**CRITICAL ILLNESS PLAN 1**

**METROPOLITAN LIFE INSURANCE COMPANY**
**NEW YORK, NEW YORK**

# NOTICE

**Notice Effective Date:** **The later of June 1, 2025 or the date that applies to the insured's Certificate as shown in the insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife.**

**This Notice applies to the Sudden Cardiac Arrest Covered Condition* included in the Covered Condition Category: Heart Attack. It describes certain administrative changes applicable to the Sudden Cardiac Arrest Covered Condition included in Your Certificate.**

In relation to the definition of Sudden Cardiac Arrest, and the Proof requirements that apply to a Clinical Diagnosis of Sudden Cardiac Arrest, We will not apply any requirement that a Covered Person must be pronounced as deceased by a Physician.

In order for this administrative notice to apply, coverage under Your Certificate must be in force on the date a Diagnosis of a Sudden Cardiac Arrest Covered Condition is made.

All other Proof requirements for benefit payment continue to apply, and benefit payment is subject to all other conditions, maximums, limitations, and other exclusions contained in the provisions of the Certificate.

Please carefully read the entirety of Your Certificate.

* In certain states Sudden Cardiac Arrest is referred to as "Sudden Cardiac Death".

**METROPOLITAN LIFE INSURANCE COMPANY**
**NEW YORK, NEW YORK**

# NOTICE

**Notice Effective Date:** **The later of June 1, 2025 or the date that applies to the insured's Certificate as shown in the insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife.**

**This Notice only applies if Your Certificate provides coverage for cancer as a Covered Condition. It describes certain administrative changes applicable to exclusions for coverage of cancer.**

If included in Your Certificate, in relation to a Diagnosis of cancer as a Covered Condition, We will not apply exclusions for any of the following:

- any cancer in the presence of human immuno-deficiency virus (HIV) for which there is a known increased risk due to the presence of Acquired Immune Deficiency Syndrome (AIDS) or the presence of HIV; or
- Kaposi Sarcoma.

All other Proof requirements for benefit payment continue to apply, and benefit payment is subject to all other conditions, maximums, limitations, and other exclusions contained in the provisions of the Certificate. Please carefully read the entirety of Your Certificate.

**METROPOLITAN LIFE INSURANCE COMPANY**
**NEW YORK, NEW YORK**

**Certificate Rider**

**Group Policy No.:** **0119920**

**Policyholder:** **ADP TotalSource, Inc.**

**Rider Effective Date:** **The later of June 1, 2025 or the date that applies to the insured's Certificate as shown in the insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife.**

Your Certificate is changed as follows:

The following notices are added to the Notices section of Your Certificate:

**NOTICES**
**GROUP CRITICAL ILLNESS INSURANCE**

**THERE MAY BE DIFFERENCES IN BENEFITS, ELIGIBILITY REQUIREMENTS, LIMITATIONS OR EXCLUSIONS THAT APPLY BASED ON STATE REQUIREMENTS FOR THE STATE IN WHICH YOU RESIDE ON THE INITIAL DATE OF YOUR COVERAGE.**

**PLEASE READ ANY NOTICE(S) THAT FOLLOW BELOW CAREFULLY. ANY SUCH NOTICE(S) PROVIDE REQUIRED DISCLOSURES AND INFORMATION ABOUT SIGNIFICANT STATE REQUIREMENTS.**

**PLEASE CONTACT US WITH QUESTIONS OR FOR ADDITIONAL INFORMATION.**

**ARKANSAS NOTICE:**

**IF YOU HAVE A QUESTION CONCERNING YOUR COVERAGE OR A CLAIM, FIRST CONTACT YOUR GROUP EMPLOYER OR GROUP ACCOUNT ADMINISTRATOR. IF, AFTER DOING SO, YOU STILL HAVE A CONCERN, YOU MAY CALL METLIFE'S TOLL-FREE TELEPHONE NUMBER: 1-800-GET-MET8**

**IF YOU ARE STILL CONCERNED AFTER CONTACTING BOTH YOUR GROUP EMPLOYER AND METLIFE, YOU SHOULD FEEL FREE TO CONTACT:**

**ARKANSAS INSURANCE DEPARTMENT**
**1 COMMERCE WAY, SUITE 102**
**LITTLE ROCK, ARKANSAS 72202**

**(800) 852-5494 or (501) 371-2640**

**YOU HAVE THE RIGHT TO FILE A COMPLAINT WITH THE ARKANSAS INSURANCE DEPARTMENT (AID). YOU MAY CALL AID TO REQUEST A COMPLAINT FORM AT (800) 852-5494 or (501) 371-2640**

**COLORADO NOTICES:**

**THIS IS A LIMITED HEALTH BENEFIT COVERAGE POLICY AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.**

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**CONTACT US**

If You have questions about Your insurance coverage You may contact MetLife at 1-800-GET-MET8.

MetLife Toll Free Number(s):

| | |
|---|---|
| For Claim Information | 1-800-GET-MET8 |
| For General Information | 1-800-GET-MET8 |

To make a complaint to MetLife, You may Write to:

Metropolitan Life Insurance Company
Attn: Consumer Relations Department
700 Quaker Lane, 2nd Floor
Warwick, Rhode Island 02886

Or call MetLife at 1-800-GET-MET8 or 1-800-438-6388.

**CONNECTICUT NOTICES:**

This Certificate does not replace or otherwise affect any statutorily required workers' compensation insurance required to be provided to you by law.

CAUTION! This Certificate PROVIDES LIMITED COVERAGE. IT IS NOT A MAJOR MEDICAL CERTIFICATE. Read it carefully.

**IDAHO NOTICES:**

**This is a supplement to health insurance and is not a substitute for Medical Coverage. Lack of Medical Coverage (or other minimum essential coverage) may result in an additional payment with Your taxes. You should have Medical Coverage when You enroll for this insurance.**

**Notice to Buyer: This is a specified disease Certificate. This Certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read Your Certificate carefully with the outline of coverage.**

**This Certificate does not replace or affect any requirement for coverage by workers' compensation insurance.**

**30-Day Right to Examine Certificate. Please read this Certificate carefully. If You are not satisfied for any reason, You may notify the Group Policyholder that You are cancelling Your Certificate within 30 days from the date of delivery by calling the number set forth in the Certificate. If You notify the Group Policyholder that You are cancelling within the 30 day period, this Certificate will be void from the beginning. We will refund any premium paid within 30 days after We receive Your notice of cancellation.**

You may contact the Idaho Department of Insurance at:

Idaho Department of Insurance
Consumer Affairs
700 W State Street, 3rd Floor
PO Box 83720
Boise, ID 83720-0043
1-800-721-3272 or 208-334-4250
www.DOI.Idaho.gov

**THE FOLLOWING COVERED CONDITION CATEGORIES ARE NOT AVAILABLE FOR, AND DO NOT APPLY TO, IDAHO RESIDENTS: FUNCTIONAL LOSS COVERED CONDITION CATEGORY AND SEVERE BURN COVERED CONDITION CATEGORY.**

**IF THE CARDIOVASCULAR DISEASE COVERED CONDITION CATEGORY IS INCLUDED IN YOUR CERTIFICATE, IT IS REPLACED WITH THE CORONARY ARTERY COVERED CONDITION CATEGORY WHICH IS DESCRIBED IN THE OUTLINE OF COVERAGE.**

**IF THE MAJOR ORGAN TRANSPLANT COVERED CONDITION CATEGORY IS INCLUDED IN YOUR CERTIFICATE, IT IS REPLACED WITH THE MAJOR ORGAN FAILURE COVERED CONDITION CATEGORY WHICH IS DESCRIBED IN THE OUTLINE OF COVERAGE.**

**MISSOURI NOTICE:**

**30 Day Right to Examine Certificate:**
**Please read the Certificate carefully. If You are not satisfied for any reason, You may notify us that you are cancelling your Certificate within 30 days from the date of delivery by calling us at 1-800-GETMET8. If you notify us that you are cancelling within the 30 day period, the Certificate will be void from the beginning. We will refund any premium or contribution paid within 30 days after we receive your notice of cancellation.**

**NEW HAMPSHIRE NOTICES:**

**THIS IS A LIMITED CERTIFICATE – READ IT CAREFULLY**

**NOTICE TO BUYER: THIS IS A SPECIFIED DISEASE INSURANCE CERTIFICATE. THIS CERTIFICATE PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. READ YOUR CERTIFICATE CAREFULLY WITH THE OUTLINE OF COVERAGE AND BUYER'S GUIDE.**

NOTICE TO BUYER: THIS IS AN ANCILLARY HEALTH INSURANCE CERTIFICATE. THIS CERTIFICATE PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

This Certificate may, at any time within 30 days after its receipt by You, be returned by delivering it or mailing it to Us or the agent through whom it was purchased. In addition, during this 30 day period, You may instead notify the Group Policyholder that You are cancelling Your Certificate by calling the Group Policyholder.

This Certificate does not provide comprehensive health insurance coverage. It is not intended to satisfy the individual mandate of the Affordable Care Act (ACA) or provide the minimum essential coverage required by the ACA (often referred to as "Major Medical Coverage"). It does not provide coverage for hospital, medical, surgical, or major medical expenses.

**THE SEVERE BURN COVERED CONDITION CATEGORY IS NOT AVAILABLE FOR, AND DOES NOT APPLY TO, NEW HAMPSHIRE RESIDENTS.**

**IF THE MAJOR ORGAN TRANSPLANT COVERED CONDITION CATEGORY IS INCLUDED IN YOUR CERTIFICATE, IT IS REPLACED WITH THE MAJOR ORGAN FAILURE COVERED CONDITION CATEGORY WHICH IS DESCRIBED IN THE OUTLINE OF COVERAGE.**

**Patients' Bill of Rights**

Pursuant to New Hampshire RSA 151:21, the rights and responsibilities of each patient admitted to a facility, except those admitted by a home health care provider, shall include, as a minimum, the following:

I. The patient shall be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care and including being informed of the name, licensure status, and staff position of all those with whom the patient has contact, pursuant to RSA 151:3-b.

II. The patient shall be fully informed of a patient's rights and responsibilities and of all procedures governing patient conduct and responsibilities. This information must be provided orally and in writing before or at admission, except for emergency admissions. Receipt of the information must be acknowledged by the patient in writing. When a patient lacks the capacity to make informed judgments the signing must be by the person legally responsible for the patient.

III. The patient shall be fully informed in writing in language that the patient can understand, before or at the time of admission and as necessary during the patient's stay, of the facility's basic per diem rate and of those services included and not included in the basic per diem rate. A statement of services that are not normally covered by medicare or medicaid shall also be included in this disclosure.

IV. The patient shall be fully informed by a health care provider of his or her medical condition, health care needs, and diagnostic test results, including the manner by which such results will be provided and the expected time interval between testing and receiving results, unless medically inadvisable and so documented in the medical record, and shall be given the opportunity to participate in the planning of his or her total care and medical treatment, to refuse treatment, and to be involved in experimental research upon the patient's written consent only. For the purposes of this paragraph "health care provider" means any person, corporation, facility, or institution either licensed by this state or otherwise lawfully providing

health care services, including, but not limited to, a physician, hospital or other health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, or psychologist, and any officer, employee, or agent of such provider acting in the course and scope of employment or agency related to or supportive of health care services.

V. The patient shall be transferred or discharged after appropriate discharge planning only for medical reasons, for the patient's welfare or that of other patients, if the facility ceases to operate, or for nonpayment for the patient's stay, except as prohibited by Title XVIII or XIX of the Social Security Act. No patient shall be involuntarily discharged from a facility because the patient becomes eligible for medicaid as a source of payment.

VI. The patient shall be encouraged and assisted throughout the patient's stay to exercise the patient's rights as a patient and citizen. The patient may voice grievances and recommend changes in policies and services to facility staff or outside representatives free from restraint, interference, coercion, discrimination, or reprisal.

VII. The patient shall be permitted to manage the patient's personal financial affairs. If the patient authorizes the facility in writing to assist in this management and the facility so consents, the assistance shall be carried out in accordance with the patient's rights under this subdivision and in conformance with state law and rules.

VIII. The patient shall be free from emotional, psychological, sexual and physical abuse and from exploitation, neglect, corporal punishment and involuntary seclusion.

IX. The patient shall be free from chemical and physical restraints except when they are authorized in writing by a physician for a specific and limited time necessary to protect the patient or others from injury. In an emergency, restraints may be authorized by the designated professional staff member in order to protect the patient or others from injury. The staff member must promptly report such action to the physician and document same in the medical records.

X. The patient shall be ensured confidential treatment of all information contained in the patient's personal and clinical record, including that stored in an automatic data bank, and the patient's written consent shall be required for the release of information to anyone not otherwise authorized by law to receive it. Medical information contained in the medical records at any facility licensed under this chapter shall be deemed to be the property of the patient. The patient shall be entitled to a copy of such records upon request. The charge for the copying of a patient's medical records shall not exceed $15 for the first 30 pages or $.50 per page, whichever is greater; provided, that copies of filmed records such as radiograms, x-rays, and sonograms shall be copied at a reasonable cost.

XI. The patient shall not be required to perform services for the facility. Where appropriate for therapeutic or diversional purposes and agreed to by the patient, such services may be included in a plan of care and treatment.

XII. The patient shall be free to communicate with, associate with, and meet privately with anyone, including family and resident groups, unless to do so would infringe upon the rights of other patients. The patient may send and receive unopened personal mail. The patient has the right to have regular access to the unmonitored use of a telephone.

XIII. The patient shall be free to participate in activities of any social, religious, and community groups, unless to do so would infringe upon the rights of other patients.

XIV. The patient shall be free to retain and use personal clothing and possessions as space permits, provided it does not infringe on the rights of other patients.

XV. The patient shall be entitled to privacy for visits and, if married, to share a room with his or her spouse if both are patients in the same facility and where both patients consent, unless it is medically contraindicated and so documented by a physician. The patient has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, including choice of room and roommate, except when the health and safety of the individual or other patients would be endangered.

XVI. The patient shall not be denied appropriate care on the basis of age, sex, gender identity, sexual orientation, race, color, marital status, familial status, disability, religion, national origin, source of income, source of payment or profession.

XVII. The patient shall be entitled to be treated by the patient's physician of choice, subject to reasonable rules and regulations of the facility regarding the facility's credentialing process.

XVIII. The patient shall be entitled to have the patient's parents, if a minor, or spouse, or next of kin, unmarried partner, or a personal representative chosen by the patient, if an adult, visit the facility, without restriction, if the patient is considered terminally ill by the physician responsible for the patient's care.

XIX. The patient shall be entitled to receive representatives of approved organizations as provided in RSA 151:28.

XX. The patient shall not be denied admission to the facility based on medicaid as a source of payment when there is an available space in the facility.

XXI. Subject to the terms and conditions of the patient's insurance plan, the patient shall have access to any provider in his or her insurance plan network and referral to a provider or facility within such network shall not be unreasonably withheld pursuant to RSA 420-J:8, XIV.

XXII. The patient shall not be denied admission, care, or services based solely on the patient's vaccination status.

XXIII. (a) In addition to the rights specified in paragraph XVIII, the patient shall be entitled to designate a spouse, family member, or caregiver who may visit the facility while the patient is receiving care. A patient who is a minor may have a parent, guardian, or person standing in loco parentis visit the facility while the minor patient is receiving care.

(b)(1) Notwithstanding subparagraph (a), a health care facility may establish visitation policies that limit or restrict visitation when:

(A) The presence of visitors would be medically or therapeutically contraindicated in the best clinical judgment of health care professionals;

(B) The presence of visitors would interfere with the care of or rights of any patient;

(C) Visitors are engaging in disruptive, threatening, or violent behavior toward any staff member, patient, or another visitor; or

(D) Visitors are noncompliant with written hospital policy.

(2) Upon request, the patient or patient's representative, if the patient is incapacitated, shall be provided the reason for denial or revocation of visitation rights under this paragraph.

(c) A health care facility may require visitors to wear personal protective equipment provided by the facility, or provided by the visitor and approved by the facility. A health care facility may require visitors to comply with reasonable safety protocols and rules of conduct. The health care facility may revoke visitation rights for failure to comply with this subparagraph.

(d) Nothing in this paragraph shall be construed to require a health care facility to allow a visitor to enter an operating room, isolation room, isolation unit, behavioral health setting or other typically restricted area or to remain present during the administration of emergency care in critical situations. Nothing in this paragraph shall be construed to require a health care facility to allow a visitor access beyond the rooms, units, or wards in which the patient is receiving care or beyond general common areas in the health care facility.

(e) The rights specified in this paragraph shall not be terminated, suspended, or waived by the health care facility, the department of health and human services, or any governmental entity, notwithstanding declarations of emergency declared by the governor or the legislature. No health care facility licensed pursuant to RSA 151:2 shall require a patient to waive the rights specified in this paragraph.

(f) Each health care facility licensed pursuant to RSA 151:2 shall post on its website:

(1) Informational materials explaining the rights specified in this paragraph;

(2) The patients' bill of rights which applies to the facility on its website; and

(3) Hospital visitation policy detailing the rights and responsibilities specified in this paragraph, and the limitations placed upon those rights by written hospital policy on its website.

(g) Unless expressly required by federal law or regulation, the department or any other state agency shall not take any action arising out of this paragraph against a health care facility for:

(1) Giving a visitor individual access to a property or location controlled by the health care facility;

(2) Failing to protect or otherwise ensure the safety or comfort of a visitor given access to a property or location controlled by the health care facility;

(3) The acts or omissions of any visitor who is given access to a property or location controlled by the health care facility.

**NEW MEXICO NOTICES:**

## NOTICE TO CONSUMER: This is a limited benefits health plan. The benefits provided are supplemental to, and not a substitute for, major medical coverage, even in combination with other limited benefits plans. To apply for an individual or small-group major medical plan, please visit the website of the New Mexico Health Insurance Exchange at www.bewellnm.com or call 1-833-862-3935 (TTY: 711).

**CONSUMER COMPLAINT NOTICE**

**If You are a resident of New Mexico, Your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If You have concerns regarding a claim, premium, or other matters relating to this coverage, You may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint for available on the OSI website and found at:**
**https://www.osi.state.nm.us/ConsumerAssistance/index.aspx.**

**NOTICE**

If You have a question concerning Your coverage or a claim, first contact the Policyholder. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Policyholder and MetLife, You should feel free to contact:

Office of Superintendent of Insurance
Consumer Assistance Bureau
PO Box 1689
Santa Fe, NM 87504-1689
Tel: 1-855-4ASK-OSI
(1-855-427-5674)

## THE AUTISM SPECTRUM DISORDER COVERED CONDITION CERTIFICATE RIDER IS NOT AVAILABLE FOR, AND DOES NOT APPLY TO, NEW MEXICO RESIDENTS

**NORTH CAROLINA NOTICES:**

**This is a supplement to health insurance and is not a substitute for Medical Coverage. Lack of Medical Coverage (or other minimum essential coverage) may result in an additional payment with Your taxes. You should have Medical Coverage when You enroll for this insurance.**

**IMPORTANT CANCELLATION INFORMATION: Please read the provision titled "Date Your Insurance Ends".**

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL:

(1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS

INSURED BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND

(2) WILLFULLY FAIL TO DELIVER AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS, IF ANY, TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES.

VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

**NORTH DAKOTA NOTICE:**

**30 Day Right to Examine Certificate:**
**Please read the Certificate carefully. If You are not satisfied for any reason, You may notify us that you are cancelling your Certificate within 30 days from the date of delivery by calling us at 1-800-GETMET8. If you notify us that you are cancelling within the 30 day period, the Certificate will be void from the beginning. We will refund any premium or contribution paid within 30 days after we receive your notice of cancellation.**

**OHIO NOTICE:**

**To make a complaint to Metropolitan Life insurance Company, You may call 1-800-GET-MET8 or Write to:**
**Metropolitan Life Insurance Company**
**700 Quaker Lane, 2nd Floor**
**Warwick, Rhode Island 02886**

**OKLAHOMA NOTICE:**

**WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.**

**SOUTH DAKOTA NOTICE:**

**This limited health benefits plan does not provide comprehensive medical coverage. It is a basic or limited benefits Certificate and is not intended to cover all medical expenses. This plan is not designed to cover the costs of serious or chronic illness.**

**TEXAS NOTICES:**

**THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.**

**Have a complaint or need help?**

If You have a problem with a claim or Your premium, call Your insurance company or HMO first. If You can't work out the issue, the Texas Department of Insurance may be able to help.

Even if You file a complaint with the Texas Department of Insurance, You should also file a complaint or appeal through Your insurance company or HMO. If You don't, You may lose Your right to appeal.

**Metropolitan Life Insurance Company**

To get information or file a complaint with Your insurance company or HMO:

**Call: Corporate Consumer Relations Department at 1-800-438-6388**

**Toll-free: 1-800-438-6388**

Email: Johnstown_Complaint_Referrals@metlife.com

Mail: Metropolitan Life Insurance Company
700 Quaker Lane, 2nd Floor
Warwick, Rhode Island 02886

**The Texas Department of Insurance**

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

**¿Tiene una queja o necesita ayuda?**

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

**Metropolitan Life Insurance Company**

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

**Llame a: Departamento de Relaciones Corporativas del Consumidor al 1-800-438-6388**

**Teléfono gratuito: 1-800-438-6388**

Correo electrónico: Johnstown_Complaint_Referrals@metlife.com

Dirección postal: Metropolitan Life Insurance Company
700 Quaker Lane, 2nd Floor
Warwick, Rhode Island 02886

**El Departamento de Seguros de Texas**

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

**UTAH NOTICE:**

**NOTICE OF PROTECTION PROVIDED BY THE UTAH LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION**

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

The Association was established to provide protection in the unlikely event that Your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with the funding from assessments paid by other insurance companies. (For the purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs) and limited health plans.)

The basic protections provided by the Association are:

- Life Insurance
  - $500,000 in death benefits
  - $200,000 in cash surrender or withdrawal values
- Accident and Health Insurance
  - $500,000 for health benefit plans
  - $500,000 in disability income insurance benefits
  - $500,000 in long-term care insurance benefits
  - $500,000 in other types of health insurance benefits
- Annuities
  - $250,000 in the present value of annuity benefits in aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to health benefit plans.

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

Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefit as the base life insurance policy or annuity contract to which it relates.

To learn more about the above protections, please visit the Association's website at www.ulhiga.org or contact:

Utah Life and Health Insurance Guaranty Assoc.
450 S Simmons Way, Suite 650
Kaysville, UT 84037
(801) 320-9955

Utah Insurance Department
4315 S. 2700 W., Suite 2300
Taylorsville, UT 84129
(801) 957-9200

**VERMONT NOTICE:**

**THIS POLICY DOES NOT MEET THE MINIMUM COVERAGE REQUIREMENTS OF THE AFFORDABLE CARE ACT. YOU SHOULD NOT PURCHASE THIS POLICY UNLESS YOU ARE ALREADY COVERED BY COMPREHENSIVE MAJOR MEDICAL COVERAGE.**

**WASHINGTON NOTICE(S):**

**Contributions for this coverage may increase as Covered Persons age.**

**THE SEVERE BURN BENEFIT COVERED CONDITION CATEGORY IS NOT AVAILABLE FOR, AND DOES NOT APPLY TO, WASHINGTON RESIDENTS.**

**WISCONSIN NOTICE:**

**KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS**

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

Metropolitan Life Insurance Company
700 Quaker Lane, 2nd Floor
Warwick, Rhode Island 02886

Toll Free Telephone: 1-800-GET-MET8

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

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517
608-266-0103

The Internal Grievance Review provision described below is added to your coverage.

**INTERNAL GRIEVANCE REVIEW**

**Expedited Grievance** means a Grievance where any of the following applies:

- the duration of the standard Grievance resolution process will result in serious jeopardy to the life or health of the Covered Person or the ability of the Covered Pperson to regain maximum function;
- in the opinion of a Physician with knowledge of the Covered Person's medical condition, the Covered Person is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Grievance; or
- a Physician with knowledge of the Covered Person's medical condition determines that the Grievance shall be treated as an Expedited Grievance.

**Grievance** means any dissatisfaction with the claims practices or administration of the insurance provided under this Certificate that is expressed in Writing to Us by You or on Your behalf.

**Grievance Procedure**

If a claim for insurance benefits is denied, We will notify You of Your right to file a Grievance. You can file a Grievance by Writing to MetLife at 700 Quaker Lane, 2nd Floor, Warwick, Rhode Island 02886, when We notify You of Your right to file a Grievance. You must do this within three years

of the date Your claim is denied. Within five business days of Our receipt of Your Grievance, We will mail to You or Your authorized representative an acknowledgement confirming receipt.

**Grievance Panel**

Once a Grievance has been filed, a Grievance Panel will promptly investigate the Grievance. The Grievance Panel will consist of at least one person with authority to take corrective action on the claim, and may include at least one person, other than You, who is insured by Us. Prior to the Grievance Panel making a final determination, You or Your authorized representative have the right to appear in person before the Grievance Panel and to present Written questions. At least seven calendar days prior to the Grievance Panel meeting, We will send You Written notification providing information as to the time and place of the meeting. After a decision has been made, a Written decision signed by one voting member of the Grievance Panel and a description of position titles of panel members involved in making the decision will be mailed to You.

**Grievance Panel Decision Notification**

For Grievances that are subject to ERISA, the decision of the Grievance Panel will be mailed to You within a reasonable period of time, no later than 60 days after the date on which We received the Grievance. However, if We determine that special circumstances require an extension of time for processing the Grievance, Written notice of such extension will be mailed to You within 60 days after the date on which We received the Grievance. The notice will explain the special circumstances requiring the extension, and the date by which We expect the Grievance Panel to reach a decision regarding the Grievance. In no event shall such an extension end later than 120 days from the date on which We received the Grievance.

For Grievances that are not subject to ERISA, the decision of the Grievance Panel will be mailed to You no later than 30 calendar days after the date We receive the Grievance. However, if the Grievance Panel is unable to resolve the Grievance within 30 days of the date We received the Grievance, the time to resolve the Grievance may be extended by Us for an additional 30 calendar days if We provide Written notice to You or, if applicable, Your authorized representative, of all of the following:

- that the Grievance Panel has not resolved the Grievance;
- when resolution of the Grievance may be expected; and
- the reason additional time is needed.

**Expedited Grievance Resolution**

If Your Grievance qualifies as an Expedited Grievance, You can file the Expedited Grievance by calling a number We will give You when We notify You of Your right to file a Grievance. An Expedited Grievance will be reviewed by a medical director who works for Us. The medical director will render a decision with respect to the Expedited Grievance within 72 hours of the date You call Us to file the Expedited Grievance. You must file an Expedited Grievance within three years of the date Your claim is denied.

**This Certificate Rider is to be attached to and made a part of the Certificate.**

Timothy J. Ring
Secretary

Michel Khalaf
President & CEO

**METROPOLITAN LIFE INSURANCE COMPANY**
**NEW YORK, NEW YORK**

# CERTIFICATE RIDER: AUTISM SPECTRUM DISORDER COVERED CONDITION CATEGORY FOR A DEPENDENT CHILD

**Group Policy No.:** **0119920**

**Policyholder:** **ADP TotalSource, Inc.**

**Rider Effective Date:** **The later of June 1, 2025 or the date that applies to the insured's Certificate as shown in the insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife.**

This Rider is added to Your Certificate and provides a benefit for a Dependent Child for the Autism Spectrum Disorder Covered Condition Category. This Rider is subject to the terms and provisions of the Group Policy and Your Certificate.

## SCHEDULE OF INSURANCE

The Autism Spectrum Disorder Covered Condition Category is added and subject to the terms and conditions of the Schedule of Insurance set forth in Your Certificate.

| COVERED CONDITION CATEGORY: AUTISM SPECTRUM DISORDER | | |
|---|---|---|
| **COVERED CONDITION** | **INITIAL BENEFIT** | **RECURRENCE BENEFIT** |
| **Autism Spectrum Disorder** | 25% of the Benefit Amount payable no more than 1 time per Dependent Child | NONE |

## ADDITIONAL DEFINITIONS THAT APPLY TO THE AUTISM SPECTRUM DISORDER COVERED CONDITION CATEGORY

**Autism Spectrum Disorder Covered Condition** means:

- Autism Spectrum Disorder.

**Autism Spectrum Disorder** means a neurodevelopmental disorder marked by both Domain 1 Deficits and Domain 2 Deficits. The Autism Spectrum Disorder must satisfy the clinical diagnostic criteria for each of the above domains as set forth in the DSM-V.

**AUTISM SPECTRUM DISORDER COVERED CONDITION CATEGORY (Continued)**

**Domain 1 Deficits** means persistent deficits with respect to social communication and social interaction.

**Domain 2 Deficits** means persistent deficits marked by restricted, repetitive patterns of behavior, interests, or activities.

**DSM-V** means the Diagnostic and Statistical Manual of Mental Disorders and which sets forth the clinical criteria to establish a Diagnosis of an Autism Spectrum Disorder Covered Condition.

**Occurs or Occurrence**, with respect to an Autism Spectrum Disorder Covered Condition, means that a Dependent Child is Diagnosed by a Physician with such Covered Condition while coverage is in effect under this Certificate for such Dependent Child. An Autism Spectrum Disorder Covered Condition will be deemed to Occur on the date the Diagnosis of an Autism Spectrum Disorder Covered Condition is made.

**INITIAL BENEFIT FOR AN AUTISM SPECTRUM DISORDER COVERED CONDITION**

We will pay the Initial Benefit for an Autism Spectrum Disorder Covered Condition shown on the Schedule, the first time that an Autism Spectrum Disorder Covered Condition Occurs for a Dependent Child.

**ADDITIONAL PROOF REQUIREMENTS FOR AN AUTISM SPECTRUM DISORDER COVERED CONDITION**

Proof of an Autism Spectrum Disorder Covered Condition requires the following information:

- a Clinical Diagnosis must be made in Writing by a Physician; and
- medical records which include documentation of standardized developmental, neuropsychological or other related assessments which under general medical standards of care would be used to establish a Diagnosis of an Autism Spectrum Disorder Covered Condition.

We will not pay for any cost incurred for any developmental, neuropsychological or other related assessments to establish a Diagnosis of an Autism Spectrum Disorder Covered Condition.

**WHEN THIS RIDER ENDS**

This Rider will end if insurance under the Certificate ends in accordance with the When Insurance Ends section of the Certificate. However, this Rider will continue if Your insurance is continued under the At Your Option: Portability Through Continuation With Premium Payment provision of the Certificate.

If a new Autism Spectrum Disorder Covered Condition Certificate Rider with a later Rider Effective Date is issued to You, this Rider will end as of the Rider Effective Date set forth on the new rider. An Autism Spectrum Disorder Covered Condition benefit will be determined according to the Autism Spectrum Disorder Covered Condition Certificate Rider that was in effect on the date that an Autism Spectrum Disorder Covered Condition Occurred.

**For information about coverage or assistance in resolving complaints contact Us at 1-800-GET-MET8**

**This Certificate Rider is to be attached to and made a part of Your Certificate.**

Timothy J. Ring
Secretary

Michel Khalaf
President & CEO

**METROPOLITAN LIFE INSURANCE COMPANY**
**NEW YORK, NEW YORK**

# CERTIFICATE OF CRITICAL ILLNESS INSURANCE

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You and Your Dependents are insured for the benefits described in this Certificate, subject to the provisions of this Certificate. References to coverage for Your Dependents throughout this Certificate only apply if insurance is in effect for Your Dependents. Please refer to the Covered Person Specifications page and Eligibility Provisions: Dependent Insurance section for details.

This Certificate is issued to You under the Group Policy and it includes the terms and provisions of the Group Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.** The Group Policy is a contract between MetLife and the Group Policyholder. It may be changed or ended without Your consent or notice to You.

| | |
|---|---|
| Group Policyholder: | ADP TotalSource, Inc. |
| Group Policy Number: | 0119920 |
| MetLife Toll Free Number: | 1-877-237-8701 |

**Important Notice: Subject to the provisions of this Certificate, including limitations, exclusions and Proof requirements, this Certificate provides limited benefits in the event You are Diagnosed with certain critical illnesses.**

**30-Day Right to Examine Certificate. Please read this Certificate carefully. If You are not satisfied for any reason, You may notify the Group Policyholder that You are cancelling Your Certificate within 30 days from the date of delivery by calling the Group Policyholder. If You notify the Group Policyholder that You are cancelling within the 30 day period, this Certificate will be void from the beginning. We will refund any premium or Contribution paid within 30 days after We receive Your notice of cancellation.**

**This is a supplement to health insurance and is not a substitute for Medical Coverage. Lack of Medical Coverage (or other minimum essential coverage) may result in an additional payment with Your taxes. You should have Medical Coverage when You enroll for this insurance.**

**THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CONTRACT. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from MetLife.**

**Maryland Residents: The Group Policy providing coverage under this Certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.**

WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.

## IMPORTANT NOTICE

For information about coverage or assistance in resolving complaints

contact Us at 1-877-237-8701

# NOTICE FOR RESIDENTS OF MAINE

You have the right to designate a third party to receive notice if Your insurance is in danger of lapsing due to a default on Your part, such as non-payment of a Contribution that is due. You may make this designation by completing a "Third Party Notice Request Form" and sending it to MetLife. Once You have made a designation, You may cancel or change it by filling out a new Third Party Notice Request Form and sending it to MetLife. The designation will be effective as of the date MetLife receives the form. Call MetLife at the toll-free telephone number shown on the face page of this Certificate to obtain a Third Party Notice Request Form.

Within 90 days after cancellation of coverage for nonpayment of premium, You, any person authorized to act on Your behalf, or any covered Dependent may request reinstatement of the Certificate on the basis that You suffered from cognitive impairment or functional incapacity at the time of cancellation.

## TABLE OF CONTENTS

**Section** **Page**

# COVERED PERSON SPECIFICATIONS

| | |
|---|---|
| Certificate Effective Date: | The later of June 1, 2025 or the date that applies to the insured's Certificate as shown in the insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife |
| Group Policyholder: | ADP TotalSource, Inc. |
| Group Policy Number: | 0119920 |
| MetLife Contact Information: | 1-877-237-8701 |
| Your Name: | See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife |
| Your Certificate Number: | See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife |
| Coverage for Your Dependents | See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife |

**Notification Requirement**
The following notification requirement(s) apply to Dependent coverage:

- If You elect coverage for Your Dependent Children, You must provide notification to Your employer, when all of Your Dependent Children: exceed the Dependent Child Age Limit; or, no longer otherwise meet the definition of a Dependent Child.
- If You elect coverage for Your Spouse, You must provide notification to Your employer, if Your Spouse no longer meets the definition of a Spouse.

You should instead provide the notification to Us if Your coverage is being continued under the At Your Option: Portability Through Continuation of Insurance With Premium Payment provision by calling the toll free number shown on this Certificate.

Please refer to the Schedule of Insurance for information regarding Your Benefit Amounts.

This Covered Person Specifications page is part of Your Certificate. Please keep it with Your Certificate.

# SCHEDULE OF INSURANCE

**IMPORTANT NOTE: Payment of the benefits listed in this Schedule of Insurance is subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate. PLEASE READ THE ENTIRE CERTIFICATE CAREFULLY.**

The benefits listed only apply to Dependents if insurance is in effect for Your Dependents under this Certificate. Please refer to the Covered Person Specifications page and the Eligibility Provisions: Dependent Insurance section of this Certificate for details.

**BENEFIT AMOUNT**

| | **For You** | **For Your Spouse** | **For Your Dependent Children** |
|---|---|---|---|
| **Benefit Amount** | See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife | See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife | See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife |

**BENEFIT SEPARATION PERIOD**

For a Recurrence Benefit for a Covered Person 90 days

Please refer to the Benefit Separation Period provision in the Limitations section for additional information.

## SCHEDULE OF INSURANCE (Continued)

| COVERED CONDITION CATEGORY: BENIGN TUMOR | | |
|---|---|---|
| **COVERED CONDITION** | **INITIAL BENEFIT** | **RECURRENCE BENEFIT** |
| **Benign Brain Tumor** | 100% of the Benefit Amount payable no more than 1 time per Covered Person | 100% of the Initial Benefit Amount |

| COVERED CONDITION CATEGORY: CANCER | | |
|---|---|---|
| **COVERED CONDITION** | **INITIAL BENEFIT** | **RECURRENCE BENEFIT** |
| **Invasive Cancer** | 100% of the Benefit Amount payable no more than 1 time per Covered Person per Occurrence of each Separate and Unrelated Invasive Cancer | 100% of the Initial Benefit Amount |
| **Non-Invasive Cancer** | 25% of the Benefit Amount payable no more than 1 time per Covered Person per Occurrence of each Separate and Unrelated Non-Invasive Cancer | 100% of the Initial Benefit Amount |
| **Skin Cancer** | 5% of the Benefit Amount, but not less than $250; payable no more than 1 time per Covered Person | 100% of the Initial Benefit Amount, but not less than $250 |

## SCHEDULE OF INSURANCE (Continued)

| COVERED CONDITION CATEGORY: CARDIOVASCULAR DISEASE | | |
|---|---|---|
| **COVERED CONDITION** | **INITIAL BENEFIT** | **RECURRENCE BENEFIT** |
| **Cardiovascular Disease treated with: Coronary Artery Bypass Graft** | 100% of the Benefit Amount payable no more than 1 time per Covered Person | 100% of the Initial Benefit Amount |

## SCHEDULE OF INSURANCE (Continued)

| COVERED CONDITION CATEGORY: CHILDHOOD DISEASE | | |
|---|---|---|
| **COVERED CONDITION** | **INITIAL BENEFIT** | **RECURRENCE BENEFIT** |
| **cerebral palsy** | 100% of the Benefit Amount payable no more than 1 time per Covered Person | None |
| **cleft lip or cleft palate** | 100% of the Benefit Amount payable no more than 1 time per Covered Person | None |
| **cystic fibrosis** | 100% of the Benefit Amount payable no more than 1 time per Covered Person | None |
| **diabetes (type 1)** | 100% of the Benefit Amount payable no more than 1 time per Covered Person | None |
| **Down syndrome** | 100% of the Benefit Amount payable no more than 1 time per Covered Person | None |
| **sickle cell anemia** | 100% of the Benefit Amount payable no more than 1 time per Covered Person | None |
| **spina bifida** | 100% of the Benefit Amount payable no more than 1 time per Covered Person | None |

## SCHEDULE OF INSURANCE (Continued)

| COVERED CONDITION CATEGORY: FUNCTIONAL LOSS | | |
|---|---|---|
| **COVERED CONDITION** | **INITIAL BENEFIT** | **RECURRENCE BENEFIT** |
| **Coma** | 100% of the Benefit Amount payable no more than 1 time per Covered Person | 100% of the Initial Benefit Amount |
| **Loss of: Ability to Speak; Hearing; or Sight** | 100% of the Benefit Amount payable no more than 1 time per Covered Person | None |
| **Paralysis of 2 or more limbs** | 100% of the Benefit Amount payable no more than 1 time per Covered Person | None |

| COVERED CONDITION CATEGORY: HEART ATTACK | | |
|---|---|---|
| **COVERED CONDITION** | **INITIAL BENEFIT** | **RECURRENCE BENEFIT** |
| **Heart Attack** | 100% of the Benefit Amount payable no more than 1 time per Covered Person | 100% of the Initial Benefit Amount |
| **Sudden Cardiac Arrest** | 100% of the Benefit Amount payable no more than 1 time per Covered Person | None |

| COVERED CONDITION CATEGORY: INFECTIOUS DISEASE | | |
|---|---|---|
| **COVERED CONDITION** | **INITIAL BENEFIT** | **RECURRENCE BENEFIT** |
| **bacterial cerebrospinal meningitis** | 25% of the Benefit Amount payable no more than 1 time per Covered Person | None |
| **diphtheria** | 25% of the Benefit Amount payable no more than 1 time per Covered Person | None |
| **encephalitis** | 25% of the Benefit Amount payable no more than 1 time per Covered Person | None |
| **Legionnaire's disease** | 25% of the Benefit Amount payable no more than 1 time per Covered Person | None |
| **malaria** | 25% of the Benefit Amount payable no more than 1 time per Covered Person | None |

## SCHEDULE OF INSURANCE (Continued)

| | | |
|---|---|---|
| **necrotizing fasciitis** | 25% of the Benefit Amount payable no more than 1 time per Covered Person | None |
| **osteomyelitis** | 25% of the Benefit Amount payable no more than 1 time per Covered Person | None |
| **rabies** | 25% of the Benefit Amount payable no more than 1 time per Covered Person | None |
| **tetanus** | 25% of the Benefit Amount payable no more than 1 time per Covered Person | None |
| **tuberculosis** | 25% of the Benefit Amount payable no more than 1 time per Covered Person | None |
| **COVID-19** | 25% of the Benefit Amount payable no more than 1 time per Covered Person | None |

| **COVERED CONDITION CATEGORY: KIDNEY FAILURE** | | |
|---|---|---|
| **COVERED CONDITION** | **INITIAL BENEFIT** | **RECURRENCE BENEFIT** |
| **Kidney Failure** | 100% of the Benefit Amount payable no more than 1 time per Covered Person | None |

| **COVERED CONDITION CATEGORY: MAJOR ORGAN TRANSPLANT** | | |
|---|---|---|
| **COVERED CONDITION** | **INITIAL BENEFIT** | **RECURRENCE BENEFIT** |
| **Major Organ Transplant** | 100% of the Benefit Amount payable no more than 1 time per Covered Person | None |

## SCHEDULE OF INSURANCE (Continued)

| COVERED CONDITION CATEGORY: OCCUPATIONAL POST-TRAUMATIC STRESS DISORDER | | |
|---|---|---|
| **COVERED CONDITION** | **INITIAL BENEFIT** | **RECURRENCE BENEFIT** |
| **Occupational Post-Traumatic Stress Disorder** | 25% of the Benefit Amount payable no more than 1 time per Covered Person | None |

| COVERED CONDITION CATEGORY: PROGRESSIVE DISEASE | | |
|---|---|---|
| **COVERED CONDITION** | **INITIAL BENEFIT** | **RECURRENCE BENEFIT** |
| **adrenal hypofunction (Addison's disease)** | 25% of the Benefit Amount payable no more than 1 time per Covered Person | None |
| **ALS** | 100% of the Benefit Amount payable no more than 1 time per Covered Person | None |
| **Alzheimer's Disease** | 100% of the Benefit Amount payable no more than 1 time per Covered Person | None |
| **Huntington's disease** | 25% of the Benefit Amount payable no more than 1 time per Covered Person | None |
| **Multiple Sclerosis** | 100% of the Benefit Amount payable no more than 1 time per Covered Person | None |
| **muscular dystrophy** | 100% of the Benefit Amount payable no more than 1 time per Covered Person | None |
| **Parkinson's Disease (Advanced)** | 100% of the Benefit Amount payable no more than 1 time per Covered Person | None |
| **poliomyelitis** | 25% of the Benefit Amount payable no more than 1 time per Covered Person | None |

| | | |
|---|---|---|
| **systemic lupus erythematosus (SLE)** | 100% of the Benefit Amount payable no more than 1 time per Covered Person | None |
| **systemic sclerosis (scleroderma)** | 25% of the Benefit Amount payable no more than 1 time per Covered Person | None |

| COVERED CONDITION CATEGORY: SEVERE BURN | | |
|---|---|---|
| **COVERED CONDITION** | **INITIAL BENEFIT** | **RECURRENCE BENEFIT** |
| **Severe Burn** | 100% of the Benefit Amount payable no more than 1 time per Covered Person | 100% of the Initial Benefit Amount |

| COVERED CONDITION CATEGORY: STROKE | | |
|---|---|---|
| **COVERED CONDITION** | **INITIAL BENEFIT** | **RECURRENCE BENEFIT** |
| **Stroke** | 100% of the Benefit Amount payable no more than 1 time per Covered Person | 100% of the Initial Benefit Amount |

## SCHEDULE OF INSURANCE (Continued)

| SUPPLEMENTAL BENEFITS | | |
|---|---|---|
| **BENEFIT** | **BENEFIT AMOUNT** | **BENEFIT MAXIMUM** |
| **Health Screening Benefit** | For You: $100 per day<br>For Your Spouse: $100 per day<br>For Your Dependent Child: $100 per day | We will pay the Health Screening Benefit:<br>1 time per Covered Person, per Calendar Year |
| **Mammogram Benefit** | For You: $200 per day<br>For Your Spouse: $200 per day<br>For Your Dependent Child: Not Applicable | We will pay the Mammogram Benefit no more than 1 time per Covered Person, per Calendar Year |
| **Lodging Benefit** | $100 per day | We will pay the Lodging Benefit for a Covered Person no more than 20 days per Calendar Year |
| **Transportation Benefit** | $0.50 per mile | We will pay the Transportation Benefit for a Covered Person up to $1,500 round trip; and $5,000 per Calendar Year |
| **Companion – Lodging and Transportation Benefit** | For Lodging: $100 per day<br><br>For Transportation: $0.50 per mile | We will pay the Lodging Benefit for an adult companion for a Covered Person no more than 20 days per Calendar Year<br><br>We will pay the Transportation Benefit for an adult companion for a Covered Person up to $1,500 round trip; and $5,000 per Calendar Year |
| **Second Opinion Benefit** | $500 per evaluation or consultation<br><br>An additional $250 if the Evaluation Center is located more than 50 miles from the Covered Person's Primary Residence | We will pay the Second Opinion Benefit for 5 second opinion(s) per Covered Person per lifetime |

## LIMITATIONS

### BENEFIT SEPARATION PERIOD

**Benefit Separation Period**
The Benefit Separation Period is the number of days that must elapse between Occurrences of Covered Conditions for a Covered Person as described below in order for a benefit to be payable.

**Recurrence Benefit Separation Period**
The Benefit Separation Period that applies to a Recurrence Benefit for a Covered Person for a subsequent Occurrence of the same Covered Condition is subject to all of the following:

- a benefit must have been payable for the prior Occurrence of the Covered Condition; and
- the Recurrence Benefit Separation Period must be satisfied in order for a Recurrence Benefit to be payable.

The Recurrence Benefit Separation Period is set forth on the Schedule. The Recurrence Benefit Separation Period is measured from the date of the most recent Occurrence of the same Covered Condition for which a benefit was payable.

Example:
The following example is provided for illustration purposes to explain how the Recurrence Separation Period will be applied and a Recurrence Benefit is calculated as described above. This example does not necessarily reflect the benefits of Your specific coverage.

| | |
|---|---|
| Recurrence Benefit Separation Period | 180 days |
| Covered Condition A Occurs on January 1st | Initial Benefit paid for Covered Condition A |
| Covered Condition A Occurs again on March 1st | The Recurrence Benefit Separation Period is measured from January 1, the date Condition A Occurred.<br><br>Result: The Recurrence Benefit for Covered Condition A is not paid because the 180 day Recurrence Benefit Separation Period had not been satisfied when Condition A Occurred again. |

# GENERAL EXCLUSIONS

The exclusions that appear below apply to all Covered Conditions and benefits set forth in this Certificate. Please note that certain Covered Conditions have additional exclusions that are set forth in the benefit provisions of this Certificate.

We will not pay benefits for any Covered Condition for a Covered Person caused by, or that takes place during:

- the Covered Person's active participation in an insurrection, rebellion, riot or terrorist act;
- the Covered Person's engagement in any illegal occupation or activity that constitutes a felony under the laws of the jurisdiction in which the activity took place;
- the Covered Person's intentionally self-inflicted injury;
- the Covered Person's suicide or attempted suicide (while sane or insane);
- war, whether declared or undeclared; or act of war;
- the Covered Person's operation, while intoxicated, of a motor vehicle involved in the incident. Motor vehicle means any vehicle that is powered by a motor, including, but not limited to: an automobile; a boat; a motorcycle; a truck; an all terrain vehicle; or a snow mobile. For purposes of this exclusion intoxicated means that the Covered Person's:
  - blood alcohol level met or exceeded .08%; or
  - blood delta-9-tetrahydrocannabinol (THC) level met or exceeded the limit established by the laws of the jurisdiction for drug-impaired driving where the incident took place;
- the Covered Person voluntarily taking or using any drug, medication or sedative unless it is:
  - taken or used as prescribed by a Physician; or
  - an "over the counter" drug, medication or sedative taken according to package directions; or
- activities required by the Covered Person to carry out the duties and responsibilities of their service in the armed forces or any auxiliary unit of the armed forces of any country or international authority.

In addition, We will not pay benefits for:

- any Covered Condition for which Diagnosis is made outside the United States, Canada or Mexico unless the Diagnosis is confirmed in the United States, in which case the Covered Condition will be deemed to Occur on the date the Diagnosis is made outside the United States, Canada or Mexico.

# DEFINITIONS

As used in this Certificate, the terms listed below will have the meanings set forth below. Other terms may be defined where they are used. When defined terms are used in this Certificate, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

**Actively at Work or Active Work** means that You are performing all of the usual and customary duties of Your job. This must be done at:

- the Group Policyholder's place of business;
- an alternate place approved by the Group Policyholder; or
- a place to which the Group Policyholder's business requires You to travel.

You will be deemed to be Actively at Work during weekends or Group Policyholder approved vacations, holidays or temporary business closures if You were Actively at Work on the last scheduled work day preceding such time off.

**Benefit Amount** means the amount We use to determine the benefit payable for a Covered Condition.

**Calendar Year** means a period of 12 consecutive months, starting on January 1 and ending on December 31 of the same year.

**Certificate** means this Certificate including any riders attached to it.

**Clinical Diagnosis** means a Diagnosis based on the study of symptoms and diagnostic test results.

**Contribution** means the amount You must pay towards the total premium charged by Us for insurance under this Certificate.

**Covered Condition** means those conditions or treatments listed in the Schedule for which a benefit is payable as described in this Certificate. A Covered Condition does not include Supplemental Benefits.

**Covered Person** means You and, if insured under the Group Policy for the insurance described in this Certificate, Your Dependents.

**Dependent** means Your Spouse and/or Dependent Child.

**Dependent Child** means the following:
- Your biological child, while such child is younger than the Dependent Child Age Limit;
- Your adopted child, while such child is younger than the Dependent Child Age Limit;
- Your stepchild, including a child of Your Domestic Partner, while such child is younger than the Dependent Child Age Limit;
- Your foster child, including such child of Your Domestic Partner, while such child is younger than the Dependent Child Age Limit.

The term Dependent Child does not mean an unborn or stillborn child.

## DEFINITIONS (Continued)

**Dependent Child Age Limit** means:
- the end of the calendar month in which the Dependent Child reaches age 26.

**Dependent Insurance** means insurance under this Certificate for Your Dependents.

**Diagnosis or Diagnosed** means the establishment of a Covered Condition by a Physician through the use of clinical and/or laboratory findings, and using generally accepted medical standards.

**Domestic Partner** means each of two people, one of whom is You, who:
1. have registered as each other's domestic partner or civil union partner with a government agency where such registration is available; or
2. are of the same or opposite sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:
   - 18 years of age or older;
   - unmarried;
   - the sole Domestic Partner of the other;
   - sharing a Primary Residence with the other; and
   - not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

   A Domestic Partner declaration attesting to the existence of an insurable interest in one another's lives must be completed and Signed by You.

**Group Policy** means the policy of insurance issued by Us to the Group Policyholder under which this Certificate is issued.

**Group Policyholder** means ADP TotalSource, Inc..

## DEFINITIONS (Continued)

**Hospital** means a short-term, acute care, general facility which:

- is primarily engaged in providing, by or under the continuous supervision of Physicians, to inpatients, diagnostic services and therapeutic services for Diagnosis, treatment and care of injured or sick persons;
- has organized departments of medicine;
- has facilities for major Surgery either on its premises or through a contractual arrangement with another Hospital;
- has a requirement that every patient must be under the care of a Physician or dentist;
- provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- is duly licensed by the agency responsible for licensing such Hospitals; and
- is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, or educational care.

**Initial Benefit** means the benefit, as specified in the Schedule, that is payable for a Covered Condition the first time that such condition Occurs for a Covered Person while coverage is in effect under this Certificate and subject to the terms and conditions of this Certificate.

**Lodging** means the following:

- an establishment licensed under the laws where it is located, such as a motel or hotel; or
- another facility that provides sleeping accommodations to the general public in exchange for a fee.

**Medical Coverage** means coverage under Medicare or an insurance policy, health maintenance organization contract, or employer's plan of self-insurance providing benefits for hospital, surgical and medical expenses or treatment. Medical Coverage does not include Medicaid.

**Medical Restriction** means a person is:

- restricted to the person's home under a Physician's care;
- receiving or applying to receive disability benefits from any source;
- an inpatient in a Hospital;
- receiving care in a hospice facility, an intermediate care facility or a long-term care facility; or
- receiving chemotherapy, radiation therapy or dialysis.

**Occurs** or **Occurrence** means, for a Covered Person, an Occurrence of a particular Covered Condition as defined in the benefit provision for that Covered Condition while coverage is in effect under this Certificate for such Covered Person.

**Physician** means:

- a person:
  - who has received a degree of doctor of medicine (M.D.), or doctor of osteopathy (D.O.); or
  - any other person whose services, according to applicable law, must be treated as Physician's services; and
- such person is acting within the scope of a valid license issued in the United States, Canada or Mexico to make a Diagnosis of a Covered Condition or to perform the services required for a Covered Condition for which a claim is made.

The term Physician does not include:

- You;
- Your Spouse or anyone to whom You are related by blood or marriage;
- anyone who is a member of Your household;
- Your adopted or stepchild;
- anyone with whom You share a business interest; or
- Your employee.

## DEFINITIONS (Continued)

**Primary Residence** means the dwelling where a person lives for the majority of the time, whether the person owns or rents the dwelling.

**Proof** means Written evidence satisfactory to Us that a claimant has satisfied the conditions and requirements for any benefit described in this Certificate. When a claim is made for any benefit described in this Certificate, Proof must establish:

- the nature and extent of the loss or condition;
- Our obligation to pay the claim; and
- the claimant's right to receive payment.

Except as provided in the Examinations and Autopsy provisions of this Certificate, Proof must be provided at the claimant's expense.

**Recur or Recurrence** means another Occurrence of the same Covered Condition for which We have already paid a benefit.

**Recurrence Benefit** means a benefit, as specified in the Schedule, that is payable for another Occurrence of the same Covered Condition for the same Covered Person for whom We have already paid a benefit while coverage is in effect under this Certificate and subject to the terms and conditions of this Certificate. The Schedule shows the Covered Conditions for which a Recurrence Benefit is payable.

**Schedule** means the Schedule of Insurance that appears in this Certificate, and the Covered Person Specifications page.

**Signed** means any symbol or method executed or adopted by a person with the present intention to authenticate a record. The signature may be transmitted by paper or electronic media, provided it is consistent with applicable law.

**Spouse** means Your lawful spouse or Your Domestic Partner.

**Supplemental Benefit(s)** are the following:

- Health Screening Benefit;
- Mammogram Benefit;
- Lodging Benefit;
- Transportation Benefit;
- Companion - Lodging and Transportation Benefit; and
- Second Opinion Benefit.

**Surgery** means a procedure performed by a Physician involving the cutting of the Covered Person's skin or tissue that in and of itself is intended to be curative or palliative. Surgery does not include endoscopic or non-invasive procedures.

**Transplant List** means the list maintained by the Organ Procurement and Transportation Network (OPTN).

**Treatment Center** means any of the following medical facilities where a Covered Person may receive treatment, which is located outside of a 50 mile radius of the Covered Person's Primary Residence:

- Hospital;
- radiation therapy center;
- chemotherapy center;
- oncology clinic; or
- specialized free-standing treatment center.

**Treatment Free** means that a Covered Person is symptom free and not receiving medical treatment or care from a Physician for the Covered Condition for which We paid an Initial Benefit or Recurrence Benefit. For purposes of this term, medical treatment does not include:

- the Covered Person receiving maintenance drug therapy while in remission; or
- routine medical assessments to verify that a Covered Condition is no longer present or remains in remission.

**United States** means the United States of America, its territories and its possessions.

**We, Us** and **Our** mean Metropolitan Life Insurance Company.

**Write, Written** or **Writing** means a record that may be transmitted by paper or electronic media, and that is consistent with applicable law.

**You** and **Your** means an employee who is insured under the Group Policy for the insurance described in this Certificate.

# ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

## ELIGIBLE CLASS

### CLASS 1

All Actively at Work worksite employees of the worksite employer are eligible, including temporary and seasonal employees. No hourly requirements

## DATE YOU ARE ELIGIBLE FOR INSURANCE

You may only become eligible for the Critical Illness Insurance available for Your eligible class.

If You are in an eligible class on the date insurance becomes available for the class, You will be eligible for insurance on the date You complete any applicable eligibility waiting period set by the Group Policyholder.

If You enter an eligible class after the date insurance becomes available to members of that class, You will be eligible for insurance on the date You complete any applicable eligibility waiting period set by the Group Policyholder.

## ENROLLMENT PROCESS

If You are eligible for insurance, You may enroll for such insurance by completing the required form. You must also provide Written permission to deduct Contributions from Your pay for such insurance, if You are required to make such Contributions.

## DATE YOUR INSURANCE TAKES EFFECT

Provided that You are Actively at Work in an eligible class, insurance under this Certificate will take effect for You on the Certificate effective date. If You are not Actively at Work in an eligible class on the date insurance would otherwise take effect, insurance will take effect on the date You return to Active Work in an eligible class.

## BENEFIT CHANGES

Once Your insurance takes effect, You may only change Your benefits in accordance with the options available through the Group Policyholder. Please contact Us or the Group Policyholder for more information.

If You are not Actively at Work in an eligible class on the date an increase in benefits would otherwise take effect, the increase will not take effect until You return to Active Work in a class that is eligible for the increase.

# ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE

## ELIGIBLE CLASS FOR DEPENDENT INSURANCE

All Class 1 employees of the Group Policyholder as specified in the Eligibility Provisions: Insurance For You section of this Certificate are eligible for Dependent Insurance.

## DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE

If You are in a class of employees who are eligible for Dependent Insurance on the date Your insurance takes effect, You will be eligible for Dependent Insurance on the later of the following:

- the date Your insurance takes effect; and
- the date an individual becomes Your first Dependent.

If You enter a class of employees who are eligible for Dependent Insurance after the date Your insurance takes effect, You will be eligible for Dependent Insurance on the later of the following:

- the date You enter a class eligible for Dependent Insurance; and
- the date an individual becomes Your first Dependent.

## ENROLLMENT PROCESS

If You become eligible for Dependent Insurance, You may enroll for such insurance by providing Us with any information We require for each Dependent to be insured. You must also provide Written permission to deduct Contributions from Your pay for Dependent Insurance, if You are required to make such Contributions.

## DATE DEPENDENT INSURANCE TAKES EFFECT

### Newborn Children

A Dependent Child born to You while insurance is in effect under the Certificate will be covered:

- from the moment of birth and does not need to be enrolled if Dependent Insurance is already in effect for at least one other Dependent Child; or
- for 31 days from the moment of birth if Dependent Insurance is not already in effect for at least one other Dependent Child. To continue coverage beyond the first 31 days, You must notify Us of the child's birth and give Written permission to deduct Contributions from Your pay for Dependent Insurance for the newborn child if You are required to make such Contributions.

The effective date of insurance for a newborn child will be determined without regard to whether the child is under a Medical Restriction.

**Adopted Children**

A Dependent Child adopted by You or Placed for Adoption with You while insurance is in effect under the Certificate will be covered:

- from the moment of birth if a Written agreement to adopt the child has been executed by You prior to the child's birth; or
- from the date of adoption or Placement for Adoption if a Written agreement to adopt the child was not executed by You prior to the child's birth.

Coverage will continue unless the child's placement is disrupted prior to legal adoption.

The child does not need to be enrolled if Dependent Coverage is already in effect for at least one other Dependent Child. If Dependent Coverage is not already in effect for at least one other Dependent Child, then to continue the child's coverage beyond the first 31 days of coverage, You must notify Us of the child's adoption or Placement for Adoption and give Written permission to deduct Contributions from Your pay for Dependent Insurance for the adopted child if You are required to make such Contributions. You must do this within 60 days of the date the child is adopted by You or Placed for Adoption with You.

The effective date of insurance for a newly adopted child will be determined without regard to whether the child is under a Medical Restriction.

**Placed for Adoption** or **Placement for Adoption** means the assumption and retention by You of a legal obligation for total or partial support of a child in anticipation of Your adoption of the child.

**Other Dependents**

Dependent Insurance for a Dependent who is not under a Medical Restriction will take effect on the later of:

- the date You are enrolled for Dependent Insurance for such Dependent; or
- the date a person becomes Your Dependent.

If a Dependent is under a Medical Restriction on the date insurance for such Dependent would otherwise take effect, insurance for the Dependent will take effect on the date the Dependent is no longer under a Medical Restriction.

**BENEFIT CHANGES**

Benefit changes with respect to a Dependent are subject to the Benefit Changes provision in the Eligibility Provisions: Insurance for You section of this Certificate.

If a Dependent for whom insurance is in effect under this Certificate is under a Medical Restriction on the date that an increase in benefits would otherwise take effect, the increase will not take effect for the Dependent until such Dependent is no longer under a Medical Restriction.

## SPECIAL RULES FOR COVERED PERSONS PREVIOUSLY INSURED UNDER ANOTHER INSURANCE POLICY ISSUED TO THE GROUP POLICYHOLDER

The Group Policy is replacing another policy of group insurance that provided similar benefits, that was issued to the Group Policyholder. This section explains how the replacement of that other group insurance policy will affect people who were covered under that policy.

In this section, the terms listed below will have the meanings listed below.

**New Policy** means the Group Policy under which this Certificate is issued.

**Old Policy** means the policy of group insurance that was replaced by the New Policy.

**Replacement Date** means the effective date of the New Policy.

**Transferring Dependents** means each of Your Dependents who:
- was insured under the Old Policy on the date it ended; and
- meets the requirements to be eligible for insurance under the New Policy, or is a Disabled Child.

If You were insured under the Old Policy on the date it ended and, You meet the requirements to be eligible for insurance under the New Policy (without regard to any requirement that You be Actively at Work), You, and each of Your Transferring Dependents will be insured under the New Policy on the Replacement Date subject to and in accordance with the provisions of this section.

You and each of Your Transferring Dependents will be automatically enrolled and insured under the New Policy on the Replacement Date.

**Disabled Child** means a child who:
- has attained the Dependent Age Limit but otherwise meets the definition of Dependent Child;
- is incapable of self-sustaining employment by reason of developmental disability, mental impairment or disorder, or physical disability; and
- is chiefly dependent on You for support and maintenance.

**Crediting of Time**

You and each Transferring Dependent will be credited for the time each such person had been continuously insured under the Old Policy on the date it ended in determining whether a Covered Condition is eligible for a Recurrence Benefit under this Certificate.

## COVERED CONDITION CATEGORY: BENIGN TUMOR

### ADDITIONAL DEFINITIONS THAT APPLY TO BENEFITS FOR THE BENIGN TUMOR COVERED CONDITION CATEGORY

**Benign Tumor Covered Condition** means the following:
- Benign Brain Tumor.

A Benign Tumor Covered Condition does not include any such tumor resulting from:
- neurofibromatosis I or II;
- Von Hippel Lindau disease;
- tuberous sclerosis; or
- Cowden disease.

**Benign Brain Tumor** means the presence of a non-cancerous tumor located in the brain, or a non-cancerous Meningioma.

Benign Brain Tumor does not include:
- acoustic neuromas;
- tumors of the skull;
- tumors of the spinal cord; or
- pituitary adenomas.

**Meningioma** means a tumor located on the membranes that cover the brain.

**Occurs or Occurrence**, with respect to a Benign Tumor Covered Condition, means a Covered Person is Diagnosed with such Covered Condition while the coverage is in effect under this Certificate for such Covered Person. A Benign Tumor Covered Condition will be deemed to Occur on the date that the Diagnosis of a Benign Tumor Covered Condition is made.

**Permanent Neurological Deficit** means the presence of one, or more, of the following deficits:
- impaired cognition;
- impaired or loss of vision;
- impaired or loss of hearing;
- impaired or loss of the ability to speak and communicate;
- balance disruption; or
- impaired or loss of ability to ambulate independently.

### INITIAL BENEFIT FOR A BENIGN TUMOR COVERED CONDITION

We will pay the applicable Initial Benefit for a Benign Tumor Covered Condition shown on the Schedule, the first time that the Benign Tumor Covered Condition Occurs for a Covered Person.

## COVERED CONDITION CATEGORY: BENIGN TUMOR (Continued)

### RECURRENCE BENEFIT FOR A BENIGN TUMOR COVERED CONDITION

For any Benign Tumor Covered Condition for which the Schedule shows a Recurrence Benefit, We will pay the applicable Recurrence Benefit for another Occurrence of the same Benign Tumor Covered Condition if:

- the subsequent Occurrence of the Benign Tumor happens after the Recurrence Benefit Separation Period has been satisfied; and
- the Covered Person has been Treatment Free for a continuous period of 90 days immediately prior to the subsequent Occurrence of the Benign Tumor Covered Condition.

### ADDITIONAL PROOF REQUIREMENTS FOR A BENIGN TUMOR COVERED CONDITION

Proof of a Benign Tumor Covered Condition requires the following additional documentation:

- a pathological or Clinical Diagnosis as described below; and
- submission of medical records evidencing that the Benign Tumor Covered Condition:
  - requires treatment by a Physician that is a Surgery or radiation therapy; or
  - resulted in a Permanent Neurological Deficit that is attributable to the Benign Tumor Covered Condition;

A pathological Diagnosis of a Benign Tumor Covered Condition must include the following:

- microscopic (histologic) examination of fixed tissues, including those taken by a biopsy; and
- magnetic resonance imaging (MRI), computerized tomography (CT scan), or other reliable imaging techniques that have been completed as part of the evaluation to Diagnose a Benign Tumor Covered Condition.

We will accept a Clinical Diagnosis of a Benign Tumor Covered Condition only if the following conditions are met:

- under generally accepted medical standards, a pathological Diagnosis cannot be made because it would be medically inappropriate or life-threatening;
- medical diagnostic testing supports the Diagnosis; and
- a Physician is treating the Covered Person for the Benign Tumor Covered Condition.

Such Proof requirements must be documented in a Written report by a Physician.

In the event a Covered Person has been paid a benefit for a Benign Brain Tumor based on a Clinical Diagnosis, but later medical evidence establishes that such Covered Condition is malignant and satisfies the Proof requirements for Invasive or Non-Invasive Cancer, We will pay the applicable benefit for a Cancer Covered Condition reduced by the Benefit Amount that We paid for the Benign Brain Tumor. In the event the Benefit Amount We had already paid for Benign Brain Tumor equals or exceeds the amount that would have been payable for a Cancer Covered Condition, We will not pay an additional benefit.

## COVERED CONDITION CATEGORY: CANCER

### ADDITIONAL DEFINITIONS THAT APPLY TO BENEFITS FOR THE CANCER COVERED CONDITION CATEGORY

**Cancer Covered Condition** means the following:
- Invasive Cancer;
- Non-Invasive Cancer; or
- Skin Cancer.

**Carcinoma in Situ** means a group of abnormal cells that remain in the location where the cells first formed.

**Chemotherapy** means the administration of drugs or biologics that are prescribed by a Physician to either eliminate the cancerous cells, or prevent or slow the growth of the cancerous cells.

**Invasive Cancer** means the presence of one or more malignant tumors with invasion of normal tissue and characterized by the uncontrollable and abnormal growth and spread of malignant cells to lymph nodes and/or a body part different from the site of cancer origin. Invasive Cancer includes the following:
- a malignant melanoma for which a pathology report shows a maximum thickness greater than 0.80 millimeters using the Breslow method of determining tumor thickness;
- a cancer that is a leukemia or lymphoma; or
- where a Covered Person has terminal cancer and has a life expectancy of 24 months or less from the date of Diagnosis and will not benefit from, or has exhausted, curative therapy.

**Occurs or Occurrence**, with respect to a Cancer Covered Condition, means a Covered Person is Diagnosed with such Covered Condition while the coverage is in effect under this Certificate for such Covered Person. A Cancer Covered Condition will be deemed to Occur on the date that the Diagnosis of the Cancer Covered Condition is made.

**Non-Invasive Cancer (including Carcinoma in Situ)** means the presence of a malignant tumor and characterized by the abnormal growth of malignant cells which are confined to the site of origin without spread to lymph nodes and/or a body part different from the site of cancer origin. Non-Invasive Cancer includes the following:
- a malignant melanoma, for which a pathology report shows a maximum thickness less than or equal to 0.80 millimeters using the Breslow method of determining tumor thickness;
- a tumor of the prostate classified as T1bN0M0, or T1cN0M0; or
- a Carcinoma in Situ classified as TisN0M0.

Non-Invasive Cancer does not include Skin Cancer.

**Separate and Unrelated** with respect to a Cancer Covered Condition means a Cancer Covered Condition that is:
- not a Recurrence of any previously Diagnosed Cancer Covered Condition;
- not a metastasis of a previously Diagnosed Cancer Covered Condition; and
- distinct in the cause and etiology from any previously Diagnosed Cancer Covered Condition.

**Skin Cancer means** any malignant growth that arises on the surface of the skin that is any of the following:
- basal cell carcinoma;
- squamous cell carcinoma; or
- malignant melanoma that remains confined to the epidermis.

**TNM Classification of Malignant Tumors** (**"TNM Staging")** means the classification standards for cancer developed by the American Joint Committee on Cancer.

## COVERED CONDITION CATEGORY: CANCER (Continued)

### INITIAL BENEFIT FOR A CANCER COVERED CONDITION

We will pay the applicable Initial Benefit for a Cancer Covered Condition shown on the Schedule for a Covered Person:

- the first time a Cancer Covered Condition Occurs for such Covered Person; or
- for a Cancer Covered Condition that is Separate and Unrelated from any prior Cancer Covered Condition for which We paid a benefit.

**Related Occurrence for a Cancer Covered Condition**

In the event a Covered Person has an initial Occurrence of a Cancer Covered Condition that is not an Invasive Cancer, and the Cancer Covered Condition for which We paid a benefit is subsequently Diagnosed as a Cancer Covered Condition for which We would pay a higher benefit as shown on the Schedule, We will pay the difference between what We paid and the applicable higher Initial Benefit amount.

### RECURRENCE BENEFIT FOR A CANCER COVERED CONDITION

For any Cancer Covered Condition for which the Schedule shows a Recurrence Benefit, We will pay the applicable Recurrence Benefit for another Occurrence of the same Cancer Covered Condition for which We have already paid a benefit if:

- the subsequent Occurrence of the Cancer Covered Condition happens after the Recurrence Benefit Separation Period has been satisfied; and
- the Covered Person has been Treatment Free for a continuous period of 90 days immediately prior to the subsequent Occurrence of the Cancer Covered Condition.

### ADDITIONAL PROOF REQUIREMENTS FOR A CANCER COVERED CONDITION

Proof of an Occurrence of a Cancer Covered Condition requires the following additional documentation:

- A pathological Diagnosis that is based upon microscopic (histologic) examination of fixed tissues, including those taken by a biopsy, or preparations of blood or bone marrow.
- If a pathological Diagnosis cannot be made because it would be medically inappropriate or life-threatening under generally accepted medical standards, We will accept a Clinical Diagnosis based on the following:
  - medical diagnostic testing that supports the Diagnosis; and
  - the Covered Person is being treated for the Cancer Covered Condition by a Physician.

In the event a Covered Person was paid a benefit for an Occurrence of a Benign Brain Tumor based on a Clinical Diagnosis, but later medical evidence establishes that such Covered Condition is malignant and meets the Proof requirements for a Cancer Covered Condition, We will pay the appropriate benefit for a Cancer Covered Condition reduced by the benefit amount that We already paid for the Benign Brain Tumor. Please refer to the Covered Condition Category: Benign Tumor section of this Certificate for details.

Such Proof requirements must be documented in a Written report by a Physician.

## COVERED CONDITION CATEGORY: CANCER (Continued)

### SPECIAL EXCLUSIONS APPLICABLE TO A CANCER COVERED CONDITION

We will not pay benefits for a Diagnosis of a Cancer Covered Condition for:

- myelodysplastic syndrome;
- any benign tumor, dysplasia, intraepithelial neoplasia or pre-malignant growth;
- any papillary tumor of the bladder classified as a maximum severity of Ta under TNM Staging;
- any tumor of the prostate classified as T1aN0M0 under TNM Staging; or
- any papillary, follicular or medullary tumor of the thyroid that is classified as a T1N0M0 or less under TNM Staging and is one centimeter or less in diameter, unless there is metastasis.

## COVERED CONDITION CATEGORY: CARDIOVASCULAR DISEASE

### ADDITIONAL DEFINITIONS THAT APPLY TO THE CARDIOVASCULAR DISEASE COVERED CONDITION CATEGORY

**Cardiovascular Disease Covered Condition** means the following:

- coronary artery disease where:
  - the arteries of the heart are damaged or diseased, valves of the heart are damaged or diseased, or there is impaired cardiac function due to the presence of plaques, or fatty deposit, buildup on the artery walls that has caused narrowing of the coronary arteries resulting in partial or complete blockage of the arteries; and
  - a treatment listed below is required to treat the coronary artery disease:
    - Coronary Artery Bypass Graft.

**Coronary Angioplasty (Percutaneous Coronary Intervention or PCI)** means a cardiac catheterization procedure to treat Cardiovascular Disease by utilizing a catheter with a balloon, laser, laser-assisted device, rotational device, stent placement or other mechanical means to unblock an occluded coronary artery.

**Coronary Artery Bypass Graft** means a heart Surgery procedure to bypass a narrowing or blockage of one or more coronary arteries using venous or arterial grafts. Surgical access to the heart may be done by a procedure that is:

- a Surgery in which a Median Sternotomy is performed; or
- a minimally invasive endoscopic cardiac Surgery procedure is performed.

Coronary Artery Bypass Graft does not include:

- Coronary Angioplasty;
- coronary angiography; or
- any other intra-catheter technique.

**Median Sternotomy** means a surgical incision in which the sternum, also known as the breastbone, is divided down the middle from top to bottom.

**Occurs** or **Occurrence**, with respect to a Cardiovascular Disease Covered Condition, means a Covered Person receives the applicable treatment specified in the definition of the term Cardiovascular Disease Covered Condition, and such treatment was performed by a Physician while the coverage is in effect under this Certificate for such Covered Person. A Cardiovascular Disease Covered Condition will be deemed to Occur on the date such treatment was performed.

### INITIAL BENEFIT FOR A CARDIOVASCULAR DISEASE COVERED CONDITION

We will pay the applicable Initial Benefit for a Cardiovascular Disease Covered Condition treatment shown on the Schedule, the first time that a Cardiovascular Disease Covered Condition Occurs for a Covered Person.

### RECURRENCE BENEFIT FOR A CARDIOVASCULAR DISEASE COVERED CONDITION

For any Cardiovascular Disease Covered Condition for which the Schedule shows a Recurrence Benefit, We will pay the applicable Recurrence Benefit for another Occurrence of the same Cardiovascular Disease Covered Condition for which We have already paid a benefit if the subsequent Occurrence happens after the Recurrence Benefit Separation Period has been satisfied.

### RULE FOR MORE THAN ONE OCCURRENCE OF A CARDIOVASCULAR DISEASE COVERED CONDITION

If the Covered Person has more than one Occurrence of a Cardiovascular Disease Covered Condition at the same time, or on the same day, for which a benefit is payable, We will pay the applicable benefit shown on the Schedule for one Cardiovascular Disease Covered Condition, which will be for the Covered Condition that pays the highest Benefit Amount.

### ADDITIONAL PROOF REQUIREMENTS FOR A CARDIOVASCULAR DISEASE COVERED CONDITION

Proof of a Cardiovascular Disease Covered Condition requires a Clinical Diagnosis and the following additional documentation:

- submission of medical records that include test results for at least one of the following:
  - cardiac perfusion scan;
  - cardiac catheterization;
  - doppler ultrasound;
  - echocardiogram;
  - electrocardiogram (EKG);
  - angiogram; or
  - positron emission tomography (PET scan); and
- that treatment for the Cardiovascular Disease Covered Condition was performed by a Physician.

Such Proof requirements must be documented in a Written report by a Physician.

### SPECIAL EXCLUSIONS APPLICABLE TO A CARDIOVASCULAR DISEASE COVERED CONDITION

We will not pay benefits for a Cardiovascular Disease Covered Condition:

- for a Heart Attack;
- for which the treatment required for payment of a benefit is received outside the United States, Canada or Mexico unless confirmation of the Cardiovascular Disease Covered Condition and treatment received is confirmed in the United States, in which case the Covered Condition will be deemed to Occur on the date the treatment was performed outside the United States, Canada or Mexico; or
- for a cardiac catheterization performed for diagnostic purposes only.

## COVERED CONDITION CATEGORY: CHILDHOOD DISEASE

### ADDITIONAL DEFINITIONS THAT APPLY TO THE CHILDHOOD DISEASE COVERED CONDITION CATEGORY

**Childhood Disease Covered Condition** means any of the following:

- cerebral palsy;
- cleft lip or cleft palate;
- cystic fibrosis;
- diabetes type 1 (diabetes type 2 is not a Covered Condition);
- Down syndrome;
- sickle cell anemia (sickle cell trait is not a Covered Condition); or
- spina bifida (spina bifida occulta is not a Covered Condition).

**Occurs or Occurrence**, with respect to a Childhood Disease Covered Condition, means a Dependent Child is Diagnosed with such Covered Condition while coverage is in effect under this Certificate for such Dependent Child. A Childhood Disease Covered Condition will be deemed to Occur on the date the Diagnosis of a Childhood Disease Covered Condition is made.

### INITIAL BENEFIT FOR A CHILDHOOD DISEASE COVERED CONDITION

We will pay the Initial Benefit shown on the Schedule for a Childhood Disease Covered Condition, the first time that a Childhood Disease Covered Condition Occurs for a Dependent Child who is a Covered Person.

If more than one Childhood Disease Covered Condition Occurs for a Dependent Child at the same time, We will only pay an Initial Benefit for one Covered Condition which will be for the Childhood Disease Covered Condition that pays the highest Benefit Amount.

### ADDITIONAL PROOF REQUIREMENTS FOR A CHILDHOOD DISEASE COVERED CONDITION

A Clinical Diagnosis of a Childhood Disease Covered Condition must be made in Writing by a Physician and substantiated in the medical records.

### SPECIAL EXCLUSIONS APPLICABLE TO A CHILDHOOD DISEASE COVERED CONDITION

We will not pay benefits for:

- a suspected or probable Diagnosis of a Childhood Covered Condition; or
- a Childhood Covered Condition that is Diagnosed for a stillborn child.

## COVERED CONDITION CATEGORY: FUNCTIONAL LOSS

### ADDITIONAL DEFINITIONS THAT APPLY TO THE FUNCTIONAL LOSS COVERED CONDITION CATEGORY

**Coma** means a continuous state of profound unconsciousness lasting for a period of 14 or more consecutive days, as confirmed by a Physician and characterized by the absence of purposeful response to commands, including:

- eye opening;
- verbal response; and
- motor response.

Coma does not include a medically induced Coma.

**Functional Loss Covered Condition** means the following:

- Coma;
- Loss of: Ability to Speak; Hearing; Sight; or
- Paralysis.

**Loss of: Ability to Speak; Hearing or Sight** means the following each of which must last for a continuous period of not less than 90 consecutive days, and is expected to be permanent, as confirmed by a Physician:

- for Loss of Ability to Speak - total loss of audible communication (aphonia), if such loss cannot be corrected to any functional degree by any procedure, air or device;
- for Loss of Hearing - deafness in both ears, such that it cannot be corrected to any functional degree by any procedure, aid or device; or
- for Loss of Sight - loss of sight in both eyes. With correction, visual acuity must be 20/200 or worse in both eyes, or the field of vision must be less than 20 degrees in both eyes. Loss of sight does not include blindness or loss of sight in one eye due to a previous existing blindness in the other eye.

**Occurs** or **Occurrence**, with respect to a Functional Loss Covered Condition means a Covered Person is Diagnosed with such Covered Condition while coverage is in effect under this Certificate for such Covered Person. A Functional Loss Covered Condition will be deemed to Occur on the date that a Diagnosis of a Functional Loss Covered Condition is made.

**Paralysis** means the total and irrevocable loss of extremity movement affecting 2 or more limbs and:

- has lasted for a continuous period of not less than 90 consecutive days, and is expected to be permanent, as confirmed by a Physician; or
- is a result of a transected spinal cord with supporting clinical and radiological evidence and no expectation of a return to function.

### INITIAL BENEFIT FOR A FUNCTIONAL LOSS COVERED CONDITION

We will pay the applicable Initial Benefit shown on the Schedule for a Functional Loss Covered Condition, the first time that a Functional Loss Covered Condition Occurs for a Covered Person.

### RECURRENCE BENEFIT FOR A FUNCTIONAL LOSS COVERED CONDITION

For any Functional Loss Covered Condition for which the Schedule shows a Recurrence Benefit, We will pay the applicable Recurrence Benefit for another Occurrence of the same Functional Loss Covered Condition for which We have already paid a benefit if the subsequent Occurrence happens after the Recurrence Benefit Separation Period has been satisfied.

## COVERED CONDITION CATEGORY: FUNCTIONAL LOSS (Continued)

### ADDITIONAL PROOF REQUIREMENTS FOR A FUNCTIONAL LOSS COVERED CONDITION

A Clinical Diagnosis of a Functional Loss Covered Condition must be made in Writing by a Physician and must be substantiated in the medical records.

### SPECIAL EXCLUSIONS APPLICABLE TO A FUNCTIONAL LOSS COVERED CONDITION

We will not pay benefits for a Functional Loss Covered Condition for any of the following:

- a Functional Loss Covered Condition that is associated with the total and irreversible loss of all brain function (brain death);
- a Functional Loss Covered Condition that is a dismemberment of an extremity; or
- any Functional Loss Covered Condition for which, in general medical opinion or practice, Surgery, an adaptive device or other corrective measure could restore function.

## COVERED CONDITION CATEGORY: HEART ATTACK

### ADDITIONAL DEFINITIONS THAT APPLY TO THE HEART ATTACK COVERED CONDITION CATEGORY

**Heart Attack Covered Condition** means the following:
- Myocardial Infarction; or
- Sudden Cardiac Arrest.

**Myocardial Infarction** means the death of a portion of the heart muscle as a result of obstruction of one or more coronary arteries due to atherosclerosis, spasm, thrombus or emboli.

Myocardial Infarction does not include Sudden Cardiac Arrest.

**Sudden Cardiac Arrest** means the sudden, unexpected loss of heart function, breathing and consciousness resulting when the heart suddenly, and unexpectedly, stops beating because of an internal electrical disturbance of the heart, which results in a Covered Person being pronounced deceased by a Physician.

**Occurs** or **Occurrence**, with respect to a Heart Attack Covered Condition, means a Covered Person is Diagnosed with such Covered Condition while coverage is in effect under this Certificate for such Covered Person. A Heart Attack Covered Condition will be deemed to Occur on the date that a Diagnosis of a Heart Attack Covered Condition is made.

### INITIAL BENEFIT FOR A HEART ATTACK COVERED CONDITION

We will pay the applicable Initial Benefit for a Heart Attack Covered Condition shown on the Schedule, the first time a Heart Attack Covered Condition Occurs for a Covered Person.

If a Covered Person sustains a Myocardial Infarction and Sudden Cardiac Arrest which Occur at the same time, or on the same day, and for which a Heart Attack Covered Condition benefit is payable, We will pay an Initial Benefit for a single Heart Attack Covered Condition which will be for the Heart Attack Covered Condition that pays the highest Benefit Amount.

### RECURRENCE BENEFIT FOR A HEART ATTACK COVERED CONDITION

For any Heart Attack Covered Condition for which the Schedule shows a Recurrence Benefit, We will pay the applicable Recurrence Benefit for another Occurrence of the same Heart Attack Covered Condition for which We have already paid a benefit if the subsequent Occurrence happens after the Recurrence Benefit Separation Period has been satisfied.

## COVERED CONDITION CATEGORY: HEART ATTACK (Continued)

### ADDITIONAL PROOF REQUIREMENTS FOR A HEART ATTACK COVERED CONDITION

Proof of a Heart Attack Covered Condition requires a pathological Diagnosis or Clinical Diagnosis as described below.

For a pathological Diagnosis of a Heart Attack Covered Condition, the following additional documentation must be provided:

- for Myocardial Infarction, documentation that shows:
  - an elevation of enzymes, troponins or other biochemical cardiac markers, and
  - two of the three following criteria associated with the Myocardial Infarction:
    - confinement in a Hospital as an inpatient;
    - documentation of electrocardiograph (EKG) changes on one or a series of electrocardiograms taken at the time the Covered Person experiences the Myocardial Infarction that are indicative of an acute Myocardial Infarction; however, if the Covered Person had any prior electrocardiogram(s), the electrocardiogram(s) presented as Proof of Myocardial Infarction must show changes from the Covered Person's last electrocardiogram, and such changes must be indicative of an acute Myocardial Infarction; or
    - documentation of imaging studies such as thallium scans, or echocardiograms which are indicative of an acute Myocardial Infarction; however, if the Covered Person had any prior imaging studies, the imaging studies presented as Proof of Myocardial Infarction must show changes from the Covered Person's last imaging studies, and such changes must be indicative of a Myocardial Infarction.
- for Sudden Cardiac Arrest, additional documentation that shows that the Sudden Cardiac Arrest was caused or contributed to by any of the following, or that the Covered Person had a documented medical history of any of the following:
  - coronary artery disease;
  - Myocardial Infarction;
  - myocarditis;
  - cardiomyopathy;
  - valvular heart disease;
  - congenital heart disease; or
  - cardiac electrical conduction abnormalities.

We will accept a Clinical Diagnosis of a Heart Attack Covered Condition only if a pathological Diagnosis cannot be made because it would be medically inappropriate or life-threatening under generally accepted medical standards. We will accept a Clinical Diagnosis of Sudden Cardiac Arrest if the sole cause of death shown on a death certificate and medical records indicates cardiovascular collapse, Sudden Cardiac Arrest, or sudden cardiac death.

Such Proof requirements must be documented in a Written report by a Physician.

## COVERED CONDITION CATEGORY: INFECTIOUS DISEASE

### ADDITIONAL DEFINITIONS THAT APPLY TO THE INFECTIOUS DISEASE COVERED CONDITION CATEGORY

**Infectious Disease Covered Condition** means each of the following diseases for which a Covered Person was confined in a Hospital as an inpatient for the number of consecutive days as specified below:

- bacterial cerebrospinal meningitis;
- diphtheria;
- encephalitis;
- Legionnaire's disease;
- malaria;
- necrotizing fasciitis;
- osteomyelitis;
- rabies;
- tetanus;
- tuberculosis; or
- COVID-19.

**Occurs** or **Occurrence**, with respect to an Infectious Disease Covered Condition, means a Covered Person is Diagnosed with such Covered Condition while the coverage is in effect under this Certificate for such Covered Person. An Infectious Disease Covered Condition will be deemed to Occur on the date a Diagnosis of an Infectious Disease Covered Condition is made.

### INITIAL BENEFIT FOR AN INFECTIOUS DISEASE COVERED CONDITION

We will pay the applicable Initial Benefit shown on the Schedule for an Infectious Disease Covered Condition, the first time that an Infectious Disease Covered Condition Occurs for a Covered Person.

### ADDITIONAL PROOF REQUIREMENTS FOR AN INFECTIOUS DISEASE COVERED CONDITION

Proof of an Infectious Disease Covered Condition requires the following additional documentation:

- a Covered Person was confined in a Hospital as an inpatient for 3 consecutive days for treatment of the Infectious Disease Covered Condition; and
- a Clinical Diagnosis:
  - made in Writing by a Physician; and
  - substantiated in the medical records.

## COVERED CONDITION CATEGORY: KIDNEY FAILURE

### ADDITIONAL DEFINITIONS THAT APPLY TO THE KIDNEY FAILURE COVERED CONDITION CATEGORY

**Kidney Failure Covered Condition** means the total, end stage, irreversible failure of all functioning kidneys, provided that a Physician has determined that such failure requires either:

- immediate and regular kidney dialysis (no less often than weekly) that is expected by such Physician to continue for at least 6 months; or
- a kidney transplant.

**Occurs** or **Occurrence**, with respect to a Kidney Failure Covered Condition, means a Covered Person is Diagnosed with such Covered Condition while coverage is in effect under this Certificate for such Covered Person. A Kidney Failure Covered Condition will be deemed to Occur on the earlier of:

- the date a Covered Person receives the first kidney dialysis treatment; or
- the date a Covered Person is placed on the Transplant List.

### INITIAL BENEFIT FOR A KIDNEY FAILURE COVERED CONDITION

We will pay the Initial Benefit for a Kidney Failure Covered Condition shown on the Schedule, the first time that a Kidney Failure Covered Condition Occurs for a Covered Person.

### ADDITIONAL PROOF REQUIREMENTS FOR A KIDNEY FAILURE COVERED CONDITION

A Clinical Diagnosis of a Kidney Failure Covered Condition must be made in Writing by a Physician and must be substantiated in the medical records.

## COVERED CONDITION CATEGORY: MAJOR ORGAN TRANSPLANT

### ADDITIONAL DEFINITIONS THAT APPLY TO THE MAJOR ORGAN TRANSPLANT COVERED CONDITION CATEGORY

**Bone Marrow** means the soft, sponge-like tissue within the bone that produces white blood cells, red blood cells and platelets.

**Major Organ Transplant Covered Condition** means the following:
- Major Organ Transplant.

**Major Organ Transplant** means:
- the irreversible failure of a Covered Person's liver for which a Physician has determined that the complete or partial replacement of the liver with a liver, or liver tissue from a human donor, is medically necessary;
- the irreversible failure of a Covered Person's heart, lung, pancreas, or any combination thereof, for which a Physician has determined that the complete replacement of such organ with an entire organ from a human donor is medically necessary;
- the irreversible failure of a Covered Person's Bone Marrow for which a Physician has determined that replacement of the Bone Marrow (stem cells) from a human donor is medically necessary; and
- for all of the above listed transplants, one of the following additional requirements are met:
  - the Covered Person has been placed on the Transplant List; or
  - such Major Organ Transplant Procedure has been performed.

**Major Organ Transplant Procedure** means a Covered Person undergoes a procedure for any of the transplant types to which the term Major Organ Transplant Covered Condition applies.

**Occurs** or **Occurrence** means, while the coverage is in effect under this Certificate for a Covered Person:
- with respect to Major Organ Transplant, the earlier of:
  - the date a Covered Person is placed on the Transplant List; or
  - the date a Covered Person undergoes a Major Organ Transplant Procedure.

If a Covered Person is placed on the Transplant List and then subsequently undergoes a Major Organ Transplant Procedure of the same organ for which the Covered Person was on the Transplant List, We will treat this as a single Occurrence of a Major Organ Transplant Covered Condition.

## COVERED CONDITION CATEGORY: MAJOR ORGAN TRANSPLANT (Continued)

### INITIAL BENEFIT FOR A MAJOR ORGAN TRANSPLANT COVERED CONDITION

We will pay the applicable Initial Benefit for a Major Organ Transplant Covered Condition shown on the Schedule, the first time that a Major Organ Transplant Covered Condition Occurs for a Covered Person.

### SPECIAL LIMITATIONS APPLICABLE TO A MAJOR ORGAN TRANSPLANT COVERED CONDITION

Payment of benefits for a Major Organ Transplant Covered Condition is subject to the following:

- Two or more organs transplanted on the same day, or during the same Surgery, shall be deemed one Occurrence of a Major Organ Transplant.

### ADDITIONAL PROOF REQUIREMENTS FOR A MAJOR ORGAN TRANSPLANT COVERED CONDITION

A Clinical Diagnosis of a Major Organ Transplant Covered Condition must be made in Writing by a Physician. In addition, documentation of the following must be provided:

- for Major Organ Transplant:
  - that the Covered Person has been placed on the Transplant List and the date of such placement; or
  - that the Major Organ Transplant has been performed.

### SPECIAL EXCLUSIONS APPLICABLE TO A MAJOR ORGAN TRANSPLANT COVERED CONDITION

We will not pay benefits for a Major Organ Transplant Covered Condition for a Covered Person:

- if prior to the Covered Person's coverage becoming effective under this Certificate, the Covered Person had been placed on a Transplant List for the same organ for which the Major Organ Transplant Procedure is performed;
- for a transplant involving organs received from non-human donors;
- for a transplant involving implantation of mechanical devices or mechanical organs; or
- for a transplant involving islet cell transplants.

## COVERED CONDITION CATEGORY: OCCUPATIONAL POST-TRAUMATIC STRESS DISORDER

### ADDITIONAL DEFINITIONS THAT APPLY TO THE OCCUPATIONAL POST-TRAUMATIC STRESS DISORDER COVERED CONDITION CATEGORY

**Occupational Post-Traumatic Stress Disorder (PTSD) Covered Condition** means that a Covered Person has a mental health disorder that is the direct result of an exposure to a Traumatic Event which takes place during the normal course of the Covered Person's regular occupational duties for the Covered Person's employer and for which remuneration is received. The Post-Traumatic Stress Disorder must satisfy the clinical diagnostic criteria set forth in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

**Occurs** or **Occurrence**, with respect to an Occupational Post-Traumatic Stress Disorder Covered Condition, means that a Covered Person is Diagnosed with such Covered Condition following and as a result of a Traumatic Event that took place while coverage is in effect under this Certificate for such Covered Person. An Occupational Post-Traumatic Stress Disorder Covered Condition will be deemed to Occur on the date of the Traumatic Event.

**Traumatic Event** means a Covered Person experiences an exposure to actual or threatened death, serious injury, or sexual violence.

### INITIAL BENEFIT FOR AN OCCUPATIONAL POST- TRAUMATIC STRESS DISORDER COVERED CONDITION

We will pay the Initial Benefit for an Occupational Post-Traumatic Stress Disorder Covered Condition shown on the Schedule the first time that an Occupational Post-Traumatic Stress Disorder Covered Condition Occurs for a Covered Person.

## COVERED CONDITION CATEGORY: OCCUPATIONAL POST-TRAUMATIC STRESS DISORDER (Continued)

### ADDITIONAL PROOF REQUIREMENTS FOR AN OCCUPATIONAL POST-TRAUMATIC STRESS DISORDER COVERED CONDITION

Proof of a Covered Person's Occupational Post-Traumatic Stress Disorder Covered Condition requires all of the following additional documentation:

- a Clinical Diagnosis made by a Physician;
- a psychological evaluation for Post-Traumatic Stress Disorder, which substantiates that the Diagnosis is the direct result of a Traumatic Event that took place after the Covered Person's effective date of coverage under this Certificate, and such psychological evaluation includes documentation that:
  - the Covered Person directly experienced or witnessed the Traumatic Event;
  - the Covered Person is experiencing recurrent, involuntary, and intrusive memories of the Traumatic Event;
  - the Covered Person is experiencing recurrent distressing dreams, dissociative reactions or flashbacks related to the Traumatic Event;
  - the Covered Person is experiencing psychological distress or physiological reactions to cues that resemble or remind the Covered Person of the Traumatic Event;
  - the Covered Person is displaying behaviors of avoidance of stimuli or external reminders associated with the Traumatic Event;
  - the Covered Person is experiencing negative alterations in cognition, mood, or behavior that begin or worsen after the Traumatic Event;
  - the Covered Person is experiencing impairments in social, occupational and other areas of daily functioning;
  - the symptoms of the Post-Traumatic Stress Disorder Covered Condition are not attributable to any of the following:
    - medication;
    - alcohol or substance abuse; or
    - another medical condition or mental health disorder; and
  - the Covered Person's symptoms have continued for at least one month following exposure to the Traumatic Event;
- Diagnosis of Occupational Post-Traumatic Stress Disorder must be made within 365 days following the date of the Traumatic Event; and
- documentation that indicates the specific date and nature of the Traumatic Event.

The psychological evaluation must be documented in a Written report by a Physician.

### SPECIAL EXCLUSIONS APPLICABLE TO AN OCCUPATIONAL POST-TRAUMATIC STRESS DISORDER COVERED CONDITION

We will not pay benefits for a Diagnosis of an Occupational Post-Traumatic Stress Disorder Covered Condition due to any of the following:

- a reactivation of symptoms related to a prior Traumatic Event that took place prior to the Covered Person's effective date of coverage under this Certificate; or
- a Traumatic Event that took place outside of the normal course of a Covered Person's regular occupational duties for such Covered Person's employer.

## COVERED CONDITION CATEGORY: PROGRESSIVE DISEASE

### ADDITIONAL DEFINITIONS THAT APPLY TO THE PROGRESSIVE DISEASE COVERED CONDITION CATEGORY

**Activities of Daily Living** means the following:
- Bathing: washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
- Dressing: putting on and taking off all items of clothing and any required braces, fasteners, or artificial limbs.
- Transferring: moving into or out of a bed, chair or wheelchair.
- Toileting: getting to and from the toilet, getting on and off the toilet, and performing related personal hygiene.
- Continence: ability to maintain control of bowel and bladder function; or, when not able to maintain control of bowel or bladder function, the ability to perform related personal hygiene (including caring for catheter or colostomy bag).
- Eating: feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by feeding tube or intravenously.

**Alzheimer's Disease** means the development of multiple, progressive Cognitive Disturbances that are manifested by memory impairment (impaired ability to learn new information or to recall previously learned information). Alzheimer's Disease must be confirmed by neuropsychological testing. Results of one of more of the following tests may be provided as confirmation in addition to the neuropsychological testing:
- computed tomography (CT);
- magnetic resonance imaging (MRI); or
- positron emission tomography (PET) documents the presence of abnormal deposits of proteins which have formed amyloid plaques and tau tangles.

Alzheimer's Disease does not include:
- other central nervous system conditions that may cause deficits in memory and cognition (e.g., cerebrovascular disease, Parkinson's Disease, normal-pressure hydrocephalus);
- systemic conditions that are known to cause Cognitive Disturbances (e.g., hypothyroidism, vitamin B12 or folic acid deficiency, niacin deficiency, hypercalcemia, or neurosyphilis);
- substance-induced conditions;
- a form of dementia that is a mental and nervous condition such as schizophrenia or psychoses;
- a form of dementia that is Other Dementia; or
- any form of dementia that is not Clinically Diagnosed as Alzheimer's Disease.

**Cognitive Disturbances** means the following intellectual impairments:
- aphasia (language disturbance);
- apraxia (impaired ability to carry out motor activities despite intact motor function);
- angosia (failure to recognize or identify objects despite intact sensory function); or
- disturbance in executive functioning (i.e. planning, organizing, sequencing, or abstracting).

**Multiple Sclerosis** means a progressive neurological condition with evidence of all of the following:
- well-defined neurological abnormalities lasting more than a continuous period of 6 months confirmed by neurological exam;
- presence of demyelination in at least two separate areas of the central nervous system;
- evidence that such demyelination damage took place at different points in time; and
- diagnostic testing results that document the following:
  - magnetic resonance imaging (MRI) that show T2 – weighted lesions;
  - an abnormal response on evoked potential testing; or
  - oligoclonal antibodies or a high immunoglobulin (IgG) index present in cerebrospinal fluid.

Multiple Sclerosis does not include clinically isolated syndrome (CIS).

**Occurs** or **Occurrence**, with respect to a Progressive Disease Covered Condition, means a Covered Person is Diagnosed with a such Covered Condition while the coverage is in effect under this Certificate for such Covered Person. A Progressive Disease Covered Condition will be deemed to Occur on the date the Diagnosis of a Progressive Disease Covered Condition is made.

**Other Dementia** means the development of multiple progressive cognitive defects:
- manifested by memory impairment and other Cognitive Disturbances; and
- for which one or more of the following tests document changes to the specific areas of the brain that result in Cognitive Disturbances: electroencephalogram (EEG); or imaging studies, including computed tomography (CT), magnetic resonance imaging (MRI), fluorodeoxyglucose positron emission tomography (FDG Pet Scan) or amyloid positron-emission tomography scan.

Other Dementia includes the following types of neurological conditions:
- dementia with Lewy bodies;
- progressive supranuclear palsy;
- corticobasal degeneration;
- Parkinson's disease dementia;
- frontotemporal dementia;
- primary progressive aphasia;
- normal-pressure hydrocephalus; or
- rapidly progressive dementia as in Creutzfeldt-Jakob disease.

Other Dementia does not include:
- Alzheimer's Disease;
- substance-induced conditions;
- a form of dementia that is a mental and nervous condition, such as schizophrenia or psychoses;
- any form of Parkinson's disease other than Parkinson's disease dementia; or
- reversible dementias such as those cause by thyroid or other hormonal abnormalities, or vitamin deficiencies.

**Parkinson's Disease (Advanced)** means a chronic, slowly progressive neurological condition affecting the brain's ability to produce dopamine and that is marked by tremor of the muscles, rigidity, slowness of movement, impaired balance, and a shuffling gait which has resulted in a Covered Person's inability to perform at least 2 Activities of Daily Living for a continuous period of 90 days.

**Progressive Disease Covered Condition** means any of the following:
- adrenal hypofunction (Addison's disease);
- Alzheimer's disease;
- amyotrophic lateral sclerosis (referred to as ALS or Lou Gehrig's Disease);
- Huntington's disease (Huntington's chorea);
- Multiple Sclerosis;
- muscular dystrophy;
- Parkinson's Disease (Advanced);
- poliomyelitis;
- systemic lupus erythematosus (SLE); or
- systemic sclerosis (scleroderma).

### INITIAL BENEFIT FOR A PROGRESSIVE DISEASE COVERED CONDITION

We will pay the applicable Initial Benefit for a Progressive Disease Covered Disease shown on the Schedule, the first time that a Progressive Disease Covered Condition Occurs for a Covered Person.

### ADDITIONAL PROOF REQUIREMENTS FOR A PROGRESSIVE DISEASE COVERED CONDITION

A Clinical Diagnosis of a Progressive Disease Covered Condition must be made in Writing by a Physician and must be substantiated by the current clinical diagnostic criteria for the condition in the medical records.

## COVERED CONDITION CATEGORY: SEVERE BURN

### ADDITIONAL DEFINITIONS THAT APPLY TO THE SEVERE BURN COVERED CONDITION CATEGORY

**Occurs** or **Occurrence**, with respect to a Severe Burn Covered Condition, means that a Covered Person sustains a Severe Burn Covered Condition while coverage is in effect under this Certificate for such Covered Person. A Severe Burn Covered Condition will be deemed to Occur on the date a Covered Person sustains a Severe Burn Covered Condition.

**Severe Burn Covered Condition** means a Covered Person has sustained a burn that is, at least, a Third-Degree Burn.

**Third-Degree Burn** means a full-thickness burn caused by acute thermal, chemical, electrical, or radiation exposure that has caused destruction of the skin dermis, epidermis and hypodermis layers.

### INITIAL BENEFIT FOR A SEVERE BURN COVERED CONDITION

We will pay the Initial Benefit for a Severe Burn Covered Condition shown on the Schedule the first time that a Severe Burn Covered Condition Occurs for a Covered Person.

### RECURRENCE BENEFIT FOR A SEVERE BURN COVERED CONDITION

We will pay the Recurrence Benefit for a Severe Burn Covered Condition shown on the Schedule for another Occurrence of a Severe Burn Covered Condition if the subsequent Occurrence happens after the Recurrence Benefit Separation Period has been satisfied.

### ADDITIONAL PROOF REQUIREMENTS FOR A SEVERE BURN COVERED CONDITION

Proof of a Severe Burn Covered Condition requires additional documentation of the following:

- the Severe Burn Covered Condition was treated by a Physician;
- the Severe Burn covers at least 18% of the Covered Person's total body surface area; and
- a Clinical Diagnosis of Severe Burn that:
  - sets forth the date the Severe Burn Occurred;
  - is made in Writing by a Physician using the current clinical diagnostic criteria and burn classification standards; and
  - is substantiated in the medical records.

## COVERED CONDITION CATEGORY: STROKE

### ADDITIONAL DEFINITIONS THAT APPLY TO THE STROKE COVERED CONDITION CATEGORY

**Stroke Covered Condition** means the following:
- Stroke.

**Stroke** means a cerebrovascular accident or incident producing measurable, functional and permanent neurological impairment caused by any of the following which result in an infarction of brain tissue:
- hemorrhage;
- thrombus; or
- embolus from an extra-cranial source.

The term Stroke does not include Transient Ischemic Attacks, or prolonged reversible ischemic attacks).

**Occurs** or **Occurrence**, with respect to a Stroke Covered Condition, means a Covered Person is Diagnosed with such Covered Condition while coverage is in effect under this Certificate for such Covered Person. A Stroke Covered Condition will be deemed to Occur on the date the Diagnosis of the Stroke Covered Condition is made.

**Transient Ischemic Attack (TIA)** means a temporary ischemic event (including prolonged reversible ischemic attacks) in which:
- there are measurable, functional neurological impairments that are focal and confined to an area of the brain perfused by a specific artery;
- there is no evidence of cerebral tissue damage on diagnostic imaging; and
- the reversible functional neurological impairments are confirmed by a Clinical Diagnosis.

### INITIAL BENEFIT FOR A STROKE COVERED CONDITION

We will pay the applicable Initial Benefit for a Stroke Covered Condition shown on the Schedule, the first time that a Stroke Covered Condition Occurs for a Covered Person.

### RECURRENCE BENEFIT FOR A STROKE COVERED CONDITION

For any Stroke Covered Condition for which the Schedule shows a Recurrence Benefit, We will pay the applicable Recurrence Benefit for another Occurrence of the same Stroke Covered Condition for which We have already paid a benefit if such subsequent Occurrence happens after the Recurrence Benefit Separation Period has been satisfied.

### ADDITIONAL PROOF REQUIREMENTS FOR A STROKE COVERED CONDITION

Proof of a Stroke Covered Condition requires the following additional documentation:
- medical records indicating objective evidence of a significant neurological, motor or sensory impairment that is functional and measurable; and
- for a Stroke – a pathological Diagnosis:
  - demonstrated on magnetic resonance imaging (MRI), computerized tomography (CT) or other reliable imaging techniques; and
  - confirmed in Writing by a Physician no earlier than 30 days after the Stroke with such impairments being present and considered permanent on the date that such Written confirmation is made.

Such Proof requirements must be documented in a Written report by a Physician.

## COVERED CONDITION CATEGORY: STROKE (Continued)

### SPECIAL EXCLUSIONS APPLICABLE TO A STROKE COVERED CONDITION

We will not pay benefits for a Diagnosis of a Stroke Covered Condition for:

- a Transient Ischemic Attack;
- cerebral symptoms due to migraine;
- cerebral injury resulting from trauma or hypoxia; or
- vascular disease affecting the eye or optic nerve or vestibular functions.

## SUPPLEMENTAL BENEFITS

### HEALTH SCREENING BENEFIT

If a Covered Person takes one of the screening/prevention measures listed below while insured under this Certificate, upon submission of Proof, We will pay the Health Screening Benefit shown on the Schedule for the day the measure was taken, subject to all of the following:

- We will pay the Health Screening Benefit amount based on the Schedule that was in effect on the day the Covered Person received the screening measure; and
- We will pay the Health Screening Benefit no more than the number of times shown on the Schedule.

The screening/prevention measures for which a Health Screening Benefit may be paid are:

- routine health check-up exam
- biopsies for cancer
- blood chemistry panel
- blood test to determine total cholesterol
- blood test to determine triglycerides
- bone marrow testing
- breast MRI
- breast ultrasound
- breast sonogram
- cancer antigen 15-3 blood test for breast cancer (CA 15-3)
- cancer antigen 125 blood test for ovarian cancer (CA 125)
- carcinoembryonic antigen blood test for colon cancer (CEA)
- carotid doppler
- chest x-rays
- clinical testicular exam
- colonoscopy
- complete blood count (CBC)
- coronavirus testing
- dental exam
- digital rectal exam (DRE)
- Doppler screening for cancer
- Doppler screening for peripheral vascular disease
- echocardiogram
- electrocardiogram (EKG)
- electroencephalogram (EEG)
- endoscopy
- eye exams
- fasting blood glucose test
- fasting plasma glucose test
- flexible sigmoidoscopy
- hearing test
- hemoccult stool specimen
- hemoglobin A1C
- human papillomavirus (HPV) vaccination
- immunization
- lipid panel
- oral cancer screening
- pap smears or thin prep pap test
- prostate-specific antigen (PSA) test
- serum cholesterol test to determine LDL and HDL levels
- serum protein electrophoresis
- skin cancer biopsy

- skin cancer screening
- skin exam
- stress test on bicycle or treadmill
- successful completion of smoking cessation program
- tests for sexually transmitted infections (STIs)
- thermography
- two hour post-load plasma glucose test
- ultrasounds for cancer detection
- ultrasound screening of the abdominal aorta for abdominal aortic aneurysms
- virtual colonoscopy

**MAMMOGRAM BENEFIT**

If You or Your Spouse undergoes a mammogram while insured under this Certificate, upon submission of Proof, We will pay the Mammogram Benefit shown on the Schedule for the day the mammogram was performed, subject to all of the following:

- We will pay the Mammogram Benefit amount based on the Schedule that was in effect on the day the mammogram was performed; and
- We will pay the Mammogram Benefit no more than the number of times shown on the Schedule.

**LODGING BENEFIT**

If a Covered Person stays in a Lodging while receiving treatment at a Treatment Center for a Covered Condition for which We paid a benefit, We will pay the Lodging Benefit shown on the Schedule for each day of the stay in the Lodging, subject to the following:

- insurance under this Certificate must be in effect for the Covered Person during the Lodging stay;
- the Lodging Benefit is payable for each day of the stay in the Lodging while treatment for the Covered Person is being received, and for the 24-hour period before and after the Covered Person's receipt of treatment;
- We will pay the Lodging Benefit up to the maximum number of days shown on the Schedule;
- You must submit Proof that the treatment was received; and
- You must submit Proof that the Covered Person incurred an expense for each day of the stay.

**TRANSPORTATION BENEFIT**

If a Covered Person receives treatment at a Treatment Center for a Covered Condition for which We paid a benefit, We will pay the Transportation Benefit shown on the Schedule for the Covered Person's travel to and from the Treatment Center. Payment of the Transportation Benefit is subject to the following:

- insurance under this Certificate must be in effect for the Covered Person during the Covered Person's travel to and from the Treatment Center;
- mileage used to determine the amount of the benefit is measured from the Covered Person's Primary Residence to the Treatment Center;
- We will pay the Transportation Benefit up to the maximums shown on the Schedule; and
- You must submit Proof that the treatment was received at the Treatment Center.

### COMPANION – LODGING AND TRANSPORTATION BENEFIT

If a Covered Person is confined as an inpatient in a Hospital or receiving treatment at a Treatment Center for a Covered Condition for which a benefit is payable under this Certificate, and an adult companion to the Covered Person travels and stays in a Lodging, We will pay the Companion – Lodging and Transportation Benefit shown on the Schedule subject to all of the following:

- the adult companion's travel and a stay in a Lodging must begin within 365 days after the Covered Condition Occurs;
- the insurance under this Certificate must be in effect for the Covered Person on the adult companion's day of travel and during the adult companion's Lodging stay; and
- You must submit Proof:
  - that the Covered Person was confined as an inpatient in a Hospital or receiving treatment at a Treatment Center for a Covered Condition for which a benefit is payable under this Certificate;
  - that the adult companion traveled a minimum distance of 50 miles from the adult companion's Primary Residence to the Hospital or Treatment Center; and
  - the adult companion's Lodging is located within 50 miles of the Hospital or Treatment Center.

With respect to the Lodging Benefit for an adult companion:

- We will pay the Lodging Benefit up to the maximum number of days shown on the Schedule; and
- You must submit Proof that the adult companion incurred an expense for each day of the stay.

With respect to the Transportation Benefit for an adult companion:

- mileage used to determine the amount of the benefit payable for travel by the adult companion is measured from the adult companion's Primary Residence to the Hospital or Treatment Center;
- We will pay the Transportation Benefit up to the maximums shown on the Schedule; and
- We will not pay a Transportation Benefit under this provision for an adult companion who travels with the Covered Person when additional transportation expenses are not incurred for the adult companion.

### SECOND OPINION BENEFIT

If a Covered Person receives an evaluation that is a second opinion at an Evaluation Center for a Covered Condition, We will pay the Second Opinion Benefit shown on the Schedule, subject to the following:

- We will only pay the Second Opinion Benefit if We have already paid a benefit for the Covered Condition for which the Covered Person is receiving a second opinion;
- insurance under this Certificate must be in effect for the Covered Person on the day the second opinion is received;
- You must submit Proof that the second opinion was received; and
- We will not pay benefits under this section for more than 5 second opinions per Covered Person while coverage is in effect under this Certificate.

**Evaluation Center** means a facility that is licensed or certified under the laws where it is located to provide diagnostic services for the Covered Condition for which evaluation is sought.

# WHEN INSURANCE ENDS

**Please Note: If insurance ends under this section, in certain cases it may be continued as stated in the Continuation of Insurance With Premium Payment section of this Certificate. Please see that section for details.**

## DATE YOUR INSURANCE ENDS

Your insurance under this Certificate will end on the earliest of:
- the date the Group Policy ends;
- the date You die;
- the date insurance ends for Your class;
- the end of the period for which the last full premium has been paid for Your insurance;
- the end of the calendar month in which You notify Us that You wish to cancel Your insurance;
- the end of the calendar month in which You cease to be in an eligible class, subject to the Change in Class provision of the Eligibility Provisions: Insurance for You section; or
- the end of the calendar month in which Your employment ends.

**For Residents of Massachusetts:**

If You are a resident of Massachusetts and Your insurance under this Certificate is ending under the above provision because Your employment has ended, instead of insurance ending on the date Your employment ends, the following timelines apply:

- If Your employment ends for any reason other than a Plant Closing or a Partial Plant Closing, Your insurance will end 31 days after the date Your employment ends. However, if during such 31 day period You become entitled to benefits under another policy that are similar to the benefits provided under this Certificate, insurance under this Certificate will end on the date You become entitled to such other benefits.

- If Your employment ends due to a Plant Closing or a Partial Plant Closing Your insurance will end 90 days after the date Your employment ends. However, if during such 90 day period, You become entitled to benefits under another policy that are similar to the benefits provided under this Certificate insurance under this Certificate will end on the date You become entitled to such other benefits.

## DATE DEPENDENT INSURANCE ENDS

A Dependent's insurance under this Certificate will end on the earliest of:
- the date Your insurance under this Certificate ends;
- the date Dependent Insurance ends under the Group Policy for all employees or for Your class;
- the end of the calendar month in which the person ceases to be a Dependent;
- the end of the calendar month in which You cease to be in a class that is eligible for Dependent Insurance;
- the end of the calendar month in which the Dependent is no longer eligible as described in the Eligible Classes for Dependent Insurance provision; or
- the end of the period for which the last full premium has been paid for insurance for the Dependent.

## CHANGE IN CLASS

If there is more than one class eligible for insurance under the Group Policy, and each class has its own certificate, instead of receiving a new certificate when You move between classes, You will remain insured under this Certificate if:
- You move to a class that is eligible for Critical Illness Insurance under the Group Policy; and
- the benefits available to Your new class are identical to the benefits available under this Certificate.

In all other cases when You move between classes, Your insurance under this Certificate will end on the date You are no longer a member of the class eligible for insurance under this Certificate.

# CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

## AT YOUR OPTION: PORTABILITY THROUGH CONTINUATION WITH PREMIUM PAYMENT

If Your insurance ends under the Date Your Insurance Ends provision of this Certificate, in certain situations, it may be continued for You and Your Dependents, as described in this provision. This is referred to in this provision as "Continued Insurance". For purposes of this provision, insurance in effect under the Group Policy for which the Group Policyholder remits premium is referred to in this provision as "Group Billed Insurance".

Except as described below, Continued Insurance is subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate.

### Requirements for Continued Insurance

Continued Insurance will be available to You if:

- Your Group Billed Insurance ends for any reason other than:
  - non-payment of premium or Contribution; or
  - the end of the Group Policy, provided that Continued Insurance will be available to You if You do not become eligible, within 30 days after the end of the Group Policy, for critical illness insurance under another policy of group insurance available through the Group Policyholder;
- We receive Your completed Written request for Continued Insurance on a form approved by Us within 60 calendar days after Your Group Billed Insurance ends; and
- You pay premiums required for Continued Insurance by the due date specified in the premium notice sent to You.

### Changes in Continued Insurance

You may elect to decrease Your insurance after the date that Continued Insurance goes into effect for You if a lower benefit option is available. In addition, You may end insurance for any or all of Your Dependents. Please contact Us for information. You may not increase insurance once Continued Insurance goes into effect.

### Contributions for Continued Insurance

The Contribution that You must pay for Continued Insurance is the amount of Your Contribution for Your Group Billed Insurance before it ended, plus any amount of premium that the Group Policyholder paid. The Contribution that You must pay for Continued Insurance will be determined on the same basis as premium rates charged for Group Billed Insurance. We have the right to change premium rates in accordance with the terms set forth in the Group Policy. All payments for Continued Insurance must be made directly to Us by the due date specified in the premium notice We send to You.

### End of Continued Insurance

Continued Insurance will end on the earliest of the following dates:

- the date You die;
- if You do not pay a Contribution that is required for Continued Insurance, the end of the period for which the last full premium has been paid for Your insurance;
- with respect to Continued Insurance for a Dependent:
  - the date Continued Insurance for You ends for any reason;
  - the end of the calendar month in which the Dependent no longer meets the definition of a Dependent; or
  - the end of the calendar month in which the Dependent is no longer eligible as described in the Eligibility Provisions: Dependent Insurance section of this Certificate.

### FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

Insurance for a Dependent Child may be continued past the age limit if that child is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law. Proof of such handicap must be sent to Us within 31 days after the date the Dependent Child attains the age limit and at reasonable intervals after such date, but no more often than annually after the two-year period following such Dependent Child's attainment of the limiting age.

Except as stated in the Date Dependent Insurance Ends provision of the When Insurance Ends section of this Certificate, insurance will continue while such Dependent Child:

- remains incapable of self-sustaining employment because of a mental or physical handicap; and
- continues to qualify as a Dependent Child, except for the age limit.

### FOR FAMILY AND MEDICAL LEAVE

Certain leaves of absence may qualify under the Family and Medical Leave Act of 1993 (FMLA) or similar state laws for continuation of insurance. Please contact the Group Policyholder for information regarding the FMLA or any similar state law.

# CLAIMS

## NOTICE OF CLAIM

You must give Us notice of a claim under this Certificate by Writing to Us or calling Us at the toll-free number shown on the face page of this Certificate within 30 days or as soon as reasonably possible from the date of the loss.

## CLAIM FORM

When We receive notice of a claim under this Certificate, We will provide You or the claimant with a claim form. If We do not provide the claim form within 15 days from the date We received notice of claim, Our claim form requirements will be satisfied if We are provided with the required Proof in support of the claim.

## PROOF OF LOSS

Proof must be provided to Us not later than 90 days after the date of the loss. If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given as soon as is reasonably possible, but in no event, other than in the absence of the legal capacity of the claimant, later than 12 months from the date of the loss.

## PAYMENT OF BENEFITS

When We receive the claim form and Proof We will review the claim and, if We approve it, We will pay benefits, subject to the terms and provisions of this Certificate and the Group Policy.

Unless You have assigned this insurance, all benefits paid under this Certificate will be paid to You, except as follows:

- If You are not alive to receive benefits that are payable to You, We will pay benefits in accordance with the provision below titled Your Beneficiary.
- If You are living when benefits are to be paid to You, but You are not legally competent to claim or receive benefits, We may pay up to $10,000 to anyone related to You by blood or marriage who We believe is entitled to payment of the benefits. If We make such a payment in good faith, We will not be liable to anyone for the amount We pay. Any remaining benefits will be paid to Your legal representative.

If benefits have been assigned, We will pay benefits in accordance with the Assignment provision of the General Provisions section.

## YOUR BENEFICIARY

A beneficiary may be named by You to receive a benefit that becomes payable to You under this Certificate that You are not alive to receive.

You may request to change Your beneficiary at any time. A beneficiary change request must be made to The Group Policyholder in Writing. Once the request is recorded, the change will take effect as of the date You sign the request, whether or not You are living when The Group Policyholder receives the request. The change will be subject to any legal restrictions. It will also be subject to any payment We made or action We took before The Group Policyholder recorded the change. If You designated two or more beneficiaries and their shares are not specified, they will share the benefit equally.

If there is no beneficiary designated or no surviving beneficiary at Your death, We will determine the beneficiary according to the following order:

1. Your Spouse, if alive;
2. Your child(ren), if there is no surviving Spouse;
3. Your parent(s), if there is no surviving child;
4. Your sibling(s), if there is no surviving parent; or
5. Your estate, if there is no surviving sibling.

Instead of making payment in the order above, We may pay Your estate. Any payment made in good faith will discharge Our liability to the extent of such payment. If a beneficiary or a Payee is a minor or incompetent to receive payment, We will pay that person's guardian.

### APPEALING A CLAIM DECISION

If We deny Your claim, You may appeal the decision by Writing to Us at the address indicated on the claim form within 180 days of receiving Our decision. Appeals must be in Writing and must include at least the following information:

- name of the Covered Person;
- name of the Group Policyholder;
- claim number;
- Group Policy number; and
- an explanation why You are appealing the decision.

As part of Your appeal, You may submit any Written comments, documents, records, or other information relating to Your claim. After We receive Your Written request appealing the decision, We will conduct a review of Your claim. We will notify You in Writing within 45 days after Our receipt of Your request for an appeal of: (i) Our decision; or (ii) if additional time will be required to complete the review. If additional time is needed, We will notify You of the reason additional time is required.

### AUTHORIZATIONS

We may require that You provide authorization for Us to obtain medical information and any other information pertinent to Your claim.

### EXAMINATIONS

With respect to a pending claim, at Our expense and as often as is reasonably necessary, in order to substantiate Our Proof requirements:

- We may require a Covered Person to have an independent examination by a Physician of Our choice; and/or
- We may require a Covered Person to have an interview by phone or in person with Our representative.

Failure of a Covered Person to have an independent exam or to be interviewed at Our request as specified in this provision may result in the denial of the claim to which the exam or interview pertains.

### AUTOPSY

With respect to a pending claim, at Our expense, in order to substantiate Our Proof requirements, We have the right to make a reasonable request for an autopsy and/or exhumation where permitted by law. Any such request will set forth the reasons We are requesting the autopsy or exhumation.

### TIME LIMIT ON LEGAL ACTIONS

No legal action may be brought to recover on a claim within 60 days after the date Proof has been given as required by this Certificate. No such action may be brought after the expiration of the applicable statute of limitations from the date Proof is required to be given under the terms of this Certificate.

### REFUND TO US FOR OVERPAYMENT OF BENEFITS

If, at any time, We determine that benefits paid under this Certificate were more than the benefits due:

- You, or any other person, entity or health care provider to whom We overpaid benefits have the obligation to reimburse Us for the amount of such overpayment; and
- We have the right to recover the amount of such overpayment from You, or any other person, entity or health care provider to whom We overpaid benefits, including offsetting future benefits payable under this Certificate to You or such other person, entity or health care provider by an amount equal to the overpayment.

# GENERAL PROVISIONS

## CHANGES IN STANDARDS

This Certificate refers to classification standards for disease that have been developed by independent third parties. If those independent third parties change the classification standards, or if new standards are developed that become generally accepted in the medical community in the United States, We will interpret this Certificate in a manner that recognizes such changed or new standards when We determine it is appropriate to do so.

## ENTIRE CONTRACT

Your insurance is provided under a contract of group insurance with the Group Policyholder. The entire contract with the Group Policyholder is made up of the following:

- the Group Policy and its Exhibits, which include the Certificate(s);
- the Group Policyholder's application; and
- any amendments and/or endorsements to the Group Policy.

## INCONTESTABILITY: STATEMENTS MADE BY YOU

Any statement made by You will be considered a representation and not a warranty. We will not use such a statement to void insurance, reduce benefits or defend a claim unless the following requirements are met:

- the statement is in a form that is in Writing;
- You have Signed the form; and
- a copy of the form has been given to You or Your beneficiary.

We will not use Your statements which relate to insurability to contest this insurance after it has been in force for 2 years, unless the statement is fraudulent. In addition, We will not use such statements to contest an increase in benefits after the increase has been in force for 2 years, unless such statement is fraudulent.

## MISSTATEMENTS

If Your or Your Dependent's age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, We will adjust the benefits and/or Contributions.

## ASSIGNMENT

The benefits under the Group Policy are not assignable prior to a claim for benefits, except as required by law.

## CONFORMITY WITH LAW

If the terms and provision of this Certificate do not conform to any applicable law, this Certificate shall be interpreted to so conform.

## STANDARD OF TIME

All insurance becomes effective and terminates at 12:01 A.M. Eastern Standard Time, or at 12:01 A.M. Eastern Daylight Time if Daylight Savings Time is then being observed.

## ACCESS TO DISCOUNTS FOR SERVICES

You will receive access to discounts for certain services, where available.