, you may also write to the State of California at:**

**Department of Insurance  
Consumer Services Division  
300 S. Spring Street, 11th FL  
Los Angeles, CA 90013  
1-800-927-HELP (4357)**

**This notice of complaint procedure is for information only and does not become a part or condition of this group policy/certificate.**

# STANDARD INSURANCE COMPANY

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

## GROUP CRITICAL ILLNESS INSURANCE CERTIFICATE AND SUMMARY PLAN DESCRIPTION

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|                              |  |
|------------------------------|--|
| Policyholder:                | Orange County Employees Association Health and Welfare Trust |
| Group Policy Number:         | 762040-B   |
| Group Policy Effective Date: | January 1, 2024  |
| State of Issue:              | California   |

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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 and Summary Plan Description or other notice that will be available to you.

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

"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.**

**YOU HAVE THE RIGHT TO REVIEW THIS CERTIFICATE AND RETURN IT WITHIN 30 DAYS FOR A FULL PREMIUM REFUND.**

**THIS POLICY IS NOT IN LIEU OF AND DOES NOT AFFECT ANY REQUIREMENT FOR COVERAGE BY WORKMENS' COMPENSATION INSURANCE.**

**THIS CERTIFICATE IS ISSUED UNDER A LIMITED BENEFIT POLICY THAT PROVIDES CRITICAL ILLNESS INSURANCE BENEFITS. IT IS NOT A SUBSTITUTE FOR ESSENTIAL HEALTH BENEFITS OR MINIMUM ESSENTIAL COVERAGE AS DEFINED IN FEDERAL LAW. 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 POLICY DOES NOT PAY BENEFITS FOR ANY SKIN MALIGNANCIES (SUCH AS BASAL CELL AND SQUAMOUS CELL CARCINOMAS, PRE-MALIGNANT LESIONS, INTRAEPITHELIAL NEOPLASIA, BENIGN TUMORS OR POLYPS) UNDER THIS GROUP POLICY.**

STANDARD INSURANCE COMPANY

By



President and CEO

## TABLE OF CONTENTS

|   |           |
|---|-----------|
| <b>COVERAGE FEATURES</b> .....                          | <b>1</b>  |
| Employer(s).....  | 1         |
| Member.....   | 1         |
| Class(es).....  | 1         |
| Eligibility Waiting Period.....                         | 1         |
| Premium Contributions.....                              | 1         |
| Coverage Amount.....                                    | 1         |
| Amount Payable.....                                     | 2         |
| Additional Benefits.....                                | 3         |
| Additional Features.....                                | 3         |
| <b>ERISA SUMMARY PLAN DESCRIPTION INFORMATION</b> ..... | <b>4</b>  |
| <b>ELIGIBILITY AND ENROLLMENT</b> .....                 | <b>5</b>  |
| Becoming Insured.....                                   | 5         |
| When Your Insurance Becomes Effective.....              | 5         |
| Changes in Your Insurance.....                          | 5         |
| Active Work Requirement.....                            | 6         |
| When Your Insurance Ends.....                           | 6         |
| <b>CHILD INSURANCE</b> .....                            | <b>6</b>  |
| When Child Insurance Becomes Effective.....             | 6         |
| Changes in Child Insurance.....                         | 7         |
| When Child Insurance Ends.....                          | 7         |
| <b>SPOUSE INSURANCE</b> .....                           | <b>7</b>  |
| Eligibility for Spouse Insurance.....                   | 7         |
| When Spouse Insurance Becomes Effective.....            | 7         |
| Changes in Spouse Insurance.....                        | 7         |
| When Spouse Insurance Ends.....                         | 8         |
| <b>CRITICAL ILLNESS BENEFITS</b> .....                  | <b>8</b>  |
| Insuring Clause.....                                    | 8         |
| Critical Illness Definitions.....                       | 8         |
| Child Diseases.....                                     | 13        |
| Additional Benefits.....                                | 18        |
| <b>EXCLUSIONS</b> .....                                 | <b>19</b> |
| General Exclusions.....                                 | 19        |
| <b>ADDITIONAL FEATURES</b> .....                        | <b>19</b> |

|   |           |
|---|-----------|
| Reinstatement.....  | 19        |
| Continuity of Coverage.....                                 | 19        |
| Continuation of Insurance (Portability) for the Member..... | 19        |
| Continuation of Insurance (Portability) for the Spouse..... | 20        |
| <b>CLAIMS AND BENEFIT PAYMENT.....</b>                      | <b>21</b> |
| Notice of Claim.....  | 21        |
| Filing a Claim.....   | 21        |
| Time Limits on Filing Proof Of Loss.....                    | 22        |
| Proof Of Loss.....  | 22        |
| Investigation of Claim.....                                 | 22        |
| Notice of Decision on Claim.....                            | 22        |
| Review Procedure.....                                       | 22        |
| Time of Payment.....  | 23        |
| Payment of Benefits.....                                    | 23        |
| Reimbursement.....  | 23        |
| Unpaid Premium.....   | 23        |
| <b>GENERAL PROVISIONS.....</b>                              | <b>23</b> |
| Assignment.....   | 23        |
| Time Limits on Legal Actions.....                           | 23        |
| Incontestability of Insurance.....                          | 24        |
| Clerical Error.....   | 24        |
| Agency.....   | 24        |
| Misstatement of Age.....                                    | 24        |
| Misstatement of Tobacco Use.....                            | 24        |
| <b>DEFINITIONS.....</b>                                     | <b>24</b> |
| <b>ERISA INFORMATION AND NOTICE OF RIGHTS.....</b>          | <b>27</b> |
| Statement of Your Rights under ERISA.....                   | 27        |

## INDEX OF DEFINED TERMS

Active Work and Actively At Work 6  
Annual Enrollment Period 5  
Calendar Year 18  
Child 24  
Childhood 25  
Civil Union 26  
Contributory 1  
Dependent(s) 25  
Domestic Partner 26  
Eligibility Waiting Period 25  
Employer 25  
Evidence Of Insurability 25  
Family Status Change 25  
Group Policy 25  
Limb 25  
Malignant 11  
Physician 26  
Prior Plan 26  
Proof Of Loss 22  
Treatment Free Period 3  
War 19





For Spouse:

The amount you elect for your Spouse and we approve in increments of \$5,000 from \$5,000 - \$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   |                                   |
| Invasive Cancer  | 100% of Coverage Amount           |
| Non-Invasive Cancer  | 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           |
| Paralysis (2 or more Limbs)  | 100% of Coverage Amount           |
| Severe Coronary Artery Disease With a Recommendation of Bypass Surgery | 25% of Coverage Amount            |
| Severe 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 6 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 | \$100 |
|--------------------------------------|-------|

### **Additional Features**

Reinstatement

Continuity of Coverage

Continuation of Insurance (Portability) for the Member

Continuation of Insurance (Portability) for the Spouse

## ERISA SUMMARY PLAN DESCRIPTION INFORMATION

|   |  |
|---|--|
| Name of Plan:   | Group Critical Illness Insurance   |
| Name, Address of Plan Sponsor:  | Orange County Employees Association Health and Welfare Trust<br>830 Ross Street<br>Santa Ana, California 92701 |
| Plan Sponsor Tax ID Number:   | 33-0660405   |
| Plan Number:  | 501  |
| Type of Plan:   | Group Insurance Plan   |
| Type of Administration:   | Contract Administration  |
| Name, Address, Phone Number of Plan Administrator:  | Plan Sponsor<br>(714) 835-3333   |
| Name, Address of Registered Agent for Service of Legal Process:   | Orange County Employees Association Health and Welfare Trust   |
| If Legal Process Involves Claims For Benefits Under The Group Policy, Additional Notification of Legal Process Must Be Sent To: | Standard Insurance Company<br>900 SW Fifth Avenue<br>Portland, Oregon  |
| Sources of Contributions:   | Member   |
| Funding Medium:   | Standard Insurance Company - Fully Insured   |
| Plan Fiscal Year End:   | December 31  |

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## ELIGIBILITY AND ENROLLMENT

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### 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.

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## SPOUSE INSURANCE

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### 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. Benefits for Non-Invasive Cancer and Severe Coronary Artery Disease with Recommendation of Bypass Surgery are offered on a reduced basis. For any Critical Illness, if a pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted instead.

### 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 has performed the appropriate neurological examination and cognitive testing

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) with demonstrated neurological deficits that have persisted for a continuous period of at least 6 months.

The diagnosis of MS must:

- Be made while insured under the Group Policy.

- Be made by a Physician.
- Be based upon neurological examination demonstrating functional impairments.
- 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) or other advanced neuroradiological technique.

Be 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.
- 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.
- 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.
- 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.



## Cancer

We cover two categories of Cancer: Invasive Cancer and Non-Invasive Cancer. Each category of Cancer is defined below. Different benefit amounts are payable for each category as shown in the Table of Critical Illness Benefits. Non-Invasive Cancer may be covered at a lesser benefit amount than Invasive Cancer, see the Table of Critical Illness Benefits for more information.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician.
- Be based on pathological or clinical evidence.

Invasive 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).

Invasive Cancer includes:

- Leukemia.
- Lymphoma.
- Sarcoma.
- Malignant melanoma or 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.

Invasive Cancer does not include:

- All cancers which are histologically classified as pre-malignant, or non-invasive having borderline malignancy, or having low malignant potential.
- Breast Cancer that has not spread to surrounding tissue and is histologically classified as T1N0M0 or equivalent (breast cancer that has not metastasized beyond the breast).
- Benign tumors or polyps or cancerous tumors that have not spread.
- Early prostate cancer that has not spread to surrounding tissue and is histologically classified as T1N0M0 or equivalent staging (prostate cancer that has not metastasized beyond the prostate).
- 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.

Non-Invasive Cancer 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.

- Early prostate cancer that has not spread to surrounding tissue and is histologically classified as T1N0M0 or equivalent staging (prostate cancer that has not metastasized beyond the prostate).
- Breast Cancer that has not spread to surrounding tissue and is histologically classified as T1N0M0 or equivalent (breast cancer that has not metastasized beyond the breast).
- Non Malignant melanoma which is not invading the reticular (lower) dermis and that is histologically classified Clark's level I or II, Breslow's depth of less than 0.75mm, or AJCC TNM stage 0 or I.

Non-Invasive Cancer does not include lesser skin malignancies, as follows:

- Basal cell and squamous cell carcinomas.

- Pre-malignant lesions.
- Intraepithelial neoplasia.
- Benign tumors or polyps.

Malignant means a tumor that grows in an uncontrolled manner, has invaded surrounding tissue, and has spread (metastasize).

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.
- 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 Physician.

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.
- 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.
- 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. 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.

Paralysis means a diagnosis of the irreversible loss of all motor function of two or more Limbs due to an accident or a disease.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician.

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.
- 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.

Severe 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.

Severe Stroke does not include Transient Ischemic Attack (TIA) and traumatic injury to brain tissue or blood vessels. A Transient Ischemic Attack (TIA) is an episode of temporary neurologic dysfunction caused by a restriction in blood supply to tissues of the brain, spinal cord, or eye that typically lasts less than an hour and not more than 24 hours and is not associated with acute tissue death.

## **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 Physician.
- 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 Physician.

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 Physician.
- 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.

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 Physician.
- 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 Physician.
- 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 Physician.
- 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 Physician.

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.

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 Physician.
- 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.

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 Physician.
- 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 Physician.
- 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 Physician.

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 Physician.
- 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.
- 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 Physician.
- Include a recommendation of surgical intervention.

Patent Ductus Arteriosus (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 Physician.

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 Physician.
- 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 Physician.

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 Physician.



## **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.
- Generally medically accepted cancer screening tests.
- 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.

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## EXCLUSIONS

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### General Exclusions

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

- War or act of War. War means declared or undeclared war, whether civil or international, 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 a felony.
- Intoxicated or under the influence of any narcotic, unless administered on the advice of a Physician.
- Cosmetic surgery. Cosmetic surgery means surgery that is performed to alter or reshape normal structures of the body in order to improve your or your Dependent's appearance. This exclusion will not apply to a Critical Illness caused or contributed to by reconstructive surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do either of the following: (a) to improve function; (b) to create a normal appearance to the extent possible. Reconstructive surgery includes medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. 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.

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## ADDITIONAL FEATURES

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### 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.

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## CLAIMS AND BENEFIT PAYMENT

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### Notice of Claim

Written notice of claim must be provided to us, or to our authorized agent, within 60 days after the date of the Critical Illness or Additional Benefits, or as soon thereafter as is reasonably possible.

### Filing a Claim

Claims should be filed on our form upon receipt of written Notice of Claim. If we do not provide our forms within 15 days after providing us Notice of Claim, you may submit your claim in a letter to us. The letter should include the date of the Critical Illness or Additional Benefits, and the cause and nature of the Critical Illness or Additional Benefits. Subject to the time period for providing notice of claim, such letter will constitute notice and proof of claim.

## **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. Failure to provide such proof within the required time limits shall not invalidate or reduce any claim if the Proof Of Loss is provided as soon as reasonably possible, but not later than one year after that 90-day period.

## **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.

## **Investigation of Claim**

During the pendency of your claim, we reserve the right to investigate a claim at any time at our expense. 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.
- Information concerning the right to bring a civil action for benefits under section 502(a) of ERISA if the claim is denied on review.

## **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.
- Information concerning the right to bring a civil action for benefits under section 502(a) of ERISA.

The Group Policy does not provide voluntary alternative dispute resolution options. However, you may contact your local U.S. Department of Labor Office and your State insurance regulatory agency for assistance.

### **Time of Payment**

We will pay benefits immediately 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 immediately.

### **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.

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## **GENERAL PROVISIONS**

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### **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 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.

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## **DEFINITIONS**

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### **Child**

Child means one of the following:

- Your child from live birth until age 26.
- Your adopted child or a child placed with you for adoption until age 26.
- The child of your Spouse and your stepchild, foster child, dependent grandchild if living in your home until age 26.
- Your adopted child until age 26.

- A child living in your home for whom you are the court appointed legal guardian until age 26.

Your child and the child of your Spouse and stepchild, foster child, dependent grandchild 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.

#### Limb

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



## Physician

An individual who is a licensed medical professional, diagnosing and treating individuals within the scope of the license. The term includes a legally licensed physician, dentist, optometrist, podiatrist, psychologist or chiropractor. 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.

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## ERISA INFORMATION AND NOTICE OF RIGHTS

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### Statement of Your Rights under ERISA

The following information and notice of rights and protections is furnished by the Plan Administrator as required by the Employee Retirement Income Security Act of 1974 (ERISA).

#### Right to Examine Plan Documents

You have the right to examine all Plan documents, including any insurance contracts or collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. These documents may be examined free of charge at the Plan Administrator's office.

#### Right to Obtain Copies of Plan Documents

You have the right to obtain copies of all Plan documents, including any insurance contracts or collective bargaining agreements, a copy of the latest annual report (Form 5500 Series), and updated summary plan description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies.

#### Right to Receive a Copy of Annual Report

The Plan Administrator must give you a copy of the Plan's summary annual financial report, if the Plan was required to file an annual report. There will be no charge for the report.

#### Right to Review of Denied Claims

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have the right: a) to know why this was done; b) to obtain copies of documents relating to the decision, without charge; and c) to have your claim reviewed and reconsidered, all within certain time schedules.

If we deny any part of your claim for a benefit that relies on a disability determination, you will receive a written notice of denial containing a copy of any internal rule or guideline relied upon in making our decision, or a statement that no such rules or guidelines exist. The notice of denial will also include information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.

If all or part of a claim is denied, you may request a review. Before we issue a decision on review for a benefit that relies on a disability decision, we will provide you, free of charge, with any new evidence or rationale considered, relied upon, or generated by us in connection with the claim, and we will provide such new evidence or rationale sufficiently in advance of the decision deadline date to give you a reasonable opportunity to respond prior to that date.

If our review results in a denial of any part of your claim for a benefit that relies on a disability decision, your written notice of denial will contain a copy of any internal rule or guideline relied upon in making our decision, or a statement that no such rules or guidelines exist. The notice of denial will also include information concerning your right to bring a civil action for benefits under section 502(a) of ERISA and a description of any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

#### Obligations of Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of all 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 Plan benefit or exercising your rights under ERISA.

## **Enforcing ERISA Rights**

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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 these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

## **Plan and ERISA Questions**

If you have any questions about the 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, U. S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Avenue N. W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.