



Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166-0188

CERTIFICATE CONFIRMATION STATEMENT
Critical Illness Insurance

PLEASE READ THE ATTACHED CERTIFICATE CAREFULLY. INSURANCE BENEFITS MAY BE SUBJECT TO CERTAIN REQUIREMENTS, LIMITATIONS AND EXCLUSIONS.

This confirmation statement supersedes any previous confirmation statement issued under this certificate.

Policyholder	American Better Health Organization
Group Number	0247173-1-G

BENEFITS

Benefit Amount for You	\$XXXX
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CRITICAL ILLNESS



**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 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: American Better Health Organization, Inc

Group Policy Number: 0247173-1-G

MetLife Toll Free Number: 1-800-GETMET8

This Is A Limited Policy — Read It Carefully.

Important Notice: Subject to the provisions of this Certificate, including limitations, exclusions and Proof requirements, this Certificate provides limited benefits in the event You are Diagnosed with certain critical illnesses.

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

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

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

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

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

NOTICE

MetLife complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. Coverage is made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender. MetLife will not deny or limit coverage based on an individual's sex assigned at birth or gender identity.

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	2
NOTICE FOR RESIDENTS OF MAINE	3
SCHEDULE OF INSURANCE	6
LIMITATIONS	10
Benefit Separation Period	10
Preexisting Condition Limitation	12
Rules For Total Benefit Amount And Reduction For Prior Claims Paid	12
GENERAL EXCLUSIONS	13
DEFINITIONS	14
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
COVERED CONDITION CATEGORY: CANCER	22
Additional Definitions That Apply To Benefits For The Cancer Covered Condition Category	22
Initial Benefit For A Cancer Covered Condition	23
Additional Proof Requirements For A Cancer Covered Condition	23
Special Exclusions Applicable To A Cancer Covered Condition	23
COVERED CONDITION CATEGORY: HEART ATTACK	24
Additional Definitions That Apply To The Heart Attack Covered Condition Category	24
Initial Benefit For A Heart Attack Covered Condition	24
Additional Proof Requirements For A Heart Attack Covered Condition	25
Preexisting Condition Limitation And A Heart Attack Covered Condition	25
COVERED CONDITION CATEGORY: MAJOR ORGAN TRANSPLANT	26
Additional Definitions That Apply To The Major Organ Transplant Covered Condition Category	26
Initial Benefit For A Major Organ Transplant Covered Condition	27
Special Limitations Applicable To A Major Organ Transplant Covered Condition	27
Additional Proof Requirements For A Major Organ Transplant Covered Condition	27
Special Exclusions Applicable To A Major Organ Transplant Covered Condition	27
COVERED CONDITION CATEGORY: STROKE	28
Additional Definitions That Apply To The Stroke Covered Condition Category	28
Initial Benefit For A Stroke Covered Condition	28
Additional Proof Requirements For A Stroke Covered Condition	28
Special Exclusions Applicable To A Stroke Covered Condition	29
Preexisting Condition Limitation And A Stroke Covered Condition	29
WHEN INSURANCE ENDS	30
Date Your Insurance Ends	30
Date Dependent Insurance Ends	30
Change In Class	30
CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT	31
At Your Option: Portability Through Continuation With Premium Payment	31
For Mentally Or Physically Handicapped Children	32
For A Dependent Child Called to Active Duty	32
CLAIMS	33

Notice of Claim.....	33
Claim Form.....	33
Proof of Loss.....	33
Payment Of Benefits.....	33
Your Beneficiary.....	33
Appealing A Claim Decision.....	34
Authorizations.....	34
Examinations.....	34
Autopsy.....	34
Time Limit on Legal Actions.....	34
Refund To Us For Overpayment Of Benefits.....	34
GENERAL PROVISIONS.....	35
Changes In Standards.....	35
Entire Contract.....	35
Time Limit On Certain Defenses.....	35
Misstatements.....	35
Assignment.....	35
Conformity with Law.....	35
Standard of Time.....	35
Access To Discounts For Services.....	35

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 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	An amount, elected by You, which is one of \$3,000, \$5,000, \$7,000, \$10,000, \$15,000, or \$25,000.	100% of the Benefit Amount for the Member.	100% of the Benefit Amount for the Member.
Total Benefit Amount	300% of the Benefit Amount elected by You.	300% of the Benefit Amount elected by You.	300% of the Benefit Amount elected by You.

BENEFIT SEPARATION PERIOD

For an Initial Benefit for a Covered Person	30 days
For a Recurrence Benefit for a Covered Person	90 days

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

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	None
Non-Invasive Cancer	5% of the Benefit Amount payable no more than 1 time per Covered Person per Occurrence of each Separate and Unrelated Non-Invasive Cancer	None

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	None

COVERED CONDITION CATEGORY: MAJOR ORGAN TRANSPLANT		
COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
Major Organ Transplant	100% of the Benefit Amount payable no more than 1 time per Covered Person	None

SCHEDULE OF INSURANCE (Continued)

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	None

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.

Initial Benefit Separation Period

The Initial Benefit Separation Period is the number of days that must elapse between an Occurrence of a Covered Condition for which a benefit is payable and an Occurrence of a different Covered Condition in order for an Initial Benefit to be payable for the later Covered Condition.

Once a Covered Condition has Occurred for which a benefit is payable, in order for an Initial Benefit to be payable for an Occurrence of any other Covered Condition that would otherwise qualify for an Initial Benefit payment, the Initial Benefit Separation Period must be satisfied. The Initial Benefit Separation Period is set forth on the Schedule.

In the event another Covered Condition Occurs within the Initial Benefit Separation Period, the following rules will apply:

- If the benefit We paid (Initial Benefit or Recurrence Benefit) for the prior Covered Condition(s) is less than the Initial Benefit amount We would pay for the new Covered Condition, We will pay an additional amount equal to:
 - the amount We would have paid for the new Covered Condition had the Initial Benefit Separation Period been satisfied; minus
 - the amount We paid for the prior Covered Condition(s).
- If the benefit We paid (Initial Benefit or Recurrence Benefit) for the prior Covered Condition is equal to or exceeds the Initial Benefit amount We would pay for the new Covered Condition, an additional amount is not payable.

Examples:

The following examples are provided for illustration purposes to explain how the Initial Benefit Separation Period will be applied and an additional amount is calculated as described above. These examples do not necessarily reflect the benefits of Your specific coverage.

Benefit Amount	\$10,000
Initial Benefit Separation Period	90 days
Benefit payable for Covered Condition A, which Occurs on January 1 st	Based on the Schedule, the plan pays 50% of the Benefit Amount = \$5,000
Initial Benefit that applies to Covered Condition B, which Occurs on February 1 st , prior to satisfaction of the Initial Benefit Separation Period	Based on the Schedule, the plan pays 100% of the Benefit Amount = \$10,000
Adjustment Calculation for Occurrence of Covered Condition B	\$10,000 minus \$5,000 (Difference between amount paid for Covered Condition A and amount that would be paid for Covered Condition B). Result: An additional \$5,000 would be payable for the Occurrence of Covered Condition B

LIMITATIONS (Continued)

Benefit Amount	\$10,000
Initial Benefit Separation Period	90 days
Benefit payable for Covered Condition A, which Occurs on January 1 st	Based on the Schedule, the plan pays 100% of the Benefit Amount = \$10,000
Initial Benefit that applies to Covered Condition B, which Occurs on February 1 st prior to satisfaction of the Initial Benefit Separation Period	Based on the Schedule, the plan pays 25% of the Benefit Amount = \$2,500
Adjustment Calculation for Occurrence of Covered Condition B	The amount payable for Covered Condition A (\$10,000) exceeded the amount that would be payable for Covered Condition B (\$2,500). Result: An additional benefit would not be payable for the Occurrence of Covered Condition B

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 1 st	Initial Benefit paid for Covered Condition A
Covered Condition A Occurs again on March 1 st	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.

LIMITATIONS (Continued)

PREEXISTING CONDITION LIMITATION

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

After coverage under the Certificate takes effect, We will not pay for an increase in the Benefit Amount for any Covered Condition that is caused by or results from a Preexisting Condition if such Covered Condition Occurs during the first 6 months after such increase in the Benefit Amount.

Preexisting Condition means a Covered Person's sickness or injury for which medical advice, treatment or care was sought by the Covered Person, or was recommended by, prescribed by or received from a Physician or other Practitioner of the Healing Arts:

- in the 3 months before such Covered Person becomes insured under this Certificate; or
- after coverage under the Certificate takes effect for such Covered Person, in the 3 months before any increase in the Benefit Amount.

For purposes of satisfying the Preexisting Condition Limitation, We will not consider the following to be medical advice, treatment or care received by the Covered Person from a Physician or other Practitioner of the Healing Arts:

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

The Preexisting Condition Limitation applies to all Covered Conditions unless otherwise stated in this Certificate.

RULES FOR TOTAL BENEFIT AMOUNT AND REDUCTION FOR PRIOR CLAIMS PAID

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

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

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

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

GENERAL EXCLUSIONS

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

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

- the Covered Person's active participation in an insurrection, rebellion, riot or terrorist act;
- the Covered Person's engagement in any illegal occupation or activity that constitutes a felony under the laws of the jurisdiction in which the activity took place;
- the Covered Person's intentionally self-inflicted injury;
- the Covered Person's suicide or attempted suicide (while sane or insane);
- war, whether declared or undeclared; or act of war;
- the Covered Person's operation, while intoxicated, of a motor vehicle involved in the incident. Motor vehicle means any vehicle that is powered by a motor, including, but not limited to: an automobile; a boat; a motorcycle; a truck; an all terrain vehicle; or a snow mobile. For purposes of this exclusion intoxicated means that the Covered Person's:
 - blood alcohol level met or exceeded .08%; or
 - blood delta-9-tetrahydrocannabinol (THC) level met or exceeded the limit established by the laws of the jurisdiction for drug-impaired driving where the incident took place;
- the Covered Person voluntarily taking or using any intoxicant or narcotic unless it is:
 - taken or used as prescribed by a Physician; or
 - an "over the counter" drug, medication or sedative taken according to package directions; or
- activities required by the Covered Person's service in the armed forces or any auxiliary unit of the armed forces of any country or international authority.

In addition, We will not pay benefits for:

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

DEFINITIONS

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

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

Certificate means this Certificate including any riders attached to it.

Clinical Diagnosis means a Diagnosis based on the study of the clinical criteria 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.

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

Dependent means Your Spouse and/or Dependent Child.

Dependent Child means the following:

- Your biological child, while such child is younger than the Dependent Child Age Limit;
- Your adopted child, while such child is younger than the Dependent Child Age Limit; or
- Your stepchild, including a child of Your Domestic Partner, while such child is younger than the Dependent Child Age Limit.

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

DEFINITIONS (Continued)

Dependent Child Age Limit means:

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

Dependent Insurance means insurance under this Certificate for Your Dependents.

Diagnosis or Diagnosed means the establishment of a Covered Condition by a Physician through the use of clinical and/or laboratory findings, and using generally accepted medical standards.

Domestic Partner means each of two people, one of whom is You, who:

1. have registered as each other's domestic partner or civil union partner 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; and
 - 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 You.

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

Group Policyholder means American Better Health Organization, Inc.

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;
- provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- is duly licensed by the agency responsible for licensing such Hospitals; and
- is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational or rehabilitative care.

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

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

Medical Restriction means a person is:

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

Member means a member in good standing of the American Better Health Organization, Inc.

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

Physician means:

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

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; or
- Your adopted or stepchild.

DEFINITIONS (Continued)

Practitioner of the Healing Arts means any person who holds a valid license in the United States, Canada or Mexico to engage in the Diagnosis or treatment of disease or any ailment of the human body, and is acting within the scope of such license.

Primary Residence means the dwelling where a person lives for the majority of the time, whether the person owns or rents the dwelling.

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.

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 or Your Domestic Partner.

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

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

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 a Member who is insured under the Group Policy for the insurance described in this Certificate.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS

All Members of the Association who are under age 70 at the time of enrollment.

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.

DATE YOUR INSURANCE TAKES EFFECT

Insurance under this Certificate will take effect for You on the Certificate effective date.

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.

ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE

ELIGIBLE CLASS FOR DEPENDENT INSURANCE

All Members of the Association who are under age 70 at the time of enrollment 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 Members 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 Members 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.

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.

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

ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE (Continued)

Adopted Children

A Dependent Child adopted by You or Placed for Adoption with You while insurance is in effect under the Certificate will be covered:

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

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

Placed for Adoption or **Placement for Adoption** means the assumption and retention by You of a legal obligation for total or partial support of a child in anticipation of Your adoption of the child.

Other Dependents

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

- the date Your insurance takes effect; 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, You, and each of Your Transferring Dependents will be insured under the New Policy on the Replacement Date subject to and in accordance with the provisions of this section.

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

Disabled Child means a child who:

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

Crediting of Time

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

- whether a Covered Condition is subject to the Preexisting Condition Limitation in this Certificate; and
- whether a Covered Condition is eligible for a Recurrence Benefit 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; or
- Non-Invasive 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.

The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

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. The Initial Benefit Separation Period does not apply to payment of the Initial Benefit for a Related Occurrence for a Cancer Covered Condition as described in this provision.

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.

SPECIAL EXCLUSIONS APPLICABLE TO A CANCER COVERED CONDITION

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

- any condition that is Skin Cancer;
- 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;
- 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; or
- 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.

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. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

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.

PREEXISTING CONDITION LIMITATION AND A HEART ATTACK COVERED CONDITION

The Preexisting Condition Limitation provision does not apply to benefits for Heart Attack.

COVERED CONDITION CATEGORY: MAJOR ORGAN TRANSPLANT

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

Bone Marrow means the soft, sponge-like tissue within the bone that produces white blood cells, red blood cells and platelets.

Major Organ Transplant Covered Condition means the following:

- Major Organ Transplant.

Major Organ Transplant means:

- the irreversible failure of a Covered Person's liver for which a Physician has determined that the complete or partial replacement of the liver with a liver, or liver tissue from a human donor, is medically necessary;
- the irreversible failure of a Covered Person's heart, lung, pancreas, or any combination thereof, for which a Physician has determined that the complete replacement of such organ with an entire organ from a human donor is medically necessary;
- the irreversible failure of a Covered Person's Bone Marrow for which a Physician has determined that replacement of the Bone Marrow (stem cells) from a human donor is medically necessary; and
- for all of the above listed transplants, one of the following additional requirements are met:
 - the Covered Person has been placed on the Transplant List; or
 - such Major Organ Transplant Procedure has been performed.

Major Organ Transplant Procedure means a Covered Person undergoes a procedure for any of the transplant types to which the term Major Organ Transplant Covered Condition applies.

Occurs or **Occurrence** means, while the coverage is in effect under this Certificate for a Covered Person:

- with respect to Major Organ Transplant, the earlier of:
 - the date a Covered Person is placed on the Transplant List; or
 - the date a Covered Person undergoes a Major Organ Transplant Procedure.

If a Covered Person is placed on the Transplant List and then subsequently undergoes a Major Organ Transplant Procedure of the same organ for which the Covered Person was on the Transplant List, We will treat this as a single Occurrence of a Major Organ Transplant Covered Condition.

COVERED CONDITION CATEGORY: MAJOR ORGAN TRANSPLANT (Continued)

INITIAL BENEFIT FOR A MAJOR ORGAN TRANSPLANT COVERED CONDITION

We will pay the applicable Initial Benefit for a Major Organ Transplant Covered Condition shown on the Schedule, the first time that a Major Organ Transplant Covered Condition Occurs for a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

SPECIAL LIMITATIONS APPLICABLE TO A MAJOR ORGAN TRANSPLANT COVERED CONDITION

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

- Two or more organs transplanted on the same day, or during the same Surgery, shall be deemed one Occurrence of a Major Organ Transplant.

ADDITIONAL PROOF REQUIREMENTS FOR A MAJOR ORGAN TRANSPLANT COVERED CONDITION

A Clinical Diagnosis of a Major Organ Transplant Covered Condition must be made in Writing by a Physician. In addition, documentation of the following must be provided:

- for Major Organ Transplant:
 - that the Covered Person has been placed on the Transplant List and the date of such placement; or
 - that the Major Organ Transplant has been performed.

SPECIAL EXCLUSIONS APPLICABLE TO A MAJOR ORGAN TRANSPLANT COVERED CONDITION

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

- if prior to the Covered Person's coverage becoming effective under this Certificate, the Covered Person had been placed on a Transplant List for the same organ for which the Major Organ Transplant Procedure is performed;
- for a transplant involving organs received from non-human donors;
- for a transplant involving implantation of mechanical devices or mechanical organs; or
- for a transplant involving islet cell transplants.

COVERED CONDITION CATEGORY: STROKE

ADDITIONAL DEFINITIONS THAT APPLY TO THE STROKE COVERED CONDITION CATEGORY

Stroke Covered Condition means the following:

- Stroke.

Stroke means a cerebrovascular accident or incident producing measurable, functional and permanent neurological impairment caused by any of the following which result in an infarction of brain tissue:

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

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

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

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

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

INITIAL BENEFIT FOR A STROKE COVERED CONDITION

We will pay the applicable Initial Benefit for a Stroke Covered Condition shown on the Schedule, the first time that a Stroke Covered Condition Occurs for a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

ADDITIONAL PROOF REQUIREMENTS FOR A STROKE COVERED CONDITION

Proof of a Stroke Covered Condition requires the following additional documentation:

- medical records indicating objective evidence of a significant neurological, motor or sensory impairment that is functional and measurable; and
- for a Stroke – a pathological Diagnosis:
 - demonstrated on magnetic resonance imaging (MRI), computerized tomography (CT) or other reliable imaging techniques; and
 - confirmed in Writing by a Physician no earlier than 30 days after the Stroke with such impairments being present and considered permanent on the date that such Written confirmation is made.

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

COVERED CONDITION CATEGORY: STROKE (Continued)

SPECIAL EXCLUSIONS APPLICABLE TO A STROKE COVERED CONDITION

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

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

PREEXISTING CONDITION LIMITATION AND A STROKE COVERED CONDITION

The Preexisting Condition Limitation provision does not apply to benefits for a Stroke Covered Condition.

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 attain age 75;
- 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.

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 You attain age 75;
- the date Dependent Insurance ends under the Group Policy for all Members or for Your class;
- the date the Total Benefit Amount is exhausted (reduced to zero) for that Dependent;
- 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 date the Total Benefit Amount is exhausted (reduced to zero) for that Dependent;
 - 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 A DEPENDENT CHILD CALLED TO ACTIVE DUTY

Dependent Insurance for a Dependent Child may be continued past the Dependent Child Age Limit at which insurance for that Dependent Child would otherwise end if the Dependent Child is a full-time student and insurance ends due to the Dependent Child being ordered to active duty (other than active duty for training) for 30 or more consecutive days as a member of the Pennsylvania National Guard or a Reserve Component of the Armed Forces of the United States.

Insurance will continue if such Dependent Child:

- reenrolls as a full-time student at an accredited school, college or university that is licensed in the jurisdiction where it is located;
- reenrolls for the first term or semester, beginning 60 or more days from the child's release from active duty;
- continues to qualify as a Dependent Child, except for the Dependent Child Age Limit; and
- submits the required Proof of the child's active duty in the National Guard or a Reserve Component of the United States Armed Forces.

Subject to the Date Dependent Insurance Ends provision of the When Insurance Ends section of this Certificate, this continuation will last until the earlier of the following dates:

- the date the insurance has been continued for a period of time equal to the duration of the child's service on active duty; or
- the date the child is no longer a full-time student at an accredited school, college or university that is licensed in the jurisdiction where it is located.

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 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, and in no event, except in the absence of the legal capacity of the claimant, later than one year from the time Proof is otherwise required.

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

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after Written Proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time Written Proof of loss is required to be furnished.

REFUND TO US FOR OVERPAYMENT OF BENEFITS

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

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

GENERAL PROVISIONS

CHANGES IN STANDARDS

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

ENTIRE CONTRACT

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

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

TIME LIMIT ON CERTAIN DEFENSES

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

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

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

MISSTATEMENTS

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

ASSIGNMENT

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

CONFORMITY WITH LAW

If any terms or provisions of this Certificate on its effective date are in conflict with the applicable statutes of the state of Pennsylvania, the conflicting terms or provisions are hereby amended to conform to the minimum requirements of such statutes.

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.

ACCESS TO DISCOUNTS FOR SERVICES

You will receive access to discounts for certain services, where available.