UnitedHealthcare®

GROUP CRITICAL ILLNESS INSURANCE CERTIFICATE OF COVERAGE

FOR BA HOLDINGS, INC.

POLICY NUMBER: 371448

EFFECTIVE DATE: January 1, 2024

CA – UHIC/2015
(9-24)

California Consumer Complaint Notice

If the Covered Person has any questions or problems with their coverage, We will be ready to help. Our contact information is:

UnitedHealthcare Insurance Company

A Stock Company

Administrative Offices: 9900 Bren Road East, Minnetonka, MN 55343

1-888-299-2070

The Covered Person may also call the California Department of Insurance for assistance. However, We ask that the Covered Person gives Us the opportunity to try to resolve the problem. Please, call us first. If, We fail to help, the Covered Person may still ask the California Department of Insurance for assistance. Their contact information is:

California Department of Insurance

Consumer Services Division

300 South Spring Street

Los Angeles, California 90013

1-800-927-HELP

(1-800-927-4357)

http://www.insurance.ca.gov/01-consumers/

UNITEDHEALTHCARE INSURANCE COMPANY
CRITICAL ILLNESS COVERAGE OUTLINE OF COVERAGE

This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal health law.

Read Your Certificate Carefully -This outline of coverage provides a very brief description of the important features of your certificate. This is not the insurance contract and only the actual policy and certificate provisions shall control. The certificate sets forth in detail the rights and obligations of both you and UnitedHealthcare Insurance Company. It is, therefore, important that you READ YOUR CERTIFICATE CAREFULLY!

Critical Illness Coverage - The certificate is designed to provide to certificate holders, restricted coverage paying benefits ONLY when certain losses occur as a result of diagnosis of a Critical Illness. Benefits are not provided for basic hospital, basic medical-surgical, or major medical expenses.
Benefits - A fixed percentage of the maximum benefit is payable for a Critical Illness. The Maximum Benefit for an employee is $30,000; a Spouse is $15,000 and each Child is $7,500.

The fixed percentage is 25% of the Maximum Benefit for a Level 2 Cancer (defined in the certificate) or a Coronary Artery Bypass. For all other Critical Illnesses listed in your certificate, the fixed percentage is 100%.

The following are some examples of Level 2 Cancer:
1. a lump in the breast that shows no evidence of metastases.
2. Papillary Carcinoma of the Thyroid that measures less than 1 cm in diameter;
3. Prostate Cancer if it has been Gleason method staged at less than 7;
4. Papillary Cancer of the Bladder if it has been TNM method staged into a class less than TaN0M0.
5. Chronic lymphocytic leukemia that has not progressed to at least Rai stage II or Binet Stage B.

Exceptions, Reductions and Limitations – There may be an eligibility waiting period before you are eligible for coverage. Once eligible, coverage may be subject to evidence of good health if you enroll late or if you enroll for an amount of coverage in excess of the guaranteed issue limits that are outlined in your certificate.

If the plan you are covered under includes cancer benefits, please be aware that no benefit will be payable for Melanomas under the Policy, except for Level 1 Skin Cancer. While the most common Melanomas are a type of Skin Cancer, some affect other parts of the body. This exclusion applies all to Melanomas.

Some conditions are not Cancer, but may be confused with Cancer because they have some potential to become Cancer in the future. For example, a polyp or small growth in the colon may be removed during a medical procedure to ensure that it does not develop into Cancer later. These kinds of conditions are not covered because they have not yet, and might not ever, become Cancer. These conditions are not covered even when a medical procedure is advisable or performed to prevent the possibility of future Cancer.

If the plan you are covered under includes benefits for Heart Attack, please be aware that Heart Attack does not include any other disease or injury involving the cardiovascular system. In addition, the following are not covered:
1. Heart Attacks that occur during a medical procedure; or
2. Cardiac Arrest not caused by a blockage of one or more coronary arteries leading to the death of a portion of the Heart (myocardial infarction) is not a Heart Attack. Cardiac Arrest alone, when not immediately preceded by such coronary blockage, is not a covered event.

For all coverage, no benefit is payable for a critical illness that:
- a) is due to war or an act of war;
- b) is due to loss sustained while on active duty as a member of the armed forces;
- c) is intentionally self-inflicted;
- d) is due to active participation in a riot, commission of or attempt to commit a felony, engagement in an illegal occupation;
- e) is sustained or contracted in consequence of being intoxicated or under the influence of any controlled substance unless administered on the advice of a Physician;
- f) is due to attempted suicide;
- g) is diagnosed outside of the US or Canada (unless the diagnosis was confirmed by a physician practicing in the US or Canada); and
- h) with respect to children, if it is caused or contributed by a congenital defect.

Cosmetic or Elective Surgery Exclusion: We will not cover a Critical Illness under the Policy if it is due to Cosmetic Surgery or Elective Surgery.

Cosmetic Surgery means surgery performed to modify or improve the appearance of a physical feature or defect. For purposes of excluding benefits, Cosmetic Surgery does not mean Reconstructive Surgery performed to correct or repair abnormal structures of the body caused by:

1. congenital defects;
2. developmental abnormalities;
3. trauma;
4. infection;
5. tumors; or
6. disease;

when intended to either improve function or create a normal appearance to the extent possible.

Reconstructive Surgery includes:

1. dental or orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures; and
2. surgery and prosthetic devices to restore and achieve symmetry incident to a mastectomy.

Elective Surgery means:

1. Cosmetic Surgery; and
2. any other surgery that is:
    a. not for the purpose of correcting or repairing abnormal structures of the body;
    b. not for the purpose of improving function; or
    c. if intended to improve appearance or create a normal appearance, is not caused by a condition listed in 1-6 above.

For purposes of excluding benefits, Elective Surgery does not include:

1. Caesarean section;
2. any surgery related to Complications of Pregnancy; or
3. bariatric surgery performed in conjunction with a diagnosis of morbid obesity.

Coverage terminates on the first to occur of: the last day of the period for which premium is paid; the date you or your dependent enter active duty of the armed forces; the last day of the month you cease to be in a class eligible for coverage; the date the master policy terminates; or the last day of the month you cease to be actively at work.

Your coverage may be continued during leave of absence or during a strike or layoff if the certificate includes such continuation provisions. When your coverage terminates because you are no longer eligible, you will have the option to continue your coverage under the portability privilege explained in your certificate

Your dependent's coverage will terminate when you are in a class that is no longer eligible for dependent coverage or if the dependent no longer meets the definition of a dependent as explained in the certificate. Coverage may be continued for children who reach the age limit and are incapacitated on that date.

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut

(Home Office)

Policyholder: BA Holdings, Inc.

Effective Date: January 1, 2024

Policy Number: 371448

Policy Anniversary Date: January 1st

Beneficiary: As on file with the Administrator

We, UnitedHealthcare Insurance Company, issue this Certificate to the Covered Person as evidence of insurance under the Policy We issued to the Policyholder shown above. This Certificate describes the benefits and other important provisions of the Policy.

The Policy is a legal contract between the Policyholder and Us and it may be changed or discontinued without the consent of the Covered Person or the Covered Person's beneficiary. The Policy may be inspected at the office of the Policyholder.

The benefits described in this Certificate insure the Covered Person and, if applicable, Dependents, provided the person is eligible, has become covered, and the required premium has been paid to Us.

Read the Group Certificate Carefully. If the Policyholder has any questions or problems with the Policy, We will be ready to help the Policyholder. The Policyholder may call upon his agent or Our Home Office for assistance at any time. If the Covered Person has questions, needs information about their insurance, or needs assistance in resolving complaints, call 1-888-299-2070.

The Certificate is signed at the Home Office of UnitedHealthcare Insurance Company by:

Tracy A. Arney, Secretary Jessica Paik, President

Administrative Office:
9900 Bren Road East
Minnetonka, MN 55343

THE POLICY PAYS NO BENEFITS FOR CERTAIN SKIN CANCERS. PLEASE REFER TO THE EXCLUSIONS UNDER THE CANCER BENEFIT SECTION.

Group Critical Illness Insurance Certificate

This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal health law.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

Eligible Class:	Employees of BA Holdings, Inc. who meet the eligibility requirements and who are Actively at Work, and their eligible Dependents.
Description of Class:	All Eligible Employees working a minimum of 30 hours per week
Employee Waiting Period:	An Employee is eligible for insurance on the first day of the month on or next following the date he begins continuous employment with the Policyholder
Maximum Benefit Amount:	Option 1 Employee: $10,000 Spouse: $5,000 Child: $2,500 Option 2* Employee: $20,000 Spouse: $10,000 Child: $5,000 Option 3* Employee: $30,000 Spouse: $15,000 Child: $7,500 *Employee may choose from lower coverage options for Spouse and Child(ren)

SCHEDULE OF BENEFITS

NOTE: As indicated in this Schedule, a reduced benefit is payable for **Cancer - Level 2** and **Coronary Artery Disease**. Cancer - Non-Invasive Level 2 includes a cancerous lump in the breast with no evidence of metastases. For example, if a Maximum Benefit Amount of $30,000 is payable for Cancer – Level 1, the amount payable for the Cancer - Level 2 is $7,500.

Critical Illness Conditions	**Percentage of Maximum Benefit Amount payable per Covered Person or Dependent**
Benign Brain Tumor	100%
Cancer Level 1	100%
Cancer Level 2	25%
Chronic Renal Failure	100%
Coma	100%
Coronary Artery Disease	25%
Heart Attack	100%
Heart Failure	100%
Major Organ Failure	100%
Permanent Paralysis	100%
Ruptured Aneurysm	100%
Stroke	100%

Child Critical Illness Category	**Percentage of Maximum Benefit Amount payable per Covered Child**
• Cerebral Palsy	25% of Employee's Amount
• Cleft Lip / Palate	25% of Employee's Amount
• Cystic Fibrosis	25% of Employee's Amount
• Down Syndrome	25% of Employee's Amount
• Muscular Dystrophy	25% of Employee's Amount
• Spina Bifida	25% of Employee's Amount

SCHEDULE OF BENEFITS

Portability • Portability Policy Age Limit	Included Coverage continued under Portability terminates at Age 75
Reoccurrence Benefit:	Included For each Critical Illness Condition, not to exceed: • 100% of Employee's Maximum Benefit Amount • 100% of Spouse's Maximum Benefit Amount • 100% of Child's Maximum Benefit Amount whichever applies
Additional Critical Illnesses Rider:	Included
Wellness Benefit:	$50 per calendar year

Maximum Age for Dependent Child: 26 years

Premium Rate Change: The Covered Person and Dependent premiums may change on any Premium Due Date if rates for the person's Class are changed under the group Policy.

GENERAL DEFINITIONS

The male pronoun, whenever used in the Policy, includes the female.

Active Work or Actively at Work: the Covered Person reports for work at his usual place of employment or any other business location where he is required to travel and is able to perform his regular occupation for the entire normal workday. The Covered Person must be working at least the minimum number of hours per week in an Eligible Class, as shown in the Schedule of Benefits.

Unless disabled on the prior workday or on the day of absence, a Covered Person will be considered Actively at Work on the following days:

1. a Saturday, Sunday or holiday which is not a scheduled workday;
2. a paid vacation day, or other scheduled or unscheduled non-workday; or
3. an excused or emergency leave of absence (except medical leave).

Change in Family Status :

1. a change in marital status (marriage, divorce, legal separation, annulment);
2. a change in the number of dependents for tax purposes (birth, legal adoption of a child, placement of a child with the Covered Person for adoption, or death of a dependent);
3. certain changes in employment status that affect benefits eligibility for the Covered Person, spouse or child, such as termination of employment, a strike or lockout, the start of or return from an unpaid leave of absence, a change in worksite, a change in work schedule (between full-time and part-time work, decrease or increase in hours);
4. a significant increase in the cost of coverage or a significant reduction in the benefit coverage under the Covered Person's insurance or his spouse's insurance; or
5. the addition, elimination, or significant curtailment of, a coverage option.

Contributory or Non-Contributory Insurance: Contributory Insurance is insurance for which the Covered Person must apply and agree to make the required premium contributions. Non-Contributory Insurance is insurance for which the Covered Person does not have to make any premium contributions.

Covered Person: the Employee insured under the Policy. References to "Covered Person," "Covered Persons" and "Covered Person's" throughout this Certificate are references to a Covered Person.

Dependent: the Covered Person's Spouse or Child, as defined below.
Spouse means a legal Spouse including a Domestic Partner. We may require proof of marriage or proof of valid domestic partnership.

Child means a Child under the Maximum Age for Dependent Child shown in the Schedule and who is:

1. a natural Child;
2. a stepchild;
3. a legally adopted Child;
4. a Child placed for adoption; or
5. a Child for whom legal guardianship has been awarded to the Covered Person or the Covered Person's Spouse.

Existing children of newly formed domestic partnerships will be covered the same as step children.

The Child will cease to be an eligible Dependent on the last day of the month following the date the Child reaches the Maximum Age for Dependent Child unless the Child is an Incapacitated Child.

A Child is an Incapacitated Child if he is:

1. unmarried;
2. physically or mentally disabled; and
3. financially dependent upon the Covered Person.

No one can be a dependent of more than one Covered Person.

Domestic Partner: a person with whom the Covered Person has established a domestic partnership and filed a valid Declaration of Domestic Partnership with the California Secretary of State or an equivalent document for registration of a domestic partnership with an authorized state or municipal agency. The Covered Person must notify Us if the domestic partnership terminates.

Employee: a person who is authorized to work and reside in the United States and is:

1. directly employed in the normal business of the Employer; and
2. Actively at Work for the Employer, or any subsidiary or affiliate insured under the Policy.

No director or officer of an Employer will be considered an Employee unless he meets the above conditions.

Employer: the Policyholder and includes any division, subsidiary, or affiliated company named in the Policy. Employer does not include Employers of other related areas of practice for which the Covered Person may also work.

Enrollment:

Enrollment Period - the Initial Enrollment Period or Re-Enrollment Period.

Initial Enrollment Period - the period during which the Employee may first apply in writing for insurance.

Re-Enrollment Period: the period of time following the Initial Enrollment Period determined by the Employer and Us during which the Covered Person may apply in writing for insurance under the Policy or change his insurance under the Policy.

Hospital or Medical Facility: a legally operated, accredited facility licensed to provide full-time care and Treatment for the condition for which benefits are payable under the Policy. It is operated by a full-time staff of licensed physicians and registered nurses. It does not include

facilities that primarily provide custodial, education or rehabilitative care, or long-term institutional care on a residential basis.

Physician: a medical doctor or doctor of osteopathy who is:

1. duly licensed in the state or Province in which the Treatment is received; and
2. practicing within the scope of that license.

For the purposes of the Policy, the term Physician does not include the Covered Person, the Covered Person's Spouse, or any family members.

Policy Anniversary Date: the annual renewal date of the group insurance contract between Us and the Policyholder.

Policyholder: the group named as the Policyholder on the face page of this Certificate.

Sickness: an illness, or disease, pregnancy or complication of pregnancy.

Treatment: as used in the Policy refers to any consultation, advice, tests, attendance or observation, supplies or equipment, including the prescription or use of prescription drugs or medicines.

We, Our and Us: UnitedHealthcare Insurance Company or its Administrator.

BENEFITS PAYABLE AND BENEFIT DEFINITIONS

Benefit Payable: Unless specifically excluded in the following Benefit Descriptions, We will pay the stated percentage of the Maximum Benefit Amount for each Critical Illness Condition shown on the Schedule of Benefits, for which the Covered Person or Dependent:

1. receives a Diagnosis of a Critical Illness; and
2. for which he is insured on the Date of Diagnosis.

A reduced benefit is payable for:

1. a lump in the breast that shows no evidence of metastases or any other Level 2 Cancer; and
2. a Coronary Artery Disease.

For example, if a Maximum Benefit Amount of $30,000 is payable for Cancer – Invasive Level 1, the amount payable for the Cancer - Non-Invasive Level 2 is $7,500.

The Schedule of Benefits outlines reductions in the Maximum Benefit Amount that occur due to age, the percentage of the Maximum Benefit Payable and the Maximum Benefit Amount for each Critical Illness.

The benefit payable will be paid as a single per diem amount in one lump sum payment following receipt of a Proof of Claim.

Critical Illness: means the Diagnosis of Benign Brain Tumor, Level 1 Cancer, Level 2 Cancer, Chronic Renal Failure, Coma, Coronary Artery Disease, Heart Attack, Heart Failure, Major Organ Failure, Paralysis, Ruptured Aneurysm and Stroke as those conditions are defined in each Benefit Description.

Diagnosis: means a diagnosis by a Physician that is all of the following:

1. in writing;
2. made while the Covered Person's insurance under the Policy is in force and is subject to all provisions of the in force Policy; and
3. based on objective clinical findings and/or laboratory investigations and supported by medical records and any diagnostic requirements stated in the Policy.

Date of Diagnosis, means:

1. for Benign Brain Tumor, the date the Physician determines a benign brain tumor is present in the Covered Person or Dependent based on:
    a. examination of tissue (biopsy or surgical excision); or
    b. specific neuroradiological examination;
2. for Cancer, the date that the tissue specimen, blood sample(s) and/or titer(s) are taken on which the diagnosis of Cancer is based;
3. for Chronic Renal Failure, the date the Physician recommends that the Covered Person or Dependent undergo hemodialysis or peritoneal dialysis at least weekly, or results in the Covered Person or Dependent being placed on the United Network of Organ Sharing (UNOS) transplant list, whichever occurs first;
4. for Coma, the date the Physician confirms that the Covered Person or Dependent has been in a Coma for a continuous period of at least 14 days;

Date of Diagnosis: based on objective clinical or pathological findings, also means:

5. for Coronary Artery Disease, the date the Physician:
   a. recommends that the Covered Person or Dependent undergo heart surgery to correct:
      i. narrowing; or
      ii. blockage of;

      one or more coronary arteries with bypass grafts; or
   b. recommends that the Covered Person or Dependent undergo balloon angioplasty, laser angioplasty, atherectomy or placement of a stent to correct narrowing or blockage of one or more coronary arteries; or
   c. determines in writing at the time that the care is being given that bypass surgery, balloon angioplasty, laser angioplasty, atherectomy or placement of a stent is necessary; and, would be recommended if the Covered Person or Dependent were well enough to undergo such surgery or procedure;
6. for Heart Attack, the date the Physician confirms that a Heart Attack (myocardial infarction) has occurred;
7. for Heart Failure, the date:
   a. the Physician recommends that the Covered Person or Dependent undergo transplant surgery;
   b. the Physician determines in writing at the time that the care is being given that transplant surgery would be necessary if the Covered Person or Dependent were well enough to undergo such surgery; or
   c. the Covered Person or Dependent is placed on the United Network of Organ Sharing (UNOS) transplant list for the organ that has failed;

   whichever occurs first;
8. for Major Organ Failure, the date:
   a. the Physician recommends that the Covered Person or Dependent undergo transplant surgery;
   b. the Physician determines in writing at the time that the care is being given that transplant surgery would be necessary if the Covered Person or Dependent were well enough to undergo such surgery; or
   c. the Covered Person or Dependent is placed on the United Network of Organ Sharing (UNOS) transplant list for the organ that has failed;

   whichever occurs first;
9. for Paralysis, the date the Physician confirms the complete loss of functional use of two or more limbs for a continuous period of at least 30 days;
10. for Ruptured Aneurysm, the date the Physician confirms that a Ruptured Aneurysm occurred;
11. for Stroke, the date the Physician confirms that a Stroke occurred.

Benign Brain Tumor: a Diagnosis of a non-malignant tumor in the brain, cranial nerves, or meninges:

1. within the skull; and
2. with a minimum size of 1 cm.

The tumor must require:

1. surgical or radiation Treatment; or
2. cause permanent irreversible neurological defects.

Diagnosis of Benign Brain Tumor must be:

1. made by a Physician who is a neurologist; and
2. documented on an MRI of the brain or by pathological diagnosis.

If the Covered Person or Dependent is unable to undergo an MRI of the brain, the tumor must be documented by a CT scan of the head, with and without contrast.

Benign Brain Tumor does not include any of the following:

1. tumors of the skull;
2. pituitary adenomas;
3. germinomas.

Cancer: means a Physician's Diagnosis of Cancer that is confirmed through the use of a medical test on a Covered Person's or Dependent's blood or tissue. A Diagnosis of Cancer that is based only on symptoms will also be recognized if:

1. there is medical evidence to support the diagnosis; and
2. a Physician is treating the Covered Person or Dependent for Cancer.

Level 1 Cancer means:

1. Cancer cells have entered a phase of uncontrolled and aggressive growth beyond the primary site and have invaded other lymph nodes or organs and tissues, except that the following types are Level 1 only at these stages:
    a. Skin Cancer, only if Breslow method staged at 1.0 mm maximum thickness or greater;
    b. Papillary Carcinoma of the Thyroid, only if measured more than 1 cm in diameter;
    c. Prostate Cancer only if having a Gleason method stage at 7 or higher;
    d. Papillary Cancer of the Bladder only if TNM method staged into a class greater than TaN0M0; or
2. abnormal growth of white blood cells in the blood, bone marrow and lymphatic system, which includes lymph nodes, lymphatic vessels, tonsils, thymus, spleen, and digestive tract lymphoid tissue. Chronic lymphocytic leukemia that has progressed to at least Rai stage II or Binet Stage B is considered Level 1 Cancer.

Examples of Level 1 Cancer: The following are some examples of Level 1 Cancer:

1. Cancer that has spread from one organ to another such as from the liver to the lung;
2. Cancer that has spread from an organ where it started to another system such as the lymphatic system or blood stream when it is not a blood Cancer that started in one of those systems;
3. Cancer that started in one organ and remains only in that organ, but it has grown into a layer of tissue beyond the place where it started such as:
   a. Colon Cancer that started on the inside colon wall and advanced into adjacent tissue next to or at the outer wall;
   b. Breast Cancer where a tumor started in one place in the breast but has grown to the point where it has invaded deeper layers of tissues within the breast;
   c. Cancer that has spread from one lobe of an organ to the other lobe of the same organ such as from one lobe of the liver to its other lobe, or from one lung to the other lung.

Level 2 Cancer means:

1. Cancer cells are found only in their primary site which is the layer of cells in which they started; or
2. Cancer cells are limited to the same organ in which they started, and there is no medical evidence that the Cancer has grown into a layer of tissue beyond the place where it started.

Examples of Level 2 Cancer: The following are some examples of Level 2 Cancer:

6. Breast Cancer where a tumor is still contained and has not grown to the point where it has invaded deeper layers of tissues within the breast.
7. Papillary Carcinoma of the Thyroid that measures less than 1 cm in diameter;
3. Prostate Cancer if it has been Gleason method staged at less than 7;
4. Papillary Cancer of the Bladder if it has been TNM method staged into a class less than TaN0M0.

Chronic lymphocytic leukemia that has not progressed to at least Rai stage II or Binet Stage B

Methods of Measuring the Severity of Cancer: To determine how severe the Cancer has become and how far it has spread, Physicians use methods which include, but are not limited to, the methods and stages in the chart below. These methods are used to confirm each specific type of Cancer. In order to be objective and consistent in how We pay claims, We will consider codes in the Covered Person's medical records to determine the Severity of Cancer.

Method	Cancer Measured	Stages (Severity Scale)
Rai	Leukemia (CLL)	0, I, II, III & IV (Least 0 to most severe Stage IV)
Binet	Leukemia (CLL).	A, B & C (Least A to most severe Stage C)
CIN	Cervical Cancer	CIN-1, CIN-2 & CIN-3 (Least CIN-1 to most severe CIN-3)
Breslow	Skin Cancer	Depth from less than or equal to .75 mm to greater than 3.0
Gleason	Prostate Cancer	Adds two scores from 1 to 5, and sum is least 1 to most severe 10
TNM	Multiple Cancers	T = the size and extent of a tumor; N = whether the abnormal cells have spread to Lymph nodes; M = whether it has metastasized (spread.)

Exclusions:
No benefit will be payable for:

1. melanomas except for melanomas that rise to the definition of Level 1 Cancer. Melanoma may begin in a tissue other than the skin, such as the eye or the intestines. Only skin cancer that is a Level 1 Cancer as defined above, is covered. No benefit is payable for any other skin cancer.
2. pre-cancerous conditions. Some conditions are not Cancer, but may be confused with Cancer because they have some potential to become Cancer in the future. For example, a polyp or small growth in the colon may be removed during a medical procedure to ensure that it does not develop into Cancer. These kinds of conditions are not covered because they have not yet, and might not ever, become Cancer. These conditions are not covered even when a medical procedure is advisable or performed to prevent the possibility of future Cancer.

Chronic Renal Failure: the chronic irreversible failure to function of both kidneys of such severity that the Physician recommends the Covered Person or Dependent undergo hemodialysis or peritoneal dialysis at least weekly, or results in the Covered Person or Dependent being placed on the United Network of Organ Sharing (UNOS) transplant list.

Coma: a condition Diagnosed as:

1. a continuous state of profound unconsciousness due to Sickness; and
2. with no reaction to external stimuli.

Coma must:

1. last for a period of 14 or more consecutive days; and
2. require:
   a. significant medical intervention; and
   b. life support measures.

Coma does not include:

1. coma caused by:
   a. Stroke; or
   b. a bodily injury resulting directly from an accident and independently of all other causes;
2. medically induced coma; or
3. a coma which results directly from drug or alcohol use.

Coronary Artery Disease: Heart disease that:

1. has been clinically diagnosed; and
2. requires the Covered Person or Dependent to undergo a surgical procedure.

The procedure must be to open a blockage of one or more coronary arteries using:

1. venous or arterial grafts (Coronary artery bypass does not include placement of intravascular stent, laser relief or other like procedures); or
2. balloon angioplasty, laser angioplasty, atherectomy or the placement of a stent to correct narrowing or blockage of one or more coronary arteries.

Such Treatment must be recommended by a Physician who is a cardiologist.

If a Physician who is a cardiologist has determined, in writing at the time the care is being given, that:

1. the Covered Person or Dependent requires one of the above procedures; but
2. is too ill to undergo the procedure;

the requirement that the procedure be recommended will be waived.

Heart Attack (myocardial infarction): means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. Heart Attack results in some permanent functional loss of heart contraction detectable by a regional contraction abnormality study on an imaging study.

The diagnosis must include all of the following criteria concurrently:
1. typical clinical symptoms such as central chest pain;
2. acute diagnostic increase of specific cardiac markers; and
3. new electrocardiographic changes of infarction.

Heart Attack does not include any other disease or injury involving the cardiovascular system. Heart Attacks that occur during a medical procedure are not included. Cardiac Arrest not caused by a Myocardial Infarction is not a Heart Attack.

Heart Failure: a Physician's Diagnosis of failure of the heart requiring the complete replacement of the Covered Person's or Dependent's heart with the heart from a human donor. This must be evidenced by placement on a national transplant list such as UNOS, unless a suitable donor is found otherwise.

Heart Failure also includes any combination heart and lung transplant.

If the Physician has determined, in writing at the time the care is being given, that:
1. the Covered Person or Dependent is too ill to undergo the replacement; but
2. would otherwise meets the criteria for the need for the replacement;

the replacement requirement is waived.

Major Organ Failure: a Diagnosis of failure of the lung, pancreas or liver requiring the complete replacement of the organ with an organ from a human donor. This must be evidenced by placement on a national transplant list such as UNOS, unless a suitable donor is found otherwise. Major Organ Failure also includes disease of the bone marrow and which requires the replacement of the Covered Person's or Dependent's bone marrow by allogeneic and/or umbilical cord blood transplant.

If the Physician has determined, in writing at the time the care is being given, that:
1. the Covered Person or Dependent is too ill to undergo the replacement; but
2. would otherwise meet the criteria for the need for the replacement;

the replacement requirement is waived.

Major Organ Failure does not include any of the following:
1. organs transplanted simultaneously with the heart; however, these may be covered under the definition of Heart Failure instead;
2. Bone marrow transplant that results from the Treatment process for cancer;
3. autologous bone marrow transplant (transplant in which the Covered Person's or Dependent's own bone marrow is used).

Permanent Paralysis: total and permanent loss of the use of two or more limbs (arms or legs or combination) due to Sickness for a continuous period of at least 30 days.

Permanent Paralysis does not include paralysis that:
1. is due to or caused by Stroke; or
2. is due to or caused by a bodily injury resulting directly from an accident and independently of all other causes.

Ruptured Aneurysm (Ruptured Cerebral, Carotid or Aortic Aneurysm): a Diagnosis by a Physician of a ruptured cerebral, carotid or aortic aneurysm. The Diagnosis must be supported by medical records. These records must include radiographically specific diagnostics such as, but not limited to:

1. angiography;
2. CT scan;
3. MRI; or
4. ultrasound.

Aorta refers to the thoracic and abdominal aorta, but not its branches.

Stroke: a cerebrovascular event resulting in measurable permanent neurological damage or impairment, including infarction of brain tissue, hemorrhage and embolism from an extra cranial source. The diagnosis must be based on objective clinical evidence of brain tissue damage for a continuous period of at least 30 days, using a current neuro imaging test such as:

1. a CT Scan (Computed Tomography);
2. MRI (Magnetic Resonance Imaging);
3. MRA (Magnetic Resonance Angiography);
4. PET Scan (Positron Emission Tomography); or
5. Arteriography or Angiography.

Stroke does not include:

1. Transient Ischemic Attacks (TIA). A transient ischemic attack (**TIA**), also called a “mini stroke,” occurs when a blood clot blocks blood flow in the brain. The block is temporary (transient), and unlike an actual stroke, Transient Ischemic Attacks do not generally kill brain tissue; or
2. attacks of Vertebrobasilar Ischemia.

Benefits Payable for the Child Critical Illness: We will pay a benefit if the Covered Person’s Child is diagnosed with a Child Critical Illness provided:

1. the Covered Person is insured under the Policy on the Child’s Date of Diagnosis; and
2. if the Child’s Date of Diagnosis is on or before the date of birth, the Child survives to live birth and becomes insured under the Policy as a Newborn Child.

This benefit is provided:

1. as part of the Covered Person’s benefits;
2. without regard to whether the Covered Person has Dependent Child coverage.

The only amount paid for the Child Critical Illnesses is the percentage of the Covered Person’s Maximum Benefit Amount shown in the Schedule. The Dependent Child amount is not also paid.

Any benefit payable will be made as a single per diem amount in one lump sum payment following receipt of a Proof of Claim for:

1. the Date of Diagnosis if that occurs after live birth; or
2. the date of live birth, if the Date of Diagnosis occurred on or before the birth.

If a Child is diagnosed with more than one Child Critical Illness under this benefit , We will only pay for one of the Child Critical illnesses. No further benefits are paid for the Child Critical Illness benefit.

Child Critical Illness Date of Diagnosis, based on objective clinical or pathological findings, means the initial date that:

1. for Cerebral Palsy, a Physician who is legally qualified in the applicable field of medicine diagnoses Cerebral Palsy;
2. for Cleft Lip/Palate, a Physician diagnoses of Cleft Lip or Palate (unilateral or bilateral clefting);
3. for Cystic Fibrosis, a Physician confirms a Diagnosis of Cystic Fibrosis via a sweat test with sweat chloride concentrations greater than 60 mmol/L;
4. for Down Syndrome, a Physician makes a Diagnosis of Down Syndrome through the study of the 21st chromosome revealing Trisomy 21, Translocation or Mosaicism;
5. for Spina Bifida, a Physician who is legally qualified in the applicable field of medicine and is familiar with the Diagnosis and/or Treatment of Spina Bifida makes a Diagnosis of Meningocele or Myelomeningocele Spina Bifida;
6. for Muscular Dystrophy, a Physician who is legally qualified in the applicable field of medicine and is familiar with the Diagnosis and/or Treatment makes a Diagnosis of Muscular Dystrophy.

Child Critical Illness: means one of the conditions defined below.

Cerebral Palsy: a non-progressive neurological defect affecting muscle control. It is characterized by spasticity and lack of coordination of movements. The Diagnosis of Cerebral Palsy must be made by a licensed Physician who is legally qualified in the applicable field of medicine.

Cerebral Palsy does not mean any other similar conditions such as:

1. degenerative nervous disorders;
2. genetic diseases,
3. muscle diseases;
4. metabolic disorders;
5. nervous system tumors;
6. coagulation disorders; or
7. other injuries or disorders which delay early development, but can be outgrown.

Child Critical Illnesses defined below:

Cleft Lip or Palate: a clinical Diagnosis of cleft lip or cleft palate. Cleft lip is a narrow opening or gap in the skin of the upper lip. It extends all the way to the base of the nose. A Cleft Palate is an opening between the roof of the mouth and the nasal cavity.

Under the policy, coverage is only provided for clefts occurring:

1. on one side of the mouth (unilateral clefting); or
2. on both sides of the mouth (bilateral clefting).

Cystic Fibrosis: a Diagnosis of Cystic Fibrosis by a Physician who is legally qualified in the applicable field of medicine where the Child has:

1. chronic lung disease; and
2. pancreatic insufficiency.

A Diagnosis of Cystic Fibrosis made via a sweat test should be based upon sweat chloride concentrations greater than 60 mmol/L.

Down Syndrome: a Diagnosis of Down Syndrome through study of the 21st chromosome. Diagnosis must be confirmed by a Physician who is legally qualified in the applicable field of medicine and is familiar with Down Syndrome Diagnosis.

Down Syndrome includes:

1. Trisomy 21, where the Child has three instead of two number 21 chromosomes;
2. Translocation, where the Child has an extra part of the 21st chromosome attached to another chromosome; or
3. Mosaicism, where the Child has an extra 21st chromosome in only some of the cells but not all of them. (The other cells have the usual pair of 21st chromosomes.)

Muscular Dystrophy: the Diagnosis of a Covered Person's Child , under age 26, as having muscular dystrophy with well-defined neurological abnormalities. The Diagnosis must be confirmed by a Physician who is legally qualified in the applicable field of medicine and by:

1. electromyography; and
2. muscle biopsy.

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

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

Diagnosis must be made by a licensed Physician who is legally qualified in the applicable field of medicine and is familiar with Spina Bifida. This policy does not cover spina bifida occulta.

Reoccurrence Benefit: We will pay a Reoccurrence Benefit equal to 50% 100% of the Maximum Benefit Amount if the Covered Person or Dependent is:

1. Diagnosed with a second occurrence of a Critical Illness for which a benefit was previously paid;
2. Diagnosis is made 6 months or more following the initial diagnosis of the Critical Illness; and
3. the Covered Person or Dependent has not received Treatment for the Critical Illness during this 6 month period. Maintenance medication or therapy is not considered to be Treatment.

Only one Reoccurrence Benefit is payable for each Critical Illness per Covered Person or Dependent.

The Reoccurrence Benefit:

1. does not apply to; and
2. will not be payable for;

an illness under the Child Critical Illness Category.

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

Covered Person's Eligibility: Employees who are Actively at Work are eligible for insurance after completion of the required Employee Waiting Period provided :

1. they are in a class of Employees who are included; and
2. customarily working at least the number of hours per week shown in the Schedule of Benefits.

New Employees will be added to the group as they become eligible.

An Employee will become eligible for insurance on the latest of the following dates:

1. the Effective Date of the Policy;
2. the end of the Employee Waiting Period shown in the Schedule of Benefits;
3. the date the Policy is changed to include the Employee's class; or
4. the date the Employee enters a class eligible for insurance.

Dependent Eligibility: Dependents are eligible for insurance on the latest of the following dates:

1. the date the Covered Person becomes eligible for Dependent Insurance;
2. the date a person becomes a Dependent; or
3. the date the Policy is amended to include the Covered Person's class as being eligible for Dependent Insurance.

The Dependent will not be eligible for Dependent Insurance if he:

1. is eligible for insurance under the Policy as a Covered Person; or
2. is a member of the armed forces on active duty, except for duty of 30 days or less for training in the Reserves or National Guard.

Enrolling in or Changing Insurance for Covered Person Insurance Under the Policy: The Employee may enroll in or change his insurance only under the following situations:

1. during the Initial Enrollment Period:
   a. if the Employee is eligible for insurance on the Effective Date, he may enroll for insurance during the Initial Enrollment Period. If an Employee fails to enroll, then he will not be insured under the Policy.
   b. if the Employee becomes eligible for insurance after the Effective Date, he may enroll for insurance during his Initial Enrollment Period.
2. during a Re-enrollment Period: The Employee may choose:
   a. to keep his same insurance;
   b. no insurance under the Policy;
   c. to enroll for insurance if not currently insured under the Policy;
   d. to change any benefit or amount that is optional;
3. within 31 days of a Change in Family Status, as defined, the Employee may choose to enroll or change the insurance for which he is eligible.

During a Re-enrollment Period, if the Covered Person does not re-enroll for insurance, he will continue to be insured for the same insurance.

Enrolling in or Changing Dependent Insurance Under the Policy:
The Employee may elect or change Dependent Insurance only under the following situations:

1. during the Initial Enrollment Period:
   a. if the Dependents are eligible for insurance on the Effective Date of the Policy, the Employee may enroll for Dependent insurance during the Initial Enrollment Period. If an Employee fails to enroll his Dependents, then the Dependents will not be insured under the Policy.
   b. if the Dependents become eligible for insurance after the Effective Date of the Policy, the Employee may enroll for Dependent Insurance during his Initial Enrollment Period.
2. during a Re-enrollment Period: The Employee may choose:
   a. to keep the same Dependent Insurance;
   b. no Dependent insurance under the Policy;
   c. to apply for Dependent Insurance under the Policy;
   d. to change any benefit or amount of Dependent Insurance that is optional;
3. within 31 days of a Change in Family Status, as defined, the Employee may choose to enroll or change his Dependent Insurance provided the Dependent is eligible.

The Employee may enroll for:

1. Dependent Insurance for Spouse only;
2. Dependent Insurance for Children only; or
3. Dependent Insurance for both Spouse and Children.

During a Re-enrollment Period, if the Covered Person does not re-enroll for Dependent Insurance, his Dependents will continue to be insured for the same insurance until the next Re-enrollment Period.

Dependents will not be insured until the Employee is insured. Dependents are not eligible for any benefit or amount that is more than the Covered Person's.

Effective Date of Covered Person Initial Insurance: If an Employee is not Actively at Work on the date his insurance is scheduled to take effect, it will take effect on the day after the date he returns to Active Work. If the Employee's insurance is scheduled to take effect on a non-working day, his Active Work status will be based on the last working day before the scheduled Effective Date of his insurance.

An Employee must use forms provided by Us when applying for insurance.

The Employee's insurance will be effective at 12:01 A.M. Eastern Standard time as follows:

1. if it is Non-contributory, on the date the Employee becomes eligible for insurance, regardless of when he applies, or
2. if it is Contributory, and the Employee makes application within 31 days after the date he first became eligible, on the later of:
   a. the date the Employee is eligible for insurance, regardless of when he applies; or
   b. the date the Employee's application is approved by Us if evidence of insurability is required.

Effective Date of Dependent Initial Insurance: No insurance will take effect on any day the Dependent is confined in a Hospital or Medical Facility. Insurance will take effect on the day following discharge from the Hospital or Medical Facility.

A Covered Person must use forms provided by Us when applying for Dependent Insurance.

The Dependent Insurance will be effective at 12:01 A.M. Eastern Standard time:

1. if it is Non-contributory, on the date the Dependent becomes eligible for insurance regardless of when application was made; or
2. if it is Contributory and the Covered Person makes application within 31 days after the date the Dependent first became eligible, on the later of:
   a. the date the Dependent becomes eligible for insurance, regardless of when application is made; or
   b. the date the Dependent's application is approved by Us, if evidence of insurability is required.

Dependents will not be insured until the Employee is insured.

Effective Date of Change in Covered Person or Dependent Insurance: A change in insurance that is made during a Re-enrollment Period will be effective at 12:01 a.m. Eastern Standard time on the later of:

1. the date of application;
2. the first day of the pay period for which contributions for his insurance are deducted; or
3. the date the Covered Person or Dependent becomes eligible for the change in insurance, regardless of when application is made.

If the Covered Person is not Actively at Work due to injury or Sickness, or is on a layoff or leave of absence, any increase in or addition to the Covered Person or Dependent insurance will be effective on the date the Covered Person returns to Active Work.

Newborn Child Provision: The Covered Person's Newborn Child will become covered by the Policy from the moment of live birth. The Newborn Child will be covered for the Critical Illness amount that applies to the Covered Person's other Children covered under the Policy. If the Covered Person has no other Children covered, then the lowest amount available to Children under the Policy applies. The Child's coverage will cease on the 31st day next following the Child's effective date unless:

1. We receive written request and any required premium to continue coverage for the Child before that date; or
2. the Covered Person's other children are covered, and we received written request and any required premium for the Child within 31 days of the day We first deny a claim on the basis that the child is not enrolled.

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS (continued)

Termination of Covered Person's Insurance: The Covered Person's insurance will terminate at 12:00 midnight Eastern Standard time on the earliest of the following dates:

1. the last day of the period for which a premium payment is made, if the next payment is not made;
2. the date he becomes a member of the armed forces on active duty, except:
   a. for duty of 30 days or less for training in the Reserves or National Guard; or
   b. to the extent coverage is continued under the Leave of Absence Continuation provision;
3. the date he ceases to be a member of a class eligible for insurance;
4. the date the Policy terminates, or with respect to a specific benefit, the date that such benefit terminates;
5. the date he ceases to be Actively at Work, unless Active Work ceases during an approved layoff, medical or non-medical leave of absence, then the insurance will continue for up to 3 months from the date he stopped Active Work; or
6. the date he is no longer Actively at Work due to a labor dispute, including but not limited to strike, work slow down or lock out.

Termination of Dependent Insurance: Insurance on a Dependent will terminate at 12:00 midnight Eastern Standard time on the earliest of the following dates:

1. the date he ceases to be a Dependent as defined in the Policy;
2. the date he ceases to be a member of a class eligible for Dependent insurance;
3. the date the Covered Person's insurance under the Policy terminates;
4. the date the Dependent becomes a member of the armed forces on active duty, except:
   a. for duty of 30 days or less for training in the Reserves or National Guard; or
   b. to the extent coverage is continued under the Leave of Absence Continuation provision;
5. the last day of the period for which a Dependent's required premium payment is made, if the next payment is not made; or
6. the date the Policy terminates, or with respect to a specific benefit, the date that such benefit terminates.

CONTINUATION AND REINSTATEMENT PROVISIONS

Continuation during Leave of Absence: If the Covered Person is on Family or Medical Leave of Absence, or other leave of absence required by an applicable state or federal law, continuation of his insurance will be governed by his Employer's policy on such leave not to exceed the greater of:

1. the leave period required by the Family and Medical Leave Act of 1993 (FMLA); or
2. the minimum leave period required by applicable state law.

We will continue the Covered Person's insurance if the cost of his insurance continues to be paid.

If the Covered Person's insurance does not continue during such Leave of Absence, then when he returns to Active Work:

1. he will not have to meet a new Employee Waiting; and
2. he will not have to give Us evidence of insurability to reinstate the insurance he had in effect before his Leave of Absence began.

However, time spent on a Leave of Absence, without insurance, does not count toward satisfying his Employee Waiting Period.

Continuation of an Incapacitated Child: If, on the date a Child reaches the Maximum Age for Dependent Child as shown in the Schedule, he is:

1. covered under the Policy; and
2. an Incapacitated Child, as defined;

his coverage will not terminate solely due to age. The Covered Person must give Us notice of the incapacity within 31 days of the termination date.

The Child's coverage will continue as long as:

1. the Child qualifies as an Incapacitated Child; and
2. the required premium is paid.

We may, from time to time, require proof of continued incapacity and dependency. After the first two years, We cannot require proof more than once each year.

Reinstatement of Rehired Employees: If a Covered Person ends employment and is rehired within a year, he may be insured on his eligibility date for the insurance that he had under the Policy on the date his employment ended.

Reinstatement following Military Service: If the Covered Person's or Dependent's insurance under the Certificate terminates due to active duty in one of the uniformed services of the United States military, he will have the right to renew coverage on the same basis as before the suspension in the coverage took place, provided:

1. he is in the service for a period of five years or less;
2. he applies for reinstatement of coverage and pays the required premium within 60 days of his discharge from the service; and
3. the Policy is still in force, he is eligible for coverage, and he is Actively at Work.

As used above, uniformed services includes service in the uniformed services as defined in Chapter 43 of Title 38. Coverage will be reinstated without evidence of insurability. The coverage will become effective on the first day of the month after military service terminates. However, the Policy will not cover a Critical Illness, loss or other disability resulting from the military service.

Reinstatement: If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by Us or Our agent duly authorized by Us to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if We or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon Our approval of such application or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless We have previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only Dates of Diagnosis sustained after the date of reinstatement. In all other respects the insured and We shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

PORTABILITY

Portability: If the Covered Person's and his insured Dependent's insurance under the Policy ends because his employment with the employer ends, he may choose to continue his and his insured Dependent's Group Critical Illness coverage under a group Portability policy without providing evidence of insurability.

The Covered Person must be insured under the Policy prior to the date his employment ends.

The Covered Person may port his insurance or his insured Dependent's insurance if coverage ends for any reason other than:

1. he failed to pay premium for the cost of his insurance;
2. he is on an approved leave of absence;
3. the group policy is terminating;
4. he is or becomes insured under another group critical illness policy;
5. he resides outside of the United States or in a state where the coverage is not available; or
6. he is actively in military service or entering active military service.

To apply for Portability insurance, within 31 days of the date the Covered Person's insurance ends he must:

1. submit a written application to Us; and
2. pay the first month's premium.

If the above conditions are met, such insurance will:

1 be issued without evidence of insurability; and

2 continue in effect provided the Covered Person continues to pay the cost of hisand his insured Dependent's insurance.

The Portability insurance will end on the earliest of:

1. the date the Covered Person fails to pay the required premium;
2. the date he becomes insured under any other group critical illness policy;
3. the date 100% of the Maximum Benefit for each of the Schedules is paid to the Covered Person, or on his behalf; or
4. the date he attains any Policy Age Limit stated in the Portability policy.

Covered Persons rehired after porting insurance must either lapse his and his insured Dependent's insurance or provide evidence of insurability.

The Portability coverage will be on the form the Insurer is then issuing for Critical Illness Portability purposes.

Insurer as used in this provision means Us or another insurance company which has agreed with Us to issue Portability coverage according to this Portability provision. The Portability coverage may differ from Your coverage under the Policy. The premium for the Portability coverage will be based on the coverage and form of the Portability policy, as well as Your age and risk class.

Portability Premium Contribution: For the first 12 months of Portability, the Covered Person's rate will be the group's current rate for the Covered Person's class. However, the Covered Person must pay the full premium including any part previously paid by his Employer.

After the first 12 months, the rate changes to a Portability rate which may be higher.

Eligibility Age Limit: The Covered Person must be under Age 70 to apply for Portability. To include Dependent coverage, the Covered Dependent must also be under Age 70.

Portability Termination Age: A Covered Person's and Dependent's Portability coverage will terminate on the first day of the month following the date he attains Age 75. If the Covered Person's Portability coverage terminates, his Dependent's coverage also terminates.

GENERAL EXCLUSIONS AND LIMITATIONS

General Exclusions: We will not cover a Critical Illness under the Policy if it is due to:

1. an act or accident of war, declared or undeclared, whether civil or international, and any substantial armed conflict between organized forces of a military nature;
2. loss sustained while on active duty as a member of the armed forces of any nation except during any time period coverage is extended under the Continuation during Leave of Absence provision;
3. any loss which is intentionally self-inflicted;
4. active participation in a riot;
5. the Covered Person's or Dependent's commission of or attempt to commit a felony, or to which a contributing cause was the Covered Person's or Dependent's engagement in an illegal occupation;
6. loss sustained or contracted in consequence of the Covered Person or Dependent being intoxicated or under the influence of any controlled substance unless administered on the advice of a Physician;
7. attempted suicide, while sane or insane.

We also will not pay a benefit for a Critical Illness:

8. for which the Covered Person's or Dependent's Date of Diagnosis for any type of Critical Illness, as defined in the Policy, was prior to his Effective Date of insurance; or
9. that was diagnosed outside of the United States or Canada, unless the diagnosis was confirmed by a Physician practicing within the United States or Canada.

Cosmetic or Elective Surgery Exclusion: We will not cover a Critical Illness under the Policy if it is due to Cosmetic Surgery or Elective Surgery.

Cosmetic Surgery means surgery performed to modify or improve the appearance of a physical feature or defect. For purposes of excluding benefits, Cosmetic Surgery does not mean Reconstructive Surgery performed to correct or repair abnormal structures of the body caused by:

1. congenital defects;
2. developmental abnormalities;
3. trauma;
4. infection;
5. tumors; or
6. disease;

when intended to either improve function or create a normal appearance to the extent possible.

Reconstructive Surgery includes:

1. dental or orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures; and
2. surgery and prosthetic devices to restore and achieve symmetry incident to a mastectomy.

Elective Surgery means:

1. Cosmetic Surgery; and
2. any other surgery that is:
   a. not for the purpose of correcting or repairing abnormal structures of the body;
   b. not for the purpose of improving function; or
   c. if intended to improve appearance or create a normal appearance, is not caused by a condition listed in 1-6 above.

For purposes of excluding benefits, Elective Surgery does not include:

1. Caesarean section;
2. any surgery related to Complications of Pregnancy; or

3. bariatric surgery performed in conjunction with a diagnosis of morbid obesity.

Multiple Critical Illness Limitation: The Covered Person and Dependent can receive a benefit for each Critical Illness only once, unless the Reoccurrence Benefit for that Critical Illness is included in the coverage.

A Covered Person or Dependent can receive benefits for different Critical Illnesses described in the Policy if the Dates of Diagnosis for each of his Critical Illness is separated by at least 90 days.

Coverage for the Covered Person or the Dependent will cease when he is not eligible for any further benefits.

GENERAL PROVISIONS

Entire Contract; Changes: The policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of Ours and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

Time Limit on Certain Defenses:

1. After two years from the date of issue of the policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for the policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of the two-year period.
2. No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of the policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage under the policy.

Grace Period: A grace period of 31 – 90 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force (subject to Our right to cancel in accordance with the cancellation provision hereof).

Unpaid Premium: Upon the payment of a claim under the policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

Notice of Claim: Written notice of claim must be given to Us within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to Us at the administrative address shown on the face page of this certificate, or to any authorized agent of Ours, with information sufficient to identify the insured, shall be deemed notice to Us.

Claim Forms: Upon receipt of a notice of claim, We will furnish to the claimant such forms as are usually furnished by Us for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proofs of Loss: Written proof of loss must be furnished to Us at Our said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which We are liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Time of Payment of Claim: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at Our option, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, We may pay such indemnity, up to an amount not exceeding $1,000.00, to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

Physical Examinations and Autopsy: We, at Our own expense shall have the right and opportunity to examine the person of the insured when and as often as We may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 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.

Change of Beneficiary: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

Misstatement of age: If the age of the insured has been misstated, all amounts payable under the policy shall be such as the premium paid would have purchased at the correct age.

Cancellation: We may cancel the policy at any time by written notice delivered to the Policyholder, or mailed to his last address as shown by Our records, stating when, not less than five days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term the Policyholder may cancel the policy at any time by written notice delivered or mailed to Us, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation by either the Policyholder or Us, We will return promptly the unearned portion of any premium paid. The Policyholder shall pay, on a pro rata basis, the earned premium which has not been paid. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

Upon providing the Policyholder with notice of Our intent to cancel, We will cease accepting applications under the Policy. However, the Policy will not terminate with respect to inforce certificates until the last certificate cancels in accordance with its termination provisions and no person remains insured under the Policy. The Policy will only terminate earlier with respect to inforce certificates if We and the Policyholder:

1. agree to such termination;
2. arrange separately or jointly for coverage under any inforce certificate to transition to a new policy; and
3. the new policy continues such coverage for the same or similar benefits.

The Termination of an Insurance Option under the Policy: We may cancel or modify any Insurance Option if the number of Employees insured falls below the greater of:

1. 10 Covered Persons; or
2. 10% of all eligible Employees.

Conformity With State Statutes: Any provision of the policy which, on its effective date, is in conflict with the statutes of California, is hereby amended to conform to the minimum requirements of such statutes.

Fraud: The falsity of any statement in the application for coverage shall not bar the right to recovery under the policy unless such **false** statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by Us.

Smoker Statement: If a Covered Person or Dependent misstates his status as a non-smoker, premiums will be subject to an equitable adjustment. If the amount of the benefit depends upon such status, then the benefit will be that which would have been payable, based upon the person's correct status.

A **Smoker** is a Covered Person or Dependent who has:

1. smoked a cigarette or cigar;
2. chewed tobacco; or
3. used tobacco or nicotine;

during the 24 month period prior to the date he enrolled for coverage.

Workers' Compensation: The Policy is not to be construed to provide benefits required by Worker's Compensation laws.

ADDITIONAL CRITICAL ILLNESSES RIDER

This rider is effective January 1, 2024. It is agreed that the Policy and Certificate are amended to add the following Categories of Critical Illness:

Additional Categories of Critical Illness	Percentage of Maximum Benefit Amount payable per Covered Person or Dependent
Amyotrophic lateral sclerosis (ALS)	100%
Complete Blindness	100%
Complete Loss of Hearing	100%
Advanced Alzheimer's	100%
Advanced Multiple Sclerosis	100%
Advanced Parkinson's	100%

Definitions under this Rider: The following definitions are added to the Definitions section:

Date of Diagnosis: The Date of Diagnosis, based on objective clinical or pathological findings, also means:

1. for ALS (Amyotrophic Lateral Sclerosis), often referred to as Lou Gehrig's Disease, the date a Physician who is legally qualified in the applicable field of medicine diagnoses that the Covered Person or Dependent has ALS based on a neurological examination and findings in one or more diagnostic tests stated in the definition of ALS; but, for benefits to be payable, coverage must remain in force to the Date a Physician confirms, in writing at the time the care is being given, that the Covered Person or Dependent is incapacitated to the extent stated in the definition of ALS;
2. for Complete Blindness, the date a Physician who is legally qualified in the applicable field of medicine makes an accurate certification of the Covered Person's or Dependent's Complete Blindness, as defined;
3. for Complete Loss of Hearing, the date a Physician who is legally qualified in the applicable field of medicine makes an accurate certification of the Covered Person's or Dependent's total and permanent hearing loss.

The initial **Date of Diagnosis** for the following Critical Illnesses must be made while the Covered Person's or Dependent's insurance under the Policy is in force and is subject to all provisions of the in force Policy. However, Policy Benefits will be payable only if coverage remains in force to the Date of Advanced Diagnosis.

4. for Advanced Alzheimer's, the date the Physician initially diagnoses the Covered Person or Dependent has Alzheimer's disease; but for benefits to be payable, coverage must remain in force to the Date a Physician confirms, in writing at the time the care is being given, that the Covered Person or Dependent is incapacitated to the extent stated in the definition of Advanced Alzheimer's;
5. for Advanced Multiple Sclerosis, the date the Physician initially diagnosed the Covered Person or Dependent has Multiple Sclerosis; but for benefits to be payable, coverage must remain in force to the Date a Physician who is a neurologist confirms, in writing at the time the care is being given, that the Covered Person or Dependent is incapacitated to the extent stated in the definition of Advanced Multiple Sclerosis;
6. for Advanced Parkinson's Disease, the date the Physician initially diagnoses the Covered Person or Dependent has Parkinson's disease; but for benefits to be payable, coverage must remain in force to the Date a Physician who is a neurologist confirms, in writing at the time the care is being given, that the Covered Person or Dependent is incapacitated to the extent stated in the definition of Advanced Parkinson's.

Amyotrophic Lateral Sclerosis ("ALS") or **Lou Gehrig's Disease**: a progressive degenerative motor neuron disease marked by:

1. muscular weakness and atrophy; and
2. with spasticity and hyperreflexia;

due to a degeneration of anterior horn cells of the spinal cord and cranial nerves.

Other motor neuron diseases are not considered to be ALS. ALS must be Diagnosed by a Physician who is legally qualified in the applicable field of medicine and based on generally acceptable principles of medicine.

ADDITIONAL CRITICAL ILLNESSES RIDER

Complete Blindness: a condition diagnosed as the irreversible loss of vision in both eyes due to Sickness. Complete Blindness must be diagnosed by a Physician who is legally qualified in the applicable field of medicine and must indicate that the best corrected visual acuity is equal to or worse than 20/200 in both eyes or the field of vision is less than 20 degrees in both eyes.

Complete Loss of Hearing: a condition diagnosed as the irreversible loss of hearing in both ears due to Sickness. Complete Loss of Hearing must be diagnosed by a licensed Physician who is legally qualified in the applicable field of medicine and must indicate a total and permanent loss of hearing in both ears with an auditory threshold of more than ninety (90) decibels in each ear at a frequency of 500-4000 cycles, as determined by audiometric testing.

Advanced Alzheimer's: the Diagnosis of Alzheimer's Disease, a progressive degenerative disease of the brain. Diagnosis must be made by a Physician who is legally qualified in the applicable field of medicine and must be supported by medical evidence that the insured exhibits loss of intellectual capacity involving impairment of memory and judgment as documented and demonstrated by neuroradiological tests (e.g. CT Scan, MRI, PET of the brain, a Karnofsky Performance Status Scale assessment of 50 or less (or equivalent)). This impairment must result in a significant reduction in mental and social functioning.

No other dementing organic brain disorders or psychiatric illnesses are included in this definition.

As used above to define Advanced Alzheimer's:

Cognitive Testing means a standardized battery of neuropsychological testing with validity measures. It does not mean a clinical screening instrument meant to select patients who might benefit from additional neuropsychological testing.

Advanced Multiple Sclerosis (MS): multiple sclerosis that is diagnosed by a Physician who is legally qualified in the applicable field of medicine. Diagnosis must be supported by neurological examination. It must demonstrate functional impairments have been met as stated in the most recent McDonald Diagnostic Criteria for MS. The Criteria must include studies of the brain or spine, or analysis of cerebrospinal fluid. If these:

1. demonstrate lesions consistent with MS, the MS must have persisted at least six months;
2. do not demonstrate such lesions, the MS must have persisted and progressed for at least 12 months.

The length of time of the progression must be supported by the presence of the lesions; or by the neurologist in writing and will be based upon notes from the time that care was being given.

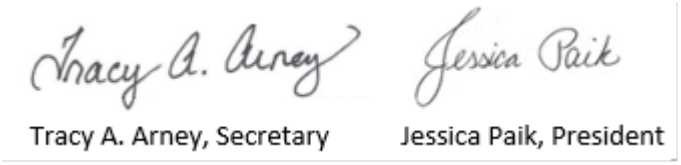
Other diseases are not considered to be MS.

Advanced Parkinson's Disease means Parkinson's Disease that is diagnosed by a Physician who is legally qualified in the applicable field of medicine. To be Advanced Parkinson's, the neurologist must confirm that it has progressed to Stage 4, based on abnormal findings from:

1. neurological examination;
2. cognitive testing; and
3. results of imaging studies.

Parkinson's disease secondary to illegal drug use and other Parkinsonism Syndromes, such as: Progressive Supranuclear Palsy, Corticobasal Degeneration, Multiple System Atrophy, Vascular Parkinsonism, and Dementia with Lewy bodies are not included.

Signed for the Company by:



Tracy A. Arney, Secretary Jessica Paik, President

UnitedHealthcare Insurance Company
Hartford, Connecticut

WAIVER OF PREMIUM

Waiver of Premium Benefit: We will continue the Covered Person's insurance without further payment of the Contributory portion of the premium while the Covered Person is Totally Disabled if he:

1. becomes Totally Disabled while a Covered Person and as the result of a Covered Critical Illness for which he:
    a. is insured under the Policy; and
    b. was Diagnosed while insured under the Policy;
2. remains Totally Disabled for a 90 consecutive day period immediately prior to the date this Waiver will commence;
3. gives Us proof of Total Disability, as required;

not to exceed a maximum Waiver period of 24 months for any one period of Total Disability.

We will waive the premium on a monthly basis, starting the first day of the month after the month during which he finished the 30 day Waiting Period. If this Waiver applies to a partial month, it will be pro-rated. This Waiver of Premium only applies to the Primary Covered Person's insurance and it does not waive premium for the cost of Dependent insurance, if any.

Total Disability or Totally Disabled: For purposes of this section, the Covered Person will be considered Totally Disabled if, due to a Covered Critical Illness:

1. he is unable to perform the material and substantial duties of his occupation at his usual place of employment; and
2. he is not in fact working at his regular place of employment**.**

Successive and Concurrent Total Disability: After the 90 day Waiting Period for this Waiver has been met, concurrent periods of Total Disability, whether due to the same or a different Critical Illness, are considered part of the same period of Total Disability. Successive periods of Total Disability that start while the Covered Person's insurance is in force, but before he has returned to Active Work for 90 consecutive days:

1. are considered part of the same period of Total Disability ;
2. are not subject to a new 90 day Waiting Period but will count toward the 24 month maximum.

If he has a new Critical Illness after the 90th day, he may begin a new Waiver, subject to satisfaction of a new 90 day Waiting Period, and again meeting all of the Policy conditions.

Benefits During Waiver Period: Benefits continued during the Waiver period are based on the Schedule in force on the date the Totally Disability started including any scheduled reductions. The Waiver will not apply to increases in coverage after the date the Total Disability started. The Portability provision does not apply during the Waiver period.

Proof of Total Disability: We will provide forms which the Covered Person must use when giving Us proof of Total Disability.

The Covered Person must give Us proof as soon as possible, but no later than 90 days after the date his Total Disability started. If he is not able to provide the proof within that time:

1. it must be sent as soon as reasonably possible; but,
2. no later than one year unless he is legally incapacitated.

We may at any time, after the Waiver starts, require proof that Total Disability continues. The Covered Person must give Us proof within 60 days after Our request. We may require the Covered Person to be examined, at Our expense, by a Physician of Our choice.

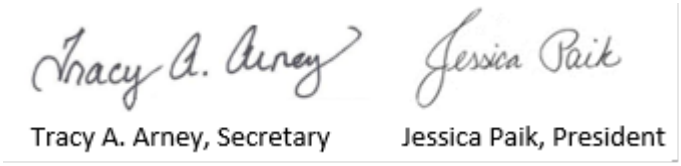
WAIVER OF PREMIUM

Termination of the Waiver Benefit: The Waiver ends on the first to occur of :

1. the date premium has been waived for 24 months;
2. the date the Covered Person:
    a. ceases to be Totally Disabled; or
    b. returns to Active Work;
3. the date the Policy terminates;
4. the date the Primary Covered Person ceases to be eligible for insurance (except that this will not apply if he is ineligible solely because he is not Actively at Work due to Total Disability covered by this Waiver;)
5. the last day of the 60-day period following Our request for proof of continued Total Disability, if he does not give Us proof or refuses to take a medical exam.

If the Covered Person is still eligible for Insurance when the Waiver ends, his Insurance may be continued in force if premium payments are resumed.

Signed for the Company by:



Tracy A. Arney, Secretary Jessica Paik, President

UnitedHealthcare Insurance Company
Hartford, Connecticut

WELLNESS BENEFIT

We will pay the amount shown on the Schedule of Benefits per calendar year for any one of the following health screening tests performed on either the Covered Person or Spouse provided the Covered Person elected coverage under the benefit.

Health screening test is defined as:

- Generally medically accepted cancer screening tests including, but not limited to:
  - Mammography;
  - CA 15-3 (blood test for breast cancer)
  - CA 125 (blood test for ovarian cancer)
  - CEA (blood test for colon cancer)
  - an annual cervical cancer screening test which includes a conventional Pap test, a human papillomavirus screening test that is approved by the federal Food and Drug Administration, or the option of any cervical cancer screening test approved by the federal Food and Drug Administration
  - PSA (blood test for prostate cancer)
  - Serum Protein Electrophoresis (blood test for myeloma)
- Stress test on a bicycle or treadmill
- Fasting blood glucose test
- Blood test for triglycerides
- Serum cholesterol test to determine level of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- Chest X-ray
- Colonoscopy
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Thermography
- Virtual Colonoscopy

This benefit will be paid as long as the Policy is in force and the Covered Person or Spouse remains insured under this Benefit of the Policy. The benefit will be paid regardless of the results of the test. The Wellness Benefit is paid in addition to any other payments the Covered Person or Spouse receives under the Policy.

Only one health screening test will be covered upon receipt by Us of adequate documentation to support the performance of the test on the Covered Person or Spouse.

Interaction with Wellness Benefit: If the Covered Person has purchased this Wellness Benefit under more than one policy issued by UnitedHealthcare Insurance Company, the Wellness Benefit for any health screening test is payable only once per calendar year, regardless of any other such benefit. Another Wellness Benefit is only payable if it is for a different health screening test issued under a separate policy.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

• hospitalization

• physician services

• hospice

• outpatient prescription drugs if you are enrolled in Medicare Part D

• other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program SHIP.

NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

- **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance

80% of death benefits but not to exceed $300,000
80% of cash surrender or withdrawal values but not to exceed $100,000

- Annuities and Structured Settlement Annuities

80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C)

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P.O Box 16860,
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927- 4357

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

Modification(s) to the Certificate

Policyholder: BA Holdings, Inc.

Policy Number: 371448

It is agreed that the Certificate is amended as follows:

Effective January 1, 2024, with respect to residents of the states as shown on the subsequent pages, the following provisions amend, replace or are added, when applicable, to the Certificate, and all other conditions apply.

Signed for UnitedHealthcare Insurance Company by:

Tracy A. Arney, Secretary Jessica Paik, President

UnitedHealthcare Insurance Company
Hartford, Connecticut 06103-3408

STATUTORY PROVISIONS

ALASKA

Residents of the state of Alaska the following provisions are included to bring your Certificate into conformity with Alaska state law:

Claim Information
Overpayment of Claim is amended to advise that we have the right to recover any overpayments within 180 days of payment of a benefit.

ARKANSAS

Residents of the state of Arkansas, the following provisions are included to bring your Certificate into conformity with Arkansas state law:

Insurer Information Notice

Any questions regarding the Policy may be directed to:

UnitedHealthcare Insurance Company
Administrative Offices
9900 Bren Road East
Minnetonka, MN 55343
1-866-615-8727

Policyholders have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:

Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, Arkansas 77202

Continuation and Reinstatement Provisions
If Dependent coverage is included, **Continuation of an Incapacitated Child** is amended to remove the 31 day notice requirement of the incapacity.

FLORIDA

Residents of the state of Florida:

The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida

The following provisions are included to bring your Certificate into conformity with Florida state law:

General Definitions
If Dependent coverage is included, the definition of **Child** is amended to include foster Child(ren).

If Dependent coverage is included and **Domestic Partnership** is defined, it is amended to remove any specific living arrangements and affiliated time period requirements.

If Dependent coverage is included, the definition of **Incapacitated Child** is amended to remove any requirement that the Child be unmarried.

Benefits Payable and Benefit Definitions
Diagnosis is amended to clarify that a diagnosis made post mortem is recognized as a diagnosis of a covered condition as long as the individual was insured under the policy on the date of death.

If Coma is a covered benefit, the **Date of Diagnosis** waiting period for Coma condition will never exceed 14 days.

Eligibility, Effective Date and Termination Provisions
If Dependent coverage is included, **Newborn Child Provision** is amended to include an adopted Child. The adopted Child will become insured on the date the Child was placed with You for adoption at the same Benefit Amount that applies to Your other Children. If no other Children are insured, then the lowest amount available to Children under the Policy applies until We are notified of another amount that is available for Children. The timeframe for notification of, and premium payment for, a newborn or adopted Child is extended to 60 days; and insurance for the newborn/adopted Child may end on the date You request.

Claim Information
The following **Time Payment of Claim** provision is added.

Time Payment of Claim: Benefits for loss covered by the Policy are paid immediately upon receipt of Proof of Claim. If special circumstances require an extension, We will notify the Covered Person within 45 days of receipt of the initial proof. Our notice will provide the Covered Person with:

1. a description of any further proof needed to perfect the claim; and
2. an explanation of why such material is needed.

Benefits for a covered loss will then be paid upon receipt of all proper Proof of Claim. If any benefit of the Policy is due on a periodic basis, it will be paid monthly.

The timeframe in which no suit may be brought in the **Legal Action** provision is amended from three years after the date
of loss to the expiration of the statute of limitations from the time Proof of Claim is required.

IDAHO

Residents of the state of Idaho, the following provisions are included to bring your Certificate into conformity with Idaho state law:

Notice to Buyer: This is a specified disease Certificate. This Certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your Certificate carefully with the outline of coverage.

10 Day Free Look: The Covered Person has the right to return this certificate within 10 days of its delivery and to have any premium paid, refunded if after examination, he is not satisfied for any reason.

Insurer Information Notice

Any questions regarding the Policy may be directed to:

UnitedHealthcare Insurance Company
Administrative Offices
9900 Bren Road East
Minnetonka, MN 55343
1-866-615-8727

If the question is not resolved, you may contact the Idaho Department of Insurance:

Idaho Department of Insurance
Consumer Affairs
700 W State Street, 3rd Floor
PO Box 83720
Boise ID 83720-0043
1-800-721-3272 or www.DOI.Idaho.gov

The following Outline of Coverage is included: CRITICAL ILLNESS COVERAGE
AS PROVIDED BY POLICY FORM UHICI-POL-ID (2020)
THIS CERTIFICATE PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE

This IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare, review the Guide to Health Insurance for People With Medicare available from the company.

(1) This coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. Persons covered under Medicaid should not purchase it. Read the Buyer's Guide to Specified Disease Insurance to review the possible limits on benefits in this type of coverage.

(2) Read Your Certificate Carefully—This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR CERTIFICATE CAREFULLY!

(3) Critical Illness coverage is designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of a critical illness. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

(4) A fixed percentage of the maximum benefit is payable for a critical illness. The critical illnesses are listed in the certificate schedule. The maximum benefit for an employee is $30,000; a spouse is $15,000 and each child is $7,500.

The fixed percentage is 25% of the maximum benefit for a Level 2 Cancer (defined in the certificate) or a Coronary Artery Bypass. For all other critical illnesses, the fixed percentage is 100%.

No benefit is payable for a critical illness that is due to:

1. an act or accident of war, declared or undeclared, whether civil or international, and any substantial armed conflict between organized forces of a military nature;
2. loss sustained while on active duty as a member of the armed forces of any nation except during any time period coverage is extended under the Continuation during Leave of Absence provision;
3. any intentionally self-inflicted Injury;
4. active participation in a riot;
5. committing or attempting to commit a felony, or participating or attempting to participate in a felony;
6. use of alcohol or the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance, whether or not prescribed by a Physician;
7. cosmetic or elective surgery; or
8. attempted suicide, while sane or insane.

We also will not pay a benefit for a Critical Illness:

9. for which the Covered Person's or Dependent's Date of Diagnosis for any type of Critical Illness, as defined in the Policy, was prior to his Effective Date of insurance; or
10. that was diagnosed outside of the United States or Canada, unless the diagnosis was confirmed by a Physician practicing within the United States or Canada.

Coverage terminates on the first to occur of: the last day of the period for which premium is paid; the last day of the month during which you or your dependent enter active duty of the armed forces; the last day of the month during which you cease to be in a class eligible for coverage; the date the master policy under which this certificate is issued terminates; or the date you cease to be actively at work.

Your coverage may be continued during an approved medical or non-medical leave of absence or during a layoff if the certificate includes such continuation provisions. When your coverage terminates because you are no longer eligible, you will have the option to continue your coverage under the portability privilege explained in your certificate.

Your dependent's coverage will terminate when you are in a class that is no longer eligible for dependent coverage or if the dependent no longer meets the definition of a dependent as explained in the certificate. Coverage may be continued for children who reach the age limit and are incapacitated on that date.

UHICI-OOC-ID (2020)
Printed in U.S.A.

General Definitions

The following definition of **Congenital Anomaly** is added:

A condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. For the purposes of this definition the term significant deviation means a deviation which impairs the function of the body and includes but is not limited to the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be congenital anomalies.

If Dependent coverage is included and **Domestic Partner** is defined, the definition of **Child** is amended to include a Child for whom legal guardianship has been awarded to the Covered Person or the Covered Person's Spouse or Domestic Partner.If Dependent coverage is included and **Domestic Partner** is defined, it is amended to always include both opposite or same sex.

The **Hospital** definition is amended to include an institute which operates either on its premises or in facilities available to the hospital on a prearranged basis.

Eligibility, Effective Date and Termination Provisions

If Dependent coverage is included, **Enrolling in or Changing Dependent Insurance Under the Policy** is amended to allow for 60 days to enroll in coverage for a newborn or newly adopted child.

If Dependent coverage is included, the **Newborn Child Provision** is amended to include adopted newborn Children that are Placed with You within 60 days of the adopted Child's date of birth, and will become covered by the Policy from the moment of live birth. An adopted newborn Child Placed with You more than 60 days after their birth is covered by the Policy from and after the date the Child is so Placed. Placed means physical placement in the care of the adopting Covered Person. If physical placement is prevented due to the medical needs of the child, "placed" means the date the adopting Covered Person signs an agreement for adoption of the child and assumes financial responsibility for the child.
We must receive notification the Child within 60 days next following the date of birth, adoption or placement for adoption. The appropriate premium, if any, must be received within 31 days of the date the monthly premium invoice is received by the Policyholder and a notice of premium, if any, is provided to You by the Policyholder.

Coverage will cease unless We receive written request and any required premium as stated above.

The coverage amount offered is the lowest amount available to Children under the Policy if no other Children are insured, until We are notified of another amount that is available for Children.

A Congenital Anomaly refers to a condition existing at or from birth that is a Significant Deviation from the common form or function of the body. Congenital Anomaly is often caused by a hereditary or developmental defect or disease.

Significant Deviation means a deviation which impairs the function of the body and includes, but is not limited to, the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be congenital anomalies.

General Exclusions and Limitations
The following exclusion is not applicable (if included in your Certificate):

- We will also not pay a benefit for a Critical Illness for which the Covered Person's or Dependent's (if applicable) Date of Diagnosis for any type of Critical Illness, as defined in the Policy, was prior to his Effective Date of insurance;

The act of war exclusion is replaced with "an act of war, declared or undeclared, whether civil or international."

The felony exclusion is replaced with "participation in a felony."

The use of alcohol exclusion is replaced with "alcoholism or drug addiction."

The cosmetic or elective surgery exclusion is replaced with "cosmetic or elective surgery except that cosmetic surgery shall not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of Congenital Anomaly of a Dependent Child."

Claim Information
Time of Claim Payment is added.

Time of Claim Payment: Benefits for loss covered by the Policy are paid upon receipt of Proof of Claim. If special circumstances require an extension, We will notify the Covered Person within 45 days of receipt of the initial proof. Our notice will provide the Covered Person with:

1. a description of any further proof needed to perfect the claim; and
2. an explanation of why such material is needed.

Benefits for a covered loss will then be paid upon receipt of all proper Proof of Claim. If any benefit of the Policy is due on a periodic basis, it will be paid monthly.

Additional Critical Illnesses Rider
If this rider is included, reference to Activities of Daily Living (ADLs) as a condition of Advanced Alzheimer's is removed.

MINNESOTA

Residents of the state of Minnesota, the following provisions are included to bring your Certificate into conformity with Minnesota state law:

General Definitions
If Dependent coverage is included, the definition of **Child** is amended to include a grandchild of either the Covered Person or the Covered Person's Spouse who is financially dependent upon and who resides with the Covered Person or the Covered Person's Spouse.

General Limitations and Exclusions
The use of alcohol exclusion is replaced with "use of narcotics, unless administered on the advice of a Physician.'

NEW HAMPSHIRE

Residents of the state of New Hampshire, the following provisions are included to bring your Certificate into conformity with New Hampshire state law:

The following disclosures are included:

This is a Limited Policy - **Read the Certificate Carefully.**

30 Day Free Look: The Covered Person has the right to return this certificate within 30 days of its delivery and to have any premium paid, refunded if after examination, he is not satisfied for any reason.

The following Outline of Coverage is included: GROUP CRITICAL ILLNESS POLICY
SPECIFIED DISEASE COVERAGE
THIS CERTIFICATE PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES
OUTLINE OF COVERAGE

1. This coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. Persons covered under Medicaid should not purchase it. Read the Buyer's Guide to Specified Disease Insurance to review the possible limits on benefits in this type of coverage.

3. Read Your Outline of Coverage Carefully. This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR CERTIFICATE CAREFULLY!

4. Specified disease coverage is designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of specified diseases. Coverage is not provided for basis hospital, basic medical-surgical, or major medical expenses.

5. *Amount and Duration of Benefits* – The coverage pays up to a total of 100% of the Maximum Benefit Amount for each of the Critical Illness Conditions shown on the Certificate Schedule of Benefits for which you or your Dependent (if applicable), receive a Diagnosis of a Critical Illness; and for which you are insured on the Date of Diagnosis. The benefit payable will be paid in a lump sum amount.

   The following Critical Illness Benefits are available under your coverage:

Maximum Benefit Amount:

Option 1
Employee: $10,000
Spouse: $5,000
Child: $2,500

Option 2*
Employee: $20,000
Spouse: $10,000
Child: $5,000

Option 3*
Employee: $30,000
Spouse: $15,000
Child: $7,500

*Employee may choose from lower coverage options for Spouse and Child(ren)

Critical Illness Conditions	**Percentage of Maximum Benefit Amount payable per Covered Person or Dependent**
Benign Brain Tumor	100%
Cancer Level 1	100%
Cancer Level 2	25%
Chronic Renal Failure	100%
Coma	100
Coronary Artery Disease	25%
Heart Attack	100%
Heart Failure	100%
Major Organ Failure	100%
Permanent Paralysis	100%
Ruptured Aneurysm	100%
Stroke	100%

Child Critical Illness Category	Percentage of Maximum Benefit Amount payable per Covered Child
• Cerebral Palsy	25% of Employee's Amount
• Cleft Lip / Palate	25% of Employee's Amount
• Cystic Fibrosis	25% of Employee's Amount
• Down Syndrome	25% of Employee's Amount
• Muscular Dystrophy	25% of Employee's Amount
• Spina Bifida	25% of Employee's Amount

Benefit Riders

Portability	Included
• Portability Policy Age Limit	Coverage continued under Portability terminates at Age 75
Reoccurrence Benefit:	For each Critical Illness Condition, not to exceed: 100% of Employee's Maximum Benefit Amount 100% of Spouse's Maximum Benefit Amount 100% of Child's Maximum Benefit Amount whichever applies
Wellness Benefit:	$50 per plan year
Additional Critical Illnesses Rider:	Included

UHICI-OOC-NH
Printed in the U.S.A.

General Definitions
If Dependent coverage is included, the **Child**, **Incapacitated Child**, and **Eligible Student** (if applicable) definitions are amended to remove the restriction of not being married.

Benefits Payable and Benefit Definitions
If **Severe Brain Damage** coverage is included, the Activities of Daily Living requirements are removed.

General Exclusions and Limitations
The use of alcohol or non medical use of narcotics exclusion is amended to remove "use of alcohol."

The cosmetic surgery exclusion is amended to clarify that cosmetic surgery does not include reconstructive surgery when service is incidental to or follows surgery resulting from trauma, infection, or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional defect.

Claim Information
Proof of Claim is amended to advise that if an extension is required, We must provide within 45 days of receipt of initial proof, a description of any further proof needed and an explanation of why such material is needed.

Additional Critical Illnesses Rider
If this rider is included, the following **Sickness** definition is added with respect to the **Complete Blindness** and **Complete Loss of Hearing** definitions:

Sickness means an illness, or disease, pregnancy or complication of pregnancy.

The **Advanced Alzheimer's** definition is amended to remove that the impairment require the insured to need Substantial Assistance to perform at least two of six Activities of Daily Living (ADLs).

The **Substantial Assistance** definition is amended as the need to have another person present and within arm's reach so as to prevent, by physical intervention, injury to the Covered Person or Dependent, if applicable, while he is performing daily activities, including activities of self-care.

Waiver of Premium
If this rider is included, **Proof of Claim** is amended to state that proof must be given as soon as reasonably possible.

NORTH CAROLINA

Residents of the state of North Carolina, the following provisions are included to bring your Certificate into conformity with North Carolina state law

Important Cancellation Information — Please Read the Provision Entitled, **Termination of Covered Person's Insurance.**

General Definitions
The "change in the number of dependents" item in the **Change in Status** definition is amended to remove the requirement that it be for tax purposes. This item is also amended to include placement of a Child in a foster home.

If Dependent coverage is included, the definition of **Child** is amended to include the following: a non-custodial Child; a foster Child from the date they are placed in a foster home; or a Child for whom You are required to provide insurance due to a court or administrative order. An adopted Child's coverage is effective from the date of placement for the purpose of adoption and continues unless placement is disrupted prior to legal adoption and the child is removed from placement.

The definition of **Hospital or Medical Facility** is amended to include: "In North Carolina, the term also means a duly licensed State tax-supported institution which may be a specialty facility for one particular type of illness or one that may not have an operating room and related equipment for surgery."

Benefits Payable and Benefit Definitions
If **Cancer** coverage is included, it is amended to clarify that if the requisite pathological/clinical diagnosis can only be made postmortem, liability will be assumed retroactively.

Continuation and Reinstatement Provisions
If Dependent coverage is included, **Continuation of an Incapacitated Child** is amended to clarify that proof of dependency may be required within 31 days of attainment of limiting age, but not more frequently than annually.

General Exclusions and Limitations
The cosmetic or elective surgery exclusion is amended to allow coverage when cosmetic surgery is performed on a child to correct a congenital defect or anomaly.

Claim Provisions
Proof of Claim is amended to extend the timeframe in which written proof of claim must be filed, to 180 days.

NORTH DAKOTA

Residents of the state of North Dakota, the following provisions are included to bring your Certificate into conformity with North Dakota state law:

The Covered Person will have 10 days to review this Certificate. If the Covered Person is not satisfied for any reason, he may send the Certificate back to Us within 10 days of its delivery. In that event, We will consider it void and refund all premium paid by the Covered Person.

General Definitions
If Dependent coverage is included, the definition of **Child** includes a child of a Dependent.

General Exclusions and Limitations
If **Pre-Existing Conditions Exclusion** is included, the definition of **Pre-existing Condition** is amended to remove that it includes any condition for which the Covered person or Dependent had symptoms for which a reasonably prudent person would have sought Treatment.

OKLAHOMA

Residents of the state of Oklahoma, the following provisions are included to bring your Certificate into conformity with Oklahoma state law:

The following disclosures are included:
Certificates delivered in the state of Oklahoma are subject to the terms and conditions of the Certificate and not the Policy. This Certificate is issued in and governed by the laws of the state of Oklahoma.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Newborn Child Provision
Any reference in the Certificate to *live birth* is replaced with *birth*.

General Exclusions and Limitations
The act of war exclusion is amended to include “when serving in the military or an auxiliary unit.”

Claim Information
Overpayment of Claim is amended to limit the recovery period to 24 months unless it is a case of claimant fraud.

The following **Time of Claim Payment** provision is added:

Time of Claim Payment: Benefits for loss covered by the Policy are paid upon receipt of Proof of Claim. If special circumstances require an extension, We will notify the Covered Person within 45 days of receipt of the initial proof. Our notice will provide the Covered Person with:

1. a description of any further proof needed to perfect the claim; and
2. an explanation of why such material is needed.

Benefits for a covered loss will then be paid upon receipt of all proper Proof of Claim. If any benefit of the Policy is due on a periodic basis, it will be paid monthly.

TEXAS

Residents of the state of Texas, the following provision is included to bring your Certificate into conformity with Texas state law:

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don’t, you may lose your right to appeal.

UnitedHealthcare Insurance Company
To get information or file a complaint with your insurance company or HMO:

Call: UnitedHealthcare Insurance Company
Toll-free: 1-866-615-8727
Mail: United HealthCare Insurance Company Administrative Offices
9900 Bren Road East, Minnetonka. MN 55343

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance,
P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de sucompañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

UnitedHealthcare Insurance Company
Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: UnitedHealthcare Insurance Company
Teléfono gratuito: 1-866-615-8727
Dirección postal: United HealthCare Insurance Company Administrative Offices,
9900 Bren Road East, Minnetonka. MN 55343

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una
queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: Consumer Protection, MC: CO-CP,
Texas Department of Insurance,
P.O. Box 12030, Austin, TX 78711-2030

07/2023

VERMONT

Residents of the state of Vermont, the following provision is included to bring your Certificate into conformity with Vermont state law:

Vermont Mandatory Civil Union
Purpose: Vermont law requires coverage for parties to a civil union equivalent to that provided married persons. If any terms of the Policy would not be equivalent, the terms are hereby amended to comply. As used in this Notice, Civil Union means one established according to Vermont law.

Definitions, Terms, Conditions and Provisions: In Vermont, the word Spouse, as used in the Policy includes a person with whom the Covered Person has received a Certificate of Civil Union under Vermont law. Any terms that refer to a marital relationship such as "marriage," "spouse," "relative," "beneficiary," "survivor," "immediate family," and any other such terms includes the relationship created by a Civil Union.

Terms that refer to the inception or dissolution of a marriage, such as "date of marriage", "divorce decree," "termination of marriage," and any other such terms include the inception or dissolution of a Civil Union.

Terms that refer to a family relationship arising from a marriage such as "family," "immediate family," "dependent," "children," "relative," "beneficiary." "survivor" and any other such terms include the family relationship created by a Civil Union. A child born or brought to a Civil Union will be a Child under the Policy if he meets all other Policy criteria to qualify under the definition of Child.

CAUTION: FEDERAL LAW RIGHTS MAY OR MAY NOT BE AVAILABLE: Vermont law grants parties to a Civil Union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to health insurance that are available to married persons under federal law may not be available to parties to a Civil Union. For example, under federal law, the Employee Income Retirement Security Act of 1974 known as “ERISA,” controls the employer /employee relationship with regard to determining eligibility for enrollment in private employer health insurance plans. Because of ERISA, Act 91 of Vermont state law does not state requirements pertaining to a private employer’s enrollment of a party to a civil union in an ERISA employee welfare benefit plan. However, governmental employers (not federal government) are required to provide health benefits to the dependents of a party to a Civil Union if the public employer provides such coverage to the dependents of married persons. Federal law also controls group health insurance continuation rights under “COBRA” for employers with 20 or more employees as well as the Internal Revenue Code treatment of health insurance premiums. As a result, parties to a Civil Union and their families may or may not have access to certain benefits under a Policy or Certificate that derive from federal law. You are advised to seek expert advice to determine your rights under the Policy.

UHICI-CIVUNION-VT

WASHINGTON

Residents of the state of Washington, the following provisions are included to bring your Certificate into conformity with Washington state law:

The following Outline of Coverage is included:

UnitedHealthcare Insurance Company
185 Asylum Street
Hartford, Connecticut
(Home Office)

IMPORTANT INFORMATION ABOUT THE COVERAGE YOU ARE BEING OFFERED

Save this statement! It may be important to you in the future. The Washington State Insurance Commissioner requires that we give you the following information about fixed payment benefits.

This coverage is not comprehensive health care insurance and will not cover the cost of most hospital and other medical services.

This disclosure provides a very brief description of the important features of the coverage being considered. It is not an insurance contract and only the actual policy provisions will control. The policy itself will include in detail the rights and obligations of both the master policyholder and UnitedHealthcare Insurance Company.

This coverage is designed to pay you a fixed dollar amount regardless of the amount that the provider charges. Payments are not based on a percentage of the provider's charge and are paid in addition to any other health plan coverage you may have.

CAUTION: If you are also covered under a High Deductible Health Plan (HDHP) and are contributing to a Health Savings Account (HSA), you should check with your tax advisor or benefit advisor prior to purchasing this coverage to be sure that you will continue to be eligible to contribute to the HSA if this coverage is purchased.

The benefits under this policy are summarized below:

1. **Type of Coverage: Critical Illness Insurance Coverage.** This certificate is designed to provide, to certificate holders, restricted coverage paying benefits ONLY when certain losses occur as a result of treatment (or diagnosis) of a Critical Illness. This certificate does NOT provide general health insurance.

2. **Benefit Amount:**

Maximum Benefit Amount	Option 1 Employee: $10,000 Spouse: $5,000 Child: $2,500 Option 2* Employee: $20,000 Spouse: $10,000 Child: $5,000 Option 3* Employee: $30,000 Spouse: $15,000 Child: $7,500 *Employee may choose from lower coverage options for Spouse and Child(ren)

Critical Illness Conditions	Percentage of Maximum Benefit Amount payable per Covered Person or Dependent
Benign Brain Tumor	100%
Cancer Level 1	100%
Cancer Level 2	25%
Chronic Renal Failure	100%
Coma	100%
Coronary Artery Disease	25%
Heart Attack	100%
Heart Failure	100%
Major Organ Failure	100%
Permanent Paralysis	100%
Ruptured Aneurysm	100%
Stroke	100%

Child Critical Illness Category	Percentage of Maximum Benefit Amount payable per Covered Child
Cerebral Palsy	25% of Employee's Amount
Cleft Lip / Palate	25% of Employee's Amount
Cystic Fibrosis	25% of Employee's Amount
Down Syndrome	25% of Employee's Amount
Muscular Dystrophy	25% of Employee's Amount
Spina Bifida	25% of Employee's Amount

Benefit Riders	
Portability	Included
• Portability Policy Age Limit	Coverage continued under Portability terminates at Age 75
Reoccurrence Benefit:	Included For each Critical Illness Condition, not to exceed: • 100% of Employee's Maximum Benefit Amount • 100% of Spouse's Maximum Benefit Amount • 100% of Child's Maximum Benefit Amount whichever applies
Wellness Benefit:	$50 per plan year
Additional Critical Illnesses Rider:	Included

3. **Benefit Trigger:** We will pay the stated percentage of the Maximum Benefit Amount for each of the Critical Illness Conditions shown on the Schedule of Benefits for which you or your Dependent (if applicable):
   1. receives a Diagnosis of a Critical Illness; and
   2. for which you are insured on the Date of Diagnosis (as defined in the Certificate).
4. **Duration of Coverage:** Your coverage terminates on the first to occur of: the last day of the period for which premium is paid; the last day of the month during which you enter active duty of the armed forces; the last day of the month during which you cease to be in a class eligible for coverage; the date the Policy terminates; the date a benefit for a Critical Illness shown on the Schedule of Benefits is paid to you; or the date you cease to be actively at work.

Your dependent's coverage will terminate when you are in a class that is no longer eligible for dependent coverage or if the dependent no longer meets the definition of a dependent as explained in the certificate. Coverage may be continued for children who reach the age limit and are incapacitated on that date.

In certain cases insurance may be continued as stated in the section of the Certificate titled ***CONTINUATION AND REINSTATEMENT PROVISIONS***.

5. **Renewability of Coverage:** The Policy will continue in force until it is canceled by either the Policyholder or UnitedHealthcare Insurance Company.

   Policy provisions that exclude, eliminate, restrict, limit, delay, or in any other manner operate to qualify payment of the benefits described above include the following:

   Coverage may be subject to evidence of good health if you enroll late or if you enroll for an amount of coverage in excess of the guaranteed issue limits that are outlined in your certificate.

We will not cover a Critical Illness under the Policy if it is due to:

1. an act or accident of war, declared or undeclared, whether civil or international, and any substantial armed conflict between organized forces of a military nature;
2. loss sustained while on active duty as a member of the armed forces of any nation except during any time period coverage is extended under the Continuation during Leave of Absence provision;
3. any loss which is intentionally self-inflicted;
4. active participation in a riot;
5. the Covered Person's or Dependent's commission of or attempt to commit a felony, or to which a contributing cause was the Covered Person's or Dependent's engagement in an illegal occupation;
6. loss sustained or contracted in consequence of the Covered Person or Dependent being intoxicated or under the influence of any controlled substance unless administered on the advice of a Physician;
7. attempted suicide, while sane or insane.

We also will not pay a benefit for a Critical Illness:

8. for which the Covered Person's or Dependent's Date of Diagnosis for any type of Critical Illness, as defined in the Policy, was prior to his Effective Date of insurance; or
9. that was diagnosed outside of the United States or Canada, unless the diagnosis was confirmed by a Physician practicing within the United States or Canada.

UHICI-OOC-WA-1
Printed in U.S.A.

General Definitions

If Dependent coverage is included and **Eligible Student** is defined, the restriction of not being married is removed.

General Exclusions and Limitations

The following exclusion is not applicable (if included in your Certificate):

- use of alcohol or the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance, whether or not prescribed by a Physician; this exclusion does not apply to the Drug and Alcohol Treatment Benefit (Inpatient) if covered under this Policy.

The act of war exclusion is replaced with “due to war or act of war, whether declared or undeclared.”

Benefits Payable and Benefit Definitions

If Coma is a covered benefit, the **Date of Diagnosis** waiting period for Coma condition will never exceed 14 days.

Eligibility, Effective Date and Termination Provisions

If Dependent coverage is included, the **Newborn Child Provision** is amended to extend the timeframe for notification of, and premium payment for, a newborn to 60 days.

This provision applies only where the interpretation of the Policy is governed by the Employee Retirement Income Security Act (ERISA).

STATEMENT OF EMPLOYEE ERISA RIGHTS

The Employee Retirement Income Security Act of 1974 (ERISA) guarantees certain rights and protections to participants of welfare plans. Federal law and regulations require that a "Statement of ERISA Rights" be included in this description of the Plan.

You may examine, without charge, all Plan documents, including any insurance contracts, collective bargaining agreements, annual reports, summary plan descriptions and other documents filed with the Department of Labor. You can examine copies of these documents in the Plan Administrator's office or at other specified locations, or you can ask your supervisor where copies of the documents are available.

If you want a personal copy of Plan documents or related material, you should send a written request to the Plan Administrator. You will be charged only the actual cost of these copies.

You are entitled to receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. These individuals, called "fiduciaries," have an obligation to administer the Plan prudently and to act in the interest of Plan participants and beneficiaries. The named fiduciary for this Plan is the Plan Sponsor. No one, including the Employer or any other person, may fire a Covered Person or otherwise discriminate against a Covered Person in any way to prevent that person from obtaining a benefit or exercising their rights under ERISA.

When you become eligible for payments from the Plan, you should follow the appropriate steps for filing a claim. In case of claim denial, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide you the materials and pay you up to $110 per day until you receive your materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in a state or federal court provided you have exhausted the procedures and complied with the timeframes for review of the adverse claim decision provided below. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay costs and legal fees. For example, if you are successful, the court may order the person you sued to pay those costs and fees. If you lose or if the court finds your suit to be frivolous, you may be ordered to pay these costs and fees.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, contact the nearest Area Office of the Employee Benefits Security Administration, United States Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

CLAIMS DENIAL FOR CRITICAL ILLNESS INSURANCE

Notice of a decision to deny a claim (in whole or in part) shall be furnished to the claimant within 45 days following the receipt of the claim. Up to two extensions of 30 days each will be allowed for processing the claim for matters beyond the Plan's control or if additional information is needed from the claimant. If special circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the expiration of the initial 45 day period.

The notice of extension shall indicate the special circumstances requiring the extension and the date by which the notice of decision with respect to the claim is expected to be furnished. If a claim is denied (in whole or in part) notice shall be provided to the claimant in writing and shall set forth: 1) the reason(s) for the denial which must contain a complete discussion of why the claim was denied, including the basis for disagreeing with the views of medical or vocational experts whose advice was obtained either by the claimant or by the plan in connection with the denial; 2) the internal rules, guidelines, protocols, standards or other similar criteria of the plan that were relied on in denying a claim or a statement that none exists; 3) a statement that the claimant is entitled to receive, upon request, the entire claim file and other relevant documents; 4) reference to the provision(s) of the Plan on which the denial is based; 5) a description of any additional material or information necessary for the claimant to perfect the claim, if the claim was denied because the claimant failed to provide all necessary information, and an explanation of why such material or information is necessary; 6) an explanation of the claim review procedure. Notices must also be provided in a culturally and linguistically appropriate manner in certain situations. If written notice of the denial is not furnished to the claimant within 45 days (or if an extension was required, 105 days) from the date the claim was received, the claim shall be deemed denied and the claimant shall then be permitted to proceed with the procedure set forth below.

REVIEW OF DENIED CLAIMS AND COMPLAINT PROCEDURE FOR CRITICAL ILLNESS INSURANCE

If a covered person or any person claiming through a covered person wishes to have a denied claim reviewed, a written request must be sent to the address identified in the claim denial letter.

Any complaint or dispute related to review of denied claims shall be resolved in accordance with the procedure set forth by the Plan Sponsor and outlined below.

1. The complainant may contact the Insurance Carrier's service representative in an attempt to resolve the complaint in an informal manner.
2. If the complainant is not satisfied with any attempts at informal resolution, the complainant must submit a written request for review of a denied claim or a written notice of the complaint or dispute to the address identified on the claim denial letter within 180 days of receipt of the claim denial notice. The complainant may submit supporting documentation or information to be considered. The complainant must submit any requested additional information or documents.
3. A written notice of the final decision will usually be sent to the complainant within 45 days of receipt of the written request for review of a denied claim or notice of a complaint or dispute. However, if special circumstances require an extension of time to reach a final decision, written notice of the final decision will be sent as soon as possible following the expiration of the initial 45 day period, but no later than 90 days following receipt of the request for review of a denied claim or notice of a complaint or dispute. If special circumstances require such an extension of time, written notice of the extension shall be furnished to the complainant prior to the expiration of the initial 45 day period. The written notice of the final decision must give specific reason(s) for the decision and include the above-referenced information set out above in the Claim Denial For Disability Insurance Section, items 1-4. A description of any applicable contractual limitations period and its expiration date must also be included. If the final written decision is not furnished to the complainant within 45 days (or if an extension was required, 90 days) from the date of receipt of the request for review of a denied claim or notice of a complaint or dispute, the request for review or the complaint or dispute shall be deemed to be rejected and denied on review. Notices must also be provided in a culturally and linguistically appropriate manner in certain situations.