

**CRITICAL ILLNESS PLAN 1**



**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: Humble Independent School District  
Group Policy Number: 0215439  
MetLife Toll Free Number: 1-800-GETMET8

**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.**

**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.**

**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.**

## **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](mailto: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](http://www.tdi.texas.gov)

Email: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

### **¿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](mailto: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](http://www.tdi.texas.gov)

Correo electrónico: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

## 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
<b>NOTICE FOR RESIDENTS OF MAINE .....</b>	<b>4</b>
<b>COVERED PERSON SPECIFICATIONS.....</b>	<b>7</b>
<b>SCHEDULE OF INSURANCE.....</b>	<b>8</b>
<b>LIMITATIONS .....</b>	<b>16</b>
Benefit Separation Period .....	16
Rules For Total Benefit Amount And Reduction For Prior Claims Paid.....	16
<b>GENERAL EXCLUSIONS .....</b>	<b>17</b>
<b>DEFINITIONS .....</b>	<b>18</b>
<b>ELIGIBILITY PROVISIONS: INSURANCE FOR YOU.....</b>	<b>23</b>
Eligible Class.....	23
Date You Are Eligible For Insurance .....	23
Enrollment Process .....	23
Date Your Insurance Takes Effect.....	23
Benefit Changes .....	23
<b>ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE.....</b>	<b>24</b>
Eligible Class For Dependent Insurance .....	24
Date You Are Eligible For Dependent Insurance.....	24
Enrollment Process .....	24
Date Dependent Insurance Takes Effect.....	24
Benefit Changes .....	25
<b>SPECIAL RULES FOR COVERED PERSONS PREVIOUSLY INSURED UNDER ANOTHER INSURANCE POLICY ISSUED TO THE GROUP POLICYHOLDER.....</b>	<b>26</b>
<b>COVERED CONDITION CATEGORY: CARDIOVASCULAR DISEASE .....</b>	<b>27</b>
Additional Definitions That Apply To The Cardiovascular Disease Covered Condition Category.....	27
Initial Benefit For A Cardiovascular Disease Covered Condition .....	28
Recurrence Benefit For A Cardiovascular Disease Covered Condition .....	28
Rule For More Than One Occurrence Of A Cardiovascular Disease Covered Condition.....	28
Additional Proof Requirements For A Cardiovascular Disease Covered Condition .....	28
Special Exclusions Applicable To A Cardiovascular Disease Covered Condition .....	28
<b>COVERED CONDITION CATEGORY: CHILDHOOD DISEASE .....</b>	<b>29</b>
Additional Definitions That Apply To The Childhood Disease Covered Condition Category .....	29
Initial Benefit For A Childhood Disease Covered Condition .....	29
Additional Proof Requirements For A Childhood Disease Covered Condition .....	29
Special Exclusions Applicable To A Childhood Disease Covered Condition .....	29
<b>COVERED CONDITION CATEGORY: FUNCTIONAL LOSS.....</b>	<b>30</b>
Additional Definitions That Apply To The Functional Loss Covered Condition Category.....	30
Initial Benefit For A Functional Loss Covered Condition .....	30
Recurrence Benefit For A Functional Loss Covered Condition .....	30
Additional Proof Requirements For A Functional Loss Covered Condition .....	31
Special Exclusions Applicable To A Functional Loss Covered Condition .....	31
<b>COVERED CONDITION CATEGORY: HEART ATTACK.....</b>	<b>32</b>
Additional Definitions That Apply To The Heart Attack Covered Condition Category .....	32
Initial Benefit For A Heart Attack Covered Condition.....	32
Recurrence Benefit For A Heart Attack Covered Condition .....	32
Additional Proof Requirements For A Heart Attack Covered Condition .....	33
<b>COVERED CONDITION CATEGORY: INFECTIOUS DISEASE .....</b>	<b>34</b>
Additional Definitions That Apply To The Infectious Disease Covered Condition Category .....	34
Initial Benefit For An Infectious Disease Covered Condition .....	34
Additional Proof Requirements For An Infectious Disease Covered Condition.....	34
<b>COVERED CONDITION CATEGORY: KIDNEY FAILURE.....</b>	<b>35</b>
Additional Definitions That Apply To The Kidney Failure Covered Condition Category.....	35
Initial Benefit For A Kidney Failure Covered Condition .....	35
Additional Proof Requirements For A Kidney Failure Covered Condition .....	35
<b>COVERED CONDITION CATEGORY: MAJOR ORGAN TRANSPLANT .....</b>	<b>36</b>
Additional Definitions That Apply To The Major Organ Transplant Covered Condition Category.....	36
Initial Benefit For A Major Organ Transplant Covered Condition .....	37
Special Limitations Applicable To A Major Organ Transplant Covered Condition .....	37
Additional Proof Requirements For A Major Organ Transplant Covered Condition .....	37
Special Exclusions Applicable To A Major Organ Transplant Covered Condition .....	37

<b>COVERED CONDITION CATEGORY: PROGRESSIVE DISEASE</b> .....	<b>38</b>
Additional Definitions That Apply To The Progressive Disease Covered Condition Category .....	38
Initial Benefit For A Progressive Disease Covered Condition .....	40
Additional Proof Requirements For A Progressive Disease Covered Condition .....	40
<b>COVERED CONDITION CATEGORY: SEVERE BURN</b> .....	<b>41</b>
Additional Definitions That Apply To The Severe Burn Covered Condition Category .....	41
Initial Benefit For A Severe Burn Covered Condition .....	41
Recurrence Benefit For A Severe Burn Covered Condition .....	41
Additional Proof Requirements For A Severe Burn Covered Condition .....	41
<b>COVERED CONDITION CATEGORY: STROKE</b> .....	<b>42</b>
Additional Definitions That Apply To The Stroke Covered Condition Category .....	42
Initial Benefit For A Stroke Covered Condition .....	42
Recurrence Benefit For A Stroke Covered Condition .....	42
Additional Proof Requirements For A Stroke Covered Condition .....	42
Special Exclusions Applicable To A Stroke Covered Condition .....	43
<b>SUPPLEMENTAL BENEFITS</b> .....	<b>44</b>
Health Screening Benefit .....	44
<b>WHEN INSURANCE ENDS</b> .....	<b>46</b>
Date Your Insurance Ends .....	46
Date Dependent Insurance Ends .....	46
Change In Class .....	46
<b>CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT</b> .....	<b>47</b>
At Your Option: Portability Through Continuation With Premium Payment .....	47
For Mentally Or Physically Handicapped Children .....	48
For Family And Medical Leave .....	48
<b>CLAIMS</b> .....	<b>49</b>
Notice of Claim .....	49
Claim Form .....	49
Proof of Loss .....	49
Payment Of Benefits .....	49
Your Beneficiary .....	50
Appealing A Claim Decision .....	51
Authorizations .....	51
Examinations .....	51
Autopsy .....	51
Time Limit on Legal Actions .....	51
Refund To Us For Overpayment Of Benefits .....	51
<b>GENERAL PROVISIONS</b> .....	<b>52</b>
Changes In Standards .....	52
Entire Contract .....	52
Incontestability: Statements Made By You .....	52
Misstatements .....	52
Assignment .....	52
Conformity with Law .....	52
Standard of Time .....	52

## COVERED PERSON SPECIFICATIONS

Certificate Effective Date:	See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife
Group Policyholder: Group Policy Number:	Humble Independent School District 0215439
MetLife Contact Information:	1-800-GETMET8
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 AND TOTAL BENEFIT AMOUNT

	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Children</b>
<b>Benefit Amount</b>	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
<b>Total Benefit Amount</b>	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

180 days

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

**SCHEDULE OF INSURANCE (Continued)**

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

**SCHEDULE OF INSURANCE (Continued)**

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

**SCHEDULE OF INSURANCE (Continued)**

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

<b>COVERED CONDITION CATEGORY: HEART ATTACK</b>		
<b>COVERED CONDITION</b>	<b>INITIAL BENEFIT</b>	<b>RECURRENCE BENEFIT</b>
<b>Heart Attack</b>	100% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person

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

**SCHEDULE OF INSURANCE (Continued)**

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

**COVERED CONDITION CATEGORY: KIDNEY FAILURE**

<b>COVERED CONDITION</b>	<b>INITIAL BENEFIT</b>	<b>RECURRENCE BENEFIT</b>
<b>Kidney Failure</b>	100% of the Benefit Amount payable no more than 1 time per Covered Person	None

**COVERED CONDITION CATEGORY: MAJOR ORGAN TRANSPLANT**

<b>COVERED CONDITION</b>	<b>INITIAL BENEFIT</b>	<b>RECURRENCE BENEFIT</b>
<b>Major Organ Transplant</b>	100% of the Benefit Amount payable no more than 1 time per Covered Person	None

## SCHEDULE OF INSURANCE (Continued)

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

**SCHEDULE OF INSURANCE (Continued)**

<b>systemic lupus erythematosus (SLE)</b>	25% of the Benefit Amount payable no more than 1 time per Covered Person	None
<b>systemic sclerosis (scleroderma)</b>	25% of the Benefit Amount payable no more than 1 time per Covered Person	None

<b>COVERED CONDITION CATEGORY: SEVERE BURN</b>		
<b>COVERED CONDITION</b>	<b>INITIAL BENEFIT</b>	<b>RECURRENCE BENEFIT</b>
<b>Severe Burn</b>	100% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person

<b>COVERED CONDITION CATEGORY: STROKE</b>		
<b>COVERED CONDITION</b>	<b>INITIAL BENEFIT</b>	<b>RECURRENCE BENEFIT</b>
<b>Stroke</b>	100% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person

**SCHEDULE OF INSURANCE (Continued)**

<b>SUPPLEMENTAL BENEFITS</b>		
<b>BENEFIT</b>	<b>BENEFIT AMOUNT</b>	<b>BENEFIT MAXIMUM</b>
<b>Health Screening Benefit</b>	For You: \$50 per day For Your Spouse: \$50 per day For Your Dependent Child: \$50 per day	We will pay the Health Screening Benefit: 1 time per Covered Person, per Calendar Year



## 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.  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.

### RULES FOR TOTAL BENEFIT AMOUNT AND REDUCTION FOR PRIOR CLAIMS PAID

The Total Benefit Amount that appears on the Schedule is the maximum aggregate amount that We will pay, per Covered Person, per lifetime, for any and all of the Covered Conditions to which this provision applies.

We will reduce the Total Benefit Amount for a Covered Person by the Benefit Amounts paid for an Occurrence of a Covered Condition under the Group Policy. All Covered Conditions reduce the Total Benefit Amount unless otherwise specifically stated in this Certificate.

We will also reduce the Total Benefit Amount for a Covered Person by the benefits paid for such Covered Person:

- under another certificate of critical illness insurance issued under the Group Policy; or
- under another policy of critical illness insurance previously issued to the Group Policyholder by Us; for a condition that would be a Covered Condition under this Certificate.

The Supplemental Benefits do not reduce the Total Benefit Amount.

## 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's 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:

- Diagnosis or treatment of a Covered Condition by a Physician who is: You; Your Spouse or anyone to whom You are related by blood or marriage; anyone who is a member of Your household; Your adopted child or step-child; anyone with whom You share a business interest; or Your employee; or
- 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 on a Full-Time basis. 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, while such child is younger than the Dependent Child Age Limit;
- Your grandchild, while such child is younger than the Dependent Child Age Limit;
- Your grandchild, while such child is younger than the Dependent Child Age Limit and who was able to be claimed by You as a dependent for Federal Income Tax purposes at the time You enrolled such grandchild; or
- a child for whom You must provide medical support under an order: issued under Texas Statutes, Chapter 154, Family Code; or enforceable by a court in the State of Texas.

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.

**Full-Time** means Active Work on the Group Policyholder's regular work schedule for the class of employees to which You belong. The work schedule must be at least 20 hours per week.

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

**Group Policyholder** means Humble Independent School District.

## 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, educational or rehabilitative 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.

**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.

## DEFINITIONS (Continued)

**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.

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

- Health Screening 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).

## **DEFINITIONS (Continued)**

**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 Active Full-Time Employees

### **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.

## **ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE (Continued)**

### **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 Placement for Adoption or adoption occurs within 31 days after the child's birth; or
- from the date of adoption or Placement for Adoption if the child is adopted by You or Placed for Adoption with You more than 31 days after the child's birth.

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 31 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 earlier of:

- 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; or
- the commencement of a suit to which You are a party, in which You seek to adopt the child.

### **A Child Covered Pursuant to a Medical Support Order**

A child for whom You are required to provide insurance pursuant to a medical support order issued under Texas Statutes Chapter 154, Family Code; or enforceable by a court in the State of Texas, that is entered while insurance is in effect under the Certificate will be covered from the date specified in the order.

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 Your obligation to cover the child and give Written permission to deduct Contributions from Your pay for Dependent Insurance for the child. You must do this within 31 days of the date You become obligated to cover the child.

The effective date of insurance for a child who becomes covered under this Certificate pursuant to a medical support order while this insurance is in effect under the Certificate will be determined without regard to whether the child is under a Medical Restriction.

### **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 regardless of whether such child is under a Medical Restriction.

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: 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.

## **COVERED CONDITION CATEGORY: CARDIOVASCULAR DISEASE (Continued)**

**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.

**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.

### 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.

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.

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 5 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, entire kidney, 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: 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.
- Contenance: 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 or 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);
- agnosia (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).

## COVERED CONDITION CATEGORY: PROGRESSIVE DISEASE (Continued)

**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;
- myasthenia gravis;
- Parkinson's Disease (Advanced);
- poliomyelitis;
- systemic lupus erythematosus (SLE); or
- systemic sclerosis (scleroderma).



## **COVERED CONDITION CATEGORY: PROGRESSIVE DISEASE (Continued)**

### **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
- hemocult stool specimen
- hemoglobin A1C
- human papillomavirus (HPV) vaccination
- immunization
- lipid panel
- mammogram
- 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

## **SUPPLEMENTAL BENEFITS (Continued)**

- 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

## 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 31 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.



## **CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT (Continued)**

### **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 before the 16<sup>th</sup> day 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 15 months from the date Proof of the loss is required. When We receive the claim form and Proof, We will review the claim and, provide notification in Writing of Our approval or denial of the claim no later than the 15<sup>th</sup> business day after the date We receive documentation in support of the claim.

### PAYMENT OF BENEFITS

If We approve a claim, We will pay benefits no later than 60 days after the date We receive Proof, subject to the terms and provisions of this Certificate and the Group Policy. If We deny the claim, Our notice will state the reason(s) for the denial. If We cannot approve or deny the claim within 15 business days after We receive documentation in support of the claim, We will provide notification within 15 business days, stating that We need additional time to review the claim and the reason(s) why. We will notify You or the claimant of Our decision to approve or deny the claim within 45 days after the date that We provide notification that We need additional time to review the claim.

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. 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.

## **CLAIMS (Continued)**

We will pay to the Texas Department of Human Services, any amounts which would have been paid to You but were paid by the Department through the Medical Assistance Act of 1967, as amended, as described below.

Benefits payable on behalf of the Dependent Child will be paid to the Texas Department of Human Services upon Written notification if:

- You have possession or access to the Dependent Child by court order or You are not entitled to possession or access to the Dependent Child and are required by court order to pay child support;
- the Texas Department of Human Services is paying benefits on behalf of the Dependent Child under Chapter 31 and 32 of the Texas Human Resources Code; and
- notification is given to Us in Writing by the Texas Department of Human Services or by You in an attachment to the first submitted claim that such claim reimbursement should be paid to the Texas Department of Human Services.

In accordance with Texas law benefits under this Certificate may be paid on behalf of a Dependent Child to a possessory or managing conservator for the Dependent Child (who is not a member of an eligible class) if such a conservator has been appointed by a court in Texas or another state. A possessory or managing conservator is entitled to be paid benefits under this section if We are provided with the following:

- Written notice that the person is a possessory or managing conservator for the Dependent Child on whose behalf the claim is made; and
- a certified copy of the court order designating the person as possessory or managing conservator for the Dependent Child or other evidence designated by rule of the Commissioner that the person is eligible for the benefits.

### **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 Us 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 We receive 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 We 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.

## **CLAIMS (Continued)**

Instead of making payment in the order above, We may pay Your estate. 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**

A legal action on a claim may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends three years after the date such Proof is required to be filed.

### **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 to a Physician or other health care provider who provides health care services to You, or 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.