

**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:	Oswego Community Unit School District 308
Group Policy Number:	0216730
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.

**Notice to Buyer: This is a critical illness insurance Certificate. Subject to the provisions of this Certificate, including limitations, exclusions and submission of Proof of a Covered Condition, this Certificate provides a limited benefit in the event You are Diagnosed with certain specified diseases, or have certain surgical procedures performed. Benefits provided are a supplement, and not a substitute for, Medical Coverage. You should have Medical Coverage when You enroll for this insurance.**

**GUARANTEED RENEWABLE**

Your coverage under this Certificate is guaranteed renewable. This means that although MetLife reserves the right to change any or all premium rates as provided in the group policy, MetLife cannot end Your coverage under this Certificate except for reasons stated in this Certificate.

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

**Notice to Residents of Illinois**

**IMPORTANT NOTICE**

**To make a complaint to Metropolitan Life insurance Company, You may write to:**

**Metropolitan Life Insurance Company  
Attn: Critical Illness  
P.O. Box 5923  
Bridgewater, New Jersey 08807-5923**

**The address of the Illinois Department of Insurance is:**

**Illinois Department of Insurance  
Public Services Division  
Springfield, Illinois 62767**

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## 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

### MAJOR ORGAN TRANSPLANT 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

### \*BENEFIT REDUCTION DUE TO AGE

#### **The Benefit Amount for You is reduced to:**

See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife

#### **The Major Organ Transplant Benefit Amount for You is reduced to:**

See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife

#### **The Total Benefit Amount for You is reduced to:**

See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife

#### **The Benefit Amount for Your Spouse or Domestic Partner is reduced to:**

See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife

#### **The Major Organ Transplant Benefit Amount for Your Spouse or Domestic Partner is reduced to:**

See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife

#### **The Total Benefit Amount for Your Spouse or Domestic Partner is reduced to:**

See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife

\*Please see the Benefit Reduction Due to Age provision.

## SCHEDULE OF INSURANCE (continued)

### BENEFITS FOR COVERED CONDITIONS

Covered Condition	Initial Benefit	Recurrence Benefit
Alzheimer's Disease	100% of Benefit Amount	NONE
Coronary Artery Bypass Graft	100% of Benefit Amount	50% of Benefit Amount
Full Benefit Cancer	100% of Benefit Amount	50% of Benefit Amount
Partial Benefit Cancer	25% of Benefit Amount	12.50% of Benefit Amount
Heart Attack	100% of Benefit Amount	50% of Benefit Amount
Kidney Failure	100% of Benefit Amount	NONE
Major Organ Transplant	100% of Major Organ Transplant Benefit Amount	NONE
Stroke	100% of Benefit Amount	50% of Benefit Amount
Listed Conditions	25% of Benefit Amount	NONE

**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. 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 or a Part-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.

**Activities of Daily Living** means any of the following:

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

**Alzheimer's Disease** means the development of multiple, progressive cognitive 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);
- anosia (failure to recognize or identify objects despite intact sensory function); and
- disturbance in executive functioning (i.e. planning, organizing, sequencing, abstracting).

**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.

**Benefit Suspension Period** means the 365 day period following the date a Covered Condition, for which this Certificate pays a benefit, Occurs with respect to a Covered Person.

**Board Certified** means a Physician has received certification in the appropriate medical specialty by a member board of the American Board of Medical Specialties.

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

## DEFINITIONS (continued)

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

- under generally accepted medical standards, a pathological Diagnosis cannot be made because it would be medically inappropriate or life-threatening;
- medical diagnostic testing supports the Diagnosis; and
- a Physician who is a Board Certified oncologist is treating the Covered Person for Partial Benefit Cancer or Full Benefit Cancer.

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

**Coronary Artery Bypass Graft** means the undergoing of open heart Surgery performed by a Physician who is a Board Certified cardiothoracic surgeon to bypass a narrowing or blockage of one or more coronary arteries using venous or arterial grafts. The procedure must be deemed medically necessary by a Physician who is a Board Certified cardiologist, and be supported by pre-operative angiographic evidence. Coronary Artery Bypass Graft does not include:

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

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

- Alzheimer's Disease;
- Coronary Artery Bypass Graft;
- Full Benefit Cancer;
- Partial Benefit Cancer;
- Heart Attack;
- Kidney Failure;
- Major Organ Transplant;
- Stroke; or
- any of the Listed Conditions.

**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.

## DEFINITIONS (continued)

**Dependent Child** means the following:

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

The term does not include an unborn or stillborn child, or any person who;

- is serving in the armed forces, or any auxiliary units of the armed forces, of any country;
- lives outside of the United States for more than 12 consecutive months; or
- is insured under the Group Policy as an employee.

A person cannot be insured as a Dependent Child of more than one employee under the Group Policy. Your adopted child will not be a Dependent Child prior to: (1) the date the child is placed in Your home for adoption; and (2) when the child is placed in Your custody pursuant to an interim court order of adoption, whichever comes first.

**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.

**Disabled** or **Disability** means that, solely due to a Covered Condition for which We have paid a benefit under this Certificate:

- while You are unemployed, You become and remain continuously unable to perform two or more Activities of Daily Living; or
- while You are employed, You become and remain continuously unable to perform any work for pay or benefits for which You are or become reasonably fitted by Your education, training or experience.

## 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 a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:
  - 18 years of age or older;
  - unmarried;
  - the sole domestic partner of the other;
  - sharing a primary residence with the other;
  - not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

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

The term "Domestic Partner" does not include any person who:

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

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.

**Full Benefit 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 provided that a Physician who is Board Certified in the medical specialty that is appropriate for the type of cancer involved has determined that:

- Surgery, radiotherapy, or chemotherapy is medically necessary;
- there is metastasis; or
- the patient has terminal cancer, is expected to die within 24 months or less from the date of Diagnosis and will not benefit from, or has exhausted, curative therapy.

**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 25 hours per week.

**Geriatrician** means a Physician specializing in the assessment and treatment of elderly people. The Physician must be Board Certified in geriatric medicine by the American Board of Geriatric Medicine.

**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.

**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.

## **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 an organized department of medicine;
- has an organized Department of major surgery either on the premises or in the facility available to the Hospital on a prearranged basis;
- 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:

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

**Initial Benefit** means the benefit, as specified in the Schedule of Insurance, that We pay:

- the first time any one of the Listed Conditions Occurs while coverage is in effect under this Certificate;
- the first time Full Benefit Cancer Occurs while coverage is in effect under this Certificate;
- any subsequent time Full Benefit Cancer Occurs while coverage is in effect under this Certificate and after an Initial Benefit has already been paid for Full Benefit Cancer if the subsequently Occurring Full Benefit Cancer is Separate & Unrelated to the Full Benefit Cancer for which an Initial Benefit has already been paid;
- the first time Partial Benefit Cancer Occurs while coverage is in effect under this Certificate;
- any subsequent time Partial Benefit Cancer Occurs while coverage is in effect under this Certificate and after an Initial Benefit has already been paid for Partial Benefit Cancer if the subsequently Occurring Partial Benefit Cancer is Separate & Unrelated to the Partial Benefit Cancer for which an Initial Benefit has already been paid; and
- the first time each of the following Covered Conditions Occurs while coverage is in effect under this Certificate: Alzheimer's Disease; Coronary Artery Bypass Graft; Heart Attack; Kidney Failure and Stroke.

## DEFINITIONS (continued)

**Kidney Failure** means the total, end stage, irreversible failure of both kidneys to function, provided that a Physician who is a Board Certified nephrologist 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.

**Listed Condition or Listed Conditions** means any of the following diseases:

- Addison's disease (adrenal hypofunction);
- amyotrophic lateral sclerosis (Lou Gehrig's disease);
- cerebrospinal meningitis (bacterial);
- cerebral palsy;
- cystic fibrosis;
- diphtheria;
- encephalitis;
- Huntington's disease (Huntington's chorea);
- Legionnaire's disease;
- malaria;
- multiple sclerosis (definitive diagnosis);
- muscular dystrophy;
- myasthenia gravis;
- necrotizing fasciitis;
- osteomyelitis;
- poliomyelitis;
- rabies;
- sickle cell anemia (excluding sickle cell trait);
- systemic lupus erythematosus (SLE);
- systemic sclerosis (scleroderma);
- tetanus; and
- tuberculosis.

**Major Organ Transplant** means:

- the irreversible failure of a Covered Person's heart, lung, pancreas, entire kidney or any combination thereof, for which a Physician has determined that the complete replacement of such organ with an entire organ from a human donor is medically necessary, and either such Covered Person has been placed on the Transplant List or such transplant procedure has been performed;
- 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 and either such Covered Person has been placed on the Transplant List or such procedure has been performed; or
- the replacement of a Covered Person's bone marrow with bone marrow from the Covered Person or another human donor, which replacement is determined to be medically necessary by a Physician who is Board Certified in hematology or oncology in order to treat irreversible failure of such Covered Person's bone marrow.

## DEFINITIONS (continued)

**Maximum Benefit Amount** means the maximum amount of benefits for which an individual in an eligible class can apply under the Group Policy.

**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.

**Neurologist** means a Physician who specializes in the diagnosis and treatment of disorders of the nervous system and who is Board Certified by the American Board of Psychiatry and Neurology, Inc.

**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 and is Board Certified by the American Board of Professional Neuropsychology.

**Occurs or Occurrence** means:

- with respect to Full Benefit Cancer, Partial Benefit Cancer, Heart Attack, Kidney Failure, Stroke or a Listed Condition that the Covered Person:
  1. experiences such Covered Condition; and
  2. is Diagnosed with such Covered Condition.
- with respect to Coronary Artery Bypass Graft, that the Covered Person undergoes a Coronary Artery Bypass Graft.
- with respect to Major Organ Transplant, that the Covered Person:
  1. is placed on the Transplant List; or
  2. undergoes such Major Organ Transplant.
- 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.

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

**Partial Benefit Cancer** means one of the following conditions that meets the TNM Staging classification and other qualifications specified below:

- carcinoma in situ classified as TisN0M0, provided that Surgery, radiotherapy or chemotherapy has been determined to be medically necessary by a Physician who is Board Certified in the medical specialty that is appropriate for the type of carcinoma in situ involved;
- malignant tumors classified as T1N0M0 or greater which are treated by endoscopic procedures alone;
- malignant melanomas classified as T1N0M0, for which a pathology report shows maximum thickness less than or equal to 0.75 millimeters using the Breslow method of determining tumor thickness; and
- tumors of the prostate classified as T1bN0M0, or T1cN0M0, provided that they are treated with a radical prostatectomy or external beam radiotherapy.

## DEFINITIONS (continued)

**Physician** means an individual who has received a degree of doctor of medicine (M.D.), or doctor of osteopathy (D.O.), and is acting within the scope of a valid license issued in the United States to Diagnose a Covered Condition or to perform the services required for a Covered Condition for which a claim is made. A Physician is not:

- You,
- Your Spouse, Your Domestic Partner or anyone to whom You are related by blood or marriage;
- anyone with whom You are residing;
- Your adopted or step-child;
- anyone with whom You share a business interest; or
- Your employee.

**Practitioner of the Healing Arts** means any person who holds a valid license in the United States to engage in the diagnosis or treatment of disease or any ailment of the human body.

**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 Coronary Artery Bypass Graft an Occurrence of Coronary Artery Bypass Graft if We have already paid an Initial Benefit for the First Occurrence of Coronary Artery Bypass Graft.
- with respect to Full Benefit Cancer, an Occurrence of Full Benefit Cancer that Occurs after an Initial Benefit was paid for an earlier Occurrence of that same Full Benefit Cancer.
- with respect to Partial Benefit Cancer, an Occurrence of Partial Benefit Cancer that Occurs after an Initial Benefit was paid for an earlier Occurrence of that same Partial Benefit Cancer.
- with respect to Heart Attack an Occurrence of Heart Attack after We have already paid an Initial Benefit for an earlier Occurrence of Heart Attack.
- with respect to Stroke an Occurrence of Stroke after We have already paid an Initial Benefit for an earlier Occurrence of Stroke.



## DEFINITIONS (continued)

**Separate & Unrelated** means a Full Benefit Cancer or a Partial Benefit Cancer that is:

- not a metastasis of a previously Diagnosed Full Benefit Cancer; and
- distinct from any previously Diagnosed Full Benefit Cancer or Partial Benefit Cancer.

**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. The term does not include any person who:

- is serving in the armed forces, or auxiliary units of the armed forces, of any country;
- lives outside the United States for more than 12 consecutive months; or
- is insured under the Group Policy as an employee.

**Stroke** means a cerebrovascular accident or incident producing measurable, functional and permanent neurological impairment (not including transient ischemic attacks (TIA), or prolonged reversible ischemic attacks) caused by any of the following which result in an infarction of brain tissue:

- hemorrhage;
- thrombus; or
- embolus from an extra-cranial source.

**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 procedures.

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

**Total Benefit Amount** means the maximum aggregate amount, as specified in the Schedule of Insurance, that We will pay for any and all Covered Conditions combined, per Covered Person, per lifetime, as provided under this Certificate. The Total Benefit Amount does not include Supplemental Benefits.

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

**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 and Part-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**

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.

## **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.

### **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 provided in the Newborn Children provision, 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 provided in the Newborn Children provision, 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 provided in the Newborn Children provision, 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 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 Dependent Child's birth. To continue coverage beyond the first 31 days You must notify Us of the child's birth and give Written permission to deduct Contributions from Your pay for Dependent Insurance for the newborn child.

### **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.

## **CRITICAL ILLNESS BENEFITS FOR ALZHEIMER'S DISEASE, CORONARY ARTERY BYPASS GRAFT, FULL BENEFIT CANCER, HEART ATTACK, KIDNEY FAILURE AND STROKE**

If any of the following Covered Conditions Occurs for a Covered Person, while such Covered Person is insured under this Certificate, Proof of the Covered Condition must be sent to Us. When We receive such Proof, We will review the claim and if We approve it, will pay the benefit described below for such Covered Condition, provided, however, that We will never pay more with respect to any Covered Person than the Total Benefit Amount shown in the Schedule of Insurance.

**100% of the Benefit Amount** is payable for an Occurrence that is not a Recurrence of the following Covered Conditions experienced by a Covered Person while such Covered Person is insured under this Certificate:

1. Alzheimer's Disease;
2. Coronary Artery Bypass Graft;
3. Full Benefit Cancer;
4. Heart Attack;
5. Kidney Failure; or
6. Stroke.

Once We have paid an Initial Benefit for Alzheimer's Disease, We will not pay another Initial Benefit for Alzheimer's Disease.

Once We have paid an Initial Benefit for Coronary Artery Bypass Graft, We will not pay another Initial Benefit for Coronary Artery Bypass Graft.

Once We have paid an Initial Benefit for Full Benefit Cancer, We will not pay another Initial Benefit for Full Benefit Cancer unless the subsequent Occurrence of Full Benefit Cancer is Separate & Unrelated.

Once We have paid an Initial Benefit for Heart Attack, We will not pay another Initial Benefit for Heart Attack.

Once We have paid an Initial Benefit for Kidney Failure, We will not pay another Initial Benefit for Kidney Failure.

Once We have paid an Initial Benefit for Stroke, We will not pay another Initial Benefit for Stroke.

Payment of this benefit reduces the Total Benefit Amount. See the *Reduction on Account of Prior Claims Paid* provision.

## **CRITICAL ILLNESS BENEFITS FOR PARTIAL BENEFIT CANCER AND LISTED CONDITIONS**

If any of the following Covered Conditions Occurs for a Covered Person, while such Covered Person is insured under this Certificate, Proof of the Covered Condition must be sent to Us. When We receive such Proof, We will review the claim and if We approve it, will pay the benefit described below for such Covered Condition, provided, however, that We will never pay more with respect to any Covered Person than the Total Benefit Amount shown in the Schedule of Insurance.

**25% of the Benefit Amount** is payable for an Occurrence that is not a Recurrence of the following Covered Conditions experienced by a Covered Person while such Covered Person is insured under this Certificate:

1. Partial Benefit Cancer; or
2. a Listed Condition.

Once We have paid an Initial Benefit for Partial Benefit Cancer, We will not pay another Initial Benefit for Partial Benefit Cancer unless the subsequent Occurrence of Partial Benefit Cancer is Separate & Unrelated.

Payment of this benefit will reduce the Total Benefit Amount. See the *Reduction on Account of Prior Claims Paid* provision.

## CRITICAL ILLNESS BENEFITS FOR MAJOR ORGAN TRANSPLANT

If Major Organ Transplant 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 below.

**100% of the Major Organ Transplant Benefit Amount** is payable for Major Organ Transplant that Occurs for a Covered Person while coverage is in effect under this Certificate.

We will only pay for one Major Organ Transplant per Covered Person while coverage is in effect under this Certificate.

## RECURRENCE BENEFIT

We will pay the Recurrence Benefit shown in the Schedule of Insurance for a Recurrence subject to the following limitations:

- We will not pay a Recurrence Benefit for a Covered Condition that Recurs during a Benefit Suspension Period; and
- We will not pay a Recurrence Benefit for either a Full Benefit Cancer or a Partial Benefit Cancer unless the Covered Person has not, for a period of 180 days, had symptoms of or been treated for the Full Benefit Cancer or Partial Benefit Cancer for which We paid an Initial Benefit.

Payment of this benefit will reduce the Total Benefit Amount. See the *Reduction on Account of Prior Claims Paid* provision.

## 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 Supplemental Benefits.

## **SUPPLEMENTAL BENEFITS**

### **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 of \$100.

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.

Payment of this benefit will not reduce the Total Benefit Amount.

## WAIVER OF PREMIUMS

If You become Disabled while you are under age 70 and insured under this Certificate, and You remain Disabled continuously for 90 days, Proof of your Disability must be sent to us in order to submit a claim for Waiver of Premium. Such Proof must be sent to us during the 90 day period that follows the 90th day of Your continuous Disability or You will not be eligible for Waiver of Premiums. As part of such Proof, We may choose a Physician to examine You to verify that You are Disabled. If We do so, We will pay for such exam.

When we receive such Proof, we will review the claim and if we approve it, we will waive the premiums due for You and Your Dependents starting with the first premium that becomes due on or after the date You have been Disabled continuously for 90 days, subject to the following:

- We will not waive premiums for any period during which You are not under the care of a Physician for the Covered Condition that causes Your Disability;
- We will not waive premiums if you do not remain insured during the first 90 days of continuous Disability; and
- We will not waive premiums if Your Disability is not solely caused by a Covered Condition for which We have paid a benefit under this Certificate.

If We waive any premium under this provision that has already been paid to Us, We will return the premium to whomever paid it to Us.

To verify that You continue to be Disabled without interruption after Our initial approval, We may periodically ask You to send Us Proof that You continue to be Disabled.

We will continue to waive premiums under this provision until the earliest of:

- the date You are no longer Disabled;
- Your seventieth birthday;
- the date You fail to send us Proof that You continue to be Disabled as required under this provision;
- 2 years from the date We first began to waive premiums; or
- the date Your insurance under this Certificate ends.

## IMPORTANT NOTICE

On the date Your insurance ends, We will not know whether You will be able to satisfy the Disability and Proof requirements specified above. For this reason, We urge You to consider taking the following steps:

**Step 1** When Your insurance ends, ask the Group Policyholder if such insurance will be continued with premium payment by the Group Policyholder. If the answer is yes, ask if such continuation will be for at least 90 days. If the answer is yes, file a claim for Waiver of Premiums under this section at the end of 90 days of continuous Disability.

If the Group Policyholder will not continue insurance as described in Step 1, proceed to Step 2.

**Step 2.** Read the section titled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT. You may have the option to continue your insurance under the Group Policy.

If the Group Policyholder does not continue Your insurance as described in Step 1 and You do not continue your insurance as described in Step 2 You will not be eligible for Waiver of Premiums because You will not have been continuously insured during the first 90 days of Disability.



## **EXCLUSIONS THAT APPLY TO SPECIFIC COVERED CONDITIONS**

### **ALZHEIMER'S DISEASE**

We will not pay benefits for a Diagnosis of Alzheimer's Disease for:

- 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.

### **CORONARY ARTERY BYPASS GRAFT**

We will not pay benefits for Coronary Artery Bypass Graft:

- performed outside the United States; or
- that does not involve median sternotomy (a surgical incision in which the sternum, also known as the breastbone, is divided down the middle from top to bottom).

### **FULL BENEFIT CANCER**

We will not pay benefits for a Diagnosis of Full Benefit Cancer for:

- any condition that is Partial Benefit Cancer;
- any benign tumor, dysplasia, intraepithelial neoplasia or pre-malignant growth;
- any papillary tumor of the bladder classified as Ta under TNM Staging;
- any tumor of the prostate classified as T1N0M0 under TNM Staging;
- any papillary tumor of the thyroid that is classified as T1N0M0 or less under TNM Staging and is one centimeter or less in diameter unless there is metastasis;
- 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;
- any non-melanoma skin cancer unless there is metastasis; or
- any malignant tumor classified as less than T1N0M0 under TNM Staging.

### **PARTIAL BENEFIT CANCER**

We will not pay benefits for a Diagnosis of Partial Benefit Cancer for:

- any benign tumor, dysplasia, intraepithelial neoplasia or pre-malignant growth;
- any papillary tumor of the bladder classified as Ta under TNM Staging;
- any tumor of the prostate classified as T1aN0M0 under TNM Staging;
- any papillary tumor of the thyroid that is classified as T1N0M0 or less under TNM Staging and is one centimeter or less in diameter;
- 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;
- any non-melanoma skin cancer; or
- any melanoma in situ classified as TisN0M0 under TNM Staging.

## **EXCLUSIONS THAT APPLY TO SPECIFIC COVERED CONDITIONS (continued)**

### **MAJOR ORGAN TRANSPLANT**

We will not pay benefits for a Major Organ Transplant:

- performed outside the United States;
- involving organs received from non-human donors;
- involving implantation of mechanical devices or mechanical organs;
- involving stem cell generated transplants; or
- involving islet cell transplants.

### **STROKE**

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

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

### **LISTED CONDITIONS**

We will not pay benefits for:

- a Diagnosis of multiple sclerosis for clinically isolated syndrome (CIS);
- a Diagnosis of systemic lupus erythematosus (SLE) for any form of Lupus that is not Diagnosed as systemic lupus erythematosus (SLE); or
- a suspected or probable Diagnosis of a Listed Condition.

## **ADDITIONAL PROOF REQUIREMENTS FOR EACH COVERED CONDITION**

### **ALZHEIMER'S DISEASE**

Proof of Alzheimer's Disease requires a Diagnosis made in Writing by a Neurologist, Geriatrician, or Neuropsychologist and supported by all of the following:

- formal neuropsychological testing performed by a Neuropsychologist confirming dementia;
- laboratory tests have been completed as part of the evaluation to rule out etiologies other than Alzheimer's Disease; and
- magnetic resonance imaging, computerized tomography or other reliable imaging techniques that have been completed as part of the evaluation to rule out etiologies other than Alzheimer's Disease.

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.

### **CORONARY ARTERY BYPASS GRAFT**

Proof of Coronary Artery Bypass Graft requires submission of medical records evidencing that the Coronary Artery Bypass Graft:

- was determined to be medically necessary by a Physician who is Board Certified in cardiology;
- was supported by pre-operative angiographic evidence; and
- has been performed.

The Covered Condition for Coronary Artery Bypass Graft will be deemed to Occur on the date that the Coronary Artery Bypass Graft is performed.

### **FULL BENEFIT CANCER**

Unless We accept a Clinical Diagnosis as provided in this Certificate, Diagnosis of Full Benefit 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 who is Board Certified in pathology. The Covered Condition for Full Benefit Cancer will be deemed to Occur upon the date that the Diagnosis of Full Benefit Cancer is made.

### **PARTIAL BENEFIT CANCER**

Unless We accept a Clinical Diagnosis as provided in this Certificate, Diagnosis of Partial Benefit Cancer must be based upon microscopic (histologic) examination of fixed tissue or preparations of blood or bone marrow. Such examination must be documented in a Written pathology report by a Physician who is Board Certified in pathology. The Covered Condition for Partial Benefit Cancer will be deemed to Occur upon the date the Diagnosis of Partial Benefit Cancer is made.

## **ADDITIONAL PROOF REQUIREMENTS FOR EACH COVERED CONDITION (continued)**

### **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.

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

### **KIDNEY FAILURE**

Diagnosis of Kidney Failure must be made in Writing by a Physician who is Board Certified in nephrology, 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.

### **MAJOR ORGAN TRANSPLANT**

Proof of Major Organ Transplant requires submission of medical records evidencing that the Major Organ Transplant was deemed medically necessary by a Physician who is Board Certified in a medical specialty that is appropriate for the organ involved and that either:

- the Covered Person has been placed on the Transplant List; or
- the Major Organ Transplant has been performed.

The Covered Condition for Major Organ Transplant will be deemed to Occur on the earlier of:

- the date the Covered Person is placed on the Transplant List; or
- the date the Major Organ Transplant is performed.

### **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 accident or incident by a Physician who is Board Certified in neurology 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. The Covered Condition for Stroke will be deemed to Occur on the date the Diagnosis of Stroke is made.

### **LISTED CONDITIONS**

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

## **LIMITATIONS**

### **BENEFIT REDUCTION DUE TO AGE**

Your Benefit Amount, Your Major Organ Transplant Benefit Amount and the Total Benefit Amount will each be reduced when You reach certain ages, as shown in the Schedule of Insurance. The Benefit Amount, the Major Organ Transplant Benefit Amount and the Total Benefit Amount for Your Spouse or Domestic Partner will each be reduced when Your Spouse or Domestic Partner reach certain ages, as shown in the Schedule of Insurance.

## **PREEXISTING CONDITION EXCLUSION**

**Preexisting Condition** means a sickness or injury for which, in the 3 months before a Covered Person becomes insured under this Certificate, or before any Benefit Increase with respect to such Covered Person medical advice, treatment or care was sought by such Covered Person, or, recommended by, prescribed by or received from a Physician or other Practitioner of the Healing Arts.

We will not pay benefits for Covered Conditions that are caused by or result from a Preexisting Condition if the Covered Condition Occurs during the first 6 months that a Covered Person is insured under this Certificate.

With respect to a Benefit Increase, We will not pay benefits for such Benefit Increase for Covered Conditions that are caused by or result from a Preexisting Condition if such Covered Condition Occurs during the first 6 months after such increase in the Total Benefit Amount.

This provision does not apply to benefits for the following Covered Conditions: Heart Attack and Stroke.

## OTHER EXCLUSIONS

### EXCLUSION FOR INTOXICATION

We will not pay benefits for any Covered Condition that is caused by, or results from, a Covered Person's involvement in an incident, where such Covered Person is intoxicated at the time of the incident and is the operator of a vehicle involved in the incident.

**Intoxicated** means that the Covered Person's alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident happened.

### GENERAL EXCLUSIONS

We will not pay benefits for any Covered Conditions caused by, or resulting from, a Covered Person:

- participating in a felony, riot or insurrection;
- intentionally causing a self-inflicted injury;
- committing or attempting to commit suicide while sane or insane;
- voluntarily taking or using any drug, medication or sedative unless it is:
  - taken or used as prescribed by a Physician, or
  - an "over the counter" drug, medication or sedative taken according to package directions;
- engaging in any illegal occupation; 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, 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.

## 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.

Please refer to the provision entitled *Waiver of Premiums* for information concerning continuation of Your insurance if Your insurance ends while You are Disabled.

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 a Preexisting Condition under the Preexisting Condition Exclusion in this Certificate; and
  2. whether a Covered Condition is subject to the Benefit Suspension Period in this Certificate.

To the extent that benefits were paid under the Old Policy with respect to a Covered Person for any Covered Condition:

- if that Covered Condition Occurs under the New Policy, it will be treated as a Recurrence provided that there is a Recurrence Benefit available under the New Policy for such Covered Condition; and
- the Total Benefit Amount with respect to such Covered Person under this Certificate will be reduced.

## **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.

## CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT (CONTINUED)

### 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.

#### If You are Disabled on the Date Your Employment Ends

If You are Disabled on the date Your employment ends and You elect to continue your insurance under this CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT section, You may at a later date become approved to have Your premiums waived under the *Waiver of Premiums* provision of this Certificate. If You are so approved, all insurance continued under this CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT section will end and We will return any premiums paid to whomever paid them for such insurance.

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

### **PAYMENT OF BENEFITS**

When We receive the claim form and Proof We will review the claim and, if We approve it, We will pay benefits subject to the terms and provisions of this Certificate and the Group Policy. If We pay benefits more than 30 days after the date We receive the claim form and Proof, We will pay interest at the rate required by Illinois law accruing from the thirtieth day after the date We pay the claim, provided that if such interest amounts to less than one dollar it will not be paid.

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

### **ENTIRE CONTRACT**

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

- the Group Policy and its Exhibits, which include the Certificate(s);
- 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 void 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 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 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.