

CRITICAL ILLNESS PLAN 1



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

NOTICE

Notice Effective Date: The later of January 1, 2026 or the Certificate Effective Date shown on the insured's corresponding personalized Covered Person Specifications page or the Group Policyholder's participant file which has been provided to MetLife.

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

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

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

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



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

CERTIFICATE OF CRITICAL ILLNESS INSURANCE

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

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

Group Policyholder: Catholic Health Services of Long Island
Group Policy Number: 0217251
MetLife Toll Free Number: 1-800-GETMET8

Important Notice: This is a limited Certificate. Subject to the provisions of this Certificate, including limitations, exclusions and Proof requirements, this Certificate provides limited benefits in the event You are Diagnosed with Cancer, Cardiovascular Disease, Heart Attack, Kidney Failure, Major Organ Failure, Progressive Disease or Stroke. Read it carefully with the Outline of Coverage.

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

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

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

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

NOTICE FOR RESIDENTS OF MAINE

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

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

TABLE OF CONTENTS

Section	Page
NOTICE FOR RESIDENTS OF MAINE	2
COVERED PERSON SPECIFICATIONS	5
SCHEDULE OF INSURANCE	6
LIMITATIONS	11
Benefit Separation Period	11
GENERAL EXCLUSIONS	12
DEFINITIONS	13
ELIGIBILITY PROVISIONS: INSURANCE FOR YOU	18
Eligible Class.....	18
Date You Are Eligible For Insurance	18
Enrollment Process	18
Date Your Insurance Takes Effect.....	18
Benefit Changes	18
ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE	19
Eligible Class For Dependent Insurance	19
Date You Are Eligible For Dependent Insurance.....	19
Enrollment Process	19
Date Dependent Insurance Takes Effect.....	19
Benefit Changes	20
SPECIAL RULES FOR COVERED PERSONS PREVIOUSLY INSURED UNDER ANOTHER INSURANCE POLICY ISSUED TO THE GROUP POLICYHOLDER	21
SPECIAL RULES FOR COVERED PERSONS PREVIOUSLY INSURED UNDER CERTAIN INDIVIDUAL POLICIES	22
COVERED CONDITION CATEGORY: CANCER	23
Additional Definitions That Apply To Benefits For The Cancer Covered Condition Category.....	23
Initial Benefit For A Cancer Covered Condition	24
Recurrence Benefit For A Cancer Covered Condition.....	24
Additional Proof Requirements For A Cancer Covered Condition.....	24
Special Exclusions Applicable To A Cancer Covered Condition	25
COVERED CONDITION CATEGORY: CARDIOVASCULAR DISEASE	26
Additional Definitions That Apply To The Cardiovascular Disease Covered Condition Category.....	26
Initial Benefit For A Cardiovascular Disease Covered Condition	27
Recurrence Benefit For A Cardiovascular Disease Covered Condition	27
Rule For More Than One Occurrence Of A Cardiovascular Disease Covered Condition.....	27
Additional Proof Requirements For A Cardiovascular Disease Covered Condition	27
Special Exclusions Applicable To A Cardiovascular Disease Covered Condition	27
COVERED CONDITION CATEGORY: HEART ATTACK	28
Additional Definitions That Apply To The Heart Attack Covered Condition Category	28
Initial Benefit For A Heart Attack Covered Condition	28
Recurrence Benefit For A Heart Attack Covered Condition	28
Additional Proof Requirements For A Heart Attack Covered Condition	29
COVERED CONDITION CATEGORY: KIDNEY FAILURE	30
Additional Definitions That Apply To The Kidney Failure Covered Condition Category.....	30
Initial Benefit For A Kidney Failure Covered Condition	30
Recurrence Benefit For A Kidney Failure Covered Condition	30
Additional Proof Requirements For A Kidney Failure Covered Condition	30
COVERED CONDITION CATEGORY: MAJOR ORGAN FAILURE	31
Additional Definitions That Apply To The Major Organ Failure Covered Condition Category.....	31
Initial Benefit For A Major Organ Failure Covered Condition	32
Recurrence Benefit For A Major Organ Failure Covered Condition	32
Special Limitation Applicable To A Major Organ Failure Covered Condition	32
Additional Proof Requirements For A Major Organ Failure Covered Condition	32
Special Exclusions Applicable To A Major Organ Failure Covered Condition	32
COVERED CONDITION CATEGORY: PROGRESSIVE DISEASE	33
Additional Definitions That Apply To The Progressive Disease Covered Condition Category.....	33
Initial Benefit For A Progressive Disease Covered Condition	35
Additional Proof Requirements For A Progressive Disease Covered Condition	35

COVERED CONDITION CATEGORY: STROKE	36
Additional Definitions That Apply To The Stroke Covered Condition Category	36
Initial Benefit For A Stroke Covered Condition	36
Recurrence Benefit For A Stroke Covered Condition	36
Additional Proof Requirements For A Stroke Covered Condition	36
Special Exclusions Applicable To A Stroke Covered Condition	37
SUPPLEMENTAL BENEFITS	38
Health Screening Benefit	38
WHEN INSURANCE ENDS	40
Date Your Insurance Ends	40
Date Dependent Insurance Ends	40
Change In Class	40
CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT	41
At Your Option: Portability Through Continuation With Premium Payment	41
For Mentally Or Physically Handicapped Children	42
For Family And Medical Leave	42
CLAIMS	43
Notice of Claim	43
Claim Form	43
Proof of Loss	43
Payment Of Benefits	43
Your Beneficiary	43
Appealing A Claim Decision	44
Authorizations	44
Examinations	44
Autopsy	44
Time Limit on Legal Actions	44
Refund To Us For Overpayment Of Benefits	44
GENERAL PROVISIONS	45
Changes In Clinical Standards	45
Entire Contract	45
Incontestability: Statements Made By You	45
Misstatements	45
Assignment	45
Conformity with Law	45
Standard of Time	45

COVERED PERSON SPECIFICATIONS

Certificate Effective Date:	The later of January 1, 2026 or the Certificate Effective Date shown on the insured's corresponding personalized Covered Person Specifications page or the Group Policyholder's participant file which has been provided to MetLife
Group Policyholder: Group Policy Number:	Catholic Health Services of Long Island 0217251
MetLife Contact Information:	1-800-GETMET8
Your Name:	See the Insured's corresponding personalized Covered Person Specifications page or the Group Policyholder's participant file which has been provided to MetLife
Your Certificate Number:	See the Insured's corresponding personalized Covered Person Specifications page or the Group Policyholder's participant file which has been provided to MetLife
Coverage for Your Dependents	See the Insured's corresponding personalized Covered Person Specifications page or the Group Policyholder's participant file which has been provided to MetLife

Notification Requirement

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

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

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

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

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

SCHEDULE OF INSURANCE

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

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

BENEFIT AMOUNT AND TOTAL BENEFIT AMOUNT

	For You	For Your Spouse	For Your Dependent Children
Benefit Amount	See the Insured's corresponding personalized Covered Person Specifications page or the Group Policyholder's participant file which has been provided to MetLife	See the Insured's corresponding personalized Covered Person Specifications page or the Group Policyholder's participant file which has been provided to MetLife	See the Insured's corresponding personalized Covered Person Specifications page or the Group Policyholder's participant file which has been provided to MetLife
Total Benefit Amount	See the Insured's corresponding personalized Covered Person Specifications page or the Group Policyholder's participant file which has been provided to MetLife	See the Insured's corresponding personalized Covered Person Specifications page or the Group Policyholder's participant file which has been provided to MetLife	See the Insured's corresponding personalized Covered Person Specifications page or the Group Policyholder's participant file which has been provided to MetLife

Minimum Benefit Amount

For each Covered Condition, the benefit will be the greater of the amount determined in accordance with this Schedule of Insurance or \$250.

BENEFIT SEPARATION PERIOD

For a Recurrence Benefit for a Covered Person 30 days

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

CERTIFICATE CHANGES

In the event We issue You a revised Certificate under the same Group Policy, without a lapse in coverage, due to:

- a change in benefit provisions made by the Group Policyholder; or
- a change in coverage made by You,

We will treat the new Certificate as a continuation of Your coverage under this Certificate.

SCHEDULE OF INSURANCE (Continued)

COVERED CONDITION CATEGORY: CANCER		
COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
Invasive Cancer	100% of the Benefit Amount payable no more than 1 time per Covered Person per Occurrence of each Separate and Unrelated Invasive Cancer	100% of the Initial Benefit Amount payable no more than 2 times per Covered Person
Non-Invasive Cancer	25% of the Benefit Amount payable no more than 1 time per Covered Person per Occurrence of each Separate and Unrelated Non-Invasive Cancer	100% of the Initial Benefit Amount payable no more than 2 times per Covered Person
Skin Cancer	25% of the Benefit Amount, payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount, payable no more than 2 times per Covered Person

COVERED CONDITION CATEGORY: CARDIOVASCULAR DISEASE		
COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
Coronary Artery Disease	100% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 2 times per Covered Person

SCHEDULE OF INSURANCE (Continued)

COVERED CONDITION CATEGORY: HEART ATTACK		
COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
Heart Attack	100% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 2 times per Covered Person

COVERED CONDITION CATEGORY: KIDNEY FAILURE		
COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
Kidney Failure	100% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 2 times per Covered Person

COVERED CONDITION CATEGORY: MAJOR ORGAN FAILURE		
COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
Major Organ Failure	100% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 2 times per Covered Person

SCHEDULE OF INSURANCE (Continued)

COVERED CONDITION CATEGORY: PROGRESSIVE DISEASE		
COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
Alzheimer's Disease	100% of the Benefit Amount payable no more than 1 time per Covered Person	None

COVERED CONDITION CATEGORY: STROKE		
COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
Stroke	100% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 2 times per Covered Person

SCHEDULE OF INSURANCE (Continued)

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

LIMITATIONS

BENEFIT SEPARATION PERIOD

Benefit Separation Period

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

Recurrence Benefit Separation Period

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

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

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

Example:

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

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

GENERAL EXCLUSIONS

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

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

- the Covered Person's active participation in an insurrection, rebellion, or riot;
- the Covered Person's engagement in any illegal occupation;
- the Covered Person's intentionally self-inflicted injury;
- the Covered Person's suicide or attempted suicide;
- war, or act of war (whether declared or undeclared);
- the Covered Person being intoxicated;
- the Covered Person being under the influence of any narcotic (unless administered on the advice of a Physician); or
- activities required by the Covered Person's service in the armed forces or any auxiliary unit of the armed forces of any country or international authority.

In addition, We will not pay benefits for:

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

DEFINITIONS

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

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

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

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

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

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

Certificate means this Certificate including any riders attached to it.

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

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

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

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

Dependent means Your Spouse and/or Dependent Child.

Dependent Child means the following:

- Your biological child, while such child is younger than the Dependent Child Age Limit;
- Your adopted child, (including a child to be adopted by You during any waiting period that must expire before adoption becomes final) while such child is younger than the Dependent Child Age Limit;
- Your stepchild, while such child is younger than the Dependent Child Age Limit;
- any other child while such child is under the Dependent Child Age Limit as follows: (a) a child for whom You or Your Spouse are a legal guardian, (b) Your or Your Spouse's foster child, (c) a child for whom You or Your Spouse are chiefly responsible to provide support, (d) a child who resides with You as a regular member of Your household, (e) a child for whom You or Your Spouse are legally required to provide insurance, or (f) a child who was able to be claimed by You or Your Spouse as a dependent for Federal Income Tax purposes. Any other child also includes a grandchild who: (a) was able to be claimed by You or Your Spouse as a dependent for Federal Income Tax purposes, (b) resides with You, (c) is in Your or Your Spouse's custody, (d) is supported by You or Your Spouse, or (e) is a child of Your Dependent Child while the Dependent Child is under the Dependent Child Age Limit; or
- a Dependent Child who is a disabled child and whose age exceeds the Dependent Child Age Limit on the Certificate Effective Date who: (a) has been diagnosed with a developmental disability, mental illness or disorder, or physical disability, (b) is incapable of self-sustaining employment, and (c) is chiefly dependent on You or Your Spouse for support and maintenance. Coverage for a disabled child will take effect in accordance with the Eligibility Provisions: Dependent Insurance section of Your Certificate without regard to whether such child is under a Medical Restriction.

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

DEFINITIONS (Continued)

A person cannot be insured for critical illness Insurance as a Dependent Child of more than one employee under the Group Policy.

Dependent Child Age Limit means:

- the end of the calendar year in which the Dependent Child reaches age 26.

Dependent Insurance means insurance under this Certificate for Your Dependents.

Diagnosis or Diagnosed means the establishment of a Covered Condition by a Physician through the use of clinical and/or laboratory findings, and using generally accepted medical standards. In the event a pathological or Clinical Diagnosis cannot be made under generally accepted medical standards because it would be medically inappropriate or life-threatening, We will accept a medically appropriate Diagnosis.

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

Group Policyholder means Catholic Health Services of Long Island.

DEFINITIONS (Continued)

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

- is primarily engaged in providing, by or under the continuous supervision of Physicians, to inpatients, diagnostic services and therapeutic services for Diagnosis, treatment and care of injured or sick persons;
- has organized departments of medicine;
- has facilities for major Surgery either on its premises or through a contractual arrangement with another Hospital;
- has a requirement that every patient must be under the care of a Physician or dentist;
- provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- is duly licensed by the agency responsible for licensing such Hospitals;
- if located in New York State, has in effect a hospitalization review plan applicable to all patients that meets at least the standards set forth in section 1861 (k) of United States Public Law 89-97; and
- is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational or rehabilitative care.

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

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

Medically Necessary means that a treatment stated in the definition of a Covered Condition:

- has been determined by a Covered Person's Physician to be required to treat such Covered Person for such Covered Condition; and
- is not primarily for the convenience of the Covered Person or Physician.

Medically Necessary treatment recommendations by a Covered Person's Physician for such Covered Person must be consistent with generally accepted published standards of medical practice and clinical protocols that are applicable to the Covered Condition.

Medical Restriction means a person is:

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

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

Physician means:

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

The term Physician does not include:

- You;
- Your Spouse or anyone to whom You are related by blood or marriage;
- anyone who is a member of Your household;
- Your adopted or stepchild; or
- anyone else in Your immediate family.

DEFINITIONS (Continued)

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

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

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

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

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

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

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

Spouse means Your lawful spouse.

Supplemental Benefit(s) are the following:

- Health Screening Benefit.

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

Total Benefit Amount means the maximum aggregate amount that We will pay, per Covered Person, per lifetime, for any and all of the Covered Conditions to which the Total Benefit Amount maximum applies (each Covered Condition Category states whether the Covered Condition Category is subject to the Total Benefit amount). The Total Benefit Amount is shown on the Schedule. The Total Benefit Amount does not apply to the Supplemental Benefits.

DEFINITIONS (Continued)

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

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

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

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

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

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

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS

CLASS 1

All Active Full-Time Employees

DATE YOU ARE ELIGIBLE FOR INSURANCE

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

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

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

ENROLLMENT PROCESS

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

DATE YOUR INSURANCE TAKES EFFECT

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

BENEFIT CHANGES

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

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

ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE

ELIGIBLE CLASS FOR DEPENDENT INSURANCE

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

DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE

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

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

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

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

ENROLLMENT PROCESS

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

DATE DEPENDENT INSURANCE TAKES EFFECT

Newborn Children

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

- from the moment of birth and does not need to be enrolled if Dependent Insurance is already in effect for at least one other Dependent Child; or
- for 60 days from the moment of birth if Dependent Insurance is not already in effect for at least one other Dependent Child. To continue coverage beyond the first 60 days, You must notify Us of the child's birth and give Written permission to deduct Contributions from Your pay for Dependent Insurance for the newborn child if You are required to make such Contributions.

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

ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE (Continued)

Adopted Children

A newborn child to be adopted by You while insurance is in effect under this Certificate will be covered for 60 days from the moment of birth if You take physical custody of the infant upon the infant's release from the Hospital and You file a petition to adopt the child within 30 days of the child's birth. To continue coverage beyond the first 60 days, You must notify Us of the child's birth, and give Written permission to deduct any required Contributions from Your pay for Dependent Insurance for the newborn child. Coverage will end if the child's placement is disrupted prior to legal adoption.

A child to be adopted by You (who is not a newborn as described above) while insurance is in effect under this Certificate will be covered during any waiting period that must expire before adoption becomes final. In order to continue coverage beyond the first 60 days, You must provide Us with notice of the child to be adopted and give Written permission to deduct any required Contributions from Your pay for Dependent Insurance for the adopted child. Coverage will end if the child's placement is disrupted prior to legal adoption.

The child does not need to be enrolled if Dependent Coverage is already in effect for at least one other Dependent Child.

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

Other Dependents

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

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

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

BENEFIT CHANGES

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

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

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

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

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

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

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

Replacement Date means the effective date of the New Policy.

Transferring Dependents means each of Your Dependents who:

- was insured under the Old Policy on the date it ended; and
- meets the requirements to be eligible for insurance under the New Policy, or is a Disabled Child.

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

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

Disabled Child means a child who:

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

Crediting of Time

You and each Transferring Dependent will be credited for the time each such person had been continuously insured under the Old Policy on the date it ended in determining:

- the length of time insurance has been in effect for the purpose of determining whether the requirements for payment of Supplemental Benefits have been met; and
- whether a Covered Condition is eligible for a Recurrence Benefit under this Certificate.

SPECIAL RULES FOR COVERED PERSONS PREVIOUSLY INSURED UNDER CERTAIN INDIVIDUAL POLICIES

Some employees insured under the Group Policy may have been previously insured for critical illness insurance under individual policies that were made available to them through the Group Policyholder. This section explains special rules that apply to those employees and their Dependents

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 an individual policy of critical illness insurance that:

- was offered to an employee of the Group Policyholder solely because of his or her employment with the Group Policyholder;
- was issued to such employee; and
- was terminated by the employee within 30 days of the date that the employee became covered under the New Policy.

Replacement Date means the effective date of the New Policy.

Transferring Person means any Covered Person:

- who was insured under an Old Policy before the Replacement Date; and
- who meets the eligibility requirements and became insured under the New Policy.

We will credit the time that a Transferring Person was continuously insured under an Old Policy on the date it ended to determine:

- the length of time insurance has been in effect for the purpose of determining whether the requirements for payment of Supplemental Benefits have been met; and
- whether a Covered Condition is eligible for a Recurrence Benefit if available under this Certificate.

COVERED CONDITION CATEGORY: CANCER

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

Cancer Covered Condition means the following:

- Invasive Cancer;
- Non-Invasive Cancer; or
- Skin Cancer.

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

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

Invasive Cancer means the presence of one or more malignant tumors with invasion of normal tissue and characterized by the uncontrollable and abnormal growth and spread of malignant cells to lymph nodes and/or a body part different from the site of cancer origin. Invasive Cancer includes the following:

- a malignant melanoma for which a pathology report shows a maximum thickness greater than 0.80 millimeters using the Breslow method of determining tumor thickness;
- a cancer that is a leukemia or lymphoma; or
- where a Covered Person has terminal cancer and has a life expectancy of 24 months or less from the date of Diagnosis and will not benefit from, or has exhausted, curative therapy.

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

Non-Invasive Cancer (including Carcinoma in Situ) means the presence of a malignant tumor and characterized by the abnormal growth of malignant cells which are confined to the site of origin without spread to lymph nodes and/or a body part different from the site of cancer origin. Non-Invasive Cancer includes the following:

- a malignant melanoma, for which a pathology report shows a maximum thickness less than or equal to 0.80 millimeters using the Breslow method of determining tumor thickness;
- a tumor of the prostate classified as T1bN0M0, or T1cN0M0; or
- a Carcinoma in Situ classified as TisN0M0.

Non-Invasive Cancer does not include Skin Cancer.

Separate and Unrelated with respect to a Cancer Covered Condition means a Cancer Covered Condition that is:

- not a Recurrence of any previously Diagnosed Cancer Covered Condition;
- not a metastasis of a previously Diagnosed Cancer Covered Condition; and
- distinct in the cause and etiology from any previously Diagnosed Cancer Covered Condition.

Skin Cancer means any malignant growth that arises on the surface of the skin that is any of the following:

- basal cell carcinoma;
- squamous cell carcinoma; or
- malignant melanoma that remains confined to the epidermis.

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

COVERED CONDITION CATEGORY: CANCER (Continued)

INITIAL BENEFIT FOR A CANCER COVERED CONDITION

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

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

Related Occurrence for a Cancer Covered Condition

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

RECURRENCE BENEFIT FOR A CANCER COVERED CONDITION

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

- the subsequent Occurrence of the Cancer Covered Condition happens after the Recurrence Benefit Separation Period has been satisfied; and
- the Covered Person has been Treatment Free for a continuous period of 30 days immediately prior to the subsequent Occurrence of the Cancer Covered Condition.

ADDITIONAL PROOF REQUIREMENTS FOR A CANCER COVERED CONDITION

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

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

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

COVERED CONDITION CATEGORY: CANCER (Continued)

SPECIAL EXCLUSIONS APPLICABLE TO A CANCER COVERED CONDITION

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

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

COVERED CONDITION CATEGORY: CARDIOVASCULAR DISEASE

ADDITIONAL DEFINITIONS THAT APPLY TO THE CARDIOVASCULAR DISEASE COVERED CONDITION CATEGORY

Cardiovascular Disease Covered Condition means the following:

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

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

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

- a Surgery in which a Median Sternotomy is performed.

Coronary Artery Bypass Graft does not include:

- Coronary Angioplasty;
- coronary angiography;
- any other intra-catheter technique; or
- a cardiac catheterization performed for diagnostic purposes only.

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

COVERED CONDITION CATEGORY: CARDIOVASCULAR DISEASE (Continued)

Occurs or Occurrence, with respect to a Cardiovascular Disease Covered Condition, means a Covered Person is Diagnosed with such Covered Condition while the coverage is in effect under this Certificate for such Covered Person. A Cardiovascular Disease Covered Condition will be deemed to Occur on the date that the Diagnosis of a Cardiovascular Disease Covered Condition is made, which includes a determination by a Physician that the applicable treatment (as set forth in the definition of the Covered Condition) is Medically Necessary.

INITIAL BENEFIT FOR A CARDIOVASCULAR DISEASE COVERED CONDITION

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

RECURRENCE BENEFIT FOR A CARDIOVASCULAR DISEASE COVERED CONDITION

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

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

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

ADDITIONAL PROOF REQUIREMENTS FOR A CARDIOVASCULAR DISEASE COVERED CONDITION

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

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

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

SPECIAL EXCLUSIONS APPLICABLE TO A CARDIOVASCULAR DISEASE COVERED CONDITION

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

- for a Heart Attack.

COVERED CONDITION CATEGORY: HEART ATTACK

ADDITIONAL DEFINITIONS THAT APPLY TO THE HEART ATTACK COVERED CONDITION CATEGORY

Heart Attack Covered Condition means the following:

- Myocardial Infarction.

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

Myocardial Infarction does not include Sudden Cardiac Arrest.

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

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

INITIAL BENEFIT FOR A HEART ATTACK COVERED CONDITION

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

RECURRENCE BENEFIT FOR A HEART ATTACK COVERED CONDITION

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

COVERED CONDITION CATEGORY: HEART ATTACK (Continued)

ADDITIONAL PROOF REQUIREMENTS FOR A HEART ATTACK COVERED CONDITION

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

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

- for Myocardial Infarction, documentation that shows:
 - an elevation of enzymes, troponins or other biochemical cardiac markers, and
 - two of the three following criteria associated with the Myocardial Infarction:
 - confinement in a Hospital as an inpatient;
 - documentation of electrocardiograph (EKG) changes on one or a series of electrocardiograms taken at the time the Covered Person experiences the Myocardial Infarction that are indicative of an acute Myocardial Infarction; however, if the Covered Person had any prior electrocardiogram(s), the electrocardiogram(s) presented as Proof of Myocardial Infarction must show changes from the Covered Person's last electrocardiogram, and such changes must be indicative of an acute Myocardial Infarction; or
 - documentation of imaging studies such as thallium scans, or echocardiograms which are indicative of an acute Myocardial Infarction; however, if the Covered Person had any prior imaging studies, the imaging studies presented as Proof of Myocardial Infarction must show changes from the Covered Person's last imaging studies, and such changes must be indicative of a Myocardial Infarction.

We will accept a Clinical Diagnosis of a Heart Attack Covered Condition only if a pathological Diagnosis cannot be made because it would be medically inappropriate or life-threatening under generally accepted medical standards.

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

COVERED CONDITION CATEGORY: KIDNEY FAILURE

ADDITIONAL DEFINITIONS THAT APPLY TO THE KIDNEY FAILURE COVERED CONDITION CATEGORY

Kidney Failure Covered Condition means the total, end stage, irreversible failure of all functioning kidneys, which was Diagnosed by a Physician based on an estimated glomerular filtration rate (eGFR) that is less than 15ml/min/1.73m².

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

INITIAL BENEFIT FOR A KIDNEY FAILURE COVERED CONDITION

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

RECURRENCE BENEFIT FOR A KIDNEY FAILURE COVERED CONDITION

We will pay the Recurrence Benefit shown on the Schedule for another Occurrence of a Kidney Failure Covered Condition for which We have already paid a benefit if the subsequent Occurrence happens after the Recurrence Benefit Separation Period has been satisfied.

ADDITIONAL PROOF REQUIREMENTS FOR A KIDNEY FAILURE COVERED CONDITION

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

COVERED CONDITION CATEGORY: MAJOR ORGAN FAILURE

ADDITIONAL DEFINITIONS THAT APPLY TO THE MAJOR ORGAN FAILURE COVERED CONDITION CATEGORY

Major Organ Failure Covered Condition means Major Organ Failure.

Major Organ Failure means that a Physician has determined that there is irreversible, permanent end-stage failure of a Covered Person's lung, liver, or any combination thereof and such Major Failure meets the following criteria:

- for end-stage heart failure, such heart failure is classified as Stage D heart disease by the American College of Cardiology (ACC) and the American Heart Association (AHA);
- for end-stage lung failure, such failure is classified as Stage 4 under the Global Initiative for Chronic Obstructive Lung Disease (GOLD) pulmonary classification system; and
- for end-stage liver failure, such failure is scored as greater than or equal to 15 under the Model for End Stage Liver Disease (MELD).

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

COVERED CONDITION CATEGORY: MAJOR ORGAN FAILURE (Continued)

INITIAL BENEFIT FOR A MAJOR ORGAN FAILURE COVERED CONDITION

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

RECURRENCE BENEFIT FOR A MAJOR ORGAN FAILURE COVERED CONDITION

Once We have paid an Initial Benefit for a Covered Person for a Major Organ Failure Covered Condition, any subsequent Occurrence of any Major Organ Failure Covered Condition will be considered a Recurrence of a Major Organ Failure Covered Condition and We will pay the Recurrence Benefit shown on the Schedule. The Recurrence Benefit Separation Period must be satisfied in order for a Recurrence Benefit to be payable.

SPECIAL LIMITATION APPLICABLE TO A MAJOR ORGAN FAILURE COVERED CONDITION

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

- a Diagnosis of a Major Organ Failure Covered Condition made at the same time, or on the same day, that includes two or more organs described in the definition of a Major Organ Failure Covered Condition shall be deemed one Occurrence of a Major Organ Failure Covered Condition.

ADDITIONAL PROOF REQUIREMENTS FOR A MAJOR ORGAN FAILURE COVERED CONDITION

A Clinical Diagnosis of a Major Organ Failure Covered Condition must be made in Writing by a Physician and include medical records with the following additional documentation:

- for end-stage heart failure – an angiogram;
- for end stage liver failure – laboratory values for serum bilirubin, serum creatine, and the international normalized ration (INR) used to determine the MELD score determined by a Physician; and
- for end-stage lung failure – a pulmonary function test.

SPECIAL EXCLUSIONS APPLICABLE TO A MAJOR ORGAN FAILURE COVERED CONDITION

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

- if at the time the Major Organ Failure Occurs, no treatment of the Major Organ Failure is recommended by a Physician due to the anticipated death of the Covered Person.

COVERED CONDITION CATEGORY: PROGRESSIVE DISEASE

ADDITIONAL DEFINITIONS THAT APPLY TO THE PROGRESSIVE DISEASE COVERED CONDITION CATEGORY

Alzheimer's Disease means the development of multiple, progressive symptoms of cognitive decline, which was Diagnosed by a Physician, and that are manifested by memory impairment (impaired ability to learn new information or to recall previously learned information).

Alzheimer's Disease does not include:

- other central nervous system conditions that may cause deficits in memory and cognition (e.g., cerebrovascular disease, Parkinson's Disease, normal-pressure hydrocephalus);
- systemic conditions that are known to cause cognitive changes (e.g., hypothyroidism, vitamin B12 or folic acid deficiency, niacin deficiency, hypercalcemia, or neurosyphilis);
- substance-induced conditions;
- a form of dementia that is a mental and nervous condition such as schizophrenia or psychoses;
- a form of dementia that is Diagnosed as any of the following:
 - dementia with Lewy bodies;
 - progressive supranuclear palsy;
 - corticobasal degeneration;
 - Parkinson's disease dementia;
 - frontotemporal dementia;
 - primary progressive aphasia;
 - normal-pressure hydrocephalus; or
 - rapidly progressive dementia as in Creutzfeldt-Jakob disease; or
- any form of dementia that is not Clinically Diagnosed as Alzheimer's Disease.

COVERED CONDITION CATEGORY: PROGRESSIVE DISEASE (Continued)

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

Progressive Disease Covered Condition means any of the following:

- Alzheimer's disease.

COVERED CONDITION CATEGORY: PROGRESSIVE DISEASE (Continued)

INITIAL BENEFIT FOR A PROGRESSIVE DISEASE COVERED CONDITION

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

ADDITIONAL PROOF REQUIREMENTS FOR A PROGRESSIVE DISEASE COVERED CONDITION

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

COVERED CONDITION CATEGORY: STROKE

ADDITIONAL DEFINITIONS THAT APPLY TO THE STROKE COVERED CONDITION CATEGORY

Stroke Covered Condition means a cerebrovascular accident or incident was Diagnosed by a Physician, which was caused by hemorrhage, thrombus or embolus, and resulted in an infarction of brain tissue producing measurable, functional and permanent neurological impairments.

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

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

Transient Ischemic Attack (TIA) means a temporary ischemic event (including prolonged reversible ischemic attacks) in which:

- there are measurable, functional neurological impairments that are focal and confined to an area of the brain perfused by a specific artery;
- there is no evidence of cerebral tissue damage on diagnostic imaging; and
- the reversible functional neurological impairments are confirmed by a Clinical Diagnosis.

INITIAL BENEFIT FOR A STROKE COVERED CONDITION

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

RECURRENCE BENEFIT FOR A STROKE COVERED CONDITION

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

ADDITIONAL PROOF REQUIREMENTS FOR A STROKE COVERED CONDITION

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

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

COVERED CONDITION CATEGORY: STROKE (Continued)

SPECIAL EXCLUSIONS APPLICABLE TO A STROKE COVERED CONDITION

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

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

SUPPLEMENTAL BENEFITS

HEALTH SCREENING BENEFIT

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

- We will pay the Health Screening Benefit amount based on the Schedule that was in effect on the day the Covered Person received the screening measure; and
- We will pay the Health Screening Benefit no more than the number of times shown on the Schedule.
- The Total Benefit Amount will not be reduced by payment of the Health Screening Benefit.

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

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

SUPPLEMENTAL BENEFITS (Continued)

- mammogram
- oral cancer screening
- pap smears or thin prep pap test
- prostate-specific antigen (PSA) test
- serum cholesterol test to determine LDL and HDL levels
- serum protein electrophoresis
- skin cancer biopsy
- skin cancer screening
- skin exam
- stress test on bicycle or treadmill
- successful completion of smoking cessation program
- tests for sexually transmitted infections (STIs)
- thermography
- two hour post-load plasma glucose test
- ultrasounds for cancer detection
- ultrasound screening of the abdominal aorta for abdominal aortic aneurysms
- virtual colonoscopy

WHEN INSURANCE ENDS

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

DATE YOUR INSURANCE ENDS

Your insurance under this Certificate will end on the earliest of:

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

For Residents of Massachusetts:

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

- If Your employment ends for any reason other than a Plant Closing or a Partial Plant Closing, Your insurance will end 31 days after the date Your employment ends. However, if during such 31 day period You become entitled to benefits under another policy that are similar to the benefits provided under this Certificate, insurance under this Certificate will end on the date You become entitled to such other benefits.
- If Your employment ends due to a Plant Closing or a Partial Plant Closing Your insurance will end 90 days after the date Your employment ends. However, if during such 90 day period, You become entitled to benefits under another policy that are similar to the benefits provided under this Certificate insurance under this Certificate will end on the date You become entitled to such other benefits.

DATE DEPENDENT INSURANCE ENDS

A Dependent's insurance under this Certificate will end on the earliest of:

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

CHANGE IN CLASS

If there is more than one class eligible for insurance under the Group Policy, and each class has its own certificate, instead of receiving a new certificate when You move between classes, You will remain insured under this Certificate if:

- You move to a class that is eligible for Critical Illness Insurance under the Group Policy; and
- the benefits available to Your new class are identical to the benefits available under this Certificate.

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

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

AT YOUR OPTION: PORTABILITY THROUGH CONTINUATION WITH PREMIUM PAYMENT

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

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

Requirements for Continued Insurance

Continued Insurance will be available to You if:

- Your Group Billed Insurance ends for any reason other than:
 - non-payment of premium or Contribution; or
 - the end of the Group Policy, provided that Continued Insurance will be available to You if You do not become eligible, within 30 days after the end of the Group Policy, for critical illness insurance under another policy of group insurance available through the Group Policyholder;
- We receive Your completed Written request for Continued Insurance on a form approved by Us within 31 calendar days after Your Group Billed Insurance ends; and
- You pay premiums required for Continued Insurance by the due date specified in the premium notice sent to You.

Changes in Continued Insurance

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

Contributions for Continued Insurance

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

End of Continued Insurance

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

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

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT (Continued)

FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

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

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

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

FOR FAMILY AND MEDICAL LEAVE

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

CLAIMS

NOTICE OF CLAIM

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

CLAIM FORM

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

PROOF OF LOSS

Proof must be provided to Us not later than 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, but in no event, other than in the absence of the legal capacity of the claimant, later than 12 months from the date of the loss.

PAYMENT OF BENEFITS

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

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

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

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

YOUR BENEFICIARY

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

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

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

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

CLAIMS (Continued)

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

APPEALING A CLAIM DECISION

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

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

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

AUTHORIZATIONS

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

EXAMINATIONS

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

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

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

AUTOPSY

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

TIME LIMIT ON LEGAL ACTIONS

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

REFUND TO US FOR OVERPAYMENT OF BENEFITS

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

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

GENERAL PROVISIONS

CHANGES IN CLINICAL STANDARDS

This Certificate includes certain clinical criteria that is required to establish a Diagnosis of a Covered Condition under this Certificate. Should the clinical criteria that is generally accepted by the medical community in the United States change as it applies to establishing a Diagnosis of a Covered Condition, We will accept a Diagnosis made by a Physician based on the current generally accepted clinical criteria for medical practice standards in order to establish a Diagnosis of a Covered Condition.

ENTIRE CONTRACT

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

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

INCONTESTABILITY: STATEMENTS MADE BY YOU

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

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

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

MISSTATEMENTS

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

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.

ASSIGNMENT

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

CONFORMITY WITH LAW

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

STANDARD OF TIME

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