

CRITICAL ILLNESS - LEVEL



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

CERTIFICATE OF 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. 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:	Catholic Health Services of Long Island
Group Policy Number:	0217251
Employee Name:	See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife
Employee Number:	See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife
Effective Date of Insurance:	See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife
MetLife Contact Information:	1-800-GET-MET8

We have issued this Certificate to You in consideration of the payment of the Contribution and the statements made in Your Enrollment Form. Your Enrollment Form is part of Your Certificate.

This is a limited Certificate. It pays benefits for Alzheimer's Disease, Cancer, Coronary Artery Disease, Heart Attack, Kidney Failure, Major Organ Transplant and Stroke. Read this Certificate Carefully, together with the required Disclosure Document.

This Certificate does not provide Essential Health Benefits as defined under the Affordable Care Act.

TABLE OF CONTENTS

Section	Page
SCHEDULE OF INSURANCE	4
DEFINITIONS.....	6
ELIGIBILITY PROVISIONS: INSURANCE FOR YOU	10
Eligible Class	10
Date You Are Eligible For Insurance	10
Enrollment Process	10
Date Your Insurance Takes Effect.....	10
Benefit Increases	10
Medical Coverage Requirement For You	10
ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE	11
Eligible Classes For Dependent Insurance	11
Date You Are Eligible For Dependent Insurance	11
Enrollment Process	11
Date Dependent Insurance Takes Effect.....	12
Newborn And Adopted Children	12
Benefit Increases	12
Medical Coverage Requirement For Your Dependents	12
CRITICAL ILLNESS BENEFITS FOR ALZHEIMER'S DISEASE	14
Initial Benefit For Alzheimer's Disease	14
Recurrence Benefit For Alzheimer's Disease.....	14
Proof Requirements For Alzheimer's Disease	14
Alzheimer's Disease And The Total Benefit Amount	14
CRITICAL ILLNESS BENEFITS FOR CANCER.....	15
Initial Benefit For Cancer.....	15
Recurrence Benefit For Cancer	15
Proof Requirements For Cancer	15
Cancer And The Total Benefit Amount.....	15
CRITICAL ILLNESS BENEFITS FOR CORONARY ARTERY DISEASE	16
Initial Benefit For Coronary Artery Disease	16
Recurrence Benefit For Coronary Artery Disease.....	16
Proof Requirements For Coronary Artery Disease	16
Coronary Artery Disease And The Total Benefit Amount	16
CRITICAL ILLNESS BENEFITS FOR HEART ATTACK.....	17
Initial Benefit For Heart attack.....	17
Recurrence Benefit For Heart Attack.....	17
Proof Requirements For Heart Attack	17
Heart Attack And The Total Benefit Amount	17
CRITICAL ILLNESS BENEFITS FOR KIDNEY FAILURE.....	18
Initial Benefit For Kidney Failure	18
Recurrence Benefit For Kidney Failure	18
Proof Requirements For Kidney Failure	18
Kidney Failure And The Total Benefit Amount	18
CRITICAL ILLNESS BENEFITS FOR MAJOR ORGAN TRANSPLANT	19
Initial Benefit For Major Organ Transplant.....	19
Recurrence Benefit For Major Organ Transplant.....	19
Proof Requirements For Major Organ Transplant.....	19
Major Organ Transplant And The Total Benefit Amount.....	19
CRITICAL ILLNESS BENEFITS FOR STROKE	20

Initial Benefit For Stroke	20
Recurrence Benefit For Stroke	20
Proof Requirements For Stroke	20
Stroke And The Total Benefit Amount	20
HEALTH SCREENING BENEFIT	21
LIMITATIONS	22
EXCLUSIONS	23
General Exclusions.....	23
WHEN INSURANCE ENDS	24
Date Your Insurance Ends	24
Date Dependent Insurance Ends.....	24
SPECIAL RULES FOR COVERED PERSONS PREVIOUSLY INSURED UNDER ANOTHER GROUP CRITICAL ILLNESS INSURANCE POLICY ISSUED TO THE GROUP POLICYHOLDER	25
CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT	26
For Mentally Or Physically Handicapped Children.....	26
For Family And Medical Leave	26
At Your Option: Continuation with premium payment.....	26
Request Period	26
Premiums for Continued Insurance	26
End of Continued Insurance	27
CLAIMS.....	28
Filing A Claim.....	28
Payment Of Benefits	28
Authorizations	29
Examinations	29
Autopsy	29
Time Limit on Legal Actions	29
GENERAL PROVISIONS.....	30
Changes in Standards.....	30
Entire Contract.....	30
Incontestability: Statements Made By You	30
Misstatements.....	30
Unpaid Premium; Excess Premium	30
Assignment	30
Conformity with Law	30

SCHEDULE OF INSURANCE

This schedule shows the benefits that You have selected under the Group Policy. You and Your Dependents will only be insured for benefits:

- for which You and Your Dependents become and remain eligible; and
- which are in effect under the Group Policy and this Certificate.

BENEFIT AMOUNT

For You	See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife
For Your Spouse or Domestic Partner	See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife
For Your Dependent Child	See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife

TOTAL BENEFIT AMOUNT

For You	See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife
For Your Spouse or Domestic Partner	See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife
For Your Dependent Child	See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife

SCHEDULE OF INSURANCE (continued)

BENEFITS FOR COVERED CONDITIONS

Covered Condition	Initial Benefit	Recurrence Benefit
Alzheimer's Disease	100% of Benefit Amount	NONE
Cancer		
Full Benefit Cancer	100% of Benefit Amount	100% of Benefit Amount
Partial Benefit Cancer	25% of Benefit Amount	25% of Benefit Amount
Skin Cancer	5% of Benefit Amount but not less than \$250	NONE
Coronary Artery Disease	100% of Benefit Amount	NONE
Heart Attack	100% of Benefit Amount	100% of Benefit Amount
Kidney Failure	100% of Benefit Amount	NONE
Major Organ Transplant	100% of Benefit Amount	NONE
Stroke	100% of Benefit Amount	100% of Benefit Amount

Health Screening Benefit: \$50

IMPORTANT NOTE: This Certificate contains certain Proof requirements, exclusions, limitations and other provisions that may reduce benefits or prevent a Covered Person from receiving any benefits under this Certificate. PLEASE READ YOUR ENTIRE CERTIFICATE CAREFULLY.

DEFINITIONS

As used in this Certificate, the terms listed below will have the meanings set forth below. Some defined terms are also 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.

Benefit Increase means a simultaneous increase in both the Benefit Amount and Total Benefit Amount.

Certificate means this Certificate including any riders attached to it.

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

Covered Condition means the following, as they are defined in this Certificate:

- Alzheimer's Disease;
- Cancer;
- Coronary Artery Disease;
- Heart Attack;
- Kidney Failure;
- Major Organ Transplant; or
- Stroke.

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

Dependent means Your Spouse, Domestic Partner and/or Dependent Child.

Dependent Child means the following:

Your biological child, adopted child, or stepchild who is under age 26.

The term does not include an unborn or stillborn child.

A person cannot be insured as a Dependent Child of more than one employee under the Group Policy. No person can be insured under the Group Policy as both an employee and as a Dependent Child. Your adopted child will not be a Dependent Child prior to:

- the date the child is placed in Your home for adoption; or
- the first date of any statutory or court ordered waiting period that must expire before such adoption becomes final.

Dependent Insurance means insurance under this Certificate for Your Dependents.

Diagnosis means the establishment of a Covered Condition by a Physician through the use of clinical and/or laboratory findings.

Diagnose means the act of making a Diagnosis.

DEFINITIONS (continued)

Domestic Partner means each of two people, one of whom is an employee of the Group Policyholder, who:

1. have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available; or
2. are of the same or opposite sex and have completed a signed declaration declaring that:
 - each person is 18 years of age or older;
 - each person is unmarried and the sole domestic partner of the other;
 - they are sharing a primary residence with each other;
 - they are not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.
 - they have a mutually dependent relationship so that each has an insurable interest in the life of the other and 2 or more of the following exist as evidence of joint responsibility for basic financial obligations:
 1. a joint mortgage or lease;
 2. designation of the Domestic Partner as beneficiary for life insurance or retirement benefits;
 3. joint wills or designation as executor and/or primary beneficiary;
 4. ownership of a joint bank account, joint credit cards or other evidence of joint financial responsibility; or
 5. other evidence of economic interdependence.

No person can be insured under the Group Policy as both an employee and as a Domestic Partner.

Enrollment Form means the Written form provided by Us that You use to enroll for insurance under the Group Policy, including any amendments thereto.

First Occurs or **First Occurrence** means, with respect to each Covered Condition, the first time after a Covered Person initially becomes insured under the Group Policy that such Covered Condition Occurs.

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 30 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 the employer named on the first page of this Certificate.

Hospital means a short-term, acute care, general hospital 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 and major Surgery;
- 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.

Hospitalized means:

- admitted for inpatient care in a Hospital;
- receiving care in a hospice facility, an intermediate care facility or a long-term care facility; or
- receiving the following treatment, wherever performed:
 - chemotherapy;
 - radiation therapy; or
 - dialysis.

Initial Benefit means the benefit, as specified in the Schedule, that We will pay for a Covered Condition that First Occurs while coverage is in effect under 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.

DEFINITIONS (continued)

Occurs or Occurrence means:

- with respect to Coronary Artery Disease, that a Physician makes a Diagnosis that Coronary Artery Bypass Graft is medically necessary to correct narrowing or blockage of any of the Covered Person's coronary arteries;
- with respect to Major Organ Transplant, that the Covered Person's Physician deems such Major Organ Transplant to be medically necessary;
- with respect to Alzheimer's Disease that the Covered Person:
 1. experiences such Covered Condition;
 2. is Diagnosed with such Covered Condition; and
 3. all other etiologies have been ruled out by a Neurologist; Geriatrician or Neuropsychologist.
- with respect to all other Covered Conditions, that the Covered Person:
 1. experiences such Covered Condition; and
 2. is Diagnosed with such Covered Condition.

Physician means an individual who:

- is validly licensed as a practitioner of the healing arts in the United States, Canadian or Mexican jurisdiction where he or she practices; and
- is acting within the lawful scope of such valid license and of his or her practice when he or she: (1) Diagnoses a Covered Condition for which a claim is made; (2) performs medical services required for a Covered Condition for which a claim is made; or (3) performs any other medical services that are to be performed by a Physician under the terms of this Certificate.

A Physician does not include You or members of Your immediate family.

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:

- with respect to Cancer, a second Occurrence of Cancer that Occurs after an Initial Benefit was paid for a First Occurrence of that same Cancer.
- with respect to any other Covered Condition, a second Occurrence of that Covered Condition after We have already paid an Initial Benefit for the First Occurrence of that Covered Condition.

Schedule means the Schedule of Insurance that appears in this Certificate.

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. No person can be insured under the Group Policy both as an employee and a Spouse.

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 procedures.

Total Benefit Amount means the maximum aggregate amount, as specified in the Schedule, that We will pay for any and all Covered Conditions, per Covered Person, per lifetime, as provided under this Certificate. The Total Benefit Amount does not include benefits paid for the Health Screening.

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

We, Us and Our mean Metropolitan Life Insurance Company.

DEFINITIONS (continued)

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 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

Except as provided in the Medical Coverage Requirement for You provision below, provided that You are Actively at Work in an eligible class, insurance under this Certificate will take effect for You on the Effective Date shown on the first page of this Certificate.

If You are not Actively at Work in an eligible class on the date insurance would otherwise take effect under the above paragraph, insurance will take effect on the date You return to Active Work in an eligible class.

BENEFIT INCREASES

If You are insured under this Certificate at the time a Benefit Increase is offered for Your eligible class, You will be eligible for the Benefit Increase if You have not already attained the Maximum Benefit Amount. You may complete the form required to elect the Benefit Increase. If You do, provided that You are Actively at Work in an eligible class, the Benefit Increase will take effect for You on the later of:

- the date it is scheduled to go into effect for Your eligible class; and
- the date You complete the form required to elect the Benefit Increase.

If You are not Actively at Work in an eligible class on the date the Benefit Increase would otherwise take effect under the above paragraph, Your Benefit Increase will take effect on the date You return to Active Work in a class that is eligible for the Benefit Increase.

MEDICAL COVERAGE REQUIREMENT FOR YOU

You must have Medical Coverage in force on the effective date of Your insurance under this Certificate. We will not approve You for insurance if Your Enrollment Form does not indicate that You are covered for Medical Coverage. Within 30 days after the effective date of Your insurance under this Certificate, We will ask You to confirm in Writing that You had Medical Coverage in force on the effective date of Your insurance under this Certificate. If You respond in Writing that Medical Coverage was not in force on the effective date of Your insurance under this Certificate, Your insurance under this Certificate will be void as of its effective date and all Contributions that You have paid for such coverage will be returned without interest.

ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE

ELIGIBLE CLASSES 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.

A Dependent will not be eligible while the Dependent:

- Is serving in the armed forces, or any auxiliary units of the armed forces, of any country; or
- Lives outside the United States, Canada or Mexico for more than 12 consecutive months.

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

Except as described in the Newborn and Adopted Children provision below, if You become eligible for Dependent Insurance, You may enroll for such insurance by providing Us with the 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.

ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE (CONTINUED)

DATE DEPENDENT INSURANCE TAKES EFFECT

Except as described in the Newborn and Adopted Children provision and Medical Coverage Requirement for Your Dependents provision below, Dependent Insurance for a Dependent will take effect on the later of the date You are eligible for Dependent Insurance and the date the Dependent becomes Your Dependent, provided that on that date the Dependent meets the following requirements:

- the Dependent is not confined at home under a Physician's care;
- the Dependent is not receiving or applying to receiving disability benefits from any source; and
- the Dependent is not Hospitalized.

Except as described in the Newborn and Adopted Children provision and Medical Coverage Requirement for Your Dependents provision below, if a Dependent does not meet these requirements 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:

- confined at home under a Physician's care;
- receiving or applying to receiving disability benefits from any source; or
- Hospitalized.

Once Dependent Insurance is in effect for at least one Dependent Child, any additional child who becomes Your Dependent Child will be insured from the date the child becomes Your Dependent Child. You do not need to enroll such additional Dependent Children for them to become insured for Dependent Insurance.

NEWBORN AND ADOPTED CHILDREN

A Dependent Child, born to You while insurance is in effect under this Certificate will be covered for 31 days from the moment of such additional Dependent Child's birth. Unless You already have Dependent Insurance in effect for other Dependent Children, to continue coverage beyond the 31 days You must enroll the child and give Written permission to deduct Contributions for Your pay for Dependent Insurance.

A Dependent Child adopted by You while insurance is in effect under this Certificate will be covered for 31 days from the moment of such Dependent Child's birth if You take custody of the Dependent Child upon such Dependent Child's release from the hospital and within 30 days of the date the Dependent Child is born You file a petition to adopt the Dependent Child. Unless You already have Dependent Insurance in effect for other Dependent Children, to continue coverage beyond the first 31 days You must enroll the child and give written permission to deduct Contributions from Your pay for Dependent Insurance.

BENEFIT INCREASES

If a Dependent is insured under this Certificate at the time a Benefit Increase is offered for Your eligible class, You may complete the form required to elect the Benefit Increase. If You do, the Benefit Increase will take effect for that Dependent on the later of the date it is scheduled to go into effect for Your eligible class and the date You complete the form required to elect the Benefit Increase provided that on that date the Dependent meets the following requirements:

- the Dependent is not confined at home under a Physician's care;
- the Dependent is not receiving or applying to receiving disability benefits from any source; and
- the Dependent is not Hospitalized.

If a Dependent does not meet these requirements on that date, the Benefit Increase will take effect on the date the Dependent is no longer:

- confined at home under a Physician's care;
- receiving or applying to receiving disability benefits from any source; or
- Hospitalized.

MEDICAL COVERAGE REQUIREMENT FOR YOUR DEPENDENTS

Each Dependent who You enroll must have Medical Coverage in force on the effective date of insurance for that Dependent under this Certificate. We will not approve such a Dependent for insurance if Your Enrollment Form does not indicate that the Dependent is covered for Medical Coverage. Within 30 days after the effective

date of that Dependent's insurance under this Certificate, We will ask You to confirm that the Dependent had Medical Coverage in force on the effective date of insurance under this Certificate.

If You respond in Writing that Medical Coverage was not in force on the effective date of insurance for Your Spouse or Domestic Partner who You enroll under this Certificate, insurance under this Certificate will be void with respect to such Spouse or Domestic Partner as of its effective date and all Contributions that You have paid for such coverage will be returned to You without interest.

If You respond in Writing that Medical Coverage was not in force on the effective date of insurance for Your Dependent Child who You enroll under this Certificate, insurance under this Certificate will be void with respect to that Dependent Child as of its effective date and all Contributions that You have paid for such coverage will be returned to You without interest if there is no insurance remaining in effect for any other Dependent Child under this Certificate.

CRITICAL ILLNESS BENEFITS FOR ALZHEIMER'S DISEASE

Alzheimer's Disease means the development of multiple, progressive cognitive deficits manifested by memory impairment (impaired ability to learn new information or to recall previously learned information) and one or more of the following cognitive disturbances:

- 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); and
- disturbance in executive functioning (i.e. planning, organizing, sequencing, abstracting).

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 dementia (e.g., hypothyroidism, vitamin B12 or folic acid deficiency, niacin deficiency, hypercalcemia, neurosyphilis);
- substance-induced conditions; or
- any form of dementia that is not diagnosed as Alzheimer's Disease.

Geriatrician means a Physician specializing in the assessment and treatment of elderly people.

Neuropsychologist means a psychologist who has completed special training in the neurological causes of brain disorders and who specializes in diagnosing and treating these illnesses using a predominantly medical approach.

Neurologist means a Physician who specializes in the diagnosis and treatment of disorders of the nervous system.

INITIAL BENEFIT FOR ALZHEIMER'S DISEASE

If Alzheimer's Disease First Occurs for a Covered Person, while such Covered Person is insured under this Certificate, Proof of the Alzheimer's Disease may be sent to Us. When We receive such Proof, We will review the claim and if We approve it, will pay the Initial Benefit shown in the Schedule for such Alzheimer's Disease.

RECURRENCE BENEFIT FOR ALZHEIMER'S DISEASE

We will not pay a Recurrence Benefit for Alzheimer's Disease.

PROOF REQUIREMENTS FOR ALZHEIMER'S DISEASE

Proof of Alzheimer's Disease requires a medically appropriate Diagnosis made in Writing by a Neurologist, Geriatrician, or Neuropsychologist. Any type of medically appropriate Diagnosis will be accepted. The Covered Condition for Alzheimer's Disease will be deemed to Occur on the date that the Diagnosis of Alzheimer's Disease is made and all other etiologies have been ruled out.

ALZHEIMER'S DISEASE AND THE TOTAL BENEFIT AMOUNT

Payment of Critical Illness Benefits for Alzheimer's Disease is subject to the Total Benefit Amount as explained in the REDUCTION ON ACCOUNT OF PRIOR CLAIMS PAID provision.

CRITICAL ILLNESS BENEFITS FOR CANCER

Cancer means the presence of one or more malignant tumors characterized by the uncontrollable and abnormal growth and spread of malignant cells with invasion of normal tissue or the presence of one or more malignant tumors where there is metastasis.

Cancer does not include any benign tumor, dysplasia, intraepithelial neoplasia or pre-malignant growth.

The Critical Illness Benefit for Cancer varies depending on the type of Cancer that Occurs:

- **Partial Benefit Cancer** means one of the following conditions that meets the TNM Staging classification and other qualifications specified below:
 1. a carcinoma in situ wherein the malignant tumor cells still lie within the tissue of the site of origin without having invaded neighboring tissue; and
 2. tumors of the prostate classified as T1N0M0, including but not limited to T1aN0M0, T1bN0M0, or T1cN0M0 under TNM Staging.
- **Skin Cancer** means any malignant growth that arises on the surface of the skin that is a:
 1. basal cell carcinoma;
 2. squamous cell carcinoma;
 3. melanoma classified as Clarks Level I (melanoma in situ); or
 4. melanoma classified as Clarks Level II.
- **Full Benefit Cancer** means any form of Cancer that is not Partial Benefit Cancer or Skin Cancer.

TNM Staging means the classification standards for cancer developed by the American Joint Committee on Cancer.

INITIAL BENEFIT FOR CANCER

If Cancer First Occurs for a Covered Person, while such Covered Person is insured under this Certificate, Proof of the Cancer may be sent to Us. When We receive such Proof, We will review the claim and if We approve it, will pay the Initial Benefit shown in the Schedule for the type of Cancer that is Diagnosed. After an Occurrence of Cancer while the Covered Person is insured under the Group Policy, a subsequent Occurrence of a Separate & Unrelated Cancer while the Covered Person is insured under the Group Policy will be deemed a First Occurrence. However, We will never pay more with respect to any Covered Person, for all First Occurrences of Cancer combined, than the Initial Benefit Amount for Full Benefit Cancer shown in the Schedule.

Separate & Unrelated means a Cancer that is:

- not a metastasis of a previously Diagnosed Cancer; and
- distinct from any previously Diagnosed Cancer.

RECURRENCE BENEFIT FOR CANCER

We will pay the Recurrence Benefit shown in the Schedule for a Recurrence of Cancer for the type of Cancer that is Diagnosed, subject to the following limitations:

- We will not pay a Recurrence Benefit for Skin Cancer; and
- the Recurrence Benefit for Cancer shall not be paid more than once.

PROOF REQUIREMENTS FOR CANCER

Diagnosis of Cancer must be based upon microscopic (histologic) examination of fixed tissues or preparations of blood or bone marrow. Such examination must be documented in a Written pathology report by a Physician. Alternatively, a clinical Diagnosis of Cancer will be accepted as evidence that Cancer exists when a pathological diagnosis is medically inappropriate. Any type of medically appropriate Diagnosis will be accepted.

The Covered Condition for Cancer will be deemed to Occur upon the date that the Diagnosis of Cancer is made.

CANCER AND THE TOTAL BENEFIT AMOUNT

Payment of Critical Illness Benefits for Cancer is subject to the Total Benefit Amount as explained in the REDUCTION ON ACCOUNT OF PRIOR CLAIMS PAID provision.

CRITICAL ILLNESS BENEFITS FOR CORONARY ARTERY DISEASE

Coronary Artery Disease means the blockage or narrowing of one or more coronary arteries due to atherosclerotic heart disease for which a Physician has determined Coronary Artery Bypass Graft to be medically necessary.

Coronary Artery Bypass Graft means open heart Surgery to bypass a narrowing of one or more coronary arteries. Coronary Artery Bypass Graft does not include:

- angioplasty (percutaneous transluminal coronary angioplasty);
- laser relief;
- stent insertion;
- coronary angiography; or
- any other intra-catheter technique.

INITIAL BENEFIT FOR CORONARY ARTERY DISEASE

If Coronary Artery Disease First Occurs for a Covered Person, while such Covered Person is insured under this Certificate, Proof of the Coronary Artery Disease may be sent to Us. When We receive such Proof, We will review the claim and if We approve it, will pay the Initial Benefit shown in the Schedule for such Coronary Artery Disease.

RECURRENCE BENEFIT FOR CORONARY ARTERY DISEASE

We will not pay a Recurrence Benefit for Coronary Artery Disease.

PROOF REQUIREMENTS FOR CORONARY ARTERY DISEASE

Proof of Coronary Artery Disease requires submission of medical records evidencing that Coronary Artery Bypass Graft was determined to be medically necessary by a Physician. The Covered Condition for Coronary Artery Disease will be deemed to Occur on the date that the Physician determines that Coronary Artery Bypass Graft is medically necessary.

CORONARY ARTERY DISEASE AND THE TOTAL BENEFIT AMOUNT

Payment of Critical Illness Benefits for Coronary Artery Disease is subject to the Total Benefit Amount as explained in the REDUCTION ON ACCOUNT OF PRIOR CLAIMS PAID provision.

CRITICAL ILLNESS BENEFITS FOR HEART ATTACK

Heart Attack (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.

INITIAL BENEFIT FOR HEART ATTACK

If Heart Attack First Occurs for a Covered Person, while such Covered Person is insured under this Certificate, Proof of the Heart Attack may be sent to Us. When We receive such Proof, We will review the claim and if We approve it, will pay the Initial Benefit shown in the Schedule for such Heart Attack.

RECURRENCE BENEFIT FOR HEART ATTACK

We will pay the Recurrence Benefit shown in the Schedule for a Recurrence of Heart Attack provided that the Recurrence Benefit for Heart Attack shall not be paid more than once.

PROOF REQUIREMENTS FOR HEART ATTACK

Diagnosis of Heart Attack must be made in Writing by a Physician and supported by medical records showing an elevation of enzymes, troponins or other biochemical cardiac markers, and two of the three following criteria associated with the Heart Attack for which a claim is being made:

1. typical chest pain characteristic of an acute myocardial infarction, requiring the Covered Person to be Hospitalized as an inpatient;
2. electrocardiograph (EKG) changes on one or a series of electrocardiograms taken at the time the Covered Person experiences the Heart Attack for which a claim is being made, which changes are indicative of an acute myocardial infarction, but, if the Covered Person had any prior electrocardiogram(s), the electrocardiogram(s) presented as Proof of Heart Attack must show changes from the Covered Person's last electrocardiogram, and such changes must be indicative of an acute myocardial infarction; or
3. confirmatory imaging studies such as thallium scans, or echocardiograms indicative of an acute myocardial infarction, but, if the Covered Person had any prior imaging studies, the imaging studies presented as Proof of Heart Attack must show changes from the Covered Person's last imaging studies, which changes must be indicative of a myocardial infarction.

However, if a pathological Diagnosis of Heart Attack is medically inappropriate, a clinical Diagnosis will be accepted. Any type of medically appropriate Diagnosis will be accepted.

The Covered Condition for Heart Attack will be deemed to Occur on the date the Diagnosis of Heart Attack is made.

HEART ATTACK AND THE TOTAL BENEFIT AMOUNT

Payment of Critical Illness Benefits for Heart Attack is subject to the Total Benefit Amount as explained in the REDUCTION ON ACCOUNT OF PRIOR CLAIMS PAID provision.

CRITICAL ILLNESS BENEFITS FOR KIDNEY FAILURE

Kidney Failure means the total, end stage, irreversible failure of both kidneys to function, 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.

Kidney Failure does not include failure of the kidneys caused by trauma.

INITIAL BENEFIT FOR KIDNEY FAILURE

If Kidney Failure First Occurs for a Covered Person, while such Covered Person is insured under this Certificate, Proof of the Kidney Failure may be sent to Us. When We receive such Proof, We will review the claim and if We approve it, will pay the Initial Benefit shown in the Schedule for such Kidney Failure.

RECURRENCE BENEFIT FOR KIDNEY FAILURE

We will not pay a Recurrence Benefit for Kidney Failure.

PROOF REQUIREMENTS FOR KIDNEY FAILURE

Diagnosis of Kidney Failure must be made in Writing by a Physician, and must be supported by medical records. The Covered Condition for Kidney Failure will be deemed to Occur on the date the Diagnosis of Kidney Failure is made.

KIDNEY FAILURE AND THE TOTAL BENEFIT AMOUNT

Payment of Critical Illness Benefits for Kidney Failure is subject to the Total Benefit Amount as explained in the REDUCTION ON ACCOUNT OF PRIOR CLAIMS PAID provision.

CRITICAL ILLNESS BENEFITS FOR MAJOR ORGAN TRANSPLANT

Major Organ Transplant means:

- the irreversible failure of a Covered Person's heart, lung, pancreas or any combination thereof, for which a Physician has determined that the complete replacement of such organ with an entire organ from a human donor is medically necessary; or
- 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 by a Physician.

Major Organ Transplant does not include:

- failure of an organ caused by trauma;
- Surgery performed outside the United States, Canada or Mexico;
- Surgery involving stem cell generated transplants; or
- Surgery involving islet cell transplants.

INITIAL BENEFIT FOR MAJOR ORGAN TRANSPLANT

If Major Organ Transplant First Occurs for a Covered Person, while such Covered Person is insured under this Certificate, Proof of Major Organ Transplant must be sent to Us. When We receive such Proof, We will review the claim and if We approve it, will pay the benefit shown in the Schedule for such Major Organ Transplant.

RECURRENCE BENEFIT FOR MAJOR ORGAN TRANSPLANT

We will not pay a Recurrence Benefit for Major Organ Transplant.

PROOF REQUIREMENTS FOR MAJOR ORGAN TRANSPLANT

Proof of Major Organ Transplant requires submission of medical records evidencing that a Major Organ Transplant was deemed medically necessary by a Physician. The Covered Condition for Major Organ Transplant will be deemed to Occur on the date the Physician determines that Major Organ Transplant is medically necessary.

MAJOR ORGAN TRANSPLANT AND THE TOTAL BENEFIT AMOUNT

Payment of Critical Illness Benefits for Major Organ Transplant is subject to the Total Benefit Amount as explained in the REDUCTION ON ACCOUNT OF PRIOR CLAIMS PAID provision.

CRITICAL ILLNESS BENEFITS FOR STROKE

Stroke means a cerebrovascular 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.

Stroke does not include:

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

INITIAL BENEFIT FOR STROKE

If Stroke First Occurs for a Covered Person, while such Covered Person is insured under this Certificate, Proof of the Stroke may be sent to Us. When We receive such Proof, We will review the claim and if We approve it, will pay the Initial Benefit shown in the Schedule for such Stroke.

RECURRENCE BENEFIT FOR STROKE

We will pay the Recurrence Benefit shown in the Schedule for a Recurrence of Stroke provided that the Recurrence Benefit for Stroke shall not be paid more than once.

PROOF REQUIREMENTS FOR STROKE

Diagnosis of Stroke must be made in Writing and be based upon medical records indicating objective evidence of significant neurological impairment that is functional, measurable and permanent as demonstrated by magnetic resonance imaging, computerized tomography or other reliable imaging techniques. Such neurological impairment must be confirmed in Writing no earlier than 30 days after the cerebrovascular incident by a Physician and be based upon objective evidence of significant neurological, motor or sensory impairment, which impairment must be present on the date that such Written confirmation is made.

However, if a pathological Diagnosis of Stroke is medically inappropriate, a clinical Diagnosis will be accepted. Any type of medically appropriate Diagnosis will be accepted.

The Covered Condition for Stroke will be deemed to Occur on the date the Diagnosis of Stroke is made.

STROKE AND THE TOTAL BENEFIT AMOUNT

Payment of Critical Illness Benefits for Stroke is subject to the Total Benefit Amount as explained in the REDUCTION ON ACCOUNT OF PRIOR CLAIMS PAID provision.

HEALTH SCREENING BENEFIT

If a Covered Person takes one of the screening/prevention measures listed below while such Covered Person is insured under this Certificate, We will pay a Health Screening Benefit upon submission of Proof that such measure was taken. When We receive such Proof, We will review it, and if We approve the claim, We will pay a Health Screening Benefit shown in the schedule.

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

- annual physical exam;
- biopsies for cancer;
- 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;
- digital rectal exam (DRE);
- Doppler screening for cancer;
- Doppler screening for peripheral vascular disease;
- echocardiogram;
- electrocardiogram (EKG);
- endoscopy;
- fasting blood glucose test;
- fasting plasma glucose test;
- flexible sigmoidoscopy;
- hemoccult stool specimen;
- hemoglobin A1C;
- human papillomavirus (HPV) vaccination;
- lipid panel;
- mammogram;
- oral cancer screening;
- pap smears or thin prep pap test;
- prostate-specific antigen (PSA) test;
- serum cholesterol test to determine LDL or HDL levels;
- serum protein electrophoresis;
- skin cancer biopsy;
- skin cancer screening;
- skin exam;
- stress test on bicycle or treadmill;
- successful completion of smoking cessation program;
- tests for sexually transmitted infections (STIs);
- thermography;
- two hour post-load plasma glucose test;
- ultrasounds for cancer detection;
- ultrasound screening of the abdominal aorta for abdominal aortic aneurysms; or
- virtual colonoscopy.

We will only pay one Health Screening Benefit per Covered Person per calendar year.

The Total Benefit Amount does not apply to the Health Screening Benefit. Prior payments of the Health Screening Benefit are disregarded when determining whether benefits for Covered Conditions will be reduced under the REDUCTION ON ACCOUNT OF PRIOR CLAIMS PAID provision.

LIMITATIONS

REDUCTION ON ACCOUNT OF PRIOR CLAIMS PAID

We will reduce what We pay for a claim so that the amount We pay, when combined with amounts for all claims We have previously paid for the same Covered Person, does not exceed the Total Benefit Amount that was in effect for that Covered Person on the date of the most recent Covered Condition.

This provision does not apply to claim payments for the Health Screening Benefit. Prior claims paid for the Health Screening Benefit are disregarded when determining whether benefits for Covered Conditions will be reduced under this REDUCTION ON ACCOUNT OF PRIOR CLAIMS PAID provision.

EXCLUSIONS

GENERAL EXCLUSIONS

We will not pay benefits for any loss for a Covered Person caused or contributed to by the Covered Person:

- participating in a felony, riot or insurrection;
- intentionally causing a self-inflicted injury;
- committing or attempting to commit suicide;
- being intoxicated or under the influence of any narcotic, unless administered on the advice of a Physician; or
- serving in the armed forces or any auxiliary unit of the armed forces of any country.

We will not pay benefits for Covered Conditions arising from war or any act of war, even if war is not declared.

We will not pay benefits for any Covered Condition for which Diagnosis is made outside the United States, Canada or Mexico, unless the Diagnosis is confirmed in the United States, Canada or Mexico, in which case the Covered Condition will be deemed to Occur on the date of the Diagnosis made outside the United States, Canada or Mexico.

WHEN INSURANCE ENDS

DATE YOUR INSURANCE ENDS

Your insurance 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 You;
- the date You cease to be in an eligible class; or
- the date Your employment ends for any reason.

DATE DEPENDENT INSURANCE ENDS

A Dependent's insurance 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 date the person ceases to be a Dependent;
- the date You cease to be in a class that is eligible for Dependent Insurance; or
- the end of the period for which the last full premium has been paid for the Dependent.

In certain cases insurance may be continued as stated in the sections titled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT. Please see that section for details.

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

The Group Policy is replacing another policy of group critical illness insurance that was issued to the Group Policyholder. This section explains how the replacement of that other group critical illness 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 critical illness insurance that was replaced by the New Policy.

Each Covered Person who was insured under the Old Policy on the date that it ended and who is eligible for insurance under the New Policy will be:

- insured under the New Policy on the date it takes effect; and
- credited for the time such Covered Person had been continuously insured under the Old Policy on the date it ended in determining:
 1. whether a Covered Condition is eligible for Recurrence Benefit in this Certificate.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

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.

Except as stated in the *Date Dependent Insurance Ends* provision of the section titled WHEN INSURANCE ENDS, 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.

AT YOUR OPTION: CONTINUATION WITH PREMIUM PAYMENT

Insurance provided under this Certificate may be continued with premium payment in certain situations, as described in this provision. This is referred to in this provision as "Continued Insurance". Evidence of insurability will not be required to obtain Continued Insurance. If You obtain Continued Insurance under this provision, You may also continue Dependent 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".

You may obtain Continued Insurance for You and for Your Dependents by making a request in Writing during the Request Period specified below if Your Group Billed Insurance ends except as described below.

Continued Insurance is not available if:

- Your Group Billed insurance ends due to Your failure to make a required Contribution; or
- Your insurance ends because the Group Policy ends and, within 30 days of the day that the Group Policy ends, You become eligible for insurance under another policy of critical illness or specified disease insurance issued to or provided through the Group Policyholder.

REQUEST PERIOD

To obtain Continued Insurance, We must receive Your completed Written request on a form approved by Us within the Request Period which begins on the date Your Group Billed Insurance ends, and ends 31 days later. If You do not request Continued Insurance within the Request Period, You cannot obtain Continued Insurance.

PREMIUMS FOR CONTINUED INSURANCE

The premium that You must pay for Continued Insurance may include the amount, if any, that You contributed for Your Group Billed Insurance before it ended, plus any amount the Employer paid. Premium rates for Continued Insurance will be the same as premium rates charged for Group Billed Insurance. Premiums rate increases or decreases that apply to Group Billed Insurance will apply to Continued Insurance as well. When You make a request to obtain Continued Insurance, You must pay the first premium during the Request Period. All premium payments must be made directly to Us. When We approve Your request for Continued Insurance, We will also provide a schedule of premiums and payment instructions.

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 premium that is required for Continued Insurance, the last day of the period for which a required premium payment was made;
- if the Group Policy ends, the date You become eligible for insurance under another policy of critical illness or specified disease insurance issued to or provided through the Group Policyholder that calculates contributions due under the replacing group policy based on Your age on the original effective date of coverage under this Certificate;
- with respect to Dependent Insurance, the date Continued Insurance for You ends for any reason; or
- with respect to Dependent Insurance, the date the Dependent no longer meets the definition of a Dependent.

If Your insurance ends, Your Dependent Insurance will also end in accordance with the *Date Dependent Insurance Ends* provision of the section titled WHEN INSURANCE ENDS.

CLAIMS

FILING A CLAIM

To file a claim for benefits under this Certificate, You must give Us notice of the claim and submit Proof of the claim to Us as described in this provision.

Notice of claim and Proof must be given to Us by following the steps set forth below:

Step 1

You must give Us notice by Writing to Us or calling Us at the toll free number shown on the face page of this Certificate within 30 days of the date of the loss.

Step 2

We will send a claim form to You and explain how to complete it. You should receive the claim form within 15 days of giving Us notice of claim.

Step 3

When You receive the claim form You should fill it out as instructed and return it with the required Proof described in this Certificate and the claim form. If You do not receive a claim form within 15 days after giving Us notice of claim, You may send Us Proof using any form sufficient to provide Us with the required Proof.

Step 4

You must give Us Proof not later than 120 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.

PAYMENT OF BENEFITS

When We receive the claim form and Proof We will review the claim and, if We approve it, We will pay benefits no later than 60 days after we receive the Proof, subject to the terms and provisions of this Certificate and the Group Policy.

All benefits paid under this Certificate while You are living will be paid to You, unless You have assigned this insurance. But, if You are not legally competent to claim or receive benefits under this Certificate, We may pay up to \$10,000 to anyone related to You by blood or marriage who We believe is entitled to it. If We make such a payment in good faith, We will not be liable to anyone for the amount We pay. Any remaining benefits will be paid to Your legal representative.

If You designated a beneficiary, upon Your death we will pay to Your beneficiary any amount that is or becomes due. You may designate a beneficiary in Your Enrollment Form. You may change Your beneficiary at any time. To do so, You must send a Signed and dated, Written request to Us using a form satisfactory to Us. Your Written request to change the beneficiary must be sent to Us no later than 90 days of the date You Sign such request.

CLAIMS (continued)

PAYMENT OF BENEFITS (continued)

You do not need the beneficiary's consent to make a change. When We receive the change, it will take effect as of the date You Signed it. The change will not apply to any payment made in good faith by Us before the change request was recorded.

If two or more beneficiaries are designated and their shares are not specified, they will share the insurance equally.

If there is no beneficiary designated or no surviving beneficiary at Your death, We may determine the beneficiary to be one or more of the following who survive You, in the order listed below:

1. Your Spouse or Domestic Partner;
2. Your child(ren);
3. Your parents(s); or
4. Your sibling(s).

Instead of making payment in the order above, We may pay Your estate. Any payment made in good faith will discharge Our liability to the extent of such payment.

AUTHORIZATIONS

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

EXAMINATIONS

At Our expense, as often as is reasonably necessary, We may require a Covered Person to have an independent examination by a Physician of Our choice.

At Our expense, as often as is reasonably necessary, We may have Our representatives conduct telephone or in-person interviews with You regarding Your claim.

AUTOPSY

At Our expense, 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.

GENERAL PROVISIONS

CHANGES IN STANDARDS

This Certificate refers to classification standards for disease that have been developed by independent third parties ("Classification Standards"). If those independent third parties change the Classification Standards, We will interpret this Certificate in a manner that recognizes such changes when We determine it is necessary 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);
- Your Enrollment Form;
- 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 contest insurance, reduce benefits or defend a claim unless the following requirements are met:

- the statement is in an Enrollment Form that is in Writing;
- You have Signed the Enrollment Form; and
- a copy of the Enrollment 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 a Benefit Increase after the Benefit Increase has been in force for 2 years, unless the 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.

If Your or Your Dependent's tobacco usage is misstated, the information regarding the correct tobacco usage will be used, as appropriate, to adjust the benefits and/or contributions.

UNPAID PREMIUM; EXCESS PREMIUM

Upon the payment of a claim under this Certificate, any Contribution owed by You that is more than 60 days past due may be deducted from the benefit amount payable to You. Any excess premium will be refunded to You.

ASSIGNMENT

The benefits under the Group Policy are not assignable except as required by law.

CONFORMITY WITH LAW

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