UnitedHealthcare Insurance Company
185 Asylum Street
Hartford, Connecticut
(Home Office)

Policyholder: ABC Company
Enrolling Group: ABC Company
Policy Number: 1234
Policy Anniversary Date: January 1st
Covered Person: As on file with the Administrator
Certificate Number: As on file with the Administrator
Certificate Effective Date: As on file with the Administrator
Beneficiary: As on file with the Administrator

We, UnitedHealthcare Insurance Company, issue this Certificate to the Covered Person as evidence of insurance under the Policy We issued to the Policyholder shown above. This Certificate describes the benefits and other important provisions of the Policy.

The Policy is a legal contract between the Policyholder and Us and it may be changed or discontinued without the consent of the Covered Person or the Covered Person's beneficiary. The Policy may be inspected at the office of the Policyholder.

The benefits described in this Certificate insure the Covered Person and, if applicable, Dependents, provided the person is eligible, has become covered, and the required premium has been paid to Us.

Read the Group Certificate Carefully. If the Policyholder has any questions or problems with the Policy, We will be ready to help the Policyholder. The Policyholder may call upon his agent or Our Home Office for assistance at any time. If the Covered Person has questions, needs information about their insurance, or needs assistance in resolving complaints, call 1-866-615-8727.

The Certificate is signed at the Home Office of UnitedHealthcare Insurance Company by:

Secretary
President

Administrative Office:
9900 Bren Road East
Minnetonka, MN 55343

Group Critical Illness Insurance Certificate

THE POLICY PROVIDES A LIMITED BENEFIT FOR CERTAIN CRITICAL ILLNESSES.
THE POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

UHICI-CERT-1
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**SCHEDULE OF BENEFITS**

**Policyholder:** ABC Company

**Eligible Class:** Employees of ABC Company who meet the eligibility requirements and who are Actively at Work, and their eligible Dependents.

**Description of Class:** All Eligible Employees working a minimum of 20 hours per week

**Employee Waiting Period:** None

**Benefit Waiting Period:** 30 days

**Maximum Benefit Amount:** Employee: $30,000
(Payable per Category below) Spouse: $10,000
Child: $2,500

**Category 1:**
- Level 1 Cancer: 100%
- Level 2 Cancer: 25%

**Category 2:**
- Heart Attack: 100%
- Heart Transplant: 100%
- Ruptured Aneurysm: 100%
- Stroke: 100%
- Coronary Artery Bypass: 25%

**Category 3:**
- Coma: 100%
- Chronic Renal Failure: 100%
- Major Organ Transplants: 100%
- Permanent Paralysis: 100%
- Severe Brain Damage: 100%
- Severe Burns: 100%

UnitedHealthcare Insurance Company
Hartford, Connecticut
Portability

Benefit Rider: Wellness Benefit Included

Occupational HIV Rider: Occupational HIV Benefit

Restoration Rider: Restoration Benefit

$100 per calendar year

$10,000

Employee: Payable up to 100% of the Maximum Benefit Amount for each Category

Spouse: Payable up to 100% of the Maximum Benefit Amount for each Category

Child: Payable up to 100% of the Maximum Benefit Amount for each Category

Coverage Reduction at Age 70: The Critical Illness and Restoration of Benefit Amounts reduce by 50% upon attainment of Age 70. If Age 70 or over at time of application, the amounts will not be more than 50% of the amounts applicable to persons in the same Class who are under Age 70.

Maximum Age for Dependent Child: 26 years

Maximum Age of Student: 26 years

Evidence of Insurability Requirements:
Evidence of insurability will be required for the following:
1. any amount of Employee Maximum Benefit Amount in excess of $30,000.
2. any amount of Spouse Maximum Benefit Amount in excess of $10,000.
3. any amount of Child Maximum Benefit Amount in excess of $2,500.

Premium Rate Change: The Covered Person and Dependent premiums may change on any Premium Due Date if rates for the person’s Class are changed under the group Policy.

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Hartford, Connecticut
GENERAL DEFINITIONS

The male pronoun, whenever used in the Policy, includes the female.

**Activ Work or Actively at Work:** the Covered Person reports for work at his usual place of employment or any other business location where he is required to travel and is able to perform his regular occupation for the entire normal workday. The Covered Person must be working at least the minimum number of hours per week in an Eligible Class, as shown in the Schedule of Benefits.

Unless disabled on the prior workday or on the day of absence, a Covered Person will be considered Actively at Work on the following days:
1. a Saturday, Sunday or holiday which is not a scheduled workday;
2. a paid vacation day, or other scheduled or unscheduled non-workday; or
3. an excused or emergency leave of absence (except medical leave).

**Benefit Waiting Period:** an exclusionary period immediately following the effective date of a person’s insurance, during which benefits are not payable. When a Critical Illness has a Date of Diagnosis within the Benefit Waiting Period, benefits are not payable on the basis of that diagnosis.

**Change in Family Status:**
1. a change in marital status (marriage, divorce, legal separation, annulment);
2. a change in the number of Dependents for tax purposes (birth, legal adoption of a Child, placement of a Child with the Covered Person for adoption, or death of a Dependent);
3. certain changes in employment status that affect benefits eligibility for the Covered Person, Spouse or Child, such as termination of employment, a strike or lockout, the start of or return from an unpaid leave of absence, a change in worksite, a change in work schedule (between full-time and part-time work, decrease or increase in hours);
4. a change of residence for the Covered Person, Spouse or Child;
5. a significant increase in the cost of coverage or a significant reduction in the benefit coverage under the Covered Person’s insurance or his Spouse’s insurance;
6. the addition, elimination, or significant curtailment of, a coverage option;
7. a change in the Covered Person’s, Spouse’s or Child’s coverage during another employer’s Annual Enrollment, Re-Enrollment period when the other plan has a different period of coverage.

**Contributory or Non-Contributory Insurance:** Contributory Insurance is insurance for which the Covered Person must apply and agree to make the required premium contributions. Non-Contributory Insurance is insurance for which the Covered Person does not have to make any premium contributions.

**Covered Person:** the Employee insured under the Policy. References to “Covered Person,” “Covered Persons” and “Covered Person’s” throughout this Certificate are references to a Covered Person.

**Dependent:** the Covered Person’s Spouse or Child, as defined below.

Spouse means a legal Spouse including a Domestic Partner.
GENERAL DEFINITIONS (continued)

Child means an unmarried Child under the Maximum Age for Dependent Child shown in the Schedule and who is:
1. a natural Child;
2. a stepchild;
3. a legally adopted Child;
4. a Child placed for adoption;
5. a Child for whom legal guardianship has been awarded to the Covered Person or the Covered Person’s Spouse.

The Child will cease to be an eligible Dependent on the last day of the Calendar Year following the date the Child reaches the Maximum Age for Dependent Child unless the Child is an Eligible Student or an Incapacitated Child.

A Child is an Incapacitated Child if he is:
1. unmarried;
2. physically or mentally disabled; and
3. financially dependent upon the Covered Person.

No one can be a dependent of more than one Covered Person.

Domestic Partner: a person of the opposite or same sex with whom the Covered Person has established a Domestic Partnership.

Domestic Partnership: a relationship between a Covered Person and one other person of the opposite or same sex. All of the following requirements apply to both persons:
1. they must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside;
2. they must not be currently married to, or a Domestic Partner of another person under either statutory or common law;
3. they must share the same permanent residence and the common necessities of life;
4. they must be at least 18 years of age;
5. they must be mentally competent to consent to contract;
6. they must be financially interdependent and have furnished documents to support the following conditions of such financial interdependence:
   a. they have a single dedicated relationship of at least six months duration;
   b. they have at least two of the following:
      - a joint ownership of an automobile;
      - a joint checking, bank or investment account;
      - a joint credit account;
      - a joint ownership or a lease for a residence identifying both partners as tenants; or
      - a will and/or life insurance policies which designates the other as primary beneficiary;
7. the Covered Person and the Domestic Partner must jointly sign the required Affidavit of Domestic Partnership prior to coverage being issued.
GENERAL DEFINITIONS (continued)

Employee: a person who is authorized to work and reside in the United States and is:
1. directly employed in the normal business of the Employer /Enrolling Group;
2. paid for services by the Enrolling Group; and
3. Actively at Work for the Employer /Enrolling Group, or any subsidiary or affiliate insured under the Policy.

No director or officer of an Employer /Enrolling Group will be considered an Employee unless he meets the above conditions.

Employer: the Policyholder and includes any division, subsidiary, or affiliated company named in the Policy. Employer does not include Employers of other related areas of practice for which the Covered Person may also work.

Enrollment:

Enrollment Period - the Initial Enrollment Period or Re-Enrollment Period.

Initial Enrollment Period - the period during which the Employee may first apply in writing for insurance.

Re-Enrollment Period: the period of time following the Initial Enrollment Period determined by the Employer and Us during which the Covered Person may apply in writing for insurance under the Policy or change his insurance under the Policy.

Hospital or Medical Facility: a legally operated, accredited facility licensed to provide full-time care and Treatment for the condition for which benefits are payable under the Policy. It is operated by a full-time staff of licensed physicians and registered nurses. It does not include facilities that primarily provide custodial, education or rehabilitative care, or long-term institutional care on a residential basis.

Injury: a bodily Injury resulting directly from an accident and independently of all other causes and the accident occurs while covered under the Policy.

Physician: a medical doctor or doctor of osteopathy who is:
1. duly licensed in the state or Province in which the Treatment is received; and
2. practicing within the scope of that license.
For the purposes of the Policy, the term Physician does not include the Covered Person, the Covered Person’s Spouse, or any family members.

Policy Anniversary Date: the annual renewal date of the group insurance contract between Us and the Policyholder.

Policyholder: the group named as the Policyholder on the face page of this Certificate.

Sickness: an illness, or disease, pregnancy or complication of pregnancy.

Treatment: as used in the Policy refers to any consultation, advice, tests, attendance or observation, supplies or equipment, including the prescription or use of prescription drugs or medicines.

We, Our and Us: UnitedHealthcare Insurance Company or its Administrator.
BENEFITS PAYABLE AND BENEFIT DEFINITIONS

Benefit Payable: We will pay up to a total of 100% of the Maximum Benefit Amount for each of the Categories shown on the Schedule of Benefits for which the Covered Person or Dependent:

1. receives a Diagnosis of a Critical Illness; and
2. for which he is insured on the Date of Diagnosis.

If the benefit paid for a Critical Illness within a specific category is less than 100%, the remainder of the Maximum Benefit Amount will be an available benefit for another Critical Illness for which a benefit has not already been paid within the specific Critical Illness category.

The benefit payable will be paid in a lump sum amount.

Critical Illness: The Diagnosis of an illness or condition as defined in this section.

Diagnosis: The diagnosis by a Physician that is all of the following:

1. in writing;
2. made while the Covered Person’s insurance under the Policy is in force and is subject to all provisions of the in force Policy; and
3. based on objective clinical findings and/or laboratory investigations and supported by medical records and any diagnostic requirements stated in the Policy.

Date of Diagnosis, based on objective clinical or pathological findings, is:

1. for Cancer, the date that the tissue specimen, blood sample(s) and/or titer(s) are taken on which the diagnosis of Cancer is based;
2. for Coronary Artery Bypass, the date that heart disease has been clinically diagnosed and requires the Covered Person or Dependent to undergo a surgical procedure to open a blockage of one or more coronary arteries using venous or arterial grafts;
3. for Heart Attack, the date the Physician confirms that a Heart Attack (myocardial infarction) has occurred;
4. for Heart Transplant, the date the Physician recommends that the Covered Person or Dependent undergo a heart transplant, or results in the Covered Person or Dependent being placed on the United Network of Organ Sharing (UNOS) transplant list. If the Covered Person or Dependent is determined by the Physician to be too ill for a transplant, but otherwise meets the criteria for placement on the UNOS list, the network requirement will be waived;
5. for Ruptured Aneurysm, the date the Physician confirms that a Ruptured Aneurysm occurred;
6. for Stroke, the date the Physician confirms that a Stroke occurred;
7. for Chronic Renal Failure, the date the Physician recommends that the Covered Person or Dependent undergo hemodialysis or peritoneal dialysis at least weekly, or results in the Covered Person or Dependent being placed on the United Network of Organ Sharing (UNOS) transplant list, whichever occurs first;
8. for Coma, the date the Physician confirms that the Covered Person or Dependent has been in a Coma for a continuous period of at least 30 days;
9. for Major Organ Transplant, due to documented major organ failure, the date the Physician recommends that the Covered Person or Dependent undergo transplant surgery, or results in the Covered Person or Dependent being placed on the United Network of Organ Sharing (UNOS) transplant list for the organ that has failed, whichever occurs first. If the Covered Person or Dependent is determined by the Physician to be too ill for a transplant, but otherwise meets the criteria for placement on the UNOS list, the network requirement will be waived;
10. for Paralysis, the date the Physician confirms the complete loss of functional use of two or more limbs for a continuous period of at least 30 days;
11. for Severe Brain Damage, the date the Physician confirms that the Severe Brain Damage has lasted for a continuous period of at least 90 days; and
12. for Severe Burns, the date the Physician confirms the presence of Severe Burns.
**Category 1 Critical Illness:** means a Level 1 or Level 2 Cancer as stated below.

**Cancer:** a pathological diagnosis of cancer. However, a clinical diagnosis of Level 1 Cancer that is based on symptoms will be recognized if:
1. a pathological diagnosis cannot be made because it is medically inappropriate or life threatening;
2. there is medical evidence to support the diagnosis; and
3. a Physician is treating the Covered Person or Dependent for Cancer.

**Level 1 Cancer** means a malignant tumor which has:
1. uncontrolled growth of malignant cells; and
2. invaded normal tissue.

It must be positively diagnosed with histopathological confirmation.

The term does not include the tumors listed below:
1. Chronic lymphocytic leukemia that has not progressed to at least:
   a. Rai stage II; or
   b. Binet Stage B.
2. All tumors that are histologically described as:
   a. premalignant;
   b. noninvasive;
   c. carcinoma in situ (including cervical dysplasia: CIN-1; CIN-2; and CIN-3);
   d. borderline malignant; or
   e. low malignant potential.
3. All skin cancers, unless:
   a. there is evidence of metastasis; or
   b. the tumor is a malignant melanoma of greater than 1.0 mm maximum thickness (regardless of Clark level or ulceration) as determined by histological examination using the Breslow method.
4. Prostate cancer; unless histologically classified as:
   a. Gleason score 7 or greater; or
   b. TNM classification T1bN0M0 or greater.
5. Papillary carcinoma of the thyroid that is:
   a. 1 cm or less in diameter; and
   b. limited to the thyroid.
6. Noninvasive papillary cancer of the bladder histologically described as TNM classification TaN0M0 or lower.

**Level 2 Cancer** means a malignant tumor which has not yet become invasive but is confined only to the superficial layer of cells from which it arose (i.e. malignant cells confirmed to the epithelium without penetration of the basement membrane).

The term does include:
1. carcinoma in-situ;
2. prostate cancer; or
3. papillary carcinoma of the thyroid, and noninvasive papillary cancer of the bladder; that is not covered under Level 1 Cancer.

Level 2 Cancer does not include the tumors listed below:
1. pre-malignant conditions or conditions with malignant potential;
2. Basal cell carcinoma and squamous cell carcinoma of the skin; or
3. Melanoma or melanoma in situ.
Category 2 Critical Illness: means Coronary Artery Bypass, Heart Attack, Heart Transplant, Ruptured Aneurysm or Stroke as defined below.

Coronary Artery Bypass: Heart disease that has been clinically diagnosed and requires the Covered Person or Dependent to undergo a surgical procedure to open a blockage of one or more coronary arteries using venous or arterial grafts. Coronary artery bypass does not include balloon angioplasty, placement of intravascular stent, laser relief or other like procedures.

Heart Attack (myocardial infarction): means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. Heart Attack results in some permanent functional loss of heart contraction detectable by a regional contraction abnormality study on an imaging study.

The diagnosis must include all of the following criteria concurrently:
1. typical clinical symptoms such as central chest pain;
2. acute diagnostic increase of specific cardiac markers; and
3. new electrocardiographic changes of infarction.

Heart Attack does not include any other disease or injury involving the cardiovascular system. Heart Attacks that occur during a medical procedure are not included. Cardiac Arrest not caused by a Myocardial Infarction is not a Heart Attack. Established (old) myocardial infarction prior to the Effective Date is excluded.

Heart Transplant: a clinical diagnosis of heart failure of such severity that the Physician recommends the Covered Person or Dependent undergo a heart transplant, or results in the Covered Person or Dependent being placed on the United Network of Organ Sharing (UNOS) transplant list. If the Covered Person or Dependent is determined by the Physician to be too ill for a transplant, but otherwise meets the criteria for placement on the UNOS list, the network requirement will be waived.

Ruptured Aneurysm (Ruptured Cerebral, Carotid or Aortic Aneurysm): the diagnosis of a Ruptured Aneurysm must be supported by:
1. Medical records; including
2. Radiographically specific diagnostic studies to objectively support the diagnosis as established by the American Academy of Radiologists.

Stroke: a cerebrovascular event resulting in measurable permanent neurological damage or impairment, including infarction of brain tissue, hemorrhage and embolism from an extra cranial source. The diagnosis must be based on objective clinical evidence of brain tissue damage for a continuous period of at least 30 days, using a current neuro imaging test such as:
1. a CT Scan (Computed Tomography);
2. MRI (Magnetic Resonance Imaging);
3. MRA (Magnetic Resonance Angiography);
4. PET Scan (Positron Emission Tomography); or
5. Arteriography or Angiography.

Stroke does not include Transient Ischemic Attacks (TIA) or attacks of Vertebrobasilar Ischemia.
Category 3 Critical Illness:

**Chronic Renal Failure:** the chronic irreversible failure to function of both kidneys of such severity that the Physician recommends the Covered Person or Dependent undergo hemodialysis or peritoneal dialysis at least weekly, or results in the Covered Person or Dependent being placed on the United Network of Organ Sharing (UNOS) transplant list.

**Coma:** the diagnosis of a state of unconsciousness for a continuous period of at least 30 days and which is not a result of Stroke. The Coma diagnosis must be supported by:
1. a Glasgow Coma Scale Score of eight or below throughout the 30 day period; and
2. an Electroencephalogram (EEG).

**Major Organ Transplant:** a clinical diagnosis of a major organ failure of a kidney, liver, both lungs, or pancreas of such severity that the Physician recommends the Covered Person or Dependent undergo transplant surgery, or results in the Covered Person or Dependent being placed on the United Network of Organ Sharing (UNOS) transplant list for the organ that has failed. If the Covered Person or Dependent is on the UNOS list for a combined transplant, only one benefit will be paid. If the Covered Person or Dependent is determined by the Physician to be too ill for a transplant, but otherwise meets the criteria for placement on the UNOS list, the network requirement will be waived.

**Permanent Paralysis:** total and permanent loss of the use of two or more limbs (arms or legs or combination) due to Injury or Sickness for a continuous period of at least 30 days, and which is not a result of Stroke.

**Severe Brain Damage:** accidental cranial trauma that:
1. results in permanent loss of cognitive ability for a continuous period of at least 90 days;
2. renders the Covered Person or Dependent unable to safely and completely perform three or more of the following Activities of Daily Living without another person’s active assistance or verbal cueing:
   a. Bathing – the ability to wash oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower;
   b. Dressing – the ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs;
   c. Toileting – the ability to get to and from the toilet, get on and off the toilet and perform associated personal hygiene;
   d. Transferring – the ability to move into or out of a bed, chair or wheelchair;
   e. Continence – the ability to maintain control of bowel and bladder functions; or, when unable to maintain control of bowel and bladder function, the ability to perform associated personal hygiene including caring for catheter or colostomy bag;
   f. Eating – the ability to feed oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

The diagnosis must be based on objective laboratory and clinical findings, including a score of seven or less on the Rancho Los Amigos Scale throughout the 90 day period.

**Severe Burns:** the diagnosis of third degree burns covering at least 20% of the surface area of the body. Third degree burns means the destruction of the skin through the entire thickness or depth of the dermis and the layer of tissue below the skin (subcutaneous tissue).
ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

**Covered Person’s Eligibility:** Employees who are Actively at Work for an Enrolling Group are eligible for insurance after completion of the required Employee Waiting Period provided:
1. they are in a class of Employees who are included; and
2. customarily working at least the number of hours per week shown in the Schedule of Benefits.

An Employee will become eligible for insurance on the latest of the following dates:
1. the Effective Date of the Policy;
2. the Effective Date of the Enrolling Group;
3. the end of the Employee Waiting Period shown in the Schedule of Benefits;
4. the date the Policy is changed to include the Employee’s class; or
5. the date the Employee enters a class eligible for insurance.

**Dependent Eligibility:** Dependents are eligible for insurance on the latest of the following dates:
1. the date the Covered Person becomes eligible for Dependent Insurance;
2. the date a person becomes a Dependent; or
3. the date the Policy is amended to include the Covered Person’s class as being eligible for Dependent Insurance.

The Dependent will not be eligible for Dependent Insurance if he:
1. is eligible for insurance under the Policy as a Covered Person; or
2. is a member of the armed forces on active duty, except for duty of 30 days or less for training in the Reserves or National Guard; or
3. has been diagnosed as having a life expectancy of less than 12 months.

**Enrolling in or Changing Insurance for Covered Person Insurance Under the Policy:** The Employee may enroll in or change his insurance only under the following situations:
1. during the Initial Enrollment Period:
   a. if the Employee is eligible for insurance on the Effective Date, he may enroll for insurance during the Initial Enrollment Period. If an Employee fails to enroll, then he will not be insured under the Policy.
   b. if the Employee becomes eligible for insurance after the Effective Date, he may enroll for insurance during his Initial Enrollment Period.
2. during a Re-enrollment Period: The Employee may choose:
   a. to keep his same insurance;
   b. no insurance under the Policy;
   c. to enroll for insurance if not currently insured under the Policy;
   d. to change any benefit or amount that is optional;
3. within 31 days of a Change in Family Status, as defined, the Employee may choose to enroll or change the insurance for which he is eligible.

During a Re-enrollment Period, if the Covered Person does not re-enroll for insurance, he will continue to be insured for the same insurance.
ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS (continued)

Enrolling in or Changing Dependent Insurance Under the Policy:
The Employee may elect or change Dependent Insurance only under the following situations:

1. during the Initial Enrollment Period:
   a. if the Dependents are eligible for insurance on the Effective Date of the Policy, the Employee may enroll for Dependent insurance during the Initial Enrollment Period. If an Employee fails to enroll his Dependents, then the Dependents will not be insured under the Policy.
   b. if the Dependents become eligible for insurance after the Effective Date of the Policy, the Employee may enroll for Dependent Insurance during his Initial Enrollment Period.

2. during a Re-enrollment Period: The Employee may choose:
   a. to keep the same Dependent Insurance;
   b. no Dependent insurance under the Policy;
   c. to apply for Dependent Insurance under the Policy;
   d. to change any benefit or amount of Dependent Insurance that is optional;

3. within 31 days of a Change in Family Status, as defined, the Employee may choose to enroll or change his Dependent Insurance provided the Dependent is eligible.

The Employee may enroll for:
1. Dependent Insurance for Spouse only;
2. Dependent Insurance for Children only; or
3. Dependent Insurance for both Spouse and Children.

During a Re-enrollment Period, if the Covered Person does not re-enroll for Dependent Insurance, his Dependents will continue to be insured for the same insurance until the next Re-enrollment Period.

Dependents will not be insured until the Employee is insured. Dependents are not eligible for any benefit or amount that is more than the Covered Person’s.

Effective Date of Covered Person Initial Insurance: If an Employee is not Actively at Work on the date his insurance is scheduled to take effect, it will take effect on the day after the date he returns to Active Work. If the Employee’s insurance is scheduled to take effect on a non-working day, his Active Work status will be based on the last working day before the scheduled Effective Date of his insurance.

An Employee must use forms provided by Us when applying for insurance.

The Employee’s insurance will be effective at 12:01 A.M. Eastern Standard time as follows:
1. if it is Non-contributory, on the date the Employee becomes eligible for insurance, regardless of when he applies, or
2. if it is Contributory, and the Employee makes application within 31 days after the date he first became eligible, on the later of:
   a. the date the Employee is eligible for insurance, regardless of when he applies; or
   b. the date the Employee’s application is approved by Us if evidence of insurability is required.

Evidence of insurability is required if an Employee applying for Contributory Insurance:
1. does not apply for insurance within 31 days after the date he first became eligible; or
2. he has previously terminated his insurance while in an eligible class; or
3. applies for an amount of insurance other than during an Enrollment Period.
ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS (continued)

Effective Date of Dependent Initial Insurance: No insurance will take effect on any day the Dependent is confined in a Hospital or Medical Facility. Insurance will take effect on the day following discharge from the Hospital or Medical Facility.

A Covered Person must use forms provided by Us when applying for Dependent Insurance.

The Dependent Insurance will be effective at 12:01 A.M. Eastern Standard time:
1. if it is Non-contributory, on the date the Dependent becomes eligible for insurance regardless of when application was made; or
2. if it is Contributory and the Covered Person makes application within 31 days after the date the Dependent first became eligible, on the later of:
   a. the date the Dependent becomes eligible for insurance, regardless of when application is made; or
   b. the date the Dependent’s application is approved by Us, if evidence of insurability is required.

Dependents will not be insured until the Employee is insured.

Evidence of insurability is required, at the Covered Person’s expense, if a Covered Person applying for Contributory Insurance:
1. does not apply for Dependent Insurance within 31 days after the date the Dependent first became eligible; or
2. has previously terminated Dependent Insurance while in an eligible class.

Effective Date of Change in Covered Person or Dependent Insurance: A change in insurance that is made during a Re-enrollment Period will be effective at 12:01 a.m. Eastern Standard time on the later of:
1. the date of application;
2. the date We approve the Covered Person’s or Dependent’s evidence of insurability form, if evidence of insurability is required;
3. the first day of the pay period for which contributions for his insurance are deducted; or
4. the date the Covered Person or Dependent becomes eligible for the change in insurance, regardless of when application is made.

If the Covered Person is not Actively at Work due to Injury or Sickness, or is on a layoff or leave of absence, any increase in or addition to the Covered Person or Dependent insurance will be effective on the date the Covered Person returns to Active Work.
ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS (continued)

Termination of Covered Person’s Insurance: The Covered Person’s insurance will terminate at 12:00 midnight Eastern Standard time on the earliest of the following dates:
1. the last day of the period for which a premium payment is made, if the next payment is not made;
2. the date he becomes a member of the armed forces on active duty, except:
   a. for duty of 30 days or less for training in the Reserves or National Guard; or
   b. to the extent coverage is continued under the Leave of Absence Continuation provision;
3. the date he ceases to be a member of a class eligible for insurance;
4. the date the Enrolling Group’s insurance under the Policy terminates;
5. the date the Policy terminates, or with respect to a specific benefit, the date that such benefit terminates; or
6. the date he ceases to be Actively at Work, unless Active Work ceases during an approved layoff, medical or non-medical leave of absence, then the insurance will continue for up to 3 months from the date he stopped Active Work.
7. the date he is no longer Actively at Work due to a labor dispute, including but not limited to strike, work slow down or lock out; or
8. the date a benefit for a Critical Illness for each Category shown on the Schedule of Benefits is paid to the Covered Person or on his behalf.

Termination of Dependent Insurance: Insurance on a Dependent will terminate at 12:00 midnight Eastern Standard time on the earliest of the following dates:
1. the date he ceases to be a Dependent as defined in the Policy;
2. the date he ceases to be a member of a class eligible for Dependent insurance;
3. the date the Covered Person’s insurance under the Policy terminates;
4. the date the Enrolling Group’s insurance under the Policy terminates;
5. the date the Dependent becomes a member of the armed forces on active duty, except:
   a. for duty of 30 days or less for training in the Reserves or National Guard; or
   b. to the extent coverage is continued under the Leave of Absence Continuation provision;
6. the last day of the period for which a Dependent’s required premium payment is made, if the next payment is not made;
7. the date the Policy terminates, or with respect to a specific benefit, the date that such benefit terminates; or
8. the date a benefit amount for a Critical Illness for each Category shown on the Schedule of Benefits is paid on behalf of that Dependent. However, payment of a Critical Illness benefit for one Dependent will not affect the insurance of other Dependents.
CONTINUATION AND REINSTATEMENT PROVISIONS

Continuation during Grace Period: A Grace Period of 31 days will be allowed for the payment of each premium after the first premium payment. During the Grace Period, the insurance will continue in effect provided the premium is paid by the Policyholder before the end of the Grace Period. The Grace Period will not continue the insurance beyond a date stated in a Termination Provision.

Continuation during Leave of Absence: If the Covered Person is on Family or Medical Leave of Absence, or other leave of absence required by an applicable state or federal law, continuation of his insurance will be governed by his Employer’s policy on such leave not to exceed the greater of:

1. the leave period required by the Family and Medical Leave Act of 1993 (FMLA)
2. the leave period required by the Uniformed Services Employment and Reemployment Rights Act (USERRA); or
3. the minimum leave period required by applicable state law.

We will continue the Covered Person's insurance if the cost of his insurance continues to be paid.

If the Covered Person’s insurance does not continue during such Leave of Absence, then when he returns to Active Work:

1. he will not have to meet a new Employee Waiting Period including a Waiting Period for insurance of a Pre-Existing Condition, if applicable; and
2. he will not have to give Us evidence of insurability to reinstate the insurance he had in effect before his Leave of Absence began.

However, time spent on a Leave of Absence, without insurance, does not count toward satisfying his Employee Waiting Period.

Continuation of an Incapacitated Child: If, on the date a Child reaches the Maximum Age for Dependent Child as shown in the Schedule, he is:

1. covered under the Policy; and
2. an Incapacitated Child, as defined;

his coverage will not terminate solely due to age. The Covered Person must give Us notice of the incapacity within 31 days of the termination date.

The Child's coverage will continue as long as:

1. the Child qualifies as an Incapacitated Child; and
2. the required premium is paid.

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

Reinstatement of Rehired Employees: If a Covered Person ends employment and is rehired within a year, he may be insured on his eligibility date for the insurance that he had under the Policy on the date his employment ended.
CONTINUATION AND REINSTATEMENT PROVISIONS

Reinstatement following Military Service: If the Covered Person's or Dependent's insurance under the Certificate terminates due to active duty in one of the uniformed services of the United States military, he will have the right to renew coverage on the same basis as before the suspension in the coverage took place, provided:

1. he is in the service for a period of five years or less;
2. he applies for reinstatement of coverage and pays the required premium within 60 days of his discharge from the service; and
3. the Policy is still in force, he is eligible for coverage, and he is Actively at Work.

As used above, uniformed services includes service in the uniformed services as defined in Chapter 43 of Title 38. Coverage will be reinstated without evidence of insurability or regard to Pre-existing Conditions except any that may have been previously excluded on the date coverage was suspended. The coverage will become effective on the first day of the month after military service terminates. However, the Policy will not cover a Critical Illness, loss or other disability resulting from the military service.
PORTABILITY

Portability: If the Covered Person’s and his insured Dependent’s insurance under the Policy ends because his employment with the employer ends, he may choose to continue his and his insured Dependent’s Group Critical Illness coverage under a group Portability policy without providing evidence of insurability.

The Covered Person must be insured under the Policy for at least 6 months prior to the date his employment ends.

The Covered Person may port his insurance or his insured Dependent’s insurance if coverage ends for any reason other than:

1. he failed to pay premium for the cost of his insurance;
2. he is on an approved leave of absence;
3. he Retires;
4. the group policy is terminating;
5. he is or becomes insured under another group critical illness policy;
6. he resides outside of the United States or in a state where the coverage is not available; or
7. he is actively in military service or entering active military service.

To apply for Portability insurance, within 31 days of the date the Covered Person’s insurance ends he must:

1. submit a written application to Us; and
2. pay the first month’s premium.

If the above conditions are met, such insurance will:

1. be issued without evidence of insurability; and
2. continue in effect provided the Covered Person continues to pay the cost of his and his insured Dependent’s insurance.

The Portability insurance will end on the earliest of:

1. the date the Covered Person fails to pay the required premium;
2. the date he Retires;
3. the date he becomes insured under any other group critical illness policy;
4. the date a benefit for a Critical Illness for each Category shown on the Schedule of Benefits is paid to the Covered Person or on his behalf; or
5. the date he attains any Policy Age Limit stated in the Portability policy.

Covered Persons rehired after porting insurance must either lapse his and his insured Dependent’s insurance or provide evidence of insurability.

The Portability coverage will be on the form the Insurer is then issuing for Critical Illness Portability purposes.

Insurer as used in this provision means Us or another insurance company which has agreed with Us to issue Portability coverage according to this Portability provision. The Portability coverage may differ from Your coverage under the Policy. The premium for the Portability coverage will be based on the coverage and form of the Portability policy, as well as Your age and risk class.

Retire means, for purposes of Portability, the Covered Person has concluded his working career on a Full-time basis and:

1. he is receiving payments from a governmental retirement plan or any employer; or
2. he is receiving Social Security Retirement benefits.
GENERAL EXCLUSIONS AND LIMITATIONS

General Exclusions: We will not cover a Critical Illness under the Policy if it is due to:
1. an act or accident of war, declared or undeclared, whether civil or international, and any substantial armed conflict between organized forces of a military nature;
2. loss sustained while on active duty as a member of the armed forces of any nation except during any time period coverage is extended under the Continuation during Leave of Absence provision;
3. any intentionally self-inflicted Injury;
4. active participation in a riot;
5. committing or attempting to commit a felony, or participating or attempting to participate in a felony;
6. use of alcohol or the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance, whether or not prescribed by a Physician;
7. cosmetic or elective surgery; or
8. attempted suicide, while sane or insane.

We also will not pay a benefit for a Critical Illness:
9. for which the Covered Person’s or Dependent’s Date of Diagnosis for any type of Critical Illness, as defined in the Policy, was prior to his Effective Date of insurance;
10. that was diagnosed outside of the United States or Canada, unless the diagnosis was confirmed by a Physician practicing within the United States or Canada; or
11. with respect to a Dependent who is a Child, that is caused by or contributed to by a congenital defect.

Pre-existing Conditions Exclusion: We will not cover any Critical Illness that begins during the first 12 months after the Covered Person’s or Dependent’s Effective Date of insurance that is caused or contributed to by a Pre-Existing Condition.

Pre-Existing Condition means any condition for which the Covered Person or Dependent within 12 months prior to his Effective Date of insurance:
1. was diagnosed by or received Treatment from a legally qualified Physician; or
2. had symptoms for which a reasonably prudent person would have sought Treatment.

If the Covered Person’s or Dependent’s insurance is increased, then a benefit based on the increased amount of insurance is not payable for a Critical Illness which is first diagnosed during the 18 months following the Effective Date of his increase in insurance, if it is caused by or contributed to by a Pre-Existing Condition. For purposes of applying this provision, Effective Date of insurance as used in the definition of Pre-Existing Condition also includes the Effective Date of the Covered Person’s or Dependent’s increase in insurance.
CONTINUITY OF INSURANCE UPON TRANSFER OF INSURANCE CARRIERS

Continuity of Insurance upon Transfer of Insurance Carriers:
The following rules apply when the Policy replaces a prior group insurance policy that is a similar
group critical illness insurance policy. If the Policy insures Critical Illnesses which were not
insured by the prior group insurance policy, benefits for these Critical Illnesses will be subject to
a Benefit Waiting Period and Pre-Existing Condition Exclusion without reference to these rules.

1. Determining the Employee Waiting Period: The continuous days during which the
   Employee was Actively at Work with the Employer immediately prior to the date the
   Employer’s insurance under the Policy is effective, will be counted towards satisfying the
   Employee Waiting Period and determining the date upon which the Employee completes
   the Employee Waiting Period.

2. Determining the Benefit Waiting Period: If the Employee was insured by the prior group
   insurance policy immediately prior to becoming eligible for insurance under this Policy
   for a period of time at least equal to the Benefit Waiting Period under this Policy, then he
   will not need to satisfy the Benefit Waiting Period of this Policy. Any insurance amount
   applied for in excess of the insurance amount issued to the Employee by the prior group
   insurance policy will be subject to the Benefit Waiting Period of the Policy.

   If the Employee was insured by the prior group insurance policy immediately prior to
   becoming eligible for insurance under this Policy for a period of time that is less than the
   Benefit Waiting Period under this Policy, then he will need to satisfy the Benefit Waiting
   Period of the Policy. The continuous days that he was insured by the prior group
   insurance policy immediately prior to the time of the transfer of insurance carriers will
   count towards satisfying the Benefit Waiting Period of this Policy. Any insurance amount
   applied for in excess of the insurance amount issued to the Employee by the prior group
   insurance policy will be subject to the entire Benefit Waiting Period of the Policy.

3. Application of Pre-Existing Condition Exclusion: If the Employee was insured by the
   prior group insurance policy immediately prior to becoming eligible for insurance under
   this Policy, he will be given credit for the time he was insured when determining whether
   the Pre-Existing Condition Exclusion would apply to his Insured Critical Illness. His
   insurance amount will be limited to the lesser of the amount that would have been paid
   by the prior group insurance policy, had insurance remained in effect, or the benefit
   payable under the Policy.
CLAIM INFORMATION

Notice of Claim: Written notice of a claim must be given to Us at Our Home Office by the
Covered Person, or his authorized representative, within 30 days after the date of the
Diagnosis of a Critical Illness. If it is not possible, written notice must be given as soon as it
is reasonably possible to do so.

The claim form is available from the Covered Person’s employer, or can be requested from
Us. If the Covered Person does not receive the form from Us within 15 days of his request,
written proof of claim should be sent to Us without waiting for the form. Written proof should
establish facts about the claim such as nature of illness and Date of Diagnosis.

Filing a Claim: The Covered Person must fill out the claim form and then give it to the
attending Physician. The Physician should fill out his section of the form and send it directly
to Us.

Proof of Claim: Written proof of claim must be filed within 90 days after the date of the
Diagnosis of a Critical Illness. However, if it is not possible to give proof within 90 days, it
must be given no later than one year after the time proof is otherwise required, except in the
absence of legal capacity.

Proof of claim must include, at the Covered Person’s expense:
1  the Date of Diagnosis;
2  a completed claim form signed by the Covered Person and Physician(s) including
documentation furnished by the Physician and supported by clinical, radiological,
histological, pathological and/or laboratory evidence of the Critical Illness. If the
claim is for the Covered Person’s Spouse, then the Spouse must also sign the claim
form; and
3  the name and address of any Hospital or Medical Facility where Treatment was
received and any Physician who provided Treatment prior to the Diagnosis.

In the event of death, an autopsy confirmation identifying the cause of death:
1. will be required for Myocardial Infarction; and
2. may also be required for other Critical Illnesses;
where allowed by law.

Payment of Claim: All benefits are payable to the Covered Person. If he dies before a
benefit is paid, We will pay any amount due to his beneficiary if he designated a beneficiary,
otherwise in the following order:
1. to his legal Spouse;
2. to his natural or legally adopted children in equal shares; or
3. to his estate.

Overpayment of Claim: We have the right to recover any overpayments due to fraud or any
error We make in processing a claim.

The Covered Person must reimburse Us in full. We will determine the method by which the
repayment is to be made. We have the right to recover overpayment from the Covered
Person’s Spouse if living, otherwise Child under the age 26 or estate.

Legal Action: The Covered Person or his Dependent, if applicable, may not bring suit to
recover under this section until 60 days after he has given Us written proof of loss. No suit
may be brought more than three years after the date of loss.
CLAIM INFORMATION

Physical Examination and Autopsy: We have the right to have a Physician of Our choice examine the Covered Person or his Dependent, if applicable, as often as reasonably necessary while the claim is pending. We may also have an autopsy made in case of death, unless not allowed by law. We will pay for the cost of the exam or autopsy.

In the event of a dispute or disagreement regarding the accuracy or appropriateness of a Diagnosis, We have the right to also request an examination of the evidence used in arriving at a Diagnosis by an independent expert that We select in the applicable field of medicine. We will pay the cost.

Fraud: We will focus on all means necessary to support fraud detection, investigation, and prosecution. It may be a crime if the Covered Person or the employer knowingly, and with intent to injure, defraud or deceive Us, files a claim containing any false, incomplete, or misleading information. These actions, as well as submission of false information, will result in denial of the Covered Person’s claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

Incontestability: No statement made by any Covered Person relating to his insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person’s lifetime, nor unless it is contained in a written instrument signed by him.

Misstatement Of Age: If a Covered Person’s age has been misstated, premiums will be subject to an equitable adjustment. If the amount of the benefit depends upon age, then the benefit will be that which would have been payable, based upon the person’s correct age.

Workers’ Compensation: The Policy is not to be construed to provide benefits required by Worker’s Compensation laws.
WELLNESS BENEFIT RIDER

We will pay the amount shown on the Schedule of Benefits per calendar year for any one of the following health screening tests performed on either the Covered Person or Spouse provided the Covered Person elected coverage under the benefit.

Health screening test is defined as:

- Stress test on a bicycle or treadmill
- Fasting blood glucose test
- Blood test for triglycerides
- Serum cholesterol test to determine level of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum Protein Electrophoresis (blood test for myeloma)
- Thermography
- Virtual Colonoscopy

This benefit will be paid as long as the Policy is in force and the Covered Person or Spouse remains insured under this Benefit of the Policy. The benefit will be paid regardless of the results of the test. The Wellness Benefit is paid in addition to any other payments the Covered Person or Spouse receives under the Policy.

Only one health screening test will be covered upon receipt by Us of adequate documentation to support the performance of the test on the Covered Person or Spouse.
RESTORATION BENEFIT RIDER

We will pay the Restoration Benefit for the Covered Person or Dependent for a Critical Illness under each Category as defined provided the Covered Person elected coverage under the benefit.

Under the Restoration Benefit, We/ the rider will reinstate 100% of the Maximum Benefit Amount and will cover the recurrence of the same Critical Illness or an occurrence of another covered Critical Illness within each benefit category. The Maximum Benefit Amount payable, as shown on the Schedule of Benefits, will be paid in a lump sum amount.

Restoration Benefit Payable: The Restoration Benefit will be payable up to 100% of the Maximum Benefit Amount if the Covered Person or Dependent is diagnosed with a covered Critical Illness and:

1. the subsequent specified covered Critical Illness is diagnosed following a 12-month consecutive period free of any previously diagnosed and additional Critical Illness; and
2. the subsequent Date of Diagnosis is while coverage under this Policy is in force.

If a Restoration Benefit for a Critical Illness within a specific category has been paid at less than 100% of the Maximum Benefit Amount, the remainder of the Restoration Benefit for a Critical Illness in that specific category, for which benefits have not already been paid under this Rider, will be available.

Reduction: Any remaining rider benefit (Maximum Benefit Amount less any partial benefit payments) will be reduced by 50% at age 70 as noted on the Schedule of Benefits.

Termination: The Termination of Covered Person’s Insurance provision in the Policy is amended to read as follows:

8. The date the Restoration Benefit totaling 100% of the Maximum Benefit Amount for each Category is paid to the Covered Person, or on his behalf.

The Termination of Dependent Insurance provision in the Policy is amended to read as follows:

8. The date a Restoration Benefit totaling 100% of the Maximum Benefit Amount for each Category shown on the Schedule of Benefits is paid on behalf of that Dependent. However, payment of the Restoration Benefit for one Dependent will not affect the insurance of other Dependents.

The Benefit Waiting Period and Pre-existing Conditions Exclusion provisions will not apply to the insurance for a Restoration Benefit. All other provisions of the Policy not specifically changed by the provisions of this Rider apply to this benefit.
OCCUPATIONAL HIV BENEFIT RIDER

We will pay the Occupational HIV Benefit shown on the Schedule of Benefits in a lump sum for exposure to the Human Immunodeficiency Virus (HIV) if:

1. a Covered Person, who elected coverage under the benefit is included within the Eligible SIC Codes shown below, sustains an Injury in the performance of his occupational duties; and
2. as a result of such Injury, the Covered Person acquires and tests positive for HIV.

Occupational HIV is a Diagnosis of HIV infection resulting from an Injury which exposed the Covered Person to HIV-contaminated body fluids and;

1. the Injury must have occurred during the normal course of duties for the occupation in which the Covered Person is regularly engaged; and
2. the HIV infection must result from the accidental exposure to the HIV-contaminated body fluids during the normal course of performing an occupation for which remuneration is earned; and
3. the contact with the body fluids must have occurred while the Covered Person’s coverage is in force.

Benefit Payable: The Occupational HIV Benefit shown on the Schedule of Benefits will be payable if:

1. the Injury is reported and recorded within 5 days of the Injury by the appropriate person according to the legislation, regulations, standards or guidelines that apply to the Covered Person’s occupation; and
2. the Injury is investigated and a written investigation report is provided by the Covered Person’s employer; and
3. a confirmatory antibody HIV test is taken within 5 days of the Injury and HIV is not present; and
4. all HIV tests are performed by a state certified and licensed laboratory; and
5. a follow-up confirmatory antibody HIV test is taken between 90 days and 180 days after the Injury and the result is positive; and
6. the Covered Person has not previously tested positive for HIV, or if the Covered Person has previously tested positive for HIV, the Covered Person subsequently tested negative for HIV prior to the date the Injury occurred.

The benefit payable under this Rider will be reduced by 50% if the Covered Person is age 70 or older on the date of diagnosis of Occupational HIV.

Exclusions: Occupational HIV excludes the following:

1. HIV infection as the result of IV drug use;
2. HIV infection as the result of sexual transmission; and
3. HIV infection determined not to have been as a result of an Injury.

Eligible SIC Codes:

1. 801x-804x Physicians and Dentists
2. 805x-906x Hospitals, Nursing Facilities
3. 807x-809x Medical/Dental Labs, Clinics, Home Health Care, Other Health Services
4. 922x Police/Fire/Corrections