BlueCross BlueShield
of Oklahoma

# Voluntary Critical Illness Insurance

## Employee Benefit Booklet

**CITY OF TULSA**

**F024608-0001**

**Class 1-01**



**10/16/2024**

# Dearborn Life Insurance Company

Administrative Office:
701 E. 22nd Street
Lombard IL 60148

(A stock life insurance company, herein called "We" "Us" or "Our")

**Having issued Group Policy No. F024608-0001**

(herein called the *Policy*)

**to**

**CITY OF TULSA**

(herein called the *Policyholder*)

## GROUP CRITICAL ILLNESS INSURANCE CERTIFICATE

CERTIFIES that *You* are insured, if *You* qualify under the ELIGIBILITY AND EFFECTIVE DATES provision, and remain insured in accordance with the terms of the *Policy. Your* insurance is subject to all the definitions, limitations and conditions of the *Policy*, and it takes effect as stated in the ELIGIBILITY AND EFFECTIVE DATES provision.

This *Certificate* describes *Your* eligibility for benefits and the terms and provisions of the *Policy.* It replaces and cancels any other *Certificate* previously issued to *You* under the *Policy.*

If the terms and provisions of this Group Insurance *Certificate* (issued to *You*) are different from the *Policy* (issued to the *Policyholder*), the *Policy* will govern. *Your* coverage may be canceled or changed in whole or in part under the terms and provisions of the *Policy.*

**READ THIS CERTIFICATE CAREFULLY**

Signed for Dearborn Life Insurance Company

Secretary President

**Voluntary Group Critical Illness Insurance Certificate**

with

Dependent Critical Illness Benefits

Non-Participating

**THIS IS A LIMITED BENEFIT CERTIFICATE. IT PROVIDES CRITICAL ILLNESS INSURANCE COVERAGE. THERE IS NO COVERAGE FOR HOSPITAL, MEDICAL-SURGICAL OR MAJOR MEDICAL EXPENSES**.

**THIS TYPE OF PLAN IS NOT CONSIDERED "MINIMUM ESSENTIAL COVERAGE" UNDER THE AFFORDABLE CARE ACT AND THEREFORE DOES NOT SATISFY THE INDIVIDUAL MANDATE THAT YOU HAVE HEALTH INSURANCE COVERAGE. IF YOU DO NOT HAVE OTHER HEALTH INSURANCE COVERAGE, YOU MAY BE SUBJECT TO A TAX PENALTY. PLEASE CONSULT YOUR TAX ADVISOR.**

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# SCHEDULE OF BENEFITS

| | |
|---|---|
| **POLICYHOLDER:** | CITY OF TULSA |
| **POLICY NUMBER:** | F024608-0001 |
| **POLICY EFFECTIVE DATE:** | January 1, 2025 |
| **ENROLLMENT PERIOD:** | 10/1-10/31 |

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| | | | |
|---|---|---|---|
| **ELIGIBILITY:**<br>**Class # 01** | All active full-time Employees, excluding Policy and Fire of the Policyholder working in the United States of America who are Actively at Work for the Policyholder and who have completed the Eligibility Waiting Period are eligible for the insurance. A full-time *Employee* is one who regularly works a minimum of 30 hours per week for the *Policyholder*. Part-time, seasonal and temporary *Employees* of the *Policyholder* are not eligible. | | |
| **Eligibility Waiting Period:** | Current *Employees*: | First of the month following 30 Days of continuous, full-time Active Work | |
| | New *Employees*: | First of the month following 30 Days of continuous, full-time Active Work | |
| **Policyholder Contribution:** | *Voluntary* Critical Illness | | 0% of premium |
| | *Voluntary Dependent* Critical Illness | | 0% of premium |

**CRITICAL ILLNESS:**

| | |
|---|---|
| **Employee Voluntary Critical Illness Amount** | Incremental selection from a minimum of $5,000 to a maximum of $30,000 in increments of $5,000 |
| **Employee Guarantee Issue Amount** | *Voluntary*: $30,000 available to all *Employees* at each *Enrollment Period* without *Evidence of Insurability* |
| **Reduction of Benefits** | None. Benefits terminate at retirement. |
| **Portability** | |
| Benefit Eligibility | *Voluntary* |
| Insured Eligibility | *Employee, Spouse, Dependent* child |
| Portability Benefit Duration | Age 65 |

**DEPENDENT CRITICAL ILLNESS:**

| | |
|---|---|
| **Guarantee Issue Amount** | *Spouse Voluntary*: $15,000 available to all *Dependents* at each *Enrollment Period* without *Evidence of Insurability* |
| **Spouse Amount** | *Voluntary*:<br>Incremental selection from a minimum of $5,000 to a maximum of $15,000 in increments of $5,000, not to exceed 50% of the *Employee* amount |
| **Dependent child Amount** | *Voluntary*:<br>Incremental selection from a minimum of $5,000 to a maximum of $15,000 in increments of $5,000, not to exceed 50% of the *Employee* amount |

**COVERED CONDITIONS SCHEDULE:**

| **Covered Condition** | **Benefit Percentage** |
|---|---|
| Advanced Alzheimer’s Disease | 100% |
| Advanced Multiple Sclerosis | 100% |
| Advanced Parkinson's Disease | 100% |
| Amyotrophic Lateral Sclerosis | 100% |
| Benign Brain Tumor | 100% |
| Recurrence Benefit | 100% |
| Coma due to Severe Traumatic Brain Injury | 100% |
| Recurrence Benefit | 100% |
| End Stage Renal Failure | 100% |
| Heart Attack | 100% |
| Recurrence Benefit | 100% |
| Major Heart Surgeries | 25% |
| Loss of Speech, Sight or Hearing | 100% |
| Major Burns | 100% |
| Major Organ Transplant | 100% |
| Paralysis | 100% |
| Severe COVID-19 Infection | 100% |
| Stroke | 100% |
| Recurrence Benefit | 100% |
| Carcinoma in situ | 25% |
| Invasive Cancer | 100% |
| Recurrence Benefit | 100% |
| Skin Cancer | 10% |
| Cerebral Palsy | 100% |
| Cleft Lip or Cleft Palate | 100% |
| Cystic Fibrosis | 100% |
| Down Syndrome | 100% |
| Spina Bifida | 100% |
| Wellness Benefit | $150 per *Calendar Year* for each insured *Employee* and covered *Dependent* |

# ELIGIBILITY AND EFFECTIVE DATE PROVISIONS

***Who is eligible for this insurance?***

The eligibility for this insurance is as indicated in the Schedule of Benefits.

The *Eligibility Waiting Period* is further defined in the Schedule of Benefits.

*You* may apply for *Voluntary* insurance coverage during the annual Enrollment Period as indicated in the Schedule of Benefits. *Your* coverage will be effective as indicated below, if *You* are *Actively at Work* on that date.

*Your Contributory* coverage for amounts up to the Guarantee Issue Amount will become effective on the latest of the following dates, if *You* are *Actively at Work* on that date:

1. If *You* enroll for coverage prior to the *Policy* effective date, the *Policy* effective date;
2. If *You* enroll for coverage within 31 days of *Your* eligibility date, on the first of the month that falls on or next follows the date *You* sign the *Enrollment Form*;
3. If *You* do not enroll for coverage within 31 days after *Your* eligibility date, *You* must wait until the next *Enrollment Period* to apply, unless *You* qualify because of a *Change in Family Status.*
    a. Initial requests for coverage or requests for changes to existing coverage made during the *Enrollment Period* will become effective on the *Policy* anniversary date.
    b. Coverage requested within 31 days of a *Change in Family Status* will become effective on the first of the month that falls on or next follows the date *You* sign the *Enrollment Form*.

***Enrollment Form*** means the application *You* complete and submit to apply for coverage under the *Policy*.

***When is Evidence of Insurability required?***

*Evidence of Insurability* is required if:

1. *You* are a late applicant, which means *You* enroll for insurance more than 31 days after *Your* eligibility date; or
2. *You* voluntarily canceled *Your* insurance and choose to reapply; or
3. *Your* coverage amount exceeds the Guarantee Issue Amount as set forth in the Schedule of Benefits; or
4. *You* apply to increase *Your* coverage amount between *Enrollment Periods*.

Receipt of premium does not constitute acceptance and does not guarantee issuance of any benefit amount. *Your* coverage will become effective on the date *We* determine that the *Evidence of Insurability* is satisfactory and *We* provide written notice of approval to *You* or the *Policyholder*.

***Evidence of Insurability*** means a statement of *Your* medical history which *We* will use to determine if *You* are approved for coverage. The costs of *Evidence of Insurability* will be provided at *Our* expense if *You* enroll within 31 days after *Your* eligibility date.

The costs of *Evidence of Insurability* will be provided at *Your* expense if *You* are a late applicant, which means *You* enroll for insurance more than 31 days after *Your* eligibility date.

***Evidence of Insurability Form*** means a form provided or approved by *Us* on which *You* provide a statement of *Your* medical history.

*You* may obtain an *Evidence of Insurability Form* from the *Policyholder*.

***What is the Enrollment period?***

Unless otherwise specified, ***Enrollment Period*** means a period of time during which *Eligible Employees* may apply for or request changes to coverage. The *Enrollment Period* is shown on the Schedule of Benefits.

*Eligible Employees* may enroll for coverage, apply for additional coverage, or request changes to their current coverage only during the *Enrollment Period*, unless they qualify because of a *Change in Family Status*.

Any *Employee* hired after an *Enrollment Period* may enroll within 31 days after their eligibility date; otherwise, he must wait for the next *Enrollment Period* to enroll unless he qualifies because of a *Change in Family Status.*

Initial requests for coverage or requests for changes to existing coverage made during the *Enrollment Period* will become effective on the anniversary date.

***If You are not Actively at Work, when does coverage become effective?***

If *You* are absent from *Active Work* on the date *Your* coverage would otherwise become effective and *Your* absence is caused by an *Injury*, *Illness* or layoff, *Your* effective date for any initial coverage or increased coverage will be deferred until the date *You* return to *Active Work*.

However, *You* will be considered *Actively at Work* on any day that is not *Your* regularly scheduled work day (including but not limited to a weekend, vacation or holiday) if *You* were *Actively at Work* on the immediately preceding scheduled work day and *You* were:

1. not *Hospital Confined*, or;
2. disabled due to an *Injury* or *Illness*.

***What happens if We are replacing a Prior Policy?***

***Effect on Actively at Work Requirement***

If *You* were insured under the *Prior Policy* on the day before the *Policy* effective date, coverage begins for this *Policy* on the *Policy* effective date and continues until the earliest of:

1. The end of the month following the date *You* become *Actively at Work*;
2. The end of any period of continuance or extension provided under the *Prior Policy*; or
3. The date coverage would otherwise end, according to the provisions of this *Policy.*

*Your* coverage under this provision is subject to payment of premium.

***Effect on Benefits***

The benefits payable under this *Policy* will be the benefits which would have been payable under the terms of the *Prior Policy* if it had remained in force; and the benefits payable under this *Policy* will be reduced by any benefits payable under the *Prior Policy* for the same *Covered Condition* for which the prior carrier is liable.

The ***Prior Policy*** is the group critical illness policy issued to the *Policyholder* whose coverage terminated immediately before the *Policy* effective date.

***Effect on Pre-existing Conditions***

If *You* have a *Diagnosis* of *Covered Condition* due to a *Pre-existing Condition* after the *Prior Policy* has been replaced by this *Policy*, benefits may be payable if:

1. *You* were insured under the *Prior Policy* at the time the *Policyholder* changed coverage from the *Prior Policy* to this *Policy*; and
2. *You* have been continuously insured under this *Policy* from the *Policy* effective date until the date *Your Covered Condition* was *Diagnosed.*

In order for benefits to be paid, *You* must satisfy the *Pre-existing Condition* exclusion under:

1. this *Policy*; or
2. the *Prior Policy*, if benefits would have been paid had the *Prior Policy* remained in force.

If *You* satisfy the *Pre-existing Condition* exclusion of this *Policy*, *We* will determine *Your* payments according to the *Policy's* provisions.

If *You* do not satisfy the *Pre-existing Condition* exclusion of this *Policy*, but *You* do satisfy the *Pre-existing Condition* provision under the *Prior Policy*:

*Your* benefit will be the lesser of:

a. The benefit that would have been payable under the terms of the *Prior Policy* if it had remained in force; or
b. The benefit under this *Policy.*

If *You* do not satisfy the *Pre-existing Condition* exclusion under either this *Policy* or the *Prior Policy*, *We* will not make any payments.

*We* will require *Proof* that *You* were insured under the *Prior Policy*.

***Changes to Your coverage***

A change in *Your* coverage may occur if:

1. *You* enroll for a different coverage option; or
2. There is a *Policy* change; or
3. *You* enter another class and become eligible for a change in benefits; or
4. *You* experience a qualified *Change in Family Status*.

If *You* are eligible for increased coverage due to a *Policy* change, the increased coverage will be effective on the date the *Policy* change is effective, as requested by the *Policyholder* and agreed on by *Us.*

Increases in coverage for reasons other than a *Policy* change will be effective the first of the month following the later of:

1. The date *You* enroll for the increased coverage; or
2. The date *You* become eligible for the increased coverage, if enrollment is not required; or
3. The date *We* approve *Your* coverage if *Evidence of Insurability* is required.

In order for *Your* increased coverage to begin, *You* must be *Actively at Work.* Increased *Contributory* coverage is subject to *Our* receipt of premium.

A decrease in coverage will take effect immediately.

Increases or decreases to *Your* benefits elected during the *Enrollment Period* will become effective on the next anniversary date, if *You* are *Actively at Work* on that day.

***Eligibility after You Terminate Employment***

If *Your* coverage ends due to termination of employment and *You* do not elect continued coverage under the Portability Benefit provision, *You* must meet all the requirements of a new *Employee* if *You* are rehired by the *Policyholder* at a later date.

If *Your* coverage ends due to termination of employment and *You* return to *Active Work* for the *Policyholder* in an eligible class within 30 days, *We* will not:

1. apply a new *Eligibility Waiting Period*; or
2. require *Evidence of Insurability*.

# CRITICAL ILLNESS INSURANCE

***What is Critical Illness Insurance?***

***Critical Illness Insurance*** is a percentage of *Your* or *Your* covered *Dependents Voluntary Critical Illness Insurance* as indicated in the Schedule of Benefits, which is payable to *You* or *Your* covered *Dependents* if *You* or *Your* covered *Dependents* experience a *Covered Condition*.

*We* will pay *You* or *Your* covered *Dependents* on *Diagnosis* of a *Covered Condition* if *You* or *Your* covered *Dependents* or *Your* or *Your* covered *Dependents* legal representative submit a claim and provide satisfactory *Proof.*

*You* or *Your* covered *Dependents* may receive multiple benefit payments if *You* or *Your* covered *Dependents* are *Diagnosed* with more than one *Covered Condition*, as long as the sum of all benefits payments does not exceed 300% of the *Critical Illness Insurance* amount under this *Certificate.*

***How do You* or *Your* covered *Dependents qualify for the Critical Illness Insurance Benefit?***

*You* or *Your* covered *Dependents* receive benefits listed in the Schedule of Benefits if a *Covered Condition* occurs after the *Policy* effective date.

***How are benefits paid if You* or *Your* covered *Dependents experience two or more Covered Conditions?***

Payments are made for each *Covered Condition You* or *Your* covered *Dependents* suffer. Each benefit payment is based on the percentage listed in the *Covered Conditions* Schedule of Benefits. The sum of all benefit payments is limited to 300% of the *Critical Illness Insurance* amount under this *Certificate.*

If an *Injury* or *Illness* causes more than one *Covered Condition*, *We* will pay for the *Covered Condition* with the greatest benefit percentage. The occurrence of each new *Covered Condition* must be separated by 180 days to be eligible for benefits.

***Are Benefits portable?***

Yes, subject to the conditions and limitations set forth in the Portability Benefit section of this *Certificate.*

***Are Benefits convertible?***

No, benefits are not convertible.

# EXCLUSIONS AND LIMITATIONS

***Are there any Exclusions and Limitations for Critical Illness Insurance?***

In addition to specific exclusions and limitations for a *Covered Condition:*

1. If an *Injury* or *Illness* causes more than one *Covered Condition* to occur, benefits are only payable under the greatest benefit level percentage and are payable once, up to 300% of the *Critical Illness Insurance* benefit in the Schedule of Benefits.
2. Benefits for a kidney transplant are covered under the *End Stage Renal Failure* benefit only.
3. If benefits are paid due to a kidney-pancreas transplant, those benefits are not payable under the *End Stage Renal Failure* benefit.
4. *You* or *Your* covered *Dependent* must be registered by the United Network of Organ Sharing (UNOS) in order for a *Major Organ Transplant,* or kidney transplant necessitated by *End Stage Renal Failure* to be a *Covered Condition* under this benefit.
5. *Covered Conditions* must be separated by 180 days to be eligible for benefits.
6. Benefits are subject to any Reduction of Benefits.
7. No benefits are payable for a *Covered Condition* if it results directly or indirectly from:
    a. being under the influence of any narcotic (except those drugs prescribed by a *Physician* and used in the manner prescribed or FDA regulated over-the-counter drugs used as recommended by the manufacturer); or
    b. *Injury* received during active participation in a *Riot,* strike or civil commotion, or any act incidental thereto; or
    c. Commission of or attempt to commit an illegal activity defined under state or federal law; or
    d. *Injury* received from driving while intoxicated or under the influence. Under the influence or intoxication is defined by the laws of the jurisdiction in which the *Accident* causing the *Injury* occurred or .08% blood alcohol content if the jurisdiction in which the *Accident* occurred does not define intoxication. Conviction is not necessary for a determination of under the influence or intoxication.

# PORTABILITY BENEFIT

***What is the Portability Benefit?***

If *Your Voluntary* group *Critical Illness Insurance*, or any portion of it, terminates, *You* may elect to continue *Your Critical Illness Insurance* in accordance with the terms of the *Policy* by paying premiums directly to *Us*. If *You* elect Portability, *You* may also elect to continue *Dependent Critical Illness Insurance* under the conditions set forth below, but *You* may not apply for *Dependent Critical Illness Insurance* at the time *You* apply for Portability. The coverages eligible for Portability and the Portability Benefit Duration are in the Schedule of Benefits.

The premiums for the coverage continued under the Portability Benefit will not be the same as the premium *You* are charged for *Your* group *Critical Illness Insurance* under the *Policy.* Portability premium will be based on:

1. *Our* current rates for the applicant's age and class of risk at the time he elects Portability; and
2. the amount of insurance continued under Portability.

The maximum amount of *Critical Illness Insurance* which may be continued under Portability is the amount of *Critical Illness Insurance* in force at the time the Portability Benefit is elected, not to exceed the Portability Benefit amount as set forth in the Schedule of Benefits.

A beneficiary designation on the *Application for Portability*, if different from the designation on *Your Enrollment Form*, shall constitute a change of beneficiary under the *Policy*, and that beneficiary designation will only apply while *Your* coverage continues under this Portability Benefit provision.

***What are Eligibility Requirements for Employee Portability?***

To be eligible for Portability, *You* must meet the following conditions:

1. *You* must have been insured under the *Policy* or the *Policy* it replaced for at least one year prior to electing Portability; and
2. *Your Critical Illness Insurance*, or a portion of it, must have terminated for reasons other than *Illness*, *Injury*, retirement or termination of the *Policy*; and
3. *You* must be less than 60 years of age.

*You* must submit an *Application for Portability* and the first premium within 31 days after the date *Your Critical Illness Insurance* terminated.

*We* reserve the right to rescind any coverage amounts continued under Portability if it can be shown that *You* misrepresented any of the information provided to support eligibility for Portability.

***Can Dependent Critical Illness Insurance be Ported if Your Eligibility Terminates or if Your Spouse's Coverage Terminates?***

Yes, *You* or *Your* insured *Spouse* may elect Portability of *Dependents' Critical Illness Insurance* if *Dependents'* insurance coverage ceases as follows:

1. *You* may apply for Portability of *Dependent Critical Illness Insurance* if *You* meet the eligibility requirements to port *Your Critical Illness Insurance* as shown above and *You* are covered for *Dependent Critical Illness Insurance* on the date *Your* coverage ceases.
2. *Your* insured *Spouse* may apply for Portability of his group *Critical Illness Insurance*, and/or *Critical Illness Insurance* on covered *Dependent* child(ren) if:
    a. *Your Spouse's Critical Illness Insurance* terminates because *You* die or *Your* eligibility for *Dependent Critical Illness Insurance* ceases for reasons other than retirement or termination of the *Policy* and *Your Spouse* is less than 60 years of age.
    b. *Your Spouse* had elected *Dependent Critical Illness Insurance* on *Eligible Dependent* child(ren) and such coverage is still in force when *Your* eligibility for *Dependent Critical Illness Insurance* ceased for reasons other than retirement or termination of the *Policy.*
    c. *Your Spouse* must have been insured for such coverage(s) under the *Policy* for at least one year prior to electing Portability.
    d. Portability is not available if *Your Spouse's Critical Illness Insurance* terminates because he no longer meets the *Policy* definition of an *Eligible Dependent Spouse*.

If these criteria are met, *You* or *Your Spouse*, must submit an *Application for Portability* and pay the first premium within 31 days after the date such *Dependent Critical Illness Insurance* terminated.

*We* reserve the right to rescind any coverage amounts continued under Portability if it can be shown that *You* or *Your Spouse* misrepresented any information provided to support eligibility for Portability of *Dependent Critical Illness Insurance*.

An ***Application for Portability*** means the application *You* complete and submit to apply for coverage under the Portability Benefit.

***When will Portable Coverage Terminate?***

Insurance continued under the Portability Benefit provision of the *Policy* will terminate at the earliest of the following:

1. the date *You* return to *Active Work* with the *Policyholder* while the *Policy* is still in force; or
2. the date required premiums are not paid when due; or

3. the end of the Portability Benefit Duration in the Schedule of Benefits; or
4. the premium due date following the date a *Dependent* ceases to meet the definition of an *Eligible Dependent*.

# DEPENDENT CRITICAL ILLNESS INSURANCE

***What is the Dependent Critical Illness Insurance Benefit?***

*We* will pay *You* the amount of *Critical Illness Insurance* set forth in the Schedule of Benefits on *Your Dependent(s)* while *Your* insurance is in force. Payment will be in one lump sum.

If *You* are not living at the time *Dependent Critical Illness Insurance* benefits become payable, *We* will pay the benefit:

1. to *Your Spouse,* if living; if not,
2. in equal shares to *Your* then living natural or legally adopted children, if any; if none,
3. in equal shares to *Your* father and mother, if living; if not,
4. in equal shares to *Your* brothers and sisters, if living; otherwise,
5. to *Your* estate.

***Who is eligible for Dependent Critical Illness Insurance?***

If *You* or *Your Spouse* are insured for *Critical Illness Insurance* under the *Policy* and belong to a class listed in the Schedule of Benefits as eligible for *Dependent Critical Illness Insurance* benefits, *You* are eligible to enroll for this benefit. If *You* or *Your Spouse* are enrolled for *Dependent Critical Illness Insurance* and subsequently acquire a new *Eligible Dependent,* that *Dependent* will automatically be covered.

Note: No eligible person may be covered more than once under the *Policy*. If a person is covered as an *Employee,* he cannot be covered as a *Spouse* or *Dependent Child* of another *Employee.* If both parents are covered as insured *Employees* under the *Policy,* only one may enroll for *Critical Illness Insurance* coverage on *Eligible Dependent Child(ren).*

***When does Dependent Critical Illness Insurance become effective?***

If *You:*

1. have completed any required *Employee Eligibility Waiting Period;* and
2. apply for *Dependent Critical Illness Insurance* no later than 31 days after becoming eligible for this benefit; and
3. have paid any applicable premium.

*Critical Illness Insurance* for *Your Eligible Dependent(s)* will become effective on the later of:

1. the first of the month that falls on or next follows the date *Your* group insurance coverage becomes effective;
2. the first of the month that falls on or next follows the effective date of the *Dependent Critical Illness Insurance* benefit; or
3. the first of the month that falls on or next follows the date *You* enroll *Your Eligible Dependent(s);*
4. the first of the month that falls on or next follows the date *You* acquire *Your Eligible Dependent(s);*
5. if *Evidence of Insurability* is required, the date *We* determine that evidence is satisfactory and *We* provide written notice to *You* or the *Policyholder* of approval.

If *You* enroll for *Dependent Critical Illness Insurance* more than 31 days after *You* are eligible to do so, *You* must furnish *Evidence of Insurability* satisfactory to *Us* for each *Dependent,* and coverage will become effective as set forth above.

If an *Eligible Dependent* is required to submit satisfactory *Evidence of Insurability* for any reason, insurance in the amount for which *We* require such evidence will become effective on the date *We* determine that the evidence is satisfactory and *We* provide notice of approval to *You* and the *Policyholder.*

***When do changes in the Dependent Critical Illness Insurance benefit become effective?***

If no *Evidence of Insurability* is required, increases in the amount of *Dependent Critical Illness Insurance* will become effective on the Policy Anniversary Date.

For amounts on which *Evidence of Insurability* is required, increases in the amount of *Dependent Critical Illness Insurance* will be effective on the date *We* determine that evidence is satisfactory and *We* provide written notice of approval date of approval to *You* and the *Policyholder*.

Any decrease in the amount of *Dependent Critical Illness Insurance* will become effective immediately on the date of the change.

# TERMINATION PROVISIONS

***When does Your coverage under the Policy end?***

Unless *Critical Illness Insurance* is continued under Portability, *Your* coverage terminates on the earliest of the following dates:

1. the date on which the *Policy* is terminated; or
2. the date *You* stop making any required contribution toward payment of premiums; or
3. the effective date of an amendment to the *Policy* which terminates insurance for the class to which *You* belong; or
4. the date *You*:
    a. die; or
    b. are no longer a member of a class eligible for this insurance; or
    c. request termination of coverage under the *Policy*; or
    d. the first of the month following the date *You* reach age 99; or
    e. are no longer *Actively at Work* as a result of a *Disability*, layoff, or leave of absence , military leave or labor dispute.

Termination will not affect *Your* claim for a covered *Loss* which occurred while the coverage was in force.

*You* may continue to be eligible for coverage, as follows:

| | |
|---|---|
| **Disability** | Until the end of the twelfth month following the month in which the *Disability* began, if all premiums are paid when due. |
| **Layoff** | Until the end of the month following the month during which the layoff began, if all premiums are paid when due. |
| **Leave of Absence** | Until the end of the twelfth month following the month during which the leave of absence began, if all premiums are paid when due, as governed by the *Policyholder's* Human Resource policy on family and medical leaves of absence or in accordance with the FMLA provision below. |
| **Labor Dispute** | Until the end of the twenty-fourth month following the month in which the labor dispute began, provided all premiums are paid when due. |
| **Military Leave** | Until the end of the twelfth month following the month in which the military leave began, if all premiums are paid when due. |

For the purposes of this provision, ***Disability*** means *You* are unable to perform all of the *Material and Substantial Duties* of *Your Regular Occupation.*

***Will coverage be continued if You are eligible for leave under FMLA?***

In the event *You* are eligible for and the *Policyholder* approves a leave of absence under the Family and Medical Leave Act of 1993 (FMLA), or any applicable state family and medical leave law (State FML), provided the required premium continues to be paid, *Your* insurance will continue for a period of up to the later of:

1. the leave period permitted by the federal Family and Medical Leave Act of 1993 and any amendments; or
2. the leave period permitted by applicable state law.

*You* are eligible for leave under this Act in order to provide care:

1. After the birth of a child; or
2. After the legal adoption of a child; or
3. After the placement of a foster child in *Your* home; or

4. To a *Spouse,* child or parent due to their serious *Illness;* or
5. For *Your* own serious health condition; or
6. For any event later added by amendment to the Act.

While granted a Family or Medical Leave of Absence:

1. The *Policyholder* must remit the premium required by the *Policy;* and
2. Coverage will terminate if *You* do not return to work as scheduled according to the terms of *Your* leave of absence agreement with the *Policyholder*.

***When does Dependent Critical Illness Insurance coverage end?***

Unless *Critical Illness Insurance* is continued under Portability, *Dependent Critical Illness Insurance* coverage will end on the earliest of:

1. the date *You* are no longer *Actively at Work* except in the case of *Disability*, layoff or leave of absence as set forth above; or
2. the date the *Policy* is terminated; or
3. the date *You* stop making any required contribution toward payment of premiums; or
4. the effective date of an amendment to the *Policy* which terminates insurance for the class to which *You* belong; or
5. the first of the month following the date:
    a. *You* are no longer a member of a class eligible for this insurance, or
    b. *You* request termination of coverage under the *Policy*, or
    c. *You* reach age 99; or
6. the date a *Dependent* child or *Spouse* no longer meets the *Policy* definition of *Eligible Dependent.*

Coverage will continue past the age limit for *Eligible Dependent* children who are primarily dependent on *You* for support and who cannot work to support themselves due to a physical or mental incapacity which began before the age limit was reached. Written proof of such incapacity must be provided to *Us* on request.

# ADVANCED ALZHEIMER'S DISEASE

***Advanced Alzheimer's Disease*** means the *Diagnosis* of loss of intellectual capacity involving impairment of memory and judgment as measured by clinical evidence and standardized testing. It must result in significant reduction in mental and social functioning which requires *Substantial Assistance* in performing at least three of the six *Activities of Daily Living (ADL)*. The inability to perform at least three of the six *ADL's* must last at least 180 days and be expected to be permanent and irreversible.

Other dementing organic brain disorders or psychiatric *Illnesses* are excluded under this *Covered Condition*.

***Substantial Assistance*** means *Hands-on Assistance* and *Stand-by Assistance*. *Stand-by Assistance* will be used to determine that *Substantial Assistance* by another person is required by *You* or *Your* covered *Dependent* to perform the *ADL*.

***Hands-on Assistance*** means the physical assistance for another person without which *You* or *Your* covered *Dependent* would be unable to perform the *ADL*.

***Stand-by Assistance*** means the presence of another person within *You* or *Your* covered *Dependents* arm's reach to prevent, by physical intervention, *Injury* to *You* or *Your* covered *Dependents* while performing an *ADL*.

***Activities of Daily Living (ADL)*** means:

1. Eating – Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
2. Toileting – Getting to and from the toilet, getting on and off the toilet and performing associated personal hygiene.
3. Transferring – Moving into or out of a bed, chair or wheelchair.
4. 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.
5. Dressing – Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

6. Continence – Ability to maintain control of bowel and bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

## ADVANCED MULTIPLE SCLEROSIS

***Advanced Multiple Sclerosis (MS)*** means the *Diagnosis of Multiple Sclerosis* with demonstrated neurological deficits that have been present for 6 months or more. *Diagnosis* is made on the basis of:

1. neurological examination demonstrating functional impairments;
2. imaging studies of the brain or spine demonstrating lesions consistent with MS; and
3. analysis of cerebrospinal fluid consistent with the *Diagnosis.*

## ADVANCED PARKINSON'S DISEASE

***Advanced Parkinson's Disease*** means *Diagnosis of Parkinson's Disease* that has progressed to Stage 4, based on abnormal findings from neurological examination, cognitive testing and results from imaging studies.

## AMYOTROPHIC LATERAL SCLEROSIS

***Amyotrophic Lateral Sclerosis (ALS)*** means the *Diagnosis* of Middle Stage as defined by the Muscular Dystrophy Association. *Diagnosis* must be made according to diagnostic criteria specific for ALS. Other motor neuron diseases are not considered to be ALS and are excluded under this *Covered Condition.*

## BENIGN BRAIN TUMOR

***Benign Brain Tumor*** means the *Diagnosis* of a tumor within the brain cavity, known or presumed to be non-malignant, that results in a fixed neurological deficit. These neurological deficits include, but are not limited to:

- Loss of vision;
- Loss of hearing; or
- Balance disruption

*Diagnosis* of the tumor and neurological deficit must be confirmed by imaging or examination findings conducted by a *Physician* board-certified as a neurologist.

Tumors of the skull, pituitary adenomas and germanomas are excluded under this *Covered Condition*.

Also excluded from this *Covered Condition* is a *Benign Brain Tumor Diagnosed* with any of the following conditions prior to *Your* or *Your* covered *Dependent's* effective date:

- Neurofibromatosis I;
- Neurofibromatosis II;
- Von Hippel Lindau;
- Tuberous Sclerosis;
- Li Fraumani Syndrome;
- Cowden Disease; or
- Turcot Syndrome

The *Date of Diagnosis* is the date the *Physician* confirms the existence of the *Benign Brain Tumor* by examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.

## COMA

***Coma*** or ***Comatose*** means the *Diagnosis* of a state of complete loss of consciousness lasting for a period of 14 or more consecutive days from which *You* cannot be aroused and there is no evidence of response to stimulation.

The *Coma* must be characterized by the absence of:

- Eye opening;
- Verbal response; and
- Motor response

The *Coma* must require intubation for respiratory assistance.

## END STAGE RENAL FAILURE

***End Stage Renal Failure*** means the *Diagnosis* of a chronic and irreversible failure of both kidneys for which dialysis on a regular basis (weekly or biweekly) is necessary. *Diagnosis* must be made by a *Physician* board-certified in nephrology.

The *Date of Diagnosis* is the date the *Physician* recommends the *Insured* begin renal dialysis.

## HEART ATTACK

***Heart Attack*** or acute ***Myocardial Infarction*** means a *Diagnosis* of an acute *Myocardial Infarction* resulting in the death of a portion of the *Insured's* heart muscle (myocardium) due to a blockage of one or more coronary arteries and resulting in the loss of the normal function of the heart. The *Diagnosis* must be made by a *Physician* board-certified as a cardiologist and based on both:

a. New clinical presentation and electro-cardiographic changes consistent with an evolving *Heart Attack*; and
b. Serial measurement of cardiac biomarkers showing a pattern and to a level consistent with a *Diagnosis of Heart Attack.*

An established (old) *Myocardial Infarction* is excluded under this *Covered Condition.*

## MAJOR HEART SURGERY

***Major Heart Surgery*** means the *Diagnosis* of either: *Aortic Surgery*, *Coronary Artery Bypass Surgery* or *Heart Valve Replacement/Repair Surgery*, as defined below.

(a) ***Aortic Surgery*.** A disease of the aorta that necessitates actually undergoing surgery of the aorta needing excision and surgical replacement of a portion of the diseased aorta with a graft. The *Diagnosis* must be made by a *Physician* board-certified as a cardiologist, cardio-vascular thoracic surgeon or vascular surgeon. For this definition, aorta means the thoracic and abdominal aorta but not its branches. Traumatic *Injury* of the aorta causing *Aortic Surgery* is excluded under this *Covered Condition*. If the *Insured* is determined to be too ill to undergo the surgery, but otherwise meets the criteria for the need for the surgery, the surgery requirement will be waived.

(b) ***Coronary Artery Bypass Surgery*.** A disease of the coronary artery that necessitates actually undergoing *Coronary Artery Bypass Surgery* using either a saphenous vein or internal mammary artery graft for the treatment of coronary heart disease deemed medically necessary to correct a narrowing or blockage of one or more coronary arteries. The *Diagnosis* must be made by a *Physician* board-certified as a cardiologist. Other surgical or nonsurgical techniques such as laser relief or any other intra-arterial procedures are excluded under this *Covered Condition*. If the Insured is determined to be too ill to undergo the surgery, but otherwise meets the criteria for the need for the surgery, the surgery requirement will be waived.

(c) ***Heart Valve Replacement/Repair Surgery*.** A disease of the heart valve that necessitates the actually undergoing open heart surgery to replace or repair one or more valves. The *Diagnosis* must be made by a *Physician* board-certified as a cardiologist or cardio-vascular surgeon. If the Insured is determined to be too ill for surgery, but otherwise meets the criteria for the need for the surgery, the surgery requirement will be waived.

## LOSS OF SPEECH, SIGHT OR HEARING

***Loss of Speech*** means the *Diagnosis* of loss of the ability to speak to the extent that the *Insured* is unintelligible to another person with normal hearing, for at least 12 months.

The *Date of Diagnosis* for *Loss of Speech* is the date a *Physician* certifies *Loss of Speech* as defined in the definition of *Loss of Speech*.

***Loss of Sight*** means *Diagnosis* of clinically proven irreversible reduction of sight in both eyes with:

- Sight in the better eye reduced to a best corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (Snellen or E-Chart Acuity); or
- Visual field restriction to 20 degrees or less in both eyes.

The *Date of Diagnosis* for *Loss of Sigh*t is the date a *Physician* certifies *Loss of Sight* as defined in the definition of *Loss of Sight*.

***Loss of Hearing*** means *Diagnosis* of permanent reduction in both ears to a point that the *Insured* is unable to hear sounds at or below 70 decibels. *Diagnosis* must be made by a board-certified or board-eligible otolaryngologist by audiometric testing.

The *Date of Diagnosis* for *Loss of Hearing* is the date the *Physician* certifies *Loss of Hearing* as defined in the definition of *Loss of Hearing*.

## MAJOR BURN

***Major Burn*** means the *Diagnosis* that *You* or *Your* covered *Dependents* have sustained third degree burns covering at least 20% of the surface area of the body.

## MAJOR ORGAN TRANSPLANT

***Major Organ Transplant*** means a *Diagnosis,* supported by clinical evidence of the major organ(s) failure which requires the malfunctioning organ(s) or tissue to be replaced with an organ(s) or tissue from a suitable human donor (excluding the recipient) under generally accepted medical procedures. The organs and tissues covered by this definition are limited to: liver, lung, entire heart, small intestine, pancreas or kidney. Excluded from this *Covered Condition* is bone marrow transplant. The *Insured* must be registered by the United Network of Organ Sharing (UNOS) in order for the *Major Organ Transplant* to be a *Covered Condition* under the *Policy*. If the *Insured* is determined to be too ill for a transplant, but otherwise meets the criteria for being registered by the UNOS, the registration requirement will be waived.

Only one *Major Organ Transplant* benefit will be paid per *Insured.*

The *Date of Diagnosis* is the date the *Insured* is placed on the UNOS list for transplantation or the NMDP list for marrow donation.

## PARALYSIS

***Paralysis*** means the *Diagnosis* of loss of use without severance of a limb as a result of an *Injury* to the spinal cord, which has continued for 12 consecutive months. *Paralysis* must be determined by a *Physician* to be permanent, total and irreversible. *Paralysis* includes *Hemiplegia, Quadriplegia, Paraplegia* and *Uniplegia*.

***Hemiplegia*** means total *Paralysis* of one arm and one leg on the same side of the body.

***Quadriplegia*** means total *Paralysis* of both arms and both legs.

***Paraplegia*** means total *Paralysis* of both legs.

***Uniplegia*** means total *Paralysis* of one limb.

The *Date of Diagnosis* is the date the *Injury* occurred which caused *Paralysis* continuing for a period of 12 consecutive months as confirmed by the attending *Physician*, or immediately if the spinal cord is completely and irreparably transected.

## STROKE

***Stroke*** means the *Diagnosis* of an acute cerebrovascular accident producing neurological impairment, resulting in *Paralysis* or other measurable objective neurological deficit persisting for at least 96 hours and expected to be permanent, and characterized as Score 3 or higher on the Modified Rankin Scale. Transient ischemic attack (mini-stroke), head *Injury*, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits are excluded under this *Covered Condition*.

The *Diagnosis* must be made by a *Physician* board-certified as a neurologist.

In the event of death, an autopsy confirmation and/or death certificate identifying *Stroke* as the cause of death will be accepted.

The *Date of Diagnosis* is the date a *Stroke* occurred based on neuroimaging consistent with an acute or subacute abnormality or other neurodiagnostic study and presence of neurological deficits persisting for a period of 30 days or greater.

## CARCINOMA IN SITU

***Carcinoma in situ*** means the *Diagnosis* of cancer where the tumor cells still lie within the tissue of origin without having invaded neighboring tissue. *Carcinoma in situ* includes melanoma not invading the dermis.

*Carcinoma in situ* does not include:

a. Non-malignant or pre-malignant lesions (such as intraepithelial neoplasia); or

b. Benign tumors or polyps.

*Carcinoma in situ* must be *Diagnosed* pursuant to a *Pathological Diagnosis* or *Clinical Diagnosis.*

***Clinical Diagnosis*** means a *Diagnosis of Carcinoma* in situ based on the study of symptoms and diagnostic test results. *We* will accept a Clinical *Diagnosis* of *Carcinoma* in situ only if the following conditions are met:

a. A *Pathological Diagnosis* cannot be made because it is medically inappropriate or is life threatening;

b. There is medical evidence to support the *Diagnosis*, and

c. A *Physician* is treating the *Insured* for *Carcinoma in situ*.

***Pathological Diagnosis*** means a *Diagnosis* of *Carcinoma in situ* based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of *Diagnosis* must be done by a *Physician* who is a board certified pathologist and whose *Diagnosis* of malignancy conforms to the standards set by the American College of Pathology.

The *Date of Diagnosis* is the date the tissue specimen, blood samples and/or titer(s) are taken on which the *Diagnosis* of *Carcinoma in situ* is based. If a *Pathological Diagnosis* cannot be made because it is medically inappropriate or life-threatening, *We* will accept a *Clinical Diagnosis.*

## INVASIVE CANCER

***Invasive Cancer*** means a *Diagnosis* of malignant neoplasm which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue, and which is not specifically otherwise excluded. Leukemias and lymphomas are included.

The following are not considered *Invasive Cancer*:

a. Non-malignant, noninvasive, dysplasia (all grades), or pre-malignant lesions (such as intraepithelial neoplasia); or

b. Benign tumors or polyps; or

c. *Carcinoma in situ*; or

d. Any Skin Cancer (other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic).

*Invasive Cancer* must be *Diagnosed* pursuant to a *Pathological Diagnosis*. If a *Pathological Diagnosis* is not possible, *Diagnosis* can be made pursuant to a *Clinical Diagnosis*.

The *Date of Diagnosis* is the date the tissue specimen, blood samples and/or titer(s) are taken on which the *Diagnosis* of Cancer is based. If a *Pathological Diagnosis* cannot be made because it is medically inappropriate or life-threatening, *We* will accept a *Clinical Diagnosis*.

***Clinical Diagnosis*** means a *Diagnosis* of *Invasive Cancer* based on the study of symptoms and diagnostic test results. *We* will accept a *Clinical Diagnosis* of *Invasive Cancer* only if the following conditions are met:

a. A *Pathological Diagnosis* cannot be made because it is medically inappropriate or is life threatening;

b. There is medical evidence to support the *Diagnosis*, and

c. A *Physician* is treating the Insured for *Invasive Cancer*.

***Pathological Diagnosis*** means a *Diagnosis* of *Invasive Cancer* based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of *Diagnosis* must be done by a *Physician* who is a board-certified pathologist and whose *Diagnosis* of malignancy conforms to the standards set by the American College of Pathology.

## SKIN CANCER

***Skin Cancer*** means the *Diagnosis* of basal cell carcinoma or squamous cell carcinoma of the skin, which does not meet the definition of *Carcinoma in situ* or cancer. Melanoma is not covered as *Skin Cancer* under this *Covered Condition*. The *Diagnosis* of *Skin Cancer* must be pursuant to a *Pathological Diagnosis* or *Clinical Diagnosis*.

The *Date of Diagnosis* is the date the tissue specimen, blood samples and/or titer(s) are taken on which the *Diagnosis* of *Carcinoma in situ* is based. If a *Pathological Diagnosis* cannot be made because it is medically inappropriate or life-threatening, *We* will accept a *Clinical Diagnosis*.

## CEREBRAL PALSY

***Cerebral Palsy*** means the *Diagnosis* of a group of disorders of the development of movement and posture causing activity limitation, attributed to progressive disturbances that occurred in the developing fetal or infant brain. The motor disorders of *Cerebral Palsy* are often accompanied by disturbances of sensation, cognition, communication, perception, and/or behavior and/or by a seizure disorder.

The *Date of Diagnosis* is the date, after live birth, in which the *Physician* diagnoses *Cerebral Palsy*.

## CLEFT LIP OR CLEFT PALATE

***Cleft Lip or Cleft Palate*** means a clinical *Diagnosis* of either *Cleft Lip or Cleft Palate.* A *Cleft Lip* appears as a narrow opening or gap in the skin of the upper lip that extends all the way to the base of the nose. A *Cleft Palate* is an opening between the roof of the mouth and the nasal cavity.

*Clefts* occurring on one side of the mouth (unilateral clefting) or on both sides of the mouth (bilateral clefting) are included.

The *Date of Diagnosis* is the date, after live birth, in which the *Physician* diagnoses *Cleft Lip or Cleft Palate.*

## CYSTIC FIBROSIS

***Cystic Fibrosis*** means a *Diagnosis* of *Cystic Fibrosis* by a *Physician* who is a licensed pediatrician or pulmonologist that a *Dependent Child* has chronic lung disease and pancreatic insufficiency. The *Diagnosis* of *Cystic Fibrosis* made via a sweat test should be based on sweat chloride concentrations greater than 60mmol/L.

The *Date of Diagnosis* is the date, after live birth, in which the *Physician* diagnoses *Cystic Fibrosis.*

## DOWN SYNDROME

***Down Syndrome*** means the *Diagnosis* by a *Physician* licensed as a pediatrician or by another *Physician* familiar with the study of the 21st chromosome.

*Down Syndrome* includes:

- Trisomy 21- An individual has three instead of two number 21 chromosomes.
- Translocation - An extra part of the 21st chromosome is attached to another chromosome.
- Mosaicism - The individual has an extra 21st chromosome in only some of the cells but not all of them. The other cells have the usual pair of 21st chromosomes.

The *Date of Diagnosis* is the date, after live birth, in which the *Physician* diagnoses *Down Syndrome.*

## SPINA BIFIDA

***Spina Bifida*** means *Diagnosis* of either of the following types of *Spina Bifida*:

- Meningocele. The protective coatings (meninges) come through the open part of the spine like a sac that is pushed out. Cerebrospinal fluid is in the sac and there is usually no nerve damage. Individuals may suffer minor disabilities. New problems can develop later in life; or
- Myelomeningocele. This occurs when the meninges (protective covering of the spinal cord) and spinal nerves come through the open part of the spine. This is the most serious type of *Spina Bifida*, which causes nerve damage and more severe disabilities.

*Diagnosis* must be made by a *Physician* familiar with *Spina Bifida*.

Spina bifida occulta is excluded.

The *Date of Diagnosis* is the date, after birth, in which the *Physician* diagnoses *Spina Bifida*.

## RECURRENCE BENEFIT

***Which Conditions are eligible for a Recurrence Benefit?***

The Recurrence Benefit is available for a *Diagnosis* of a *Recurrence* of the following *Covered Conditions*:

- *Stroke*
- *Benign Brain Tumor*
- *Coma*
- *Heart Attack*
- *Invasive Cancer*

***Recurrence*** means a *Recurrence* of the same condition after being treatment free for 12 months from the original payment of the *Covered Condition.* The Recurrence Benefit can only be paid one time per *Covered Condition*.

## GENERAL PROVISIONS

***Entire Contract; Changes***

The *Policy*, the *Policyholder's Application*, the *Employee's Certificate* of coverage, and *Your* application, if any, and any other attached papers, form the entire contract between the parties. Coverage under the *Policy* can be amended by mutual consent between the *Policyholder* and *Us.* No change in the *Policy* is valid unless approved in writing by one of *Our* executive officers and unless such approval is endorsed hereon or attached hereto. No agent has the right to change the *Policy* or to waive any of its provisions.

***Statements on the Application***

In the absence of fraud, all statements made in any signed application are considered representations and not warranties (absolute guarantees). No representation by:

1. the *Policyholder* in applying for the *Policy* will make it void unless the representation is contained in his signed *Application;* or
2. any *Employee* in applying for insurance under the *Policy* will be used to reduce or deny a claim unless a copy of the application for insurance, signed by the *Employee,* is or has been given to the *Employee*.

***Legal Actions***

Unless otherwise provided by federal law, no legal action of any kind may be filed against *Us:*

1. until 60 days after *Proof* has been given; or
2. more than 3 years after *Proof* must be filed, unless the law in the state where *You* live allows a longer period of time.

***Clerical Error***

Clerical error or omission by *Us* to the *Policyholder* will not:

1. Prevent *You* from receiving coverage, if *You* are entitled to coverage under the terms of the *Policy;* or
2. Cause coverage to begin or coverage to continue for *You* when the coverage would not otherwise be effective.

If the *Policyholder* gives *Us* information about *You* that is incorrect, *We* will:

1. Use the facts to decide whether *You* have coverage under the *Policy* and in what amounts; and
2. Make a fair adjustment of the premium.

***Time Limit on Certain Defenses***

The validity of the *Policy* shall not be contested, except for non-payment of premiums, after it has been in force for two years from the date of issue. The validity of the *Policy* shall not be contested on the basis of a statement made relating to insurability by any person covered under the *Policy* after such insurance has been in force for two years during such person's lifetime, and shall not be contested unless the statement is contained in a written instrument signed by the person making such statement.

***Premium Provisions***

Premiums are payable in United States dollars on or before their due dates. The *Policyholder* has agreed to deduct from *Your* pay any premiums payable for *Your Voluntary/Supplemental* coverage. The *Policyholder* agrees to remit such premiums for the entire time coverage under the *Policy* is in effect.
Premium charges for increases in insurance amounts becoming effective during a *Policy* month will begin on the next premium due date. Premium charges for insurance terminating during a *Policy* month will cease at the end of the month in which such insurance terminates. This method of charging premium is for accounting purposes only. It will not extend any insurance coverage beyond the date it would otherwise have terminated.

***Misstatement of Age***

If *You* have misstated *Your* age or the age of a *Dependent* the true age will be used to determine:

1. the effective date or termination date of insurance; and
2. the amount of insurance; and
3. any other rights or benefits.

Premiums will be adjusted to reflect the premiums that would have been paid if the true age had been known.

***Conformity with State Statutes and Regulations***

Any provision of the *Policy* which, on its effective date, conflicts with the statutes and regulations of the state in which the *Policy* was issued, it is automatically changed to meet the minimum requirements of such statutes.

***Retention of Discretion***
*We* shall have the exclusive right to interpret the terms of the *Policy.* The decision about whether to pay any claim, in whole or in part, is within *Our* sole discretion and such decisions shall be final and conclusive.

# UNIFORM CLAIM PROVISIONS

***Initial Notice of Claim***

*We* must receive written notice of *Loss* within 30 days of the date of *Loss*, or as soon as reasonably possible. The *Policyholder* can assist with the appropriate telephone number and address of *Our* Claim Department. Notice may be sent to *Our* Claim Department at the address shown on the claim form or given to any authorized agent of *Ours.*

***Claim Forms***

Within 15 days of *Our* being notified in writing of a claim, *We* will supply the claimant with the necessary claim forms. The claim form is to be completed and signed by the claimant, the *Policyholder* and the claimant's *Physician.* If the appropriate claim forms are not received within 15 days, then the claimant will be considered to have met the requirements for written *Proof* of loss if *We* receive written *Proof,* which describes the occurrence, extent and nature of the Loss.

***Time Limit for Filing Your Claim***

*We* must receive written *Proof* within 90 days after the date a *Loss* is incurred. If it is not possible to give *Us* written *Proof* within 90 days, the claim is not affected if the *Proof* is given as soon as possible. However, unless the claimant is legally incapacitated, written *Proof* of loss must be given no later than one year after the time *Proof* is otherwise due.

No benefits are payable for claims submitted more than 1 year after the time *Proof* is due. However, benefits may be paid if it can be shown that:

1. It was not reasonably possible to give written *Proof* during the one year period, and
2. *Proof* satisfactory to Us was given as soon as was reasonably possible.

*We* will give *You* written response to *Your* claim, usually within 45 days. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, *We* notify *You* in writing that an extension is necessary due to matters beyond *Our* control, identify those matters and gives the date by which *We* expect to render a decision. If the extension is due to *Your* failure to submit information necessary to decide *Your* claim, the time for decision shall be tolled from the date on which *We* send *You* notice of the extension until the date *We* receive *Your* response to *Our* request. This period will be no longer than 45 days after *We* have requested the information. At that time *We* will decide *Your* claim based on the information *We* have at that time.

***Payment of Claims***

If a claim or any portion of a claim is determined to have defects or improprieties, including a lack of any required substantiating documentation, or particular circumstances requiring special treatment, *We* will provide written notice of such deficiency within 30 calendar days after receipt of the claim. If a claim is not paid within 45 days of proper *Proof* of loss, *We* will pay simple interest of 10% per year.

***Physical Examination/Autopsy***

On receipt of a claim, *We* may have an *Insured* examined, at *Our* expense, at any reasonable time. *We* may have an autopsy performed, at *Our* expense, if it is not prohibited by any applicable local law(s).

***Who will receive Your Critical Illness Insurance Benefits?***

*Critical Illness Insurance* benefits are payable to *You* unless such benefits have been assigned. The *Policyholder* may not be named as beneficiary. In the event of *Your* death prior to *Critical Illness Insurance* benefits being paid, benefits will be paid according to the Facility of Payment provision.

***Facility of Payment***

If no named beneficiary survives *You* or if *You* do not name a beneficiary, *We* will pay the amount of insurance:

1. to *Your Spouse*, if living; if not,
2. in equal shares to *Your* then living natural or legally adopted children, if any; if none,
3. in equal shares to *Your* father and mother, if living; if not,
4. in equal shares to *Your* brothers and/or sisters, if living; if not,
5. to *Your* estate.

***Do I have the Right to Appeal a Claim Denial?***

If *Your* claim is denied, in whole or in part, *You* will receive a written notice giving the following:

- the reason or reasons for the denial;

- the *Policy* provisions on which the denial is based;
- an explanation of what other material or information, if any, may be needed to process the claim and why it is needed;
- the steps that *You* have to follow to have the claim reviewed;
- a statement that *You* have the right to bring a civil action under section 502(a) of ERISA after *You* appeal *Our* decision and after *You* receive a written denial on appeal; and
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion; or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to *You* upon request; and
- if denial is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to *Your* medical circumstances, or (ii) a statement that such explanation will be provided to *You* free of charge upon request.

If the claim has been denied, in whole or in part, *You* can appeal the denial to *Us* for a full and fair review. *You* have at least 180 days to appeal from the claim denial.

*You* may:

a. request a review upon written application within 180 days of the claim denial;

b. request, free of charge, copies of all documents, records and other information relevant to *Your* claim; and

c. submit written comments, documents, records and other information relating to *Your* claim, without regard to whether such information was submitted or considered in the initial benefit determination.

*We* will make a decision no more than 45 days after *We* receive *Your* appeal. The time for decision may be extended for one additional 45 day period provided that, prior to the extension, *We* notify *You* in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If *Your* claim is extended due to *Your* failure to submit information necessary to decide *Your* claim on appeal, the time for *Your* decision shall be tolled from the date on which the notification of the extension is sent to *You* until the date *We* receive *Your* response to the request.

The decision on appeal will provide the following:

- the reason or reasons for the decision;
- the Plan provision on which the decision is based;
- a statement that *You* are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to *Your* claim for benefits;
- a statement of the claimant's right to bring an action under section 502(a) of ERISA;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision either (i) the specific rule, guideline, protocol or other similar criterion; or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the decision and that a copy will be provided free of charge to *You* upon request;
- if the decision is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to *Your* medical circumstances, or (ii) a statement that such explanation will be provided to *You* free of charge upon request; and
- the following statement: "*You* and *Your* plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact *Your* local U.S. Department of Labor Office and *Your* State insurance regulatory agency."

# GENERAL DEFINITIONS

***Accident*** or ***Accidental*** means a sudden, unexpected event that was not reasonably foreseeable.

***Actively at Work or Active Work*** means that *You* must:

1. work for the *Policyholder* on a full-time active basis; or

2. work at least the minimum number of hours set forth in the Schedule of Benefits: and either:
    a. work at the *Policyholder's* usual place of business; or
    b. work at a location to which the *Policyholder's* business requires *You* to travel; and
3. not be a temporary or seasonal *Employee;* and
4. be paid regular earnings by the *Policyholder.*

*You* will be considered *Actively at Work* if *You* were actually at work on the day immediately preceding:

1. a weekend (except for one or both of these days if they are scheduled days of work);
2. holidays (except when such holiday is a scheduled work day);
3. paid vacations;
4. any non-scheduled work day;
5. excused leave of absence (except medical leave and lay-off); or
6. emergency leave of absence (except emergency medical leave); and
7. *You* were not *Hospital Confined* or disabled due to an *Injury* or *Illness.*

***Application*** means the document which sets forth the eligible classes, the amounts of insurance, and other relevant information pertaining to the plan of insurance for which the *Policyholder* applied.

***Certificate*** means this *Critical Illness Insurance Certificate.*

***Change in Family Status*** means a change in status as defined in the regulations under Internal Revenue Code section 125, unless *Your* employer's cafeteria plan document or human resource *Policy* contains more restrictive provisions. In that event, *Your* employer may restrict the situations where *You* can change *Your* coverage.

***Contributory*** means *You* pay all or a portion of the premium for this insurance coverage.

***Covered Conditions*** means an *Illness* or *Injury* listed in the *Covered Conditions* Schedule.

***Date of Diagnosis*** means the date the *Diagnosis* is made by a *Physician* through the use of clinical and/or laboratory findings as supported by *You* or *Your* covered *Dependents'* medical records. *Date of Diagnosis* may be further defined for a specific *Covered Condition*; if so, that definition will control over this definition.

***Dependent* or *Eligible Dependent*** means:

1. *Your* lawful *Spouse;* and/or
2. *Your* unmarried child(ren) who are less than age 26 and are not in active military service.

*Eligible Dependents* include:

1. *Your* natural or step child.
2. a child placed with *You* for adoption from the date of placement or the date *You* are party in a suit in which *You* seek the adoption of the child. Eligibility will continue unless the child is removed from placement.
3. a child of *Your* child who is *Your Dependent* for federal income tax purposes at the time application for coverage of the child of *Your* child is made.

***Diagnosis/Diagnosed*** means the definitive establishment of a *Covered Condition* by a *Physician.*

***Employee* or *Eligible Employee*** means an *Actively at Work*, full-time *Employee* as shown in the Schedule of Benefits whose principal employment is with the *Policyholder*, at the *Policyholder's* usual place of business or such place(s) that the *Policyholder's* normal course of business may require, and who is reported on the *Policyholder's* records for Social Security and withholding tax purposes.

***Illness*** means sickness, disease, pregnancy or complications of pregnancy.

***Injury*** means bodily harm resulting directly from an *Accident* and independently of all other causes.

***Insured*** means an *Employee* or Eligible Dependent covered under the *Policy.*

***Male Pronoun*** whenever used includes the female.

***Material and Substantial Duties*** means duties that are normally required for the performance of *Your Regular Occupation* and cannot be reasonably omitted or modified.

***Physician*** means a person other than *You* or *Your* covered *Dependent*, a member of *You* or *Your* covered *Dependents'* immediate family or *You* or *Your* covered *Dependents'* business associate, who is licensed to and actively practicing medicine in the United States, and is licensed to treat *Illness* and *Injury*. The *Physician* must be providing services within the scope of his license and must be a board certified specialist where required under the terms of a *Covered Condition*.

***Policy*** means the contract between the *Policyholder* and *Us* including the *Application*, this *Certificate* and any amendments, riders or endorsements.

***Policyholder*** means the person, firm, or institution to whom the *Policy* was issued. *Policyholder* also means any covered subsidiaries or affiliates set forth on the face of the *Policy*. If the *Policyholder* is an association the term *Participating Employer* shall be substituted for *Policyholder*.

***Proof*** means evidence satisfactory to *Us* that *You* or *Your* covered *Dependents* has a *Covered Condition*. *We* reserve the right to determine, at *Our* sole discretion, if *Proof* is acceptable under the terms of the *Policy*.

***Regular Occupation*** means the occupation that *You* are routinely performing when *Your Critical Illness Insurance* terminates due to *Disability*. *We* will look at *Your* occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific *Policyholder* or at a specific location.

***Riot*** means all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether with or without a common intent and whether or not damage to person or property or unlawful act is the intent or the consequence of such disorder.

***Spouse*** means lawful *Spouse*.

***Student*** means an *Eligible Dependent* child who, on the date of *Your* death, is:

1. A full-time post-high school *Student* in a school of higher education; or
2. A *Student* in the 12th grade but who becomes a full-time post-high school *Student* in a school of higher education within 365 days after *Your* death.

***Voluntary*** means coverage for which *You* pay 100% of the premium.

***We, Our*** and ***Us*** means Dearborn Life Insurance Company.

***You, Your*** and ***Yours*** means the *Eligible Employee* to whom this *Certificate* is issued and whose insurance is in force under the terms of the *Policy*.

**DEARBORN LIFE INSURANCE COMPANY**

**Chicago, Illinois**

Administrative Office: 701 E. 22nd Street · Lombard, IL 60148

# COVID-19 RIDER

This Rider is effective 01/01/2025. It is part of the *Policy* or *Certificate* to which it is attached. It is subject to all provisions of the *Policy* or *Certificate* not in conflict with the provisions of this Rider.

## SEVERE COVID-19 INFECTION

*Severe COVID-19 Infection* means the *Diagnosis* of the *COVID-19* strain of the Human Coronavirus, also known as 2019-nCoV.

*Diagnosis* means a clinically approved, positive medical test confirmed by a *Physician* showing positive for *COVID-19* and a *Physician* recommends confinement in an I*ntensive Care Unit* and placement on a ventilator due to abnormal oxygen levels in the lungs.

The *Date of Diagnosis* is the date the *Physician* recommends confinement in an *Intensive Care Unit* and placement on a ventilator due to the *Diagnosis* of *COVID-19*.

*Intensive Care Unit* means a place which:

- Is a specially designated area of the hospital called an *Intensive Care Unit* that provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care; and
- Is separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement; and
- Is permanently equipped with special lifesaving equipment for the care of the critically ill or injured; and
- Is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the *Intensive Care Unit* on a 24-hour basis; and
- Has a *Physician* assigned to the *Intensive Care Unit* on a full-time basis.

An *Intensive Care Unit* is not a progressive care unit, an intermediate care unit, a private monitored room, sub-acute *Intensive Care Unit*, an observation unit or any facility not meeting the definition of an *Intensive Care Unit* as defined above.

An *Intensive Care Unit* that meets the definition above includes hospital units with the following names:
- Intensive Care Unit;
- Coronary Care Unit;
- Neonatal Intensive Care Unit;
- Pulmonary Care Unit;
- Burn Unit; or
- Transplant Unit.

The Benefit Percentage is 100%.

Nothing contained in this Rider shall be held to alter or affect any provision or condition of your coverage other than as stated above.

Michael W. Watters

President

DL9-CI-COVID19 0920

**DEARBORN LIFE INSURANCE COMPANY**

**Chicago, Illinois**

Administrative Office: 701 E. 22nd Street · Lombard, IL 60148

# CERTIFICATE AMENDMENT

This Amendment, effective 01/01/2025, is part of the *Certificate* to which it is attached. It is subject to all provisions of the *Certificate* not in conflict with the provisions of this Amendment.

## WELLNESS BENEFIT

***What is the Wellness Benefit?***

If, while insured under the *Policy*, *You* or *Your* covered *Dependent* undergo any of the *Wellness Tests* indicated below, *We* will pay the amount as set forth in the Schedule of Benefits.

***Wellness Tests*** include:

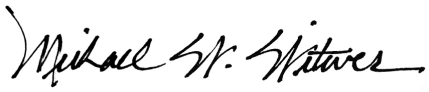
- Blood test for triglycerides;
- Bone marrow aspiration or biopsy;
- CA 15-3 (blood test for breast cancer);
- CA-125 (blood test for ovarian cancer);
- CEA (blood test for colon cancer);
- Carotid Doppler;
- Chest x-ray;
- Colonoscopy;
- COVID-19 screening;
- Echocardiogram;
- Electrocardiogram;
- Fasting blood glucose test;
- Fasting plasma glucose (FPG);
- Flexible sigmoidoscopy;
- Hemoglobin A1C (HbA1c);
- Hemocult stool analysis;
- Mammography;
- Pap smear;
- PSA (blood test for prostate cancer);
- Serum cholesterol test to determine HDL and LDL levels;
- Serum protein electrophoresis (blood test for myeloma);
- Skin cancer biopsy;
- Stress test on a bicycle or treadmill;
- Thermography;
- Thin prep pap test;
- Two hour post-load plasma glucose; or
- Vaccinations; or
- Virtual colonoscopy.

The *Wellness Benefit* is payable once per *Calendar Year* for each insured *Employee* and covered *Dependent*.

For the purposes of the *Wellness Benefit*, *Calendar Year* is the period beginning January 1st and ending December 31st.

The *Wellness Tests* must be performed while the *Insured's* coverage under the *Policy* is in force. *Proof* must be provided that the test was performed and the *Insured* incurred an expense.

Nothing contained in this Amendment shall be held to alter or affect any provision or condition of your coverage other than as stated above.



President

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

This notice provides a **brief summary** of the Oklahoma Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Oklahoma law, which determines who and what is covered and the amounts of coverage. The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Oklahoma law, with funding from assessments paid by other insurance companies. (For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs).)

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 for health benefit plans (see definition below)
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $300,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except that with regard to hospital, medical and surgical insurance benefits, the maximum amount that will be paid is $500,000.

"Health benefit plan" is defined in 36 O.S. §2024(7) and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance (LTCI).

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

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

Oklahoma Life & Health Insurance Guaranty Association
201 Robert S. Kerr, Suite 600
Oklahoma City, OK 73102

Oklahoma Department of Insurance
3625 NW 56th Street, Suite 100
Oklahoma City, OK 73112
1-800-522-0071 or (405) 521-2828

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

# END OF CERTIFICATE

Administrative Office:

**701 E. 22nd Street • Lombard, Illinois 60148**