

**CRITICAL ILLNESS - ATT AGE**



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

**CERTIFICATE OF INSURANCE**

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You and Your Dependents are insured for the benefits described in this Certificate, subject to the provisions of this Certificate. This Certificate is issued to You under the Group Policy and it includes the terms and provisions of the Group Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.**

The Group Policy is a contract between MetLife and the Group Policyholder. It may be changed or ended without Your consent or notice to You.

Group Policyholder:	Bristol Management Services, Inc.
Group Policy Number:	5965484
Employee Name:	See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife
Employee Number:	See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife
Effective Date of Insurance:	See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife
MetLife Contact Information:	1-800-GET-MET8

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

**Notice to Buyer: This is a critical illness insurance Certificate. Subject to the provisions of this Certificate, including limitations, exclusions and submission of Proof of a Covered Condition, this Certificate provides a limited benefit in the event You are Diagnosed with certain specified diseases, or have certain surgical procedures performed. *This Certificate pays nothing for certain forms of cancer.* See the definitions of Full Benefit Cancer and Partial Benefit Cancer, and the exclusions that apply to Full Benefit Cancer and Partial Benefit Cancer in the section titled "Exclusions that Apply to Specific Covered Conditions."**

This is a supplement to health insurance. It is not a substitute for hospital or medical expense insurance, a health maintenance organization (HMO) contract, or major medical expense insurance. You must have Medical Coverage, as defined in this Certificate, in place in order to enroll for this insurance.

**FOR CALIFORNIA RESIDENTS: READ YOUR CERTIFICATE CAREFULLY TO REVIEW LIMITATIONS. IF YOU ARE AT LEAST 65 YEARS OLD ON THE EFFECTIVE DATE OF THIS CERTIFICATE, YOU MAY RETURN THIS CERTIFICATE TO US WITHIN 30 DAYS FROM THE DATE YOU RECEIVE IT. IF YOU RETURN IT WITHIN 30 DAYS, THE CERTIFICATE WILL BE CONSIDERED NEVER TO HAVE BEEN ISSUED. WE WILL REFUND ANY PREMIUM PAID FOR INSURANCE UNDER THIS CERTIFICATE.**

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

**IMPORTANT NOTICE**

**TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT METLIFE  
AT:**

**METROPOLITAN LIFE INSURANCE COMPANY  
ATTN: CONSUMER RELATIONS DEPARTMENT  
1-800-GET-MET8 (OR 1-800-438-6388)  
500 SCHOOLHOUSE ROAD  
JOHNSTOWN, PA 15904**

**IF, AFTER CONTACTING METLIFE REGARDING A COMPLAINT, YOU FEEL THAT A  
SATISFACTORY RESOLUTION HAS NOT BEEN REACHED, YOU MAY FILE A COMPLAINT  
WITH THE CALIFORNIA INSURANCE DEPARTMENT AT:**

**CALIFORNIA DEPARTMENT OF INSURANCE  
CONSUMER COMMUNICATIONS BUREAU  
300 SOUTH SPRING STREET, SOUTH TOWER  
LOS ANGELES, CA 90013**

**WEBSITE: <http://www.insurance.ca.gov/>**

**1-800-927-4357 (within California)  
1-213-897-8921 (outside California)**

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## SCHEDULE OF INSURANCE

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

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

### **BENEFIT AMOUNT**

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

### **MAJOR ORGAN TRANSPLANT BENEFIT AMOUNT**

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

### **TOTAL BENEFIT AMOUNT**

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

**SCHEDULE OF INSURANCE (continued)**

**BENEFITS FOR COVERED CONDITIONS**

Covered Condition	Initial Benefit	Recurrence Benefit
Alzheimer's Disease	100% of Benefit Amount	NONE
Coronary Artery Bypass Graft	100% of Benefit Amount	50% of Benefit Amount
Full Benefit Cancer	100% of Benefit Amount	50% of Benefit Amount
Partial Benefit Cancer	25% of Benefit Amount	12.5% of Benefit Amount
Heart Attack	100% of Benefit Amount	50% of Benefit Amount
Kidney Failure	100% of Benefit Amount	NONE
Major Organ Transplant	100% of Major Organ Transplant Benefit Amount	NONE
Stroke	100% of Benefit Amount	50% of Benefit Amount
Listed Conditions	25% of Benefit Amount	NONE

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

## DEFINITIONS

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

**Actively at Work or Active Work** means that You are performing all of the usual and customary duties of Your job on a Full-Time basis. This must be done at:

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

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

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

- aphasia (language disturbance);
- apraxia (impaired ability to carry out motor activities despite intact motor function);
- anosia (failure to recognize or identify objects despite intact sensory function); and
- disturbance in executive functioning (i.e. planning, organizing, sequencing, abstracting).

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

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

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

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

## DEFINITIONS (continued)

**Clinical Diagnosis** means a Diagnosis of Partial Benefit Cancer or Full Benefit Cancer based on the study of symptoms and diagnostic test results. We will accept a Clinical Diagnosis of Partial Benefit Cancer or Full Benefit Cancer only if it is made by a Physician and consistent with generally accepted medical standards in the United States to Diagnose the Partial Benefit Cancer or the Full Benefit Cancer based solely on a Clinical Diagnosis.

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

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

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

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

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

**Covered Mammogram** means each of the following when provided to a female Covered Person upon the referral of a Physician, nurse practitioner or certified nurse midwife who is: (a) providing care to such female Covered Person; and (2) acting within the scope of a valid license with respect to the provision of such care:

- one baseline mammogram for such Covered Person age 35 to 39 inclusive;
- one mammogram every two years for such female Covered Person age 40 to 49 inclusive, provided, however, that upon the recommendation of the female Covered Person's Physician, one mammogram per year;
- one mammogram per year for such female Covered Person age 50 and over.

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

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

## **DEFINITIONS (continued)**

**Dependent Child** means the following:

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

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

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

A person cannot be insured as a Dependent Child of more than one employee under the Group Policy. Your adopted child will not be a Dependent Child prior to the date the child is placed in Your home for adoption. Your stepchild will not be a Dependent Child prior to the date the child's parent becomes Your Spouse or Domestic Partner.

**Dependent Insurance** means insurance under this Certificate for Your Dependents.

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

**Diagnose** means the act of making a Diagnosis.

## DEFINITIONS (continued)

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

1. have established a domestic partnership pursuant to Section 297 of the California Family Code; or
2. are of the same or opposite sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:
  - 18 years of age or older;
  - unmarried;
  - the sole domestic partner of the other;
  - sharing a primary residence with the other;
  - not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

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

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

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

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

**First Occurs or First Occurrence** means, with respect to:

- Full Benefit Cancer, the first time after a Covered Person initially becomes insured under the Group Policy that such Covered Condition Occurs;
- Full Benefit Cancer, after an Occurrence of Full Benefit Cancer while the Covered Person is insured under the Group Policy, an Occurrence of a Separate and Unrelated Full Benefit Cancer;
- Partial Benefit Cancer, the first time after a Covered Person initially becomes insured under the Group Policy that such Covered Condition Occurs;
- Partial Benefit Cancer, after an Occurrence of Partial Benefit Cancer while the Covered Person is insured under the Group Policy, an Occurrence of a Separate and Unrelated Partial Benefit Cancer; or
- all other Covered Conditions the first time after a Covered Person initially becomes insured under the Group Policy that such Covered Condition Occurs.

## DEFINITIONS (continued)

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

Full Benefit Cancer does not include:

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

***This Certificate pays nothing for certain forms of cancer. Read this Certificate carefully.***

**Full-Time** means Active Work on the Group Policyholder's regular work schedule for the class of employees to which You belong. The work schedule must be at least 30 hours per week.

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

**Group Policyholder** means the employer named on the first page of this Certificate.

**Heart Attack** (myocardial infarction) means the death of a portion of the heart muscle as a result of obstruction of one or more coronary arteries due to atherosclerosis, spasm, thrombus or emboli.

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

- is primarily engaged in providing, by or under the continuous supervision of Physicians, to inpatients, diagnostic services and therapeutic services for Diagnosis, treatment and care of injured or sick persons;
- has organized departments of medicine and major surgery;
- has a requirement that every patient must be under the care of a Physician or dentist;
- provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- is duly licensed by the agency responsible for licensing such Hospitals; and
- is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational or rehabilitative care.

**Hospitalized** means:

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

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

## **DEFINITIONS (continued)**

**Kidney Failure** means the total, end stage, irreversible failure of both kidneys to function, provided that a Physician has determined that such failure requires either:

- immediate and regular kidney dialysis (no less often than weekly) that is expected by such Physician to continue for at least 6 months; or
- a kidney transplant.

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

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

**Major Organ Transplant** means:

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

## DEFINITIONS (continued)

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

**Medical Coverage** means coverage under Medicare or an insurance policy, health maintenance organization contract, or employer's plan of self-insurance providing comprehensive benefits for hospital, surgical and medical expenses or treatment.

**Occurs or Occurrence** means:

- with respect to Full Benefit Cancer, Partial Benefit Cancer, Heart Attack, Kidney Failure, Stroke or a Listed Condition that the Covered Person:
  1. experiences such Covered Condition; and
  2. is Diagnosed with such Covered Condition.
- with respect to Coronary Artery Bypass Graft, that the Covered Person undergoes a Coronary Artery Bypass Graft.
- with respect to Major Organ Transplant, that the Covered Person:
  1. is placed on the Transplant List; or
  2. undergoes such Major Organ Transplant.
- with respect to Alzheimer's Disease that the Covered Person:
  1. experiences such Covered Condition;
  2. is Diagnosed with such Covered Condition; and
  3. all other etiologies have been ruled out by a Neurologist; Geriatrician or Neuropsychologist.

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

- carcinoma in situ which is a tumor that fulfills all pathologic criteria for malignancy except that it has not invaded the supporting structure of the organ on which it arose (for example, some cancers of the breast are carcinoma in situ), provided that the carcinoma in situ is classified as TisN0M0 and that Surgery, radiotherapy or chemotherapy has been determined to be medically necessary by a Physician who practices in the medical specialty that is appropriate for the type of carcinoma in situ involved;
- malignant melanomas classified as T1N0M0, for which a pathology report shows maximum thickness less than or equal to 0.75 millimeters using the Breslow method of determining tumor thickness; and
- tumors of the prostate classified as T1bN0M0, or T1cN0M0.

Partial Benefit Cancer does not include:

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

***This Certificate pays nothing for certain forms of cancer. Read this Certificate carefully.***

## DEFINITIONS (continued)

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

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

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

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

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

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

**Recur or Recurrence** means:

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

## DEFINITIONS (continued)

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

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

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

**Spouse** means Your lawful spouse. The term does not include any person who:

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

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

- hemorrhage (bleeding, loss of a large amount of blood from the blood vessels);
- thrombus (a stationary blood clot along the wall of a blood vessel); or
- embolus (a mass such as an air bubble, detached blood clot, or foreign body that travels through the bloodstream and lodges in a blood vessel) from an extra-cranial source.

**Supplemental Benefit(s)** are the following:

- Health Screening Benefit.

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

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

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

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

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

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

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

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

## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOU**

### **ELIGIBLE CLASS**

#### **CLASS 1**

All Active Full-Time Employees.

### **DATE YOU ARE ELIGIBLE FOR INSURANCE**

You may only become eligible for the insurance available for Your eligible class.

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

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

### **ENROLLMENT PROCESS**

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

### **DATE YOUR INSURANCE TAKES EFFECT**

Provided that You are Actively at Work in an eligible class, insurance under this Certificate will take effect for You on the Effective Date shown on the first page of this Certificate.

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

### **BENEFIT INCREASES**

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

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

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

## **ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE**

### **ELIGIBLE CLASSES FOR DEPENDENT INSURANCE**

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

### **DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE**

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

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

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

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

### **ENROLLMENT PROCESS**

Except as provided in the Newborn Children provision, if You become eligible for Dependent Insurance, You may enroll for such insurance by providing Us with the information We require for each Dependent to be insured. You must also provide Written permission to deduct Contributions from Your pay for Dependent Insurance, if You are required to make such Contributions.

## **ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE (CONTINUED)**

### **DATE DEPENDENT INSURANCE TAKES EFFECT**

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

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

Except as provided in the Newborn Children provision, if a Dependent does not meet these requirements on the date insurance for such Dependent would otherwise take effect, insurance for the Dependent will take effect on the date the Dependent is no longer:

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

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

### **NEWBORN CHILDREN**

A Dependent Child born to You while insurance is in effect under this Certificate will be covered for 31 days from the moment of such Dependent Child's birth. To continue coverage beyond the first 31 days You must notify Us of the child's birth and give Written permission to deduct Contributions from Your pay for Dependent Insurance for the newborn child.

### **BENEFIT INCREASES**

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

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

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

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

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

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

**100% of the Benefit Amount** is payable for the following Covered Conditions that First Occur for a Covered Person while such Covered Person is insured under this Certificate:

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

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

***This Certificate pays nothing for certain forms of cancer. Read this Certificate carefully.***

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

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

**25% of the Benefit Amount** is payable for the following Covered Conditions that First Occur for a Covered Person while such Covered Person is insured under this Certificate:

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

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

***\*This certificate pays nothing for basal cell carcinoma and squamous cell carcinoma unless there is metastasis. Read this Certificate carefully.*** No benefits are payable under either Full Benefit Cancer or Partial Benefit Cancer for any benign tumor, dysplasia, intraepithelial neoplasia or pre-malignant growth; any papillary tumor of the bladder classified as Ta under TNM Staging; or any tumor of the prostate classified as T1N0M0 under TNM Staging. Several other conditions are also excluded from either Full Benefit Cancer or Partial Benefit Cancer. See the Exclusions that Apply to Specific Covered Conditions on page 52 for details.

## MAMMOGRAM BENEFIT

If a Covered Person undergoes a Covered Mammogram while such Covered Person is insured under this Certificate, Proof of the Covered Mammogram must be sent to Us. When We receive such Proof, We will review the claim and if We approve it, will pay \$200 for such Covered Mammogram.

## CRITICAL ILLNESS BENEFITS FOR MAJOR ORGAN TRANSPLANT

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

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

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

## RECURRENCE BENEFIT

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

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

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

### REDUCTION ON ACCOUNT OF PRIOR CLAIMS PAID

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

For example, suppose the Total Benefit Amount is \$20,000, and in the first two years that insurance is in effect We pay claims for You totaling \$15,000.

Further suppose that in the third year that insurance is in effect for You under the Group Policy another claim becomes payable for You for which the Benefit Amount is \$10,000. The \$10,000 Benefit Amount when added to the \$15,000 that was already paid would equal \$25,000, which would exceed the Total Benefit Amount by \$5,000. Therefore, the amount payable for this claim would be reduced by \$5,000 as follows:

\$10,000	(amount calculated before reduction)
<u>- \$5,000</u>	(reduction of benefit on account of prior claims paid)
\$5,000	(amount payable for the claim in this example)

## EXCLUSIONS THAT APPLY TO SPECIFIC COVERED CONDITIONS

### ALZHEIMER'S DISEASE

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

- other central nervous system conditions that may cause deficits in memory and cognition (e.g., cerebrovascular disease, Parkinson's disease, normal-pressure hydrocephalus);
- systemic conditions that are known to cause dementia (e.g., hypothyroidism, vitamin B12 or folic acid deficiency, niacin deficiency, hypercalcemia, neurosyphilis);
- substance-induced conditions; or
- any form of dementia that is not diagnosed as Alzheimer's Disease.

### CORONARY ARTERY BYPASS GRAFT

We will not pay benefits for Coronary Artery Bypass Graft:

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

### FULL BENEFIT CANCER

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

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

### PARTIAL BENEFIT CANCER

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

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

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

### **MAJOR ORGAN TRANSPLANT**

We will not pay benefits for a Major Organ Transplant:

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

### **STROKE**

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

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

### **LISTED CONDITIONS**

We will not pay benefits for:

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

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

### **ALZHEIMER'S DISEASE**

Proof of Alzheimer's Disease requires a Diagnosis made in Writing by a Physician and supported by all of the following:

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

The Covered Condition for Alzheimer's Disease will be deemed to Occur on the date that the Diagnosis of Alzheimer's Disease is made and all other etiologies have been ruled out.

### **CORONARY ARTERY BYPASS GRAFT**

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

- was determined to be medically necessary by a Physician;
- was supported by pre-operative angiographic evidence; and
- has been performed.

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

### **FULL BENEFIT CANCER**

Diagnosis of Full Benefit Cancer that is not a Clinical Diagnosis must be based upon microscopic (histologic) examination of fixed tissues or preparations of blood or bone marrow. Such examination must be documented in a Written pathology report by a Physician. The Covered Condition for Full Benefit Cancer will be deemed to Occur upon the date that the Diagnosis of Full Benefit Cancer is made.

### **PARTIAL BENEFIT CANCER**

Diagnosis of Partial Benefit Cancer that is not a Clinical Diagnosis must be based upon microscopic (histologic) examination of fixed tissue or preparations of blood or bone marrow. Such examination must be documented in a Written pathology report by a Physician. The Covered Condition for Partial Benefit Cancer will be deemed to Occur upon the date the Diagnosis of Partial Benefit Cancer is made.

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

### **HEART ATTACK**

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

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

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

### **KIDNEY FAILURE**

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

### **MAJOR ORGAN TRANSPLANT**

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

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

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

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

### **STROKE**

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

### **LISTED CONDITIONS**

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

## SUPPLEMENTAL BENEFITS

### HEALTH SCREENING BENEFIT

If a Covered Person takes one of the screening/prevention measures listed below while such Covered Person is insured under this Certificate, We will pay a Health Screening Benefit upon submission of Proof that such measure was taken. When We receive such Proof, We will review it, and if We approve the claim, We will pay a Health Screening Benefit of \$50 for the day the Covered Person receives the measure.

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

- annual physical exam;
- biopsies for cancer;
- blood test to determine total cholesterol;
- blood test to determine triglycerides;
- bone marrow testing;
- breast MRI;
- breast ultrasound;
- breast sonogram;
- cancer antigen 15-3 blood test for breast cancer (CA 15-3);
- cancer antigen 125 blood test for ovarian cancer (CA 125);
- carcinoembryonic antigen blood test for colon cancer (CEA);
- carotid doppler;
- any cervical cancer screening test approved by the federal Food and Drug Administration, upon the referral of the the Covered Person's health care provider;
- chest x-rays;
- clinical testicular exam;
- colonoscopy;
- digital rectal exam (DRE);
- Doppler screening for cancer;
- Doppler screening for peripheral vascular disease;
- echocardiogram;
- electrocardiogram (EKG);
- endoscopy;
- fasting blood glucose test;
- fasting plasma glucose test;
- flexible sigmoidoscopy;
- hemoccult stool specimen;
- hemoglobin A1C;
- a human papillomavirus screening test that is approved by the federal Food and Drug Administration;
- human papillomavirus (HPV) vaccination;
- lipid panel;
- oral cancer screening;
- pap smears or thin prep pap test;
- prostate-specific antigen (PSA) test;
- serum cholesterol test to determine LDL or HDL levels;
- serum protein electrophoresis;
- skin cancer biopsy;
- skin cancer screening;
- skin exam;
- stress test on bicycle or treadmill;
- successful completion of smoking cessation program;
- tests for sexually transmitted infections (STIs);
- thermography;
- two hour post-load plasma glucose test;
- ultrasounds for cancer detection;
- ultrasound screening of the abdominal aorta for abdominal aortic aneurysms; or
- virtual colonoscopy.

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

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

## **OTHER EXCLUSIONS**

### **INTOXICANTS AND CONTROLLED SUBSTANCES**

We shall not be liable for any loss sustained or contracted in consequence of the Covered Person's being intoxicated or under the influence of any controlled substance unless administered on the advice of a Physician.

### **ILLEGAL OCCUPATION OR COMMISSION OF A FELONY**

We shall not be liable for any loss to which a contributing cause was the commission of or attempt to commit a felony by the Covered Person whose injury or sickness is the basis of claim, or to which a contributing cause was such Covered Person's being engaged in an illegal occupation.

### **GENERAL EXCLUSIONS**

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

- intentionally causing a self-inflicted injury;
- committing or attempting to commit suicide while sane or insane; or
- serving in the armed forces or any auxiliary unit of the armed forces of any country.

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

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

## WHEN INSURANCE ENDS

### DATE YOUR INSURANCE ENDS

Your insurance will end on the earliest of:

- the date the Group Policy ends;
- the date You die;
- the date insurance ends for Your class;
- the end of the period for which the last full premium has been paid for You;
- the date You cease to be in an eligible class; or
- the date Your employment ends for any reason.

### DATE DEPENDENT INSURANCE ENDS

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

- the date Your insurance under this Certificate ends;
- the date Dependent Insurance ends under the Group Policy for all employees or for Your class;
- the date the person ceases to be a Dependent;
- the date You cease to be in a class that is eligible for Dependent Insurance; or
- the end of the period for which the last full premium has been paid for the Dependent.

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

## **CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT**

### **FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN**

Insurance for a Dependent Child may be continued past the age limit if that child is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law. Proof of such handicap must be sent to Us within 31 days after the date the Dependent Child attains the age limit and at reasonable intervals after such date.

Except as stated in the *Date Dependent Insurance Ends* provision of the section titled WHEN INSURANCE ENDS, insurance will continue while such Dependent Child:

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

### **FOR FAMILY AND MEDICAL LEAVE**

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

## **CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT (CONTINUED)**

### **AT YOUR OPTION: CONTINUATION WITH PREMIUM PAYMENT**

Insurance provided under this Certificate may be continued with premium payment in certain situations, as described in this provision. This is referred to in this provision as "Continued Insurance". Evidence of insurability will not be required to obtain Continued Insurance. If You obtain Continued Insurance under this provision, You may also continue Dependent Insurance. For purposes of this provision, insurance in effect under the Group Policy for which the Group Policyholder remits premium is referred to in this provision as "Group Billed Insurance".

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

Continued Insurance is not available if:

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

### **REQUEST PERIOD**

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

### **PREMIUMS FOR CONTINUED INSURANCE**

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

### **END OF CONTINUED INSURANCE**

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

- the date You die;
- if You do not pay a premium that is required for Continued Insurance, the last day of the period for which a required premium payment was made;
- if the Group Policy ends, the date You become eligible for insurance under another policy of critical illness or specified disease insurance issued to or provided through the Group Policyholder;
- with respect to Dependent Insurance, the date Continued Insurance for You ends for any reason; or
- with respect to Dependent Insurance, the date the Dependent no longer meets the definition of a Dependent.

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

## **CLAIMS**

### **FILING A CLAIM**

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

### **NOTICE OF CLAIM**

Written notice of claim must be given to Us within 20 days after the Covered Condition Occurs, or as soon thereafter as is reasonably possible. Notice given by or on behalf of You to Us at 1-800-Get-Met8, or to any authorized agent of MetLife, with information sufficient to identify You, shall be deemed notice to Us.

### **CLAIM FORMS**

Upon receipt of a Written notice of claim, We will give the claimant such forms as are usually given by Us for filing Proof of loss. If We do not do this within 15 days after a claimant gives Us such notice, the claimant shall be deemed to have complied with the requirements under this Certificate as to Proof of loss upon submitting, within the time fixed in this Certificate for filing Proof of loss, Written Proof covering the Occurrence for which claim is made.

### **PROOFS OF LOSS**

Written Proof of loss must be given to Us within 90 days after the date of any such loss. Failure to give such Proof within the time required shall neither 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 the legal capacity of the claimant, later than one year from the time Proof is otherwise required.

### **TIME OF PAYMENT OF CLAIM**

Amounts payable under this Policy for any loss will be paid to You immediately upon receipt of due Written Proof of such loss.

### **PAYMENT OF CLAIMS**

Any claim that becomes payable after Your death will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed in this Certificate and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to Your estate.

If any claim under this Certificate shall be payable to Your estate or to a person who is a minor or otherwise not competent to give a valid release, We may pay such claim up to an amount not exceeding \$1,000 to any relative by blood or marriage of the claimant who is deemed by Us to be equitably entitled to it. Any payment made by Us in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

## **CLAIMS (continued)**

### **AUTHORIZATIONS**

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

### **PHYSICAL EXAMINATIONS AND AUTOPSY**

We, at Our expense, shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of a claim when and as often as it may be reasonably be required during the pendency of a claim under this Certificate, and to make an autopsy in the 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 Certificate prior to the expiration of 60 days after Written Proof of loss has been given in accordance with the requirements of this Certificate. No such action shall be brought after the expiration of three years after the time Written Proof of loss is required to be given.

### **CHANGE OF BENEFICIARY**

The right to change of beneficiary is reserved to You, and the legal action consent of the beneficiary or beneficiaries shall not be requisite to any change in beneficiary.

## GENERAL PROVISIONS

### ENTIRE CONTRACT: CHANGES

The Group Policy (including the application of the Group Policyholder, the Enrollment Forms of people insured under the Group Policy, and any amendments or endorsements to the Group Policy) constitutes the entire contract between the parties, and any statement made by the Group Policyholder or any Covered Person shall, in the absence of fraud, be deemed a representation and not a warranty. No such statement shall avoid the insurance or reduce the benefits under the Group Policy or be used in defense to a claim under the Group Policy unless it is contained in a Written application, nor shall any such statement of the Group Policyholder, except a fraudulent misstatement, be used at all to void the Group Policy after it has been in force for three years from the date of its issue, nor shall any such misstatement, be used at all in defense to a claim for loss incurred after the insurance coverage, with respect to which such claim is made, has been in effect for three years from the date it became effective.

No change in the Group Policy shall be valid unless approved by an executive officer of MetLife and unless such approval be endorsed or attached to the Group Policy. No agent has authority to change the Group Policy or waive any of its provisions.

### TIME LIMIT ON CERTAIN DEFENSES

No claim for loss incurred after three years from the effective date of the insurance coverage with respect to which the claim is made 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 the coverage with respect which the claim is made, provided that We will not pay benefits for any Covered Condition that does not First Occur for a Covered Person while such Covered Person is insured under this Certificate.

### ASSIGNMENT

The insurance rights and benefits under this Certificate are assignable. MetLife will recognize the assignee(s) under such assignment as owner(s) of a right, title and interest in this Certificate if:

1. a Written form, conclusively establishing the assignment has been completed;
2. the Written form has been Signed by the assignor, the assignee(s) and the Group Policyholder; and
3. the Written form is delivered to MetLife for recording.

### CONFORMITY WITH STATE STATUTES

Any provision of this Certificate which, on its effective date, is in conflict with the laws of the State of California is hereby amended to conform to the minimum requirements of such statute.