Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company 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.

Continental American Insurance Company

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

Call: Continental American Insurance Company at 1-800-433-3036

Toll-free:

1-800-433-3036

Email: cscmail@aflac.com

Mail: Continental American Insurance Company
Post Office Box 427
Columbia, South Carolina 29202

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call: 1-800-252-3439

Online: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714

¿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 su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Continental American Insurance Company

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

Llame a: Continental American Insurance Company al 1-800-433-3036

Teléfono gratuito:

1-800-433-3036

Correo electrónico: cscmail@aflac.com

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Dirección postal: Continental American Insurance Company
Post Office Box 427
Columbia, South Carolina 29202

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: 1-800-252-3439

En línea: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to $500,000 for health benefit plans, with some exceptions.
  - Up to $300,000 for disability income benefits.
  - Up to $300,000 for long-term care insurance benefits.
  - Up to $200,000 for all other types of health insurance.

- **Life insurance**:
  - Up to $100,000 in net cash surrender or withdrawal value.
  - Up to $300,000 in death benefits.

- **Individual annuities:** Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.

- **Individual aggregate limit:** Up to $300,000 per person, regardless of the number of policies or contracts. A limit of $500,000 may apply for people with health benefit plans.

- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:	For questions about insurance, contact:
Texas Life and Health Insurance Guaranty Association 1601 Congress Avenue Austin, TX 78701 1-800-982-6362 or www.txlifega.org	**Texas Department of Insurance** P.O. Box 149104 Austin, TX 78714-9104 1-800-252-3439 or www.tdi.texas.gov

Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

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CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Continuation of Coverage Endorsement

This Endorsement is part of the Policy and Certificate to which it is attached. This Endorsement is subject to all the definitions, terms, and other provisions of the Policy and Certificate to which it is attached, unless those terms are inconsistent with this Endorsement.

EFFECTIVE DATE
If issued at the same time as the Certificate, this Endorsement becomes effective when the Certificate becomes effective. If issued after the Certificate, this Endorsement will have a later Effective Date.

The following provisions are added after the Continuation Privilege provision in your Certificate:
CONTINUATION OF COVERAGE
If the Group Policy is terminated by the Policyholder and is not replaced with another group policy you may apply to continue the coverage you had on the Group Policy termination date. This includes any in-force Spouse or Dependent Child coverage. The Group Policy will be continued as if the Group Policy is in force for those who have applied to continue their coverage under this provision. The members will continue to have coverage, with their Certificates remaining in force.

The Company will apply the same benefits and plan provisions as shown in your Certificate on the date you are eligible to continue coverage under this provision. Your continued coverage is subject to all of the provisions, exclusions and limitations of the Group Policy.

To keep your Certificate in force, you must:

- Apply to the Company in writing under this Continuation of Coverage provision within 31 days after the date your Certificate would terminate, **and**
- Pay the required premium no later than 31 days after the date the Certificate would terminate and on each premium due date thereafter to the Company at our Customer Service Center in Columbus, Georgia.

PREMIUMS
Initial premium rates will be based on the rates in effect at the time you apply to continue your coverage. Premium rates can be changed by the Company at any time upon 60 days written notice to you. Any such change will be applied to all Certificates in your class and will not be based on your or your Spouse and Dependent Children's health or other individual factors.

You may decrease, but not increase, the amount of your coverage, and the amount of your Spouse's coverage, if any.

TERMINATION
Your continued coverage, including any in-force Spouse or Dependent Child coverage, will end:

- 31 days after the date you fail to pay any required premium.

- When coverage is terminated by the Company. We will provide you a 31-day advance written notice of any termination.
- On the date you die (unless your Spouse elects to become the Primary Insured under the Successor Insured provision, if applicable).

Once continued coverage is cancelled it cannot be reinstated. If your coverage terminates, we will provide benefits for valid claims that arose while your coverage was active.

CONTRACT

This Endorsement is part of the Certificate. It will terminate when:

- The Certificate terminates, or
- Premiums are no longer paid for this Endorsement.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Group Critical Illness Insurance Policy

Policyholder Name:	**FORT BEND ISD**	**Jurisdiction**	Texas
Group Policy Number	CTR0026193866	**Non-Participating**	
Effective Date	January 1, 2025	**Anniversary Date**	January 1, 2026

This limited Plan provides supplemental benefits only. It does not constitute comprehensive health insurance coverage and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

This Plan provides benefits for the Critical Illnesses listed in the Policy Schedule.

Please read it carefully.

This policy is not a Medicare supplement policy.

NOTICE: This Policy may be subject to an increase in premium at time of renewal.

This is not a policy of workers' compensation insurance. The employer does not become a subscriber to the workers' compensation system by purchasing this policy, and if the employer is a non-subscriber, the employer loses those benefits which would otherwise accrue under the workers' compensation laws. The employer must comply with the workers' compensation law as it pertains to non-subscribers and the required notifications that must be filed and posted.

The Policyholder as shown on the Policy Schedule applied for coverage under this Group Critical Illness Insurance Policy (the "Plan"). This Plan is issued by Continental American Insurance Company (the "Company," "CAIC," "we," "us," or "our"). Based on the Master Application and the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages.

You will notice that certain words and phrases (including some medical terms and the names of Plan documents) in this document are capitalized. The capitalized words refer to terms with very specific definitions as they apply to this insurance Plan.

This Plan is a legal contract between the Company and the Policyholder. All material printed by the Company on the following pages is part of the Plan. This Plan is delivered in and governed by the laws of the jurisdiction shown on the Policy Schedule.

In witness whereof, the Company executes this Plan at its home office in Columbia, South Carolina, on the Effective Date.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

Group Critical Illness Insurance
Non-Participating

Table of Contents

SECTION I – ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION

PRIMARY INSURED

Eligibility

An Employee is eligible to be covered under this Plan if they are Actively at Work for their employer and included in the class that is eligible for coverage, as shown on the Master Application.

Insureds are defined as those who might be eligible for coverage under this Plan in the following categories:

- **Employee Coverage** – We insure the Employee and any Dependent Children. The Employee is the ***Primary Insured*** under this Plan.
- **Employee and Spouse Coverage** – We insure the Employee, Spouse, and any Dependent Children.

Employees should refer to *Type of Coverage* in their Certificate Schedule to determine who is covered under the Certificate.

Details for adding Insureds to Plan coverage are outlined in the Dependent Coverage – Effective Date provision.

Effective Date

The Plan's Effective Date is shown on the Policy Schedule. This Plan becomes effective on the Policy Effective Date at 12:01 a.m., as determined by the Policyholder's address.

An eligible Employee must enroll in this Plan and agree to pay the required premiums for coverage to become effective. An Employee must enroll within 31 days of the date they first become eligible for coverage. *The first premium must have been paid for coverage to become effective*.

We may require evidence of insurability satisfactory to us if the amount of coverage applied for exceeds the guaranteed-issue amount, if any, or if we do not receive the Application within 31 days after the Employee was first eligible for coverage. Evidence of insurability may also be required based on an agreement between the Policyholder and us.

The Employee's Effective Date is the date their insurance takes effect. After we receive and approve the Application, that date is either:

- The date shown on the Certificate Schedule if the Employee is Actively at Work on that date, or
- The date the Employee returns to an Actively-at-Work status if they were not Actively at Work on the date shown on the Certificate Schedule.

Termination of an Employee's Insurance

An Employee's insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The 31st day after the premium due date (the last day of the Grace Period), if the premium has not been paid.
- The date the Employee no longer belongs to an eligible class.

If an Insured's coverage terminates, we will provide benefits for valid claims that arose while the Insured's coverage was active.

DEPENDENT COVERAGE

Eligibility
Dependents may be eligible for coverage under this Plan. **Employees should refer to the Type of Coverage on their Certificate Schedule to determine Dependent eligibility.** A ***Dependent*** is the Spouse of an Employee or the Dependent Child of an Employee (details included in the **Definitions** section). An eligible Spouse must not currently be disabled or unable to work and be at least 18 years of age.

Effective Date
The Effective Date for a Spouse is:
- The date shown on the Certificate Schedule if that Spouse is not confined to a hospital and is eligible for coverage on that date, or
- The first day of the month following the date the Spouse is no longer confined to a hospital (if that Spouse was confined to a hospital on the Certificate Schedule date) and is eligible for coverage on that date.

A Spouse may be added to the Plan after the Employee's Effective Date within 31 days after a Life Event or during an approved enrollment period. To be added, the Employee must complete an Application to add their Spouse to the Plan. The Company will assign the Effective Date for a Spouse's coverage after approving the application. For Spouse coverage to become effective, the Spouse must be included in the premium payment.

The Effective Date for a Dependent Child is:
- The Employee Effective Date, or
- The moment of birth for a newborn child, the date the petition is filed for adoption for adopted children, or the date of the Employee's marriage for step-children.

Termination of Dependent Insurance
Dependent Coverage will terminate on the earliest of the following:
- When the Certificate terminates,
- On the premium due date following the date we receive the Employee's written request to terminate Dependent coverage,
- When premiums are no longer paid for Dependent coverage (subject to the Grace Period),
- For Spouse coverage, when the Insured no longer meets the definition of Spouse because of annulment, divorce, or other reason, or
- For Dependent Child coverage, when the Child no longer qualifies as a Dependent because they reach age 26 or other reason. (Dependent Children who reach age 26 will have coverage continued until the last day of the month in which they turn age 26.)

Plan Termination
The **Company** has the right to cancel the Plan on any premium due date for the following reasons:
- The premium is not paid before the end of the Grace Period,
- The number of participating Employees is less than the number mutually agreed upon by the Company and the Policyholder in the signed Master Application,
- The Policyholder fails to perform any of the obligations that relate to this Policy or that are required by applicable law,
- The Policyholder no longer offers coverage to a particular class of Employees,
- The Policyholder no longer serves a class of Employees who reside in a particular geographical area, or
- The Policyholder does not provide timely information that is reasonably required.

The **Policyholder** has the right to cancel the Plan on any premium due date.
- To do this, the Policyholder must give the Company at least 31 days' written notice.
- The Plan will end on the date in the written notice or the date the Company receives the notice, whichever is later.

All outstanding premiums are due upon Plan termination. If the Company receives premium payments after the Plan terminates, this will not reinstate the Plan.

The Policyholder has the sole responsibility of notifying Certificateholders in writing of the Plan's termination as soon as reasonably possible. If the Plan terminates, it—and all Certificates and Riders issued under the Plan—will terminate on the specified termination date. The termination occurs as of 12:01 a.m. at the Policyholder's address.

Portability Privilege

When an Employee is no longer a member of an eligible class and their coverage would otherwise end, they may elect to continue their coverage under this Plan. The Employee may continue the coverage they had on the date their Certificate would otherwise terminate, including any in-force Spouse or Dependent Child coverage, without any additional underwriting requirements.

To keep their coverage in force, the Employee must:

- Notify the Company in writing within 31 days after the date their coverage would otherwise terminate. They may notify us by sending written notice to P.O. Box 84079, Columbus, GA 31993-9101 or by calling the Customer Service number at 800.433.3036, and
- Pay the required premium directly to the Company no later than 31 days after the date their coverage would otherwise terminate and on each premium due date thereafter.

Ported coverage will end on the earliest of the following dates:

- 31 days after the premium due date (the last day of the Grace Period), if the premium has not been paid, or
- The date the Group Plan is terminated.

If the Employee qualifies for this Portability Privilege, then the Company will apply the same Benefits and Plan Provisions as shown in their previously-issued Certificate. Notification of any changes in the Plan will be provided directly by the Company.

Extension of Benefits

If coverage under the Policy or any Riders that are in force ends while an Insured is confined in a Hospital for a covered Critical Illness, the Company will continue to pay benefits for confinement that become payable after the date coverage under the Policy or any Riders ends if the Insured meets the following requirements:

- The confinement must be continuous after the date of termination; and
- Coverage must not have ended as a result of the Insured's or, in the case of a Dependent Child or Spouse, the Primary Insured's voluntary termination of coverage.

This Extension of Benefits terminates upon the earliest of the following:

- The date the Insured is no longer confined to a Hospital;
- The date the Insured receives the maximum benefit for being confined to a Hospital; or
- 90 days after the date coverage would otherwise terminate.

Hospital means a place that meets all of the following criteria: Is legally licensed and operated as a hospital, provides overnight care of injured and sick people, is supervised by a Doctor, has full-time nurses supervised by a registered nurse, and has on-site use of X-ray equipment, laboratory, and surgical facilities.

The term Hospital specifically excludes any facility not meeting the definition of Hospital as defined in this Plan, including but not limited to: A nursing home, an extended-care facility, a skilled nursing facility, a rest home or home for the aged, a rehabilitation facility, a facility for the Treatment of alcoholism or drug addiction, or an assisted living facility.

SECTION II – PREMIUM PROVISIONS

Premium Payments

Premiums should be paid to the Company at P.O. Box 84069, Columbus, Georgia, 31908-4069. The first premiums are due on this Plan's Effective Date. After that, premiums are due on the first day of each month that the Plan remains in effect.

Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period provision.

Premium Changes
Unless we have agreed in writing not to increase premiums, the premium may change:

- On the Group Policy Anniversary Date based on renewal underwriting. (The Group Policy Anniversary Date is shown on the Policy Schedule and falls on the same date each year thereafter.)
- Whenever the terms or conditions of the Plan are modified. The new premium rates will apply only to premiums due on or after the rate change takes effect.

We will provide the Policyholder a 60-day advance written notice of any change to a premium.

Premiums on the Group Policy Anniversary Date are determined by the Attained Age of each Employee. The Attained Age rates are shown in the Schedule of Premiums.

Grace Period
This Plan has a 31-day Grace Period. If a premium is not paid on or before its due date, the premium may be paid during the next 31 days. During the Grace Period, the Plan will stay in force, unless the Policyholder has given the Company written notice of its intention to discontinue the Plan. If the Plan is discontinued, the Plan's termination date will be the latest date for which premium has been paid.

SECTION III - DEFINITIONS
When the terms below are used in this Plan, the following definitions apply:

Accident means an event that results in accidental bodily injury to an Insured, independent of disease or bodily infirmity. A ***Covered Accident*** is an Accident that occurs while coverage is in force.

Actively at Work (Active Work) refers to an Employee's ability to perform their regular employment duties for a full normal workday. The Employee may perform these activities either at their employer's regular place of business or at a location where they are required to travel to perform the regular duties of their employment.

Acute Coronary Syndrome is an obstruction of the coronary arteries that occurs as a result of Myocardial Infarction with or without ST elevation. This is determined by an electrocardiogram (ECG). Acute Coronary Syndrome includes unstable angina but does not include stable angina.

Arteriosclerosis means a disease of the arteries characterized by plaque deposits on the arteries' inner walls, resulting in their abnormal thickening and loss of elasticity.

Arteriovenous Malformation means a congenital disease of the blood vessels in the brain, brain stem, or spinal cord that is characterized by a complex, tangled web of abnormal arteries and veins and may be connected by one or more fistulas.

Atherosclerosis means a disease in which plaque builds up inside a person's arteries.

Attained Age means the Employee's age on their Certificate Effective Date and on each Group Policy Anniversary Date thereafter.

Benign Brain Tumor is a mass or growth of abnormal, noncancerous cells in the brain. The tumor is composed of similar cells that do not follow normal cell division and growth patterns and develop into a mass of cells that microscopically do not have the characteristic appearance of a Cancer. Benign Brain Tumor must be caused by Multiple Endocrine Neoplasia, Neurofibromatosis, or Von Hippel-Lindau Syndrome.

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> ***Multiple Endocrine Neoplasia*** is a genetic disease in which one or more of the endocrine glands are overactive or form a tumor.
>
> ***Neurofibromatosis*** is a genetic disease in which the nerve tissue grows tumors that may be benign and may cause serious damage by compressing nerves and other tissue.

Von Hippel-Lindau Syndrome is a genetic disease that predisposes a person to have benign or malignant tumors.

Bone Marrow Transplant (Stem Cell Transplant) means a procedure to replace damaged or destroyed bone marrow with healthy bone marrow stem cells. For a benefit to be payable, a Bone Marrow Transplant (Stem Cell Transplant) must be caused by at least one of the following diseases:

- Aplastic anemia
- Congenital neutropenia
- Severe immunodeficiency syndromes
- Sickle cell anemia
- Thalassemia
- Fanconi anemia
- Leukemia
- Lymphoma
- Multiple myeloma

The Bone Marrow Transplant (Stem Cell Transplant) benefit is not payable if the Transplant results from a covered Critical Illness for which a benefit has been paid under this Plan.

Brain Aneurysm is a weak area in the wall of a blood vessel of the brain that causes the blood vessel to bulge, balloon out, or rupture.

Cancer (internal or invasive) is a disease that meets either of the following definitions:

- A malignant tumor characterized by:
    - The uncontrolled growth and spread of malignant cells, and
    - The invasion of distant tissue.
- A disease meeting the diagnostic criteria of malignancy, as established by the American Board of Pathology. A Pathologist must have examined and provided a report on the histocytologic architecture or pattern of the tumor, tissue, or specimen.

Cancer (internal or invasive) also includes:

- Melanoma that is Clark's Level III or higher ***or*** Breslow depth equal to or greater than 0.77mm,
- Myelodysplastic syndrome - RCMD (refractory cytopenia with multilineage dysplasia),
- Myelodysplastic syndrome - RAEB (refractory anemia with excess blasts),
- Myelodysplastic syndrome - RAEB-T (refractory anemia with excess blasts in transformation), or
- Myelodysplastic syndrome - CMML (chronic myelomonocytic leukemia).

The following are **not** considered internal or invasive Cancers:

- Pre-malignant tumors or polyps
- Carcinomas in Situ
- Any superficial, non-invasive Skin Cancers including basal cell and squamous cell carcinoma of the skin
- Melanoma in Situ
- Melanoma that is Diagnosed as
    - Clark's Level I or II,
    - Breslow depth less than 0.77mm, **or**
    - Stage 1A melanomas under TNM Staging
- Metastatic Cancer

Carcinoma in Situ is Non-Invasive Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

Melanoma in Situ means melanoma cells that occur only on the outer layer of the skin (the epidermis), where there is no invasion of the deeper layer (the dermis).

Non-Invasive Cancer is a Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

For the purposes of this Plan, a Non-Invasive Cancer is:

- Internal Carcinoma in Situ
- Myelodysplastic Syndrome - RA (refractory anemia)
- Myelodysplastic Syndrome - RARS (refractory anemia with ring sideroblasts)
- Myeloproliferative Blood Disorder

Premalignant conditions or conditions with malignant potential, other than those specifically named above, are **not** considered Non-Invasive Cancer.

Skin Cancer, as defined in this Plan, is **not** considered Non-Invasive Cancer and therefore is not payable under the Non-Invasive Cancer benefit.

Skin Cancer is a Cancer that forms in the tissues of the skin.

The following are considered Skin Cancers:

- Basal cell carcinoma
- Squamous cell carcinoma of the skin
- Melanoma in Situ
- Melanoma that is Diagnosed as:
  - Clark's Level I or II,
  - Breslow depth less than 0.77mm, or
  - Stage 1A melanomas under TNM Staging

These conditions are not payable under the Cancer (internal or invasive) benefit.

Cancer, Non-Invasive Cancer, Metastatic Cancer or Skin Cancer must be Diagnosed in one of two ways:

1. ***Pathological Diagnosis*** is a Diagnosis based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This Diagnosis must be made by a certified Pathologist and conform to the American Board of Pathology standards.

2. ***Clinical Diagnosis*** is based only on the study of symptoms. The Company will accept a Clinical Diagnosis only if**:**
   - A Doctor cannot make a Pathological Diagnosis because it is medically inappropriate or life-threatening,
   - Medical evidence exists to support the Diagnosis, and
   - A Doctor is treating the Insured for Cancer or Carcinoma in Situ.

Cardiomyopathy means a disease with measurable deterioration of the function of the myocardium, and is typically characterized by breathlessness and swelling of the legs.

Chronic Kidney Disease means a disease characterized by the gradual loss in renal function over time due to diabetes mellitus, Hypertension, glomerulonephritis, polycystic kidney disease, autoimmune disease, or genetic disease.

Claimant means a person who is authorized to make a claim under the Certificate.

Coma means a state of continuous, profound unconsciousness, lasting at least seven consecutive days, and characterized by the absence of:

- Spontaneous eye movements,
- Response to painful stimuli, and
- Vocalization.

Coma does not include a medically-induced coma.

To be payable as an Accident benefit, the Coma must be caused solely by or be solely attributed to a Covered Accident.

To be considered a Critical Illness, the Coma must be caused solely by or be solely attributed to one of the following diseases:

- **Brain Aneurysm**, which is an excessive, localized enlargement of an artery in the brain caused by a weakening of the artery wall, usually due to a defect in the vessel at birth or resulting from high blood pressure.
- **Diabetes**, which is a metabolic disease characterized by the inadequate secretion or utilization of insulin.
- **Encephalitis**, which is a disease characterized by inflammation of the brain, usually caused by a direct viral infection or a hypersensitive reaction to a virus or foreign protein.
- **Epilepsy**, which is a neurological disease characterized by sudden, recurring attacks of motor, sensory, or psychic malfunction with or without loss of consciousness or convulsive seizures.
- **Hyperglycemia**, which is a disease where an excessive amount of glucose circulates in the blood plasma.
- **Hypoglycemia,** which is a disease where blood glucose concentrations fall below the necessary level to support the body's need for energy and stability throughout its cells.
- **Meningitis**, which is a disease caused by viral or bacterial infection and characterized by inflammation of the meninges.

Complete Remission is defined as having no Symptoms and no Signs that can be identified to indicate the presence of Cancer.

Coronary Artery Bypass Surgery means open heart surgery to correct the narrowing or blockage of one or more coronary arteries with bypass grafts and where such narrowing or blockage is attributed to Coronary Artery Disease or Acute Coronary Syndrome. This excludes any non-surgical procedure, such as, but not limited to, balloon angioplasty, laser relief, or stents.

Coronary Artery Disease occurs when the coronary arteries become damaged due to acute coronary occlusion, coronary atherosclerosis, aneurysm and/or dissection of the coronary arteries, or coronary atherosclerosis due to lipid rich plaque.

Critical Illness is a disease or a sickness as defined in the Plan that first manifests while your coverage is in force.

Any loss due to Critical Illness must begin while your coverage is in force. Critical Illness includes only the following, provided such Critical Illness meets all applicable definitions contained in the Plan and, where indicated, is caused by an underlying condition:

- Bone Marrow Transplant (Stem Cell Transplant)
- Cancer (internal or invasive)
- Coma
- Coronary Artery Bypass Surgery
- Heart Attack (Myocardial Infarction)
- Kidney Failure (End-Stage Renal Failure)
- Loss of Sight
- Loss of Speech
- Loss of Hearing
- Major Organ Transplant
- Non-Invasive Cancer
- Paralysis
- Stroke
- Sudden Cardiac Arrest
- Type I Diabetes
- Metastatic Cancer

Date of Diagnosis is defined as follows:

- ***Benign Brain Tumor:*** The date a Doctor determines a Benign Brain Tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.
- ***Bone Marrow Transplant (Stem Cell Transplant):*** The date the surgery occurs.
- ***Cancer:*** The day tissue specimens, blood samples, or titer(s) are taken (Diagnosis of Cancer and/or Carcinoma in Situ is based on such specimens).
- ***Coma***: The first day of the period for which a Doctor confirms a Coma that is due to one of the underlying diseases and that has lasted for at least seven consecutive days.

- ***Coronary Artery Bypass Surgery:*** The date the surgery occurs.
- ***Heart Attack (Myocardial Infarction):*** The date the infarction (death) of a portion of the heart muscle occurs. This is based on the criteria listed under the Heart Attack (Myocardial Infarction) definition.
- ***Kidney Failure (End-Stage Renal Failure):*** The date a Doctor recommends that an Insured begin renal dialysis.
- ***Loss of Sight:*** The date the loss due to one of the underlying diseases is objectively determined by a Doctor to be total and irreversible.
- ***Loss of Speech:*** The date the loss due to one of the underlying diseases is objectively determined by a Doctor to be total and irreversible.
- ***Loss of Hearing:*** The date the loss due to one of the underlying diseases is objectively determined by a Doctor to be total and irreversible.
- ***Major Organ Transplant:*** The date the surgery occurs.
- ***Metastatic Cancer:*** The date a Doctor determines Cancer has metastasized to other parts of the body from the original site.
- ***Non-Invasive Cancer:*** The day tissue specimens, blood samples, or titer(s) are taken (Diagnosis of Cancer and/or Carcinoma in Situ is based on such specimens).
- ***Paralysis:*** The date a Doctor Diagnoses an Insured with Paralysis due to one of the underlying diseases as specified in this Plan, where such Diagnosis is based on clinical and/or laboratory findings as supported by the Insured's medical records.
- ***Skin Cancer:*** The date the skin biopsy samples are taken for microscopic examination.
- ***Stroke:*** The date the Stroke occurs (based on documented neurological deficits and neuroimaging studies).
- ***Sudden Cardiac Arrest:*** The date the pumping action of the heart fails (based on the Sudden Cardiac Arrest definition).
- ***Type I Diabetes:*** The date a Doctor Diagnoses an Insured as having Type I Diabetes based on clinical and/or laboratory findings as supported by medical records.

Dependent Children are an Employee's or an Employee's Spouse's natural children, step-children, grandchildren who are the Employee's dependents for federal income tax purposes at the time the application for coverage of the grandchild is made, foster children, children subject to legal guardianship, adopted children, children for whom the Employee is required to provide medical support, or Children Placed for Adoption, who are younger than age 26. However, we will continue coverage for Dependent Children insured under the Plan after the age of 26 if they are incapable of self-sustaining employment due to mental or physical disability, and are chiefly dependent on a parent for support and maintenance. The Employee or the Employee's Spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the Dependent Child's 26th birthday.

The insurance on any Dependent Child will terminate on the last day of the month in which the Dependent Child turns age 26; it is the Employee's responsibility to notify us in writing when coverage on a Dependent Child terminates. Termination will be without prejudice to any claim originating prior to the date of termination. Our acceptance of any applicable premium after such date will be considered as premium for only the remaining persons who qualify as Insureds under this Plan. When coverage on all Dependent Children terminates, the Employee must notify the Company, in writing, and elect whether to continue this Plan on an Employee or Employee and Spouse Coverage basis. After such notice, we will arrange for the payment of the appropriate premium due, including returning any unearned premium, if applicable.

Children Placed for Adoption are Children for whom the Employee has entered a decree of adoption, Employee has initiated adoption proceedings, or is party to a suit in which the Employee seeks to adopt the child. A decree of adoption must be entered within one year from the date proceedings were initiated, unless extended by order of the court.

Diagnosis (***Diagnosed***) refers to the definitive and certain identification of an illness or disease that:

- Is made by a Doctor and
- Is based on clinical or laboratory investigations, as supported by the Insured's medical records.

The illness must meet the requirements outlined in this Plan for the particular Critical Illness being Diagnosed.

Doctor is a person who is duly qualified as a practitioner of the healing arts acting within the scope of their license, and:

- Is licensed to practice medicine; prescribe and administer drugs; or to perform surgery, or
- Is a duly qualified medical practitioner according to the laws and regulations in the state in which Treatment is made.

Employee is a person who meets eligibility requirements under **Section I – Eligibility, Effective Date, and Termination** and who is covered under this Plan. The Employee is the Primary Insured under this Plan.

Family Member includes the Employee's Spouse as well as the following members of the Employee's immediate family:

- Son
- Daughter
- Mother
- Father
- Sister
- Brother

This includes step-Family Members and Family-Members-in-law.

Heart Attack (Myocardial Infarction) is the death of a portion of the heart muscle (myocardium) caused by a blockage of one or more coronary arteries due to Coronary Artery Disease or Acute Coronary Syndrome.

Heart Attack (Myocardial Infarction) does not include:

- Any other disease or injury involving the cardiovascular system.
- Cardiac Arrest not caused by a Heart Attack (Myocardial Infarction).

Diagnosis of a Heart Attack (Myocardial Infarction) must include the following:

- New and serial electrocardiographic (ECG) findings consistent with Heart Attack (Myocardial Infarction), and
- Elevation of cardiac enzymes above generally accepted laboratory levels of normal. (In the case of creatine physphokinase (CPK) a CPK-MB measurement must be used.)

Confirmatory imaging studies, such as thallium scans, MUGA scans, or stress echocardiograms may also be used.

Hypertension means a disease that is characterized by elevated blood pressure in the arteries with a systolic reading of at least 140 mmHg and a diastolic reading of at least 90 mmHg.

Kidney Failure (End-Stage Renal Failure) means end-stage renal failure caused by End-Stage Renal Disease, which results in the chronic, irreversible failure of both kidneys to function.

Kidney Failure (End-Stage Renal Failure) is covered only under the following conditions:

- A Doctor advises that regular renal dialysis, hemo-dialysis, or peritoneal dialysis (at least weekly) is necessary to treat the Kidney Failure (End-Stage Renal Failure); or
- The Kidney Failure (End-Stage Renal Failure) results in kidney transplantation.

Life Event means an event that qualifies an Employee to make changes to benefits at times other than their enrollment period. Events qualifying as Life Events are established solely by the Policyholder.

Loss of Sight means the total and irreversible loss of all sight in both eyes.

To be payable as an Accident benefit, Loss of Sight must be caused solely by or be solely attributed to a Covered Accident.

To be considered a Critical Illness, Loss of Sight must be caused solely by or be solely attributed to one of the following diseases:

- **Retinal Disease**, which is a disease that affects the retina of the eye;
- **Optic Nerve Disease**, which is a disease that affects the optic nerve of the eye; or
- **Hypoxia**, which is a disease characterized by a deficiency in the amount of oxygen reaching the tissues of the eyes.

Loss of Speech means the total and permanent loss of the ability to speak.

To be payable as an Accident benefit, Loss of Speech must be caused solely by or be solely attributed to a Covered Accident.

To be considered a Critical Illness, Loss of Speech must be caused solely by or be solely attributable to one of the following diseases:

- **Alzheimer's Disease**, which is a progressive mental deterioration due to generalized degeneration of the brain; or
- **Arteriovenous Malformation**, which is a congenital disease of blood vessels in the brain, brain stem, or spinal cord that is characterized by a complex, tangled web of abnormal arteries and veins connected by one or more fistulas.

Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of Hearing does not include hearing loss that can be corrected by the use of a hearing aid or device.

To be payable as an Accident benefit, Loss of Hearing must be caused solely by or be solely attributed to a Covered Accident.

To be considered a Critical Illness, Loss of Hearing must be caused solely by or be solely attributed to one of the following diseases:

- **Alport Syndrome**, which is an inherited disease of the kidney caused by a genetic mutation and can be characterized by hearing loss;
- **Autoimmune Inner Ear Disease**, which is an inflammatory condition of the inner ear occurring when the body's immune system attacks cells in the inner ear that are mistaken for bacteria or a virus;
- **Chicken Pox**, which is an acute contagious disease that is caused by the varicella-zoster virus and is characterized by skin eruptions, slight fever, and malaise;
- **Diabetes**, which is a metabolic disease characterized by the inadequate secretion or utilization of insulin;
- **Goldenhar Syndrome**, which is rare congenital disease that causes abnormalities in the face and head and can cause hearing loss;
- **Meniere's Disease**, which is a disorder of the inner ear that causes spontaneous episodes of vertigo, hearing loss, ear ringing, and a feeling of fullness or pressure in the ear;
- **Meningitis**, which is a disease characterized by inflammation of the meninges caused by viral or bacterial infection; or
- **Mumps**, which is an infectious disease caused by paramyxovirus, and characterized by inflammatory swelling of the parotid and/or other salivary glands.

Maintenance Drug Therapy is a course of systemic medication given to a patient after a Cancer goes into Complete Remission because of primary Treatment. Maintenance Drug Therapy includes ongoing hormonal therapy, immunotherapy, or chemo-prevention therapy. Maintenance Drug Therapy is meant to decrease the risk of Cancer recurrence; it is not meant to treat a Cancer that is still present.

Major Organ Transplant means undergoing surgery as a recipient of a covered transplant of a human heart, lung, liver, kidney, or pancreas. A transplant must be caused by one or more of the following diseases:

- Bronchiectasis, which is a lung disease state defined by localized, irreversible dilation of the bronchial tree caused by destruction of the muscle and elastic tissue.
- Cardiomyopathy, which is a heart disease characterized by the measurable deterioration of the function of the heart muscle, where the heart muscle becomes enlarged, thick, or rigid.
- Cirrhosis, which is a liver disease characterized by replacement of liver tissue by fibrosis, scar tissue, and regenerative nodules, leading to loss of liver function.
- Chronic obstructive pulmonary disease, which is a lung disease characterized by persistently poor airflow as a result of breakdown of lung tissue and dysfunction of the small airways.
- Congenital Heart Disease, which is heart disease characterized by abnormalities in cardiovascular structures that occur before birth.
- Coronary Artery Disease
- Cystic fibrosis, which is a hereditary disease of the exocrine glands affecting the pancreas, respiratory system, and sweat glands. It is characterized by the production of abnormally viscous mucus by the affected glands.
- Hepatitis, which is a disease caused by the hepatitis A, B, or C virus and is characterized by the inflammation of the liver.

- Interstitial lung disease, which is a lung disease that affects the interstitium of the lungs.
- Lymphangioleiomyomatosis, which is a lung disease characterized by an indolent, progressive growth of smooth muscles cells throughout the lungs, pulmonary blood vessels, lymphatics, and pleurae.
- Polycystic liver disease, which is characterized by multiple variable-sized cysts lined by cuboidal epithelium.
- Pulmonary fibrosis, which is a lung disease where the lung tissue becomes thickened, stiff, and scarred due to chronic inflammation.
- Pulmonary hypertension, which is a disease characterized by increased pressure in the pulmonary artery and results in the thickening of the pulmonary arteries and the narrowing of these blood vessels, which causes the right side of the heart to become enlarged.
- Sarcoidosis, which is a disease characterized by the growth of granulomatous lesions that appear in the body.
- Valvular heart disease, which is a disease of the heart valves.

If, while the Certificate in force, the Insured is placed on a transplant list for a Major Organ Transplant due to one of the above-identified diseases, we will pay 25% of the Critical Illness benefit. The remainder of the Critical Illness benefit will become payable on the date the surgery occurs. A Major Organ Transplant benefit is not payable if the Major Organ Transplant results from a covered Critical Illness for which a benefit has been paid.

Malignant Hypertension is blood pressure that is so high that it actually causes damage to organs, particularly in the nervous system, the cardiovascular system, and/or the kidneys. One type of such damage is called papilledema, a condition in which the optic nerve leading to the eye becomes dangerously swollen, threatening vision.

Metastatic Cancer means a Cancer (internal or invasive) that has spread from the part of the body where it was first formed to other parts of the body. This occurs when cancer cells break away from the original tumor, travel through the blood or lymph system, and form new tumors in other organs or tissues of the body. When this occurs, the new metastatic tumor is the same type of Cancer as the original tumor even though located in a different area of the body.

Paralysis *or* ***Paralyzed*** means the permanent, total, and irreversible loss of muscle function to the whole of at least two limbs.

To be payable as an Accident benefit, the Paralysis must be caused solely by or be solely attributed to a Covered Accident.

To be considered a Critical Illness, Paralysis must be caused solely by or be solely attributed to one or more of the following diseases:

- **Amyotrophic Lateral Sclerosis**, which is a progressive degeneration of the motor neurons of the central nervous system, leading to wasting of the muscles and paralysis;
- **Cerebral Palsy**, which is a disorder of movement, muscle tone, or posture that is caused by injury or abnormal development in the immature brain. Cerebral Palsy can be characterized by stiffness and movement difficulties, or by involuntary and uncontrolled movements;
- **Parkinson's disease**, which is a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement; or
- **Poliomyelitis**, which is an acute infectious disease caused by the poliovirus and characterized by fever, motor paralysis, and atrophy of skeletal muscles. This often results in permanent disability and deformity, and is marked by inflammation of nerve cells in the anterior gray matter in each lateral half of the spinal cord.

The Diagnosis of Paralysis must be supported by neurological evidence.

Pathologist is a Doctor who is:

- Licensed to practice medicine, and
- Licensed by the American Board of Pathology to practice pathologic anatomy.

A Pathologist also includes an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Severe Burn or ***Severely Burned*** means a burn resulting from fire, heat, caustics, electricity, or radiation. The burn must meet all of the following criteria:

- Be a full-thickness or third-degree burn, as determined by a Doctor. A ***Full-Thickness Burn*** or ***Third-Degree Burn*** is the destruction of the skin through the entire thickness or depth of the dermis (or possibly into underlying tissues). This results in loss of fluid and sometimes shock.
- Cause cosmetic disfigurement to the body's surface area of at least 35 square inches.
- Be caused solely by or be solely attributed to a Covered Accident.

Signs and/or Symptoms are the evidence of disease or physical disturbance observed by a Doctor or other medical professional. The Doctor (or other medical professional) must observe these Signs while acting within the scope of their license.

Spouse is your legal wife or husband who is listed on your Application.

Stroke means apoplexy due to rupture or acute occlusion of a cerebral artery. The apoplexy must cause complete or partial loss of function involving the motion or sensation of a part of the body and must last more than 24 hours. Stroke must be either:

- ***Ischemic***: Due to advanced Arteriosclerosis or Arteriosclerosis of the arteries of the neck or brain, or vascular embolism, or
- ***Hemorrhagic***: Due to uncontrolled Hypertension, Malignant Hypertension, Brain Aneurysm, or Arteriovenous Malformation.

The Stroke must be positively Diagnosed by a Doctor based upon documented neurological deficits and confirmatory neuroimaging studies.

Stroke does not include:

- Transient Ischemic Attacks (TIAs)
- Head injury
- Chronic cerebrovascular insufficiency
- Reversible ischemic neurological deficits unless brain tissue damage is confirmed by neurological imaging

Stroke will be covered only if the Insured submits evidence of the neurological damage by providing:

- Computed Axial Tomography (CAT scan) images, or
- Magnetic Resonance Imaging (MRI).

Sudden Cardiac Arrest is the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction due to Coronary Artery Disease, Cardiomyopathy, or Hypertension.

Sudden Cardiac Arrest is not a Heart Attack (Myocardial Infarction). A Sudden Cardiac Arrest benefit is not payable if the Sudden Cardiac Arrest is caused by or contributed to by a Heart Attack (Myocardial Infarction).

Transient Ischemic Attack (TIA) occurs when blood flow to part of the brain is temporarily blocked or reduced. For a benefit to be payable, the TIA must be caused by one or more of the following diseases:

- Advanced Arteriosclerosis
- Arteriosclerosis of the arteries of the neck or brain
- Vascular embolism
- Hypertension
- Malignant Hypertension
- Brain Aneurysm
- Arteriovenous Malformation.

The TIA must be positively Diagnosed by a Doctor based upon documented neurological deficits and confirmatory neuroimaging studies.

Treatment or ***Medical Treatment*** is the consultation, care, or services provided by a Doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines.

Treatment-Free From Cancer refers to the period of time without the consultation, care, or services provided by a Doctor. This includes receiving diagnostic measures and taking prescribed drugs and medicines. Treatment does not include Maintenance Drug Therapy or routine follow-up visits to verify whether Cancer or Carcinoma in Situ has returned.

Type I Diabetes means a form of diabetes mellitus causing total insulin deficiency of an Insured along with continuous dependence on exogenous insulin in order to maintain life. Type I Diabetes excludes Gestational Diabetes and Prediabetes.

SECTION IV - BENEFIT PROVISIONS

The benefit amounts payable under this section are shown in the Policy Schedule. The Company will pay benefits for a Critical Illness in the order the events occur.

Critical Illness Benefit

Initial Diagnosis Benefit

We will pay the Critical Illness benefit when an Insured is Diagnosed with one of the Critical Illnesses shown in the Benefit Schedule, and when such Diagnosis is caused by or solely attributed to an underlying disease as identified herein. We will pay this benefit if:

- The initial Date of Diagnosis is while the Insured's coverage is in force, and
- The Certificate does not exclude the illness or condition by name or by specific description.

Benefits will be based on the Face Amount in effect on the Critical Illness Date of Diagnosis.

Additional Diagnosis Benefit

Once benefits have been paid for a Critical Illness, the Company will pay benefits for each different Critical Illness when the Date of Diagnosis for the new Critical Illness is separated from the prior, different Critical Illness by at least 3 consecutive months and the new Critical Illness is not caused or contributed by a Critical Illness for which benefits have been paid.

Reoccurrence Benefit

Once benefits have been paid for a Critical Illness, benefits are payable for that same Critical Illness when the Date of Diagnosis for the Reoccurrence of that Critical Illness is separated from the prior occurrence of that Critical Illness by at least 3 consecutive months and the Critical Illness is not caused or contributed by a Critical Illness for which benefits have been paid.

Non-Invasive Cancer Benefit

We will pay the amount shown in the Policy Schedule for the Diagnosis of a Non-Invasive Cancer. This benefit is payable in addition to all other applicable benefits.

Metastatic Cancer Benefit

We will pay the amount shown in the Policy Schedule for the Diagnosis of a Metastatic Cancer.

Additional Benefits

Additional Benefits are payable if the Date of Diagnosis is while the Insured's coverage is in force, and the Certificate does not exclude the illness or condition by name or by specific description.

Skin Cancer Benefit

We will pay the amount shown in the Policy Schedule for the Diagnosis of Skin Cancer. This benefit is payable 1 per calendar year.

Health Screening Benefit

We will pay the amount shown in the Policy Schedule for Health Screening Tests performed while an Insured's coverage is in force. This benefit is payable 1 per calendar year, per Insured up to the maximum shown on the Certificate Schedule. Benefits are payable for Covered Dependent Children at 100.00% of the Employee benefit amount.

This benefit is only payable for Health Screening Tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations.

Health Screening Tests include, but are not limited to, the following:

- Blood test for triglycerides
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- Non-diagnostic vascular screening
- DNA stool analysis
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum cholesterol test to determine level of HDL and LDL
- Serum protein electrophoresis (blood test for myeloma)
- Spiral CT screening for lung cancer
- Stress test on a bicycle or treadmill
- Thermography
- HIV test performed via nucleic acid test (NAT)
- HPV test performed via Pap smear
- Biopsies
- Genetic Screening Test performed in a medical facility
- Human Coronavirus test
- Dental Exams
- Vision Exams
- Immunizations
- Mental Health Screening

Benign Brain Tumor Benefit
We will pay the amount shown in the Certificate Schedule for the initial Diagnosis of a Benign Brain Tumor.

Accident Benefit
We will pay the amount shown in the Benefit Schedule if an Insured sustains a Covered Accident and suffers any of the following, which is solely due to, caused by, and attributed to, the Covered Accident:
- Coma
- Loss of Sight
- Loss of Speech
- Loss of Hearing
- Severe Burn
- Paralysis

Waiver of Premium Benefit
If an Employee becomes Totally Disabled as defined in this Plan due to a covered Critical Illness, we will waive premiums for the Employee and any currently covered Dependents (this includes any Riders that are in force).

Total Disability or ***Totally Disabled*** means the Employee is completely unable to perform all of the substantial and material duties and functions of their occupation and any other gainful occupation in which the Employee earns substantially the same compensation earned before the disability.

After 90 days of Total Disability, all Plan premiums will be waived if:
- The Employee's Total Disability began before the age of 65;
- The Employee's Total Disability has continued without interruption for at least 90 days, during which time the Employee and/or the Policyholder have paid premiums; and
- The Employee provides proof of Total Disability as required by us. Satisfactory Proof of Loss for Total Disability must be provided at least once every 12 months.

Pending our approval of a claim for the Waiver of Premium Benefit, premiums should be paid as they are due. Premiums that were paid for the first 90 days of Total Disability will be refunded after the claim for this benefit is approved.

Waiver of Premium will continue until the earliest of the following:
- The premium due date following the Employee's 65th birthday,
- The date the Company has waived premiums for a total of 24 months of Total Disability,
- The date the Employee refuses to provide proof of continuing Total Disability,
- The date the Employee's Total Disability ends, or
- The date coverage ends according to the Termination provisions in **Section I – Eligibility, Effective Date, and Termination.**

If the Employee is still eligible for coverage when they return to Active Work, coverage for any Insured may be continued if premium payments are resumed.

SECTION V – EXCLUSIONS

Exclusions
We will not pay for loss due to any of the following:

- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured
- **Suicide** – committing or attempting to commit suicide, while sane or insane
- **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job
- **Participation in Aggressive Conflict** of any kind, including:
  - War (declared or undeclared) or military conflicts
  - Insurrection or riot
  - Civil commotion or civil state of belligerence
- **Illegal substance abuse, which includes the following:**
  - Abuse of legally-obtained prescription medication
  - Illegal use of non-prescription drugs
- An error, mishap, or malpractice during medical, diagnostic, or surgical treatment or procedure
- Diagnosis of a Critical Illness made by a Family Member.

SECTION VI – CLAIM PROVISIONS

Notice of Claim
Written notice of claim must be given to us:

- Within 60 days after the Date of Diagnosis, or
- As soon as reasonably possible.

When we receive written Notice of Claim, we will send a claim form. If the Claimant does not receive the claim form within 15 days after the notice is sent, written Proof of Loss can be sent to us without waiting for the form. Notice must include the Employee's name and the Certificate number. Notice can be mailed to the Company at:

P.O. Box 84075, Columbus, GA 31993-9103

Failure to give notice within the time prescribed does not invalidate or reduce any claim if it was not reasonably possible to give the notice within that time and notice was given as soon as was reasonably possible.

Proof of Loss
Proof of Loss refers to documentation that supports a claim. (This information is often found in standardized medical documents, such as hospital bills and operative reports. It includes a statement by the treating Doctor.) Proof of Loss establishes the nature and extent of the loss, the Company's obligation to pay the claim, and the Claimant's right to receive payment.

The Claimant must provide Proof of Loss to the Company at:

P.O. Box 84075, Columbus, GA 31993-9103

Proof of Loss must be given to us within 90 days of the Date of Diagnosis. Failure to give Proof of Loss within such time shall not invalidate or reduce any claim if such Proof of Loss is given as soon as reasonably possible. The Company will not accept Proof of Loss any later than one year and three months after the Date of Diagnosis, except in the absence of the Claimant's legal mental capacity.

The Claimant will be responsible for the cost of obtaining a completed claim form. We may request additional Proof of Loss, such as records from hospitals or Doctors. The Claimant will be responsible for the cost of obtaining these records.

We may require authorizations to obtain medical and psychiatric information as well as non-medical information, including personal financial information.

When we receive the claim and due Proof of Loss, we will review the Proof of Loss. If we approve the claim, we will pay the benefits subject to the terms of the Certificate.

Physical Examination and Autopsy
The Company may have an Insured examined as often as reasonably necessary while a claim is pending. In the case of death, the Company may also require an autopsy, unless prohibited by law. The Company will cover all costs for exams or autopsy.

Prompt Payment of Benefits
For benefits other than for loss of time, the Company will, once we receive the required Proof of Loss, pay, deny, or settle each submitted claim not later than the 60th day after the date Proof of Loss is received. Subject to written Proof of Loss, all accrued benefits payable under the policy for loss of time will be paid at least monthly during the period for which the insurer is liable. Any balance remaining unpaid at the end of that time will be paid as soon as possible after the Proof of Loss is received.

Payment of Claims
We will pay all benefits to the Employee unless otherwise assigned. For any benefits that remain unpaid at the time of death, we will pay those benefits in the following order:
- To the Employee's beneficiary or the beneficiary's assignee,
- To the Employee's surviving Spouse,
- To the Employee's estate.

Special Rules for the Payment of Claims for Dependent Children
When required by law, We will provide for benefits payable for a Dependent Child to be paid to the Texas Health and Human Services Commission if such agency paid, through medical assistance, for the treatment received by the Dependent Child for a Covered Condition.

When required by law, We will provide for benefits payable for a Dependent Child to be paid to the Dependent Child’s possessory or managing conservator if that individual:
1. provides a written notice that the individual is a possessory or managing conservator of the Dependent Child on whose behalf the claim is made; and
2. provides a certified copy of a court order designating the individual as possessory or managing conservator of the Dependent Child or other relevant evidence.

Unpaid Premium
When a claim is paid, we may deduct any premium due and unpaid from the claim payment.

Changing of Beneficiary
A change in beneficiary must be submitted in writing to our Home Office in a form acceptable to us and signed by the Employee. Unless otherwise specified by the Employee, a change in beneficiary will take effect on the date the notice of change is signed. We will not be liable for any action taken before notice is received and recorded at the Home Office.

Claim Review
If a claim is denied, the Employee will be given written notice of:
- The reason for the denial,
- The Plan provision that supports the denial, and
- The Employee's right to ask for a review of the claim.

Appeals Procedure
Before filing any lawsuit—and no later than 60 days after notice of denial of a claim—the Employee, the Claimant, or an authorized representative of either must appeal any denial of benefits under the Plan by sending a written request for review of the denial to our Home Office.

Legal Action
The Employee cannot take legal action against us for benefits under this Plan:
- Within 60 days after the Employee has sent us written Proof of Loss, or
- More than three years from the time written proof is required to be given.

SECTION VII – GENERAL PROVISIONS

Entire Contract Changes
This insurance is provided under a contract of Group Critical Illness insurance with the Policyholder. The entire Contract of Insurance is made up of:
- The Policy;
- The Certificates of insurance;
- The Application of the Policyholder, a copy of which is attached to and made part of the Policy when issued; and
- Any Riders, Endorsements, or Amendments to the Policy or Certificate.

In the absence of fraud, a statement made by the Policyholder or an Insured is considered a representation and not a warranty. A statement made by the Policyholder or an Insured may not be used in any contest under the Plan, unless a copy of the written instrument containing the statement is or has been provided to:
- The person making the statement; or
- If the statement was made by the Insured and the Insured has died or become incapacitated, the Insured's beneficiary or personal representative.

Changes to this Plan:
- Will not be valid unless approved in writing by an officer of the Company,
- Must be noted on or attached to the Contract, and
- May not be made by any insurance agent (nor can an agent waive any Plan provisions).

Misstatement of Age
If an age has been misstated on the Application, the benefits will be those that the paid premium would have purchased at the correct age.

Successor Insured
If an Employee dies while covered under their Certificate and their Spouse is also insured under this Plan at the time of their death, then their surviving Spouse may elect to become the Primary Insured at the current Spouse Face Amount. This would include continuation of any Dependent Child coverage that is in force at that time.

To become the Primary Insured and keep coverage in force, the surviving Spouse must:
- Notify the Company in writing within 31 days after the date of the Employee's death; and
- Pay the required premium to the Company no later than 31 days after the date of the Employee's death, and on each premium due date thereafter.

If the Certificate does not cover a surviving Spouse, the Certificate will terminate from the date of the Employee's death. All unearned premium from the date of the Employee's death will be refunded.

Time Limit on Certain Defenses

After two years from the Employee's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on the Employee's Application. This does not apply to fraudulent misstatements.

Clerical Error
Clerical error by the Policyholder will not end coverage or continue terminated coverage. In the event of a clerical error, the Company will make a premium adjustment.

Individual Certificates
The Company will give the Policyholder a Certificate for each Employee. The Certificate will set forth:

- The coverage,
- To whom benefits will be paid, and
- The rights and privileges under the Plan.

Required Information
The Policyholder will be responsible for furnishing all information and proofs that the Company may reasonably require with regard to the Plan.

Conformity with State Statutes
This Plan was issued on its Effective Date in the state noted on the Master Application. Any Plan provision that conflicts with that state's statutes is amended to conform to the minimum requirements of those statutes.

SECTION VIII – INCORPORATION OF RIDER PROVISIONS

The attached listed Certificate Riders are made a part of this Plan.

Rider Name	Form Number
Childhood Conditions Rider	C22302TX
Progressive Disease Rider	C22303TX
Specified Disease Rider	C22306TX

POLICY SCHEDULE

Group Policyholder:	FORT BEND ISD
Group Policy Number:	CTR0026193866
Group Policy Effective Date:	January 1, 2025
Group Policy Anniversary Date:	January 1, 2026
Jurisdiction:	Texas
Face Amount:	See Certificates
Spouse Amount:	See Certificates
Covered Dependent Children:	100.00% of applicable Face Amount
Benefit Percentages:	
Bone Marrow Transplant (Stem Cell Transplant)	100.00% of applicable Face Amount
Cancer (internal or invasive)	100.00% of applicable Face Amount
Coma	100.00% of applicable Face Amount
Coronary Artery Bypass Surgery	100.00% of applicable Face Amount
Heart Attack (Myocardial Infarction)	100.00% of applicable Face Amount
Kidney Failure (End-Stage Renal Failure)	100.00% of applicable Face Amount
Loss of Sight	100.00% of applicable Face Amount
Loss of Speech	100.00% of applicable Face Amount
Loss of Hearing	100.00% of applicable Face Amount
Major Organ Transplant	100.00% of applicable Face Amount
Paralysis	100.00% of applicable Face Amount
Stroke	100.00% of applicable Face Amount
Sudden Cardiac Arrest	50.00% of applicable Face Amount
Type I Diabetes	50.00% of applicable Face Amount
Metastatic Cancer	100.00% of applicable Face Amount
Non-Invasive Cancer	25.00% of applicable Face Amount
Maximum Payable for Additional Diagnosis Benefit:	1 per 3 months
Maximum Payable for Reoccurrence Benefit:	1 per 3 months
Additional Benefits:	
Health Screening Benefit Amount:	$50.00 per Insured
Maximum per Insured:	1 per Calendar Year
Health Screening Benefit for Covered Dependent Children:	100.00% of Health Screening Benefit Amount
Maximum:	1 per Calendar Year
Skin Cancer:	$500.00
Skin Cancer for Covered Dependent Children:	50.00% of Skin Cancer Benefit Amount
Maximum per Covered Person:	1 per Calendar Year
Benign Brain Tumor:	100.00% of applicable Face Amount
Accident Benefits:	
Loss of Sight	100.00% of applicable Face Amount
Loss of Speech	100.00% of applicable Face Amount
Loss of Hearing	100.00% of applicable Face Amount
Severe Burns	100.00% of applicable Face Amount
Paralysis	100.00% of applicable Face Amount
Coma	100.00% of applicable Face Amount
Waiver of Premium:	Yes

This Plan is delivered in and governed by the laws of the jurisdiction shown above.

This Plan is age-banded. That means Employees' rates may increase on the Group Policy Anniversary Date. Premiums at the Policy Anniversary Date are determined by the Employee's Attained Age rate, as shown in the Policy Schedule of Premiums.

BENEFIT SCHEDULE

Critical Illness Benefits

The applicable benefit amount is payable for the following Critical Illnesses, provided such Critical Illness meets all applicable definitions contained in the Plan and is caused by an underlying disease as set forth herein:

- Bone Marrow Transplant (Stem Cell Transplant)
- Cancer (internal or invasive)
- Coma
- Coronary Artery Bypass Surgery
- Heart Attack (Myocardial Infarction)
- Kidney Failure (End-Stage Renal Failure)
- Loss of Sight
- Loss of Speech
- Loss of Hearing
- Major Organ Transplant
- Non-Invasive Cancer
- Paralysis
- Stroke
- Sudden Cardiac Arrest
- Type I Diabetes
- Metastatic Cancer

Additional Benefits

Health Screening Benefit
Skin Cancer Benefit
Benign Brain Tumor Benefit

Accident Benefits

Coma
Loss of Sight
Loss of Speech
Loss of Hearing
Severe Burn
Paralysis

Waiver of Premium Benefit

Schedule of Premiums

FORT BEND ISD - Monthly

Uni Tobacco-Employee					
Issue Age	$10,000	$15,000	$20,000	$25,000	$30,000
18- 24	3.60	5.40	7.20	9.00	10.80
25 - 34	4.60	6.90	9.20	11.50	13.80
35 - 44	7.40	11.10	14.80	18.50	22.20
45 - 54	12.20	18.30	24.40	30.50	36.60
55 - 64	20.40	30.60	40.80	51.00	61.20
65 +	37.90	56.85	75.80	94.75	113.70

Uni Tobacco-Spouse					
Issue Age	$10,000	$15,000	$20,000	$25,000	$30,000
18- 24	3.60	5.40	7.20	9.00	10.80
25 - 34	4.60	6.90	9.20	11.50	13.80
35 - 44	7.00	10.50	14.00	17.50	21.00
45 - 54	12.80	19.20	25.60	32.00	38.40
55 - 64	24.20	36.30	48.40	60.50	72.60
65 +	47.40	71.10	94.80	118.50	142.20

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Childhood Conditions Rider
To Certificate of Insurance for Group Critical Illness

This Rider is part of the Certificate to which it is attached. We have issued this Rider because:

- You paid the additional premium for this Rider, and
- We have accepted your Application.

This Rider is subject to all the definitions, exclusions, terms, and other provisions of the Certificate to which it is attached, unless those terms are inconsistent with this Rider.

The benefits are available to covered Dependent Children as defined in your Certificate. Diagnosis must occur while this Rider is in force.

EFFECTIVE DATE

If issued at the same time as the Certificate, this Rider becomes effective when the Certificate becomes effective. If issued after the Certificate, this Rider will have a later Effective Date.

DEFINITIONS

When the terms below are used in this Rider, the following definitions apply (other applicable terms and definitions are included in the **Definitions** section of your Certificate):

Date of Diagnosis is defined as follows**:**

- ***Autism Spectrum Disorder:*** The date a Doctor Diagnoses a Dependent Child as having Autism Spectrum Disorder and where such Diagnosis is supported by medical records.
- ***Cystic Fibrosis:*** The date a Doctor Diagnoses a Dependent Child as having Cystic Fibrosis and where such Diagnosis is supported by medical records.
- ***Cerebral Palsy:*** The date a Doctor Diagnoses a Dependent Child as having Cerebral Palsy and where such Diagnosis is supported by medical records.
- ***Cleft Lip or Cleft Palate***: The date a Doctor Diagnoses a Dependent Child as having Cleft Lip or Cleft Palate and where such Diagnosis is supported by medical records.
- ***Down Syndrome:*** The date a Doctor Diagnoses a Dependent Child as having Down Syndrome and where such Diagnosis is supported by medical records.
- ***Phenylalanine Hydroxylase Deficiency Disease (PKU):*** The date a Doctor Diagnoses a Dependent Child as having PKU and where such Diagnosis is supported by medical records.
- ***Spina Bifida:*** The date a Doctor Diagnoses a Dependent Child as having Spina Bifida and where such Diagnosis is supported by medical records.

Autism Spectrum Disorder is a biological based neurodevelopment disorder characterized by impairment in two major domains:

- Deficits in social communication and interaction; and
- Restricted repetitive patterns of behavior, interests, and activities.

A Doctor must Diagnose Autism Spectrum Disorder based on the diagnostic criteria stipulated in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) at the time the loss occurs. The Diagnosis must include the DSM severity level specifier for both major domains listed above.

Cystic Fibrosis is a hereditary chronic disease of the exocrine glands. This disease is characterized by the production of viscid mucus that obstructs the pancreatic ducts and bronchi, leading to infection and fibrosis.

Cerebral Palsy is a disorder of movement, muscle tone, or posture that is caused by injury or abnormal development in the immature brain. Cerebral Palsy can be characterized by stiffness and movement difficulties, involuntary and uncontrolled movements, or disturbed sensation.

- ***Spastic Cerebral Palsy*** is characterized by stiffness and movement difficulties.
- ***Athetoid Cerebral Palsy*** is characterized by involuntary and uncontrolled movements.
- ***Ataxic Cerebral Palsy*** is characterized by a disturbed sense of balance and depth perception.

Cleft Lip occurs when there is an opening (one or two vertical fissures) in the lip. A ***Cleft Palate*** occurs when the two sides of a palate do not join, resulting in an opening in the roof of the mouth or soft tissue in the back of the mouth. Sometimes, an opening in the bones of the upper jaw or upper gum accompanies a Cleft Palate.

A Cleft Lip or Palate can occur on one or both sides of the face. If a Dependent Child has both a Cleft Lip and Cleft Palate or has one on each side of the face, we will pay this benefit only once.

Down Syndrome is a chromosomal condition characterized by the presence of an extra copy of genetic material on the 21st chromosome, either in whole or part.

Phenylalanine Hydroxylase Deficiency Disease (PKU) is an autosomal recessive metabolic genetic disorder characterized by homozygous or compound heterozygous mutations in the gene for the hepatic enzyme phenylalanine hydroxylase (PAH), rendering it nonfunctional. A Doctor must Diagnose this disease based on a PKU test.

Spina Bifida refers to any birth defect involving incomplete closure of the spinal canal or spine. This includes:

- ***Spina Bifida Cystica,*** which is a condition where a cyst protrudes through the defect in the vertebral arch.
- ***Spina Bifida Occulta,*** which is a condition where the bones of the spine do not close, but the spinal cord and meninges remain in place. Skin usually covers the defect.
- ***Meningoceles,*** which is a condition where the tissue covering the spinal cord sticks out of the spinal defect, but the spinal cord remains in place.
- ***Myelomeningocele*****,** which is a condition where the un-fused portion of the spinal column allows the spinal cord to protrude through an opening. The meningeal membranes that cover the spinal cord form a sac enclosing the spinal elements.

BENEFIT PROVISIONS
We will pay the benefit shown on the Rider Schedule if a Dependent Child is Diagnosed with one of the conditions listed in the Rider Schedule if the Date of Diagnosis is while this Rider is in force.

We will pay the benefit amount shown if a Dependent Child is Diagnosed with Autism Spectrum Disorder and such Diagnosis includes more than one DSM severity level specifiers. No benefit is payable if the DSM severity level specifier is less than Level 1.

For any subsequent Childhood Condition to be covered, the Date of Diagnosis of the subsequent Childhood Condition must be 3 months or more after the date the Dependent Child first qualified for any previously paid Childhood Condition Benefit.

GENERAL PROVISIONS

Time Limit on Certain Defenses
After two years from your Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on your Application. This does not apply to fraudulent misstatements.

CONTRACT
This Rider is part of the Critical Illness Certificate. It will terminate when:

- The Certificate terminates,
- Premiums are no longer paid for this Rider, subject to the Grace Period, or
- The covered Dependent Child reaches age 26 (details in the **Definitions** section of your Certificate).

This Rider is subject to all of the terms of the Certificate to which it is attached unless any such terms are inconsistent with the terms of this Rider.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

BENEFITS

Autism Spectrum Disorder	$3,000.00
Cystic Fibrosis	See Covered Dependent Children Amount in the Certificate Schedule
Cerebral Palsy	See Covered Dependent Children Amount in the Certificate Schedule
Cleft Lip or Cleft Palate	See Covered Dependent Children Amount in the Certificate Schedule
Down Syndrome	See Covered Dependent Children Amount in the Certificate Schedule
Phenylalanine Hydroxylase Deficiency Disease (PKU)	See Covered Dependent Children Amount in the Certificate Schedule
Spina Bifida	See Covered Dependent Children Amount in the Certificate Schedule

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Progressive Disease Rider
To Certificate of Insurance for Group Critical Illness

This Rider is part of the Certificate to which it is attached. We have issued this Rider because:

- You paid the additional premium for this Rider, and
- We have accepted your Application.

This Rider is subject to all the definitions, exclusions, terms, and other provisions of the Certificate to which it is attached, unless those terms are inconsistent with this Rider.

The benefits are available to those Insureds designated in the Certificate Schedule. Diagnosis must occur while this Rider is in force.

EFFECTIVE DATE
If issued at the same time as the Certificate, this Rider becomes effective when the Certificate becomes effective. If issued after the Certificate, this Rider will have a later Effective Date.

DEFINITIONS
When the terms below are used in this Rider, the following definitions apply (other applicable terms and definitions are included in the **Definitions** section of your Certificate):

Date of Diagnosis is defined as follows:

- **Advanced Alzheimer's Disease:** The date a Doctor Diagnoses the Insured incapacitated due to Alzheimer's disease.
- **Advanced Parkinson's Disease:** The date a Doctor Diagnoses the Insured incapacitated due to Parkinson's disease.
- **Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease):** The date a Doctor Diagnoses an Insured as having ALS and where such Diagnosis is supported by medical records.
- **Chronic Obstructive Pulmonary Disease (COPD):** The date a Doctor Diagnoses an Insured as having COPD based on clinical and/or laboratory findings as supported by medical records.
- **Crohn's Disease:** The date a Doctor Diagnoses an Insured as having Crohn's Disease based on clinical and/or laboratory findings as supported by medical records.
- **Sustained Multiple Sclerosis:** The date a Doctor Diagnoses an Insured as having Multiple Sclerosis and where such Diagnosis is supported by medical records.

Activities of Daily Living (ADLs) are activities used in measuring levels of personal functioning capacity. These activities are normally performed without assistance, allowing personal independence in everyday living. For the purposes of this Plan, ADLs include the following:

- **Bathing** – the ability to wash oneself in a tub, shower, or by sponge bath. This includes the ability to get into and out of the tub or shower with or without the assistance of equipment;
- **Dressing** – the ability to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs;
- **Toileting** – the ability to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene with or without the assistance of equipment;
- **Transferring** – the ability to move in and out of a bed, chair, or wheelchair with or without the assistance of equipment;
- **Mobility** – the ability to walk or wheel on a level surface from one room to another with or without the assistance of equipment;

- **Eating** – the ability to get nourishment into the body by any means once it has been prepared and made available with or without the assistance of equipment; and
- **Continence** – the ability to voluntarily maintain control of bowel and/or bladder function. In the event of incontinence, the ability to maintain a reasonable level of personal hygiene.

Advanced Alzheimer's Disease means Alzheimer's Disease that causes the Insured to be incapacitated. Alzheimer's Disease is a progressive degenerative disease of the brain that is Diagnosed by a psychiatrist or neurologist as Alzheimer's Disease. To be incapacitated due to Alzheimer's Disease, the Insured must:

- Exhibit the loss of intellectual capacity involving impairment of memory and judgment, resulting in a significant reduction in mental and social functioning; and
- Require substantial physical assistance from another adult to perform at least three ADLs.

Advanced Parkinson's Disease means Parkinson's Disease that causes the Insured to be incapacitated. Parkinson's Disease is a brain disorder that is Diagnosed by a psychiatrist or neurologist as Parkinson's Disease. To be incapacitated due to Parkinson's Disease, the Insured must:

- Exhibit at least two of the following clinical manifestations:
    a. Muscle rigidity
    b. Tremor
    c. Bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses); and
- Require substantial physical assistance from another adult to perform at least three ADLs.

Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease) means a chronic, progressive motor neuron disease occurring when nerve cells in the brain and spinal cord that control voluntary movement degenerate, causing muscle weakness and atrophy, eventually leading to paralysis.

Chronic Obstructive Pulmonary Disease (COPD) means a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible.

Crohn's Disease means a chronic inflammatory bowel disease that affects the lining of the digestive tract.

Sustained Multiple Sclerosis means a chronic degenerative disease of the central nervous system in which gradual destruction of myelin occurs in the brain or spinal cord or both, interfering with the nerve pathways. Sustained Multiple Sclerosis results in one of the following symptoms for at least 90 consecutive days:

- Muscular weakness,
- Loss of coordination,
- Speech disturbances, or
- Visual disturbances.

BENEFIT PROVISIONS

We will pay the Benefit shown on the Rider Schedule if an Insured is Diagnosed with one of the diseases that is listed in the Rider Schedule if the Date of Diagnosis is while this Rider is in force.

The Progressive Disease benefit is payable only once per disease.

For any subsequent Progressive Disease to be covered, the Date of Diagnosis of the subsequent Progressive Disease must be 3 months or more after the date the Insured first qualified for any previously paid Progressive Disease Benefit.

GENERAL PROVISIONS

Time Limit on Certain Defenses

After two years from your Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on your Application. This does not apply to fraudulent misstatements.

CONTRACT
This Rider is part of the Critical Illness Certificate. It will terminate when:

- That Certificate terminates, or
- Premiums are no longer paid for this Rider, subject to the Grace Period.

This Rider is subject to all of the terms of the Critical Illness Certificate to which it is attached unless those terms are inconsistent with this Rider.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

BENEFITS

Advanced Alzheimer's Disease	100.00% of applicable Face Amount
Advanced Parkinson’s Disease	100.00% of applicable Face Amount
Amyotrophic Lateral Sclerosis (ALS)	100.00% of applicable Face Amount
Chronic Obstructive Pulmonary Disease (COPD)	25.00% of applicable Face Amount
Crohn’s Disease	25.00% of applicable Face Amount
Sustained Multiple Sclerosis	100.00% of applicable Face Amount
Maximum per Insured, per lifetime	**1 time, per Progressive Disease**

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Specified Disease Rider
To Certificate of Insurance for Group Critical Illness

This Rider is part of the Certificate to which it is attached. We have issued this Rider because:

- You paid the additional premium for this Rider, and
- We have accepted your Application.

This Rider is subject to all the definitions, exclusions, terms, and other provisions of the Certificate to which it is attached, unless those terms are inconsistent with this Rider.

The benefits are available to those Insureds designated in the Certificate Schedule. Diagnosis must occur while this Rider is in force.

EFFECTIVE DATE
If issued at the same time as the Certificate, this Rider becomes effective when the Certificate becomes effective. If issued after the Certificate, this Rider will have a later Effective Date.

DEFINITIONS
When the terms below are used in this Rider, the following definitions apply (other applicable terms and definitions are included in the **Definitions** section of your Certificate):

Date of Diagnosis is defined for each Specified Disease as follows:

- ***Adrenal Hypofunction (Addison's Disease):*** The date a Doctor Diagnoses an Insured as having Adrenal Hypofunction and where such Diagnosis is supported by medical records.
- ***Cerebrospinal Meningitis:*** The date a Doctor Diagnoses an Insured as having Cerebrospinal Meningitis and where such Diagnosis is supported by medical records.
- ***Diphtheria*****:** The date a Doctor Diagnoses an Insured as having Diphtheria based on clinical and/or laboratory findings as supported by medical records.
- ***Encephalitis****:* The date a Doctor Diagnoses an Insured as having Encephalitis and where such Diagnosis is supported by medical records.
- ***Human Coronavirus****:* The date a Doctor Diagnoses an Insured as having Human Coronavirus based on laboratory findings as supported by viral testing or a blood test.
- ***Huntington's Chorea:*** The date a Doctor Diagnoses an Insured as having Huntington's Chorea based on clinical findings as supported by medical records.
- ***Legionnaire's Disease:*** The date a Doctor Diagnoses an Insured as having Legionnaire's Disease by finding *Legionella* bacteria in a clinical specimen taken from the Insured.
- ***Lyme Disease****:* The date a Doctor Diagnoses an Insured as having Lyme Disease and where such Diagnosis is supported by medical records.
- ***Malaria*****:** The date a Doctor Diagnoses an Insured as having Malaria and where such Diagnosis is supported by medical records.
- ***Muscular Dystrophy:*** The date a Doctor Diagnoses an Insured as having Muscular Dystrophy and where such Diagnosis is supported by medical records.
- ***Myasthenia Gravis:*** The date a Doctor Diagnoses an Insured as having Myasthenia Gravis and where such Diagnosis is supported by medical records.
- ***Necrotizing Fasciitis:*** The date a Doctor Diagnoses an Insured as having Necrotizing Fasciitis and where such Diagnosis is supported by medical records.
- ***Osteomyelitis*****:** The date a Doctor Diagnoses an Insured as having Osteomyelitis and where such Diagnosis is supported by medical records.
- ***Poliomyelitis*****:** The date a Doctor Diagnoses an Insured as having Poliomyelitis and where such Diagnosis is supported by medical records.

- ***Rabies*:** The date a Doctor Diagnoses an Insured as having Rabies and where such Diagnosis is supported by medical records.
- ***Sickle Cell Anemia:*** The date a Doctor Diagnoses an Insured as having Sickle Cell Anemia and where such Diagnosis is supported by medical records.
- ***Systemic Lupus:*** The date a Doctor Diagnoses an Insured as having Systemic Lupus and where such Diagnosis is supported by medical records.
- ***Systemic Sclerosis (Scleroderma):*** The date a Doctor Diagnoses an Insured as having Systemic Sclerosis and where such Diagnosis is supported by medical records.
- ***Tetanus:*** The date a Doctor Diagnoses an Insured as having Tetanus by finding Clostridium tetani bacteria in a clinical specimen taken from the Insured.
- ***Tuberculosis:*** The date a Doctor Diagnoses an Insured as having Tuberculosis by finding Mycobacterium tuberculosis bacteria in a clinical specimen taken from the Insured.

Adrenal Hypofunction (Addison's Disease) means a disease occurring when the body's adrenal glands do not produce sufficient steroid hormones.

Adrenal Hypofunction does not include secondary and tertiary adrenal insufficiency.

Cerebrospinal Meningitis means a disease resulting in the inflammation of the meninges of both the brain and spinal cord caused by infection from viruses, bacteria, or other microorganisms or from Cancer.

Diphtheria means an infectious disease caused by the bacterium *Corynebacterium diphtheriae* and characterized by the production of a systemic toxin and the formation of a false membrane lining of the mucous membrane of the throat and other respiratory passages, causing difficulty in breathing, high fever, and/or weakness.

Diphtheria can be Diagnosed either through laboratory tests that confirm Diphtheria through a culture obtained from the infected area or through clinical observation of visible symptoms.

Encephalitis means an inflammation of the brain, usually caused by a direct viral infection or a hyper-sensitivity reaction to a virus or foreign protein.

Hospital means a place that meets all of the following criteria:
- Is legally licensed and operated as a hospital,
- Provides overnight care of injured and sick people,
- Is supervised by a Doctor,
- Has full-time nurses supervised by a registered nurse, and
- Has on-site use of X-ray equipment, laboratory, and surgical facilities.

The term *Hospital* specifically excludes any facility not meeting the definition of Hospital as defined in this Plan, including but not limited to:
- A nursing home,
- An extended-care facility,
- A skilled nursing facility,
- A rest home or home for the aged,
- A rehabilitation facility,
- A facility for the Treatment of alcoholism or drug addiction, or
- An assisted living facility.

Hospital Intensive Care Unit means a place that meets all of the following criteria:
- Is a specifically designated area of the Hospital called a Hospital Intensive Care Unit;
- Provides the highest level of medical care;
- Is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
- Is separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement;
- Is permanently equipped with special life-saving equipment for the care of the critically ill or injured;
- Is under close observation by a specially trained nursing staff assigned exclusively to the Hospital Intensive Care Unit 24 hours a day; and

- Has a Doctor assigned to the Hospital Intensive Care Unit on a full-time basis.

The term *Hospital Intensive Care Unit* specifically excludes any type of facility not meeting the definition of Hospital Intensive Care Unit as defined in this Plan, including but not limited to private monitored rooms, surgical recovery rooms, observation units, and the following step-down units:

- A progressive care unit,
- A sub-acute intensive care unit, or
- An intermediate care unit.

Human Coronavirus means a severe type of virus having a lipid envelope studded with club-shaped spike proteins that infects humans, leading to an upper respiratory infection or Pneumonia, and spread through the air by coughing, sneezing, close personal contact, or touching a contaminated object or surface. This does not include the following Human Coronaviruses: 229E, NL63, OC43, and HKU1.

Huntington's Chorea means a hereditary disease characterized by gradual loss of brain function and voluntary movement due to degenerative changes in the cerebral cortex and basal ganglia.

Legionnaire's Disease means an infectious lung disease caused by species of the aerobic bacteria belonging to the genus *Legionella*.

Lyme Disease means an inflammatory disease caused by bacteria that are transmitted by ticks that is characterized initially by a rash, headache, fever, and chills, and later by possible arthritis and neurological and cardiac disorders.

Malaria means an infectious disease characterized by cycles of chills, fever, and sweating, caused by the bite of an anopheles mosquito infected with a protozoan of the genus *Plasmodium*.

Muscular Dystrophy means a genetic disease that causes progressive weakness and degeneration in the musculoskeletal system and where such muscles are replaced by scar tissue and fat. Muscular Dystrophy is characterized by progressive skeletal muscle weakness, defects in muscle proteins, and the death of muscle cells and tissues.

Myasthenia Gravis means a disease characterized by progressive weakness and exhaustibility of voluntary muscles without atrophy or sensory disturbance and caused by an autoimmune attack on acetylcholine receptors at the neuromuscular junction.

Necrotizing Fasciitis means a severe soft tissue infection by bacteria that is marked by edema and necrosis of subcutaneous tissues with involvement of adjacent fascia and by painful red swollen skin over the affected areas.

Osteomyelitis means an infectious inflammatory disease of the bone that typically results from a bacterial infection and may result in the death of bone tissue.

Poliomyelitis (Polio) means an acute infectious disease caused by the poliovirus and characterized by fever, motor paralysis, and atrophy of skeletal muscles. It often results in permanent disability and deformity, and marked by inflammation of nerve cells in the anterior gray matter in each lateral half of the spinal cord.

Rabies means an acute viral disease of the nervous system caused by a rhabdovirus, which is usually transmitted through the bite of a rabid animal. It is typically characterized by increased salivation, abnormal behavior, and eventual paralysis.

Sickle Cell Anemia means a hereditary disease caused by a genetic blood disorder. It is characterized by red blood cells that assume an abnormal, rigid, sickle shape due to a mutation on the hemoglobin gene.

Systemic Lupus means an autoimmune disease where the body's immune system attacks healthy tissue, leading to long-term inflammation. This disease is primarily characterized by joint pain and swelling.

Systemic Sclerosis (Scleroderma) means a progressive autoimmune disease characterized by the hardening and tightening of the skin and connective tissues.

Tetanus means a disease marked by rigidity and spasms of the voluntary muscles, caused by the bacterium Clostridium tetani.

Tuberculosis means an infectious disease caused by Mycobacterium tuberculosis bacteria. It is characterized by the growth of nodules in the bodily tissues, as well as by fever, cough, difficulty breathing, caseation, pleural effusions, and fibrosis.

BENEFIT PROVISIONS

Tier I – Specified Disease Benefit: We will pay the Benefit shown on the Rider Schedule if an Insured is Diagnosed with one of the Tier I Specified Diseases listed below, and if the Date of Diagnosis is while this Rider is in force:

- Adrenal Hypofunction
- Cerebrospinal Meningitis
- Diphtheria
- Encephalitis
- Huntington's Chorea
- Legionnaire's Disease
- Lyme Disease
- Malaria
- Muscular Dystrophy
- Myasthenia Gravis
- Necrotizing Fasciitis
- Osteomyelitis
- Poliomyelitis
- Rabies
- Sickle Cell Anemia
- Systemic Lupus
- Systemic Sclerosis (Scleroderma)
- Tetanus
- Tuberculosis

For any subsequent Tier I Specified Disease to be covered, the Date of Diagnosis of the subsequent Tier I Specified Disease must be 3 Months or more after the date the Insured first qualified for any previously paid Tier I Specified Disease Benefit.

Tier II – Specified Disease Benefit: We will pay the Benefit shown on the Rider Schedule if an Insured is Diagnosed with one of the Tier II Specified Diseases listed below, and such Diagnosis results in either a period of Hospital confinement or a period of Hospital Intensive Care Unit confinement as a direct result of the Tier II Specified Disease. Furthermore, the Date of Diagnosis must be while this Rider is in force.

In order to receive a Tier II Specified Disease Benefit the Insured must be confined to a Hospital or confined to a Hospital Intensive Care Unit as a direct result of a Tier II Specified Disease. In addition, the Insured must be receiving Treatment for the Tier II Specified Disease for the minimum number of days shown in the Rider Schedule. Only the highest eligible benefit amount shown on the Rider Schedule will be payable under these benefits. In the event a lower benefit amount was previously paid under these benefits for any period of Hospital confinement and that confinement is extended or the Insured is moved to an Intensive Care Unit triggering a higher payment, the difference between the previous paid benefit amount and the new benefit amount will be provided:

- Human Coronavirus

For any subsequent Tier II Specified Disease to be covered, the Date of Diagnosis of the subsequent Tier II Specified Disease must be 3 Months or more after the date the Insured first qualified for any previously paid Tier II Specified Disease Benefit.

This benefit is limited to the maximum shown in the Rider Schedule.

GENERAL PROVISIONS

Time Limit on Certain Defenses
After two years from your Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on your Application. This does not apply to fraudulent misstatements.

CONTRACT

This Rider is part of the Critical Illness Certificate. It will terminate when:

- That Certificate terminates, or
- Premiums are no longer paid for this Rider, subject to the Grace Period.

This Rider is subject to all of the terms of the Critical Illness Certificate to which it is attached unless those terms are inconsistent with this Rider.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

Benefits

Tier I Specified Disease Benefit:

Adrenal Hypofunction (Addison's Disease)	50.00% of applicable Face Amount
Cerebrospinal Meningitis	50.00% of applicable Face Amount
Diphtheria	50.00% of applicable Face Amount
Encephalitis	50.00% of applicable Face Amount
Huntington's Chorea	50.00% of applicable Face Amount
Legionnaire's Disease	50.00% of applicable Face Amount
Lyme Disease	50.00% of applicable Face Amount
Malaria	50.00% of applicable Face Amount
Muscular Dystrophy	50.00% of applicable Face Amount
Myasthenia Gravis	50.00% of applicable Face Amount
Necrotizing Fasciitis	50.00% of applicable Face Amount
Osteomyelitis	50.00% of applicable Face Amount
Poliomyelitis (Polio)	50.00% of applicable Face Amount
Rabies	50.00% of applicable Face Amount
Sickle Cell Anemia	50.00% of applicable Face Amount
Systemic Lupus	50.00% of applicable Face Amount
Systemic Sclerosis (Scleroderma)	50.00% of applicable Face Amount
Tetanus	50.00% of applicable Face Amount
Tuberculosis	50.00% of applicable Face Amount

Tier II Specified Disease Benefit:

Human Coronavirus	10.00% of applicable Face Amount if confined to a Hospital for 4-10 days 25.00% of applicable Face Amount if confined to a Hospital for 11 or more days 40.00% of applicable Face Amount if confined to an Intensive Care Unit
Maximum per Insured per Lifetime	1 time

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Certificate of Insurance For
Group Critical Illness Insurance Policy

This limited Plan provides supplemental benefits only. It does not constitute comprehensive health insurance coverage and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

This Plan provides benefits for the Critical Illnesses listed in the Benefit Schedule.

Please read it carefully.

This certificate is not a Medicare supplement policy.

NOTICE: This Certificate may be subject to an increase in premium at time of renewal.

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

Your Employer (the “Policyholder”) applied for coverage under this Group Critical Illness Insurance Policy (the “Plan”). This Plan is issued by Continental American Insurance Company (the “Company,” “CAIC,” “we,” “us,” or “our”). For the purposes of this Plan, “you” (including “your” and “yours”) refers to you. Based on the application process and the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages.

You will notice that certain words and phrases (including some medical terms and the names of Plan documents) in this document are capitalized. The capitalized words refer to terms with very specific definitions as they apply to this insurance Plan.

We certify that you are insured under the Group Critical Illness Policy (the “Plan”). The Plan was issued to the Policyholder. This coverage provides benefits for loss resulting from Critical Illness. The Certificate is subject to the Definitions, Exclusions, and other provisions of the Plan.

Certain provisions of the Plan are summarized in this Certificate. All provisions of the Plan, whether contained in your Certificate or not, apply to the insurance referred to by the Certificate.

The Certificate Effective Date is shown in the Certificate Schedule. The Certificate will terminate as provided in the provision titled “Termination of Your Insurance” in Section I. This Certificate will remain in effect for the period for which the premium has been paid. This Certificate may be continued for further periods as stated in the Plan.

This Certificate, when it becomes effective, automatically replaces any Certificate or Certificates previously issued to you under the Plan.

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SECTION I – ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION

PRIMARY INSURED

Eligibility
You are eligible to be covered under this Plan if you are Actively at Work for your employer and included in the class that is eligible for coverage, as shown on the Master Application.

Insureds are defined as those who might be eligible for coverage under this Plan in the following categories:

- **Employee Coverage** – We insure the Employee and any Dependent Children. The Employee is the ***Primary Insured*** under this Plan.
- **Employee and Spouse Coverage** – We insure the Employee, Spouse, and any Dependent Children.

You should refer to *Type of Coverage* in your Certificate Schedule to determine who is covered under this Certificate.

Details for adding Insureds to Plan coverage are outlined in the Dependent Coverage – Effective Date provision.

Effective Date
Your Employee Effective Date is shown on the Certificate Schedule.

Your Employee Effective Date is the date your insurance takes effect. After we receive and approve the Application, that date is either:

- The date shown on the Certificate Schedule if you are Actively at Work on that date, or
- The date you return to an Actively-at-Work status if you were not Actively at Work on the date shown on the Certificate Schedule.

Termination of Your Insurance
Your insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The 31st day after the premium due date (the last day of the Grace Period), if the premium has not been paid.
- The date you no longer belong to an eligible class.

If an Insured's coverage terminates, we will provide benefits for valid claims that arose while their coverage was active.

DEPENDENT COVERAGE

Eligibility
Dependents may be eligible for coverage under this Plan. **You should refer to the Type of Coverage on the Certificate Schedule to determine Dependent eligibility.** A ***Dependent*** is your Spouse or your Dependent Child (details included in the **Definitions** section). An eligible Spouse must not currently be disabled or unable to work and be at least 18 years of age.

Effective Date
The Effective Date for a Spouse is:
- The date shown on the Certificate Schedule if that Spouse is not confined to a hospital and is eligible for coverage on that date, or
- The first day of the month following the date the Spouse is no longer confined to a hospital (if that Spouse was confined to a hospital on the Certificate Schedule date) and is eligible for coverage on that date.

A Spouse may be added to the Plan after the Employee's Effective Date within 31 days after a Life Event or during an approved enrollment period. To be added, the Employee must complete an Application to add their Spouse to the Plan. The Company will assign the Effective Date for a Spouse's coverage after approving the application. For Spouse coverage to become effective, the Spouse must be included in the premium payment.

The Effective Date for a Dependent Child is:
- The Employee Effective Date, or
- The moment of birth for a newborn child, the date the petition is filed for adoption for adopted children, or the date of the Employee's marriage for step-children.

A day begins at 12:01 a.m. standard time at the Employee's, Spouse's, or Dependent Child's place of residence.

Termination of Dependent Insurance
Dependent Coverage will terminate on the earliest of the following:
- When the Certificate terminates,
- On the premium due date following the date we receive your written request to terminate Dependent coverage,
- When premiums are no longer paid for Dependent coverage (subject to the Grace Period),
- For Spouse coverage, when the Insured no longer meets the definition of Spouse because of annulment, divorce, or other reason, or
- For Dependent Child coverage, when the Child no longer qualifies as a Dependent because they reach age 26 or other reason. (Dependent Children who reach age 26 will have coverage continued until the last day of the month in which they turn age 26.)

Plan Termination
The **Company** has the right to cancel the Plan on any premium due date for the following reasons:
- The premium is not paid before the end of the Grace Period,
- The number of participating Employees is less than the number mutually agreed upon by the Company and the Policyholder in the signed Master Application,
- The Policyholder fails to perform any of the obligations that relate to this Policy or that are required by applicable law,
- The Policyholder no longer offers coverage to a particular class of Employees,
- The Policyholder no longer serves a class of Employees who reside in a particular geographical area, or
- The Policyholder does not provide timely information that is reasonably required.

The **Policyholder** has the right to cancel the Plan on any premium due date.
- To do this, the Policyholder must give the Company at least 31 days' written notice.
- The Plan will end on the date in the written notice or the date the Company receives the notice, whichever is later.

All outstanding premiums are due upon Plan termination. If the Company receives premium payments after the Plan terminates, this will not reinstate the Plan.

The Policyholder has the sole responsibility of notifying Certificateholders in writing of the Plan's termination as soon as reasonably possible. If the Plan terminates, it—and all Certificates and Riders issued under the Plan—will terminate on the specified termination date. The termination occurs as of 12:01 a.m. at the Policyholder's address.

Portability Privilege

When you are no longer a member of an eligible class and your coverage would otherwise end, you may elect to continue your coverage under this Plan. You may continue the coverage you had on the date your Certificate would otherwise terminate, including any in-force Spouse or Dependent Child coverage, without any additional underwriting requirements.

To keep your coverage in force, you must:

- Notify the Company in writing within 31 days after the date your coverage would otherwise terminate. You may notify us by sending written notice to P.O. Box 84079, Columbus, GA 31993-9101 or by calling the Customer Service number at 800.433.3036, and
- Pay the required premium directly to the Company no later than 31 days after the date your coverage would otherwise terminate and on each premium due date thereafter.

Ported coverage will end on the earliest of the following dates:

- 31 days after the premium due date (the last day of the Grace Period), if the premium has not been paid, or
- The date the Group Plan is terminated.

If you qualify for this Portability Privilege, then the Company will apply the same Benefits and Plan Provisions as shown in your previously-issued Certificate. Notification of any changes in the Plan will be provided directly by the Company.

Extension of Benefits

If coverage under the Certificate or any Riders that are in force ends while an Insured is confined in a Hospital for a covered Critical Illness, the Company will continue to pay benefits for confinement that become payable after the date coverage under the Certificate or any Riders ends if the Insured meets the following requirements:

- The confinement must be continuous after the date of termination; and
- Coverage must not have ended as a result of the Insured's or, in the case of a Dependent Child or Spouse, the Primary Insured's voluntary termination of coverage.

This Extension of Benefits terminates upon the earliest of the following:

- The date the Insured is no longer confined to a Hospital;
- The date the Insured receives the maximum benefit for being confined to a Hospital; or
- 90 days after the date coverage would otherwise terminate.

Hospital means a place that meets all of the following criteria: Is legally licensed and operated as a hospital, provides overnight care of injured and sick people, is supervised by a Doctor, has full-time nurses supervised by a registered nurse, and has on-site use of X-ray equipment, laboratory, and surgical facilities.

The term Hospital specifically excludes any facility not meeting the definition of Hospital as defined in this Plan, including but not limited to: A nursing home, an extended-care facility, a skilled nursing facility, a rest home or home for the aged, a rehabilitation facility, a facility for the Treatment of alcoholism or drug addiction, or an assisted living facility.

SECTION II – PREMIUM PROVISIONS

Premium Payments

Premiums should be paid to the Company at P.O. Box 84069, Columbus, Georgia, 31908-4069. The first premiums are due on this Plan's Effective Date. After that, premiums are due on the first day of each month that the Plan remains in effect.

Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period provision.

Premium Changes
Unless we have agreed in writing not to increase premiums, the premium may change:

- On the Group Policy Anniversary Date based on renewal underwriting. (The Group Policy Anniversary Date is shown on the Policy Schedule and falls on the same date each year thereafter.)
- Whenever the terms or conditions of the Plan are modified. The new premium rates will apply only to premiums due on or after the rate change takes effect.

We will provide the Policyholder a 60-day advance written notice of any change to a premium.

Premiums on the Group Policy Anniversary Date are determined by your Attained Age. The Attained Age rates are shown in the Schedule of Premiums.

Grace Period
This Plan has a 31-day Grace Period. If a premium is not paid on or before its due date, the premium may be paid during the next 31 days. During the Grace Period, the Plan will stay in force, unless the Policyholder has given the Company written notice of its intention to discontinue the Plan. If the Plan is discontinued, the Plan's termination date will be the latest date for which premium has been paid.

SECTION III - DEFINITIONS

When the terms below are used in this Plan, the following definitions apply:

Accident means an event that results in accidental bodily injury to an Insured, independent of disease or bodily infirmity. A ***Covered Accident*** is an Accident that occurs while coverage is in force.

Actively at Work (Active Work) refers to your ability to perform your regular employment duties for a full normal workday. You may perform these activities either at your employer's regular place of business or at a location where you are required to travel to perform the regular duties of your employment.

Acute Coronary Syndrome is an obstruction of the coronary arteries that occurs as a result of Myocardial Infarction with or without ST elevation. This is determined by an electrocardiogram (ECG). Acute Coronary Syndrome includes unstable angina but does not include stable angina.

Arteriosclerosis means a disease of the arteries characterized by plaque deposits on the arteries' inner walls, resulting in their abnormal thickening and loss of elasticity.

Arteriovenous Malformation means a congenital disease of the blood vessels in the brain, brain stem, or spinal cord that is characterized by a complex, tangled web of abnormal arteries and veins and may be connected by one or more fistulas.

Atherosclerosis means a disease in which plaque builds up inside a person's arteries.

Attained Age means your age on your Certificate Effective Date and on each Group Policy Anniversary Date thereafter.

Benign Brain Tumor is a mass or growth of abnormal, noncancerous cells in the brain. The tumor is composed of similar cells that do not follow normal cell division and growth patterns and develop into a mass of cells that microscopically do not have the characteristic appearance of a Cancer. Benign Brain Tumor must be caused by Multiple Endocrine Neoplasia, Neurofibromatosis, or Von Hippel-Lindau Syndrome.

> ***Multiple Endocrine Neoplasia*** is a genetic disease in which one or more of the endocrine glands are overactive or form a tumor.
>
> ***Neurofibromatosis*** is a genetic disease in which the nerve tissue grows tumors that may be benign and may cause serious damage by compressing nerves and other tissue.

Von Hippel-Lindau Syndrome is a genetic disease that predisposes a person to have benign or malignant tumors.

Bone Marrow Transplant (Stem Cell Transplant) means a procedure to replace damaged or destroyed bone marrow with healthy bone marrow stem cells. For a benefit to be payable, a Bone Marrow Transplant (Stem Cell Transplant) must be caused by at least one of the following diseases:

- Aplastic anemia
- Congenital neutropenia
- Severe immunodeficiency syndromes
- Sickle cell anemia
- Thalassemia
- Fanconi anemia
- Leukemia
- Lymphoma
- Multiple myeloma

The Bone Marrow Transplant (Stem Cell Transplant) benefit is not payable if the Transplant results from a covered Critical Illness for which a benefit has been paid under this Plan.

Brain Aneurysm is a weak area in the wall of a blood vessel of the brain that causes the blood vessel to bulge, balloon out, or rupture.

Cancer (internal or invasive) is a disease that meets either of the following definitions:

- A malignant tumor characterized by:
    - The uncontrolled growth and spread of malignant cells, and
    - The invasion of distant tissue.
- A disease meeting the diagnostic criteria of malignancy, as established by the American Board of Pathology. A Pathologist must have examined and provided a report on the histocytologic architecture or pattern of the tumor, tissue, or specimen.

Cancer (internal or invasive) also includes:

- Melanoma that is Clark's Level III or higher ***or*** Breslow depth equal to or greater than 0.77mm,
- Myelodysplastic syndrome - RCMD (refractory cytopenia with multilineage dysplasia),
- Myelodysplastic syndrome - RAEB (refractory anemia with excess blasts),
- Myelodysplastic syndrome - RAEB-T (refractory anemia with excess blasts in transformation), or
- Myelodysplastic syndrome - CMML (chronic myelomonocytic leukemia).

The following are **not** considered internal or invasive Cancers:

- Pre-malignant tumors or polyps
- Carcinomas in Situ
- Any superficial, non-invasive Skin Cancers including basal cell and squamous cell carcinoma of the skin
- Melanoma in Situ
- Melanoma that is Diagnosed as
    - Clark's Level I or II,
    - Breslow depth less than 0.77mm, **or**
    - Stage 1A melanomas under TNM Staging
- Metastatic Cancer

Carcinoma in Situ is Non-Invasive Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

Melanoma in Situ means melanoma cells that occur only on the outer layer of the skin (the epidermis), where there is no invasion of the deeper layer (the dermis).

Non-Invasive Cancer is a Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

For the purposes of this Plan, a Non-Invasive Cancer is:

- Internal Carcinoma in Situ
- Myelodysplastic Syndrome - RA (refractory anemia)
- Myelodysplastic Syndrome - RARS (refractory anemia with ring sideroblasts)
- Myeloproliferative Blood Disorder

Premalignant conditions or conditions with malignant potential, other than those specifically named above, are **not** considered Non-Invasive Cancer.

Skin Cancer, as defined in this Plan, is **not** considered Non-Invasive Cancer and is therefore not payable under the Non-Invasive Cancer benefit.

Skin Cancer is a Cancer that forms in the tissues of the skin.

The following are considered Skin Cancers:

- Basal cell carcinoma
- Squamous cell carcinoma of the skin
- Melanoma in Situ
- Melanoma that is Diagnosed as
  - Clark's Level I or II,
  - Breslow depth less than 0.77mm, or
  - Stage 1A melanomas under TNM Staging

These conditions are not payable under the Cancer (internal or invasive) benefit.

Cancer, Non-Invasive Cancer, Metastatic Cancer or Skin Cancer must be Diagnosed in one of two ways:

1. ***Pathological Diagnosis*** is a Diagnosis based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This Diagnosis must be made by a certified Pathologist and conform to the American Board of Pathology standards.

2. ***Clinical Diagnosis*** is based only on the study of symptoms. The Company will accept a Clinical Diagnosis only if**:**
   - A Doctor cannot make a Pathological Diagnosis because it is medically inappropriate or life-threatening,
   - Medical evidence exists to support the Diagnosis, and
   - A Doctor is treating the Insured for Cancer or Carcinoma in Situ.

Cardiomyopathy means a disease with measurable deterioration of the function of the myocardium, and is typically characterized by breathlessness and swelling of the legs.

Chronic Kidney Disease means a disease characterized by the gradual loss in renal function over time due to diabetes mellitus, Hypertension, glomerulonephritis, polycystic kidney disease, autoimmune disease, or genetic disease.

Claimant means a person who is authorized to make a claim under the Certificate.

Coma means a state of continuous, profound unconsciousness, lasting at least seven consecutive days, and characterized by the absence of:

- Spontaneous eye movements,
- Response to painful stimuli, and
- Vocalization.

Coma does not include a medically-induced coma.

To be payable as an Accident benefit, the Coma must be caused solely by or be solely attributed to a Covered Accident.

To be considered a Critical Illness, the Coma must be caused solely by or be solely attributed to one of the following diseases:

- **Brain Aneurysm**, which is an excessive, localized enlargement of an artery in the brain caused by a weakening of the artery wall, usually due to a defect in the vessel at birth or resulting from high blood pressure.
- **Diabetes**, which is a metabolic disease characterized by the inadequate secretion or utilization of insulin.
- **Encephalitis**, which is a disease characterized by inflammation of the brain, usually caused by a direct viral infection or a hypersensitive reaction to a virus or foreign protein.
- **Epilepsy**, which is a neurological disease characterized by sudden, recurring attacks of motor, sensory, or psychic malfunction with or without loss of consciousness or convulsive seizures.
- **Hyperglycemia**, which is a disease where an excessive amount of glucose circulates in the blood plasma.
- **Hypoglycemia,** which is a disease where blood glucose concentrations fall below the necessary level to support the body's need for energy and stability throughout its cells.
- **Meningitis**, which is a disease caused by viral or bacterial infection and characterized by inflammation of the meninges.

Complete Remission is defined as having no Symptoms and no Signs that can be identified to indicate the presence of Cancer.

Coronary Artery Bypass Surgery means open heart surgery to correct the narrowing or blockage of one or more coronary arteries with bypass grafts and where such narrowing or blockage is attributed to Coronary Artery Disease or Acute Coronary Syndrome. This excludes any non-surgical procedure, such as, but not limited to, balloon angioplasty, laser relief, or stents.

Coronary Artery Disease occurs when the coronary arteries become damaged due to acute coronary occlusion, coronary atherosclerosis, aneurysm and/or dissection of the coronary arteries, or coronary atherosclerosis due to lipid rich plaque.

Critical Illness is a disease or a sickness as defined in the Plan that first manifests while your coverage is in force.

Any loss due to Critical Illness must begin while your coverage is in force. Critical Illness includes only the following, provided such Critical Illness meets all applicable definitions contained in the Plan and, where indicated, is caused by an underlying condition:

- Bone Marrow Transplant (Stem Cell Transplant)
- Cancer (internal or invasive)
- Coma
- Coronary Artery Bypass Surgery
- Heart Attack (Myocardial Infarction)
- Kidney Failure (End-Stage Renal Failure)
- Loss of Sight
- Loss of Speech
- Loss of Hearing
- Major Organ Transplant
- Non-Invasive Cancer
- Paralysis
- Stroke
- Sudden Cardiac Arrest
- Type I Diabetes
- Metastatic Cancer

Date of Diagnosis is defined as follows:

- ***Benign Brain Tumor:*** The date a Doctor determines a Benign Brain Tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.
- ***Bone Marrow Transplant (Stem Cell Transplant):*** The date the surgery occurs.
- ***Cancer:*** The day tissue specimens, blood samples, or titer(s) are taken (Diagnosis of Cancer and/or Carcinoma in Situ is based on such specimens).
- ***Coma***: The first day of the period for which a Doctor confirms a Coma that is due to one of the underlying diseases and that has lasted for at least seven consecutive days.

- ***Coronary Artery Bypass Surgery:*** The date the surgery occurs.
- ***Heart Attack (Myocardial Infarction):*** The date the infarction (death) of a portion of the heart muscle occurs. This is based on the criteria listed under the Heart Attack (Myocardial Infarction) definition.
- ***Kidney Failure (End-Stage Renal Failure):*** The date a Doctor recommends that an Insured begin renal dialysis.
- ***Loss of Sight:*** The date the loss due to one of the underlying diseases is objectively determined by a Doctor to be total and irreversible.
- ***Loss of Speech:*** The date the loss due to one of the underlying diseases is objectively determined by a Doctor to be total and irreversible.
- ***Loss of Hearing:*** The date the loss due to one of the underlying diseases is objectively determined by a Doctor to be total and irreversible.
- ***Major Organ Transplant:*** The date the surgery occurs.
- ***Metastatic Cancer:*** The date a Doctor determines Cancer has metastasized to other parts of the body from the original site.
- ***Non-Invasive Cancer:*** The day tissue specimens, blood samples, or titer(s) are taken (Diagnosis of Cancer and/or Carcinoma in Situ is based on such specimens).
- ***Paralysis:*** The date a Doctor Diagnoses an Insured with Paralysis due to one of the underlying diseases as specified in this Plan, where such Diagnosis is based on clinical and/or laboratory findings as supported by the Insured's medical records.
- ***Skin Cancer:*** The date the skin biopsy samples are taken for microscopic examination.
- ***Stroke:*** The date the Stroke occurs (based on documented neurological deficits and neuroimaging studies).
- ***Sudden Cardiac Arrest:*** The date the pumping action of the heart fails (based on the Sudden Cardiac Arrest definition).
- ***Type I Diabetes:*** The date a Doctor Diagnoses an Insured as having Type I Diabetes based on clinical and/or laboratory findings as supported by medical records.

Dependent Children are your or your Spouse's natural children, step-children, grandchildren who are your dependents for federal income tax purposes at the time the application for coverage of the grandchild is made, foster children, children subject to legal guardianship, adopted children, children for whomyou are required to provide medical support, or Children Placed for Adoption, who are younger than age 26. However, we will continue coverage for Dependent Children insured under the Plan after the age of 26 if they are incapable of self-sustaining employment due to mental or physical disability, and are chiefly dependent on a parent for support and maintenance. You or your Spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the Dependent Child's 26th birthday.

The insurance on any Dependent Child will terminate on the last day of the month in which the Dependent Child turns age 26; it is your responsibility to notify us in writing when coverage on a Dependent Child terminates. Termination will be without prejudice to any claim originating prior to the date of termination. Our acceptance of any applicable premium after such date will be considered as premium for only the remaining persons who qualify as Insureds under this Plan. When coverage on all Dependent Children terminates, you must notify the Company, in writing, and elect whether to continue this Plan on an Employee or Employee and Spouse Coverage basis. After such notice, we will arrange for the payment of the appropriate premium due, including returning any unearned premium, if applicable.

Children Placed for Adoption are Children for whom you have entered a decree of adoption, have initiated adoption proceedings, or are party to a suit in which you seek to adopt the child. A decree of adoption must be entered within one year from the date proceedings were initiated, unless extended by order of the court.

Diagnosis (***Diagnosed***) refers to the definitive and certain identification of an illness or disease that:

- Is made by a Doctor and
- Is based on clinical or laboratory investigations, as supported by your medical records.

The illness must meet the requirements outlined in this Plan for the particular Critical Illness being Diagnosed.

Doctor is a person who is duly qualified as a practitioner of the healing arts acting within the scope of their license, and:

- Is licensed to practice medicine; prescribe and administer drugs; or to perform surgery, or
- Is a duly qualified medical practitioner according to the laws and regulations in the state in which Treatment is made.

Employee is a person who meets eligibility requirements under **Section I – Eligibility, Effective Date, and Termination**, and who is covered under this Plan. The Employee is the Primary Insured under this Plan.

Family Member includes your Spouse as well as the following members of your immediate family:

- Son
- Daughter
- Mother
- Father
- Sister
- Brother

This includes step-Family Members and Family-Members-in-law.

Heart Attack (Myocardial Infarction) is the death of a portion of the heart muscle (myocardium) caused by a blockage of one or more coronary arteries due to Coronary Artery Disease or Acute Coronary Syndrome.

Heart Attack (Myocardial Infarction) does not include:

- Any other disease or injury involving the cardiovascular system.
- Cardiac Arrest not caused by a Heart Attack (Myocardial Infarction).

Diagnosis of a Heart Attack (Myocardial Infarction) must include the following:

- New and serial electrocardiographic (ECG) findings consistent with Heart Attack (Myocardial Infarction), and
- Elevation of cardiac enzymes above generally accepted laboratory levels of normal. (In the case of creatine physphokinase (CPK) a CPK-MB measurement must be used.)

Confirmatory imaging studies, such as thallium scans, MUGA scans, or stress echocardiograms may also be used.

Hypertension means a disease that is characterized by elevated blood pressure in the arteries with a systolic reading of at least 140 mmHg and a diastolic reading of at least 90 mmHg.

Kidney Failure (End-Stage Renal Failure) means end-stage renal failure caused by End-Stage Renal Disease, which results in the chronic, irreversible failure of both kidneys to function.

Kidney Failure (End-Stage Renal Failure) is covered only under the following conditions:

- A Doctor advises that regular renal dialysis, hemo-dialysis, or peritoneal dialysis (at least weekly) is necessary to treat the Kidney Failure (End-Stage Renal Failure); or
- The Kidney Failure (End-Stage Renal Failure) results in kidney transplantation.

Life Event means an event that qualifies an Employee to make changes to benefits at times other than their enrollment period. Events qualifying as Life Events are established solely by the Policyholder.

Loss of Sight means the total and irreversible loss of all sight in both eyes.

To be payable as an Accident benefit, Loss of Sight must be caused solely by or be solely attributed to a Covered Accident.

To be considered a Critical Illness, Loss of Sight must be caused solely by or be solely attributed to one of the following diseases:

- **Retinal Disease**, which is a disease that affects the retina of the eye;
- **Optic Nerve Disease**, which is a disease that affects the optic nerve of the eye; or
- **Hypoxia**, which is a disease characterized by a deficiency in the amount of oxygen reaching the tissues of the eyes.

Loss of Speech means the total and permanent loss of the ability to speak.

To be payable as an Accident benefit, Loss of Speech must be caused solely by or be solely attributed to a Covered Accident.

To be considered a Critical Illness, Loss of Speech must be caused solely by or be solely attributable to one of the following diseases:

- **Alzheimer's Disease**, which is a progressive mental deterioration due to generalized degeneration of the brain; or
- **Arteriovenous Malformation**, which is a congenital disease of blood vessels in the brain, brain stem, or spinal cord that is characterized by a complex, tangled web of abnormal arteries and veins connected by one or more fistulas.

Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of Hearing does not include hearing loss that can be corrected by the use of a hearing aid or device.

To be payable as an Accident benefit, Loss of Hearing must be caused solely by or be solely attributed to a Covered Accident.

To be considered a Critical Illness, Loss of Hearing must be caused solely by or be solely attributed to one of the following diseases:

- **Alport Syndrome**, which is an inherited disease of the kidney caused by a genetic mutation and can be characterized by hearing loss;
- **Autoimmune Inner Ear Disease**, which is an inflammatory condition of the inner ear occurring when the body's immune system attacks cells in the inner ear that are mistaken for bacteria or a virus;
- **Chicken Pox**, which is an acute contagious disease that is caused by the varicella-zoster virus and is characterized by skin eruptions, slight fever, and malaise;
- **Diabetes**, which is a metabolic disease characterized by the inadequate secretion or utilization of insulin;
- **Goldenhar Syndrome**, which is rare congenital disease that causes abnormalities in the face and head and can cause hearing loss;
- **Meniere's Disease**, which is a disorder of the inner ear that causes spontaneous episodes of vertigo, hearing loss, ear ringing, and a feeling of fullness or pressure in the ear;
- **Meningitis**, which is a disease characterized by inflammation of the meninges caused by viral or bacterial infection; or
- **Mumps**, which is an infectious disease caused by paramyxovirus, and characterized by inflammatory swelling of the parotid and/or other salivary glands.

Maintenance Drug Therapy is a course of systemic medication given to a patient after a Cancer goes into Complete Remission because of primary Treatment. Maintenance Drug Therapy includes ongoing hormonal therapy, immunotherapy, or chemo-prevention therapy. Maintenance Drug Therapy is meant to decrease the risk of Cancer recurrence; it is not meant to treat a Cancer that is still present.

Major Organ Transplant means undergoing surgery as a recipient of a covered transplant of a human heart, lung, liver, kidney, or pancreas. A transplant must be caused by one or more of the following diseases:

- Bronchiectasis, which is a lung disease state defined by localized, irreversible dilation of the bronchial tree caused by destruction of the muscle and elastic tissue.
- Cardiomyopathy, which is a heart disease characterized by the measurable deterioration of the function of the heart muscle, where the heart muscle becomes enlarged, thick, or rigid.
- Cirrhosis, which is a liver disease characterized by replacement of liver tissue by fibrosis, scar tissue, and regenerative nodules, leading to loss of liver function.
- Chronic obstructive pulmonary disease, which is a lung disease characterized by persistently poor airflow as a result of breakdown of lung tissue and dysfunction of the small airways.
- Congenital Heart Disease, which is heart disease characterized by abnormalities in cardiovascular structures that occur before birth.
- Coronary Artery Disease
- Cystic fibrosis, which is a hereditary disease of the exocrine glands affecting the pancreas, respiratory system, and sweat glands. It is characterized by the production of abnormally viscous mucus by the affected glands.
- Hepatitis, which is a disease caused by the hepatitis A, B, or C virus and is characterized by the inflammation of the liver.
- Interstitial lung disease, which is a lung disease that affects the interstitium of the lungs.

- Lymphangioleiomyomatosis, which is a lung disease characterized by an indolent, progressive growth of smooth muscles cells throughout the lungs, pulmonary blood vessels, lymphatics, and pleurae.
- Polycystic liver disease, which is characterized by multiple variable-sized cysts lined by cuboidal epithelium.
- Pulmonary fibrosis, which is a lung disease where the lung tissue becomes thickened, stiff, and scarred due to chronic inflammation.
- Pulmonary hypertension, which is a disease characterized by increased pressure in the pulmonary artery and results in the thickening of the pulmonary arteries and the narrowing of these blood vessels, which causes the right side of the heart to become enlarged.
- Sarcoidosis, which is a disease characterized by the growth of granulomatous lesions that appear in the body.
- Valvular heart disease, which is a disease of the heart valves.

If, while the Certificate in force, the Insured is placed on a transplant list for a Major Organ Transplant due to one of the above-identified diseases, we will pay 25% of the Critical Illness benefit. The remainder of the Critical Illness benefit will become payable on the date the surgery occurs. A Major Organ Transplant benefit is not payable if the Major Organ Transplant results from a covered Critical Illness for which a benefit has been paid.

Malignant Hypertension is blood pressure that is so high that it actually causes damage to organs, particularly in the nervous system, the cardiovascular system, and/or the kidneys. One type of such damage is called papilledema, a condition in which the optic nerve leading to the eye becomes dangerously swollen, threatening vision.

Metastatic Cancer means a Cancer (internal or invasive) that has spread from the part of the body where it was first formed to other parts of the body. This occurs when cancer cells break away from the original tumor, travel through the blood or lymph system, and form new tumors in other organs or tissues of the body. When this occurs, the new metastatic tumor is the same type of Cancer as the original tumor even though located in a different area of the body.

Paralysis *or* ***Paralyzed*** means the permanent, total, and irreversible loss of muscle function to the whole of at least two limbs.

To be payable as an Accident benefit, the Paralysis must be caused solely by or be solely attributed to a Covered Accident.

To be considered a Critical Illness, Paralysis must be caused solely by or be solely attributed to one or more of the following diseases:
- **Amyotrophic Lateral Sclerosis**, which is a progressive degeneration of the motor neurons of the central nervous system, leading to wasting of the muscles and paralysis;
- **Cerebral Palsy**, which is a disorder of movement, muscle tone, or posture that is caused by injury or abnormal development in the immature brain. Cerebral Palsy can be characterized by stiffness and movement difficulties, or by involuntary and uncontrolled movements;
- **Parkinson's disease**, which is a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement; or
- **Poliomyelitis**, which is an acute infectious disease caused by the poliovirus and characterized by fever, motor paralysis, and atrophy of skeletal muscles. This often results in permanent disability and deformity, and is marked by inflammation of nerve cells in the anterior gray matter in each lateral half of the spinal cord.

The Diagnosis of Paralysis must be supported by neurological evidence.

Pathologist is a Doctor who is:
- Licensed to practice medicine, and
- Licensed by the American Board of Pathology to practice pathologic anatomy.

A Pathologist also includes an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Severe Burn or ***Severely Burned*** means a burn resulting from fire, heat, caustics, electricity, or radiation. The burn must meet all of the following criteria:

- Be a full-thickness or third-degree burn, as determined by a Doctor. A ***Full-Thickness Burn*** or ***Third-Degree Burn*** is the destruction of the skin through the entire thickness or depth of the dermis (or possibly into underlying tissues). This results in loss of fluid and sometimes shock.
- Cause cosmetic disfigurement to the body's surface area of at least 35 square inches.
- Be caused solely by or be solely attributed to a Covered Accident.

Signs and/or Symptoms are the evidence of disease or physical disturbance observed by a Doctor or other medical professional. The Doctor (or other medical professional) must observe these Signs while acting within the scope of their license.

Spouse is your legal wife or husband who is listed on your Application.

Stroke means apoplexy due to rupture or acute occlusion of a cerebral artery. The apoplexy must cause complete or partial loss of function involving the motion or sensation of a part of the body and must last more than 24 hours. Stroke must be either:

- ***Ischemic***: Due to advanced Arteriosclerosis or Arteriosclerosis of the arteries of the neck or brain, or vascular embolism, or
- ***Hemorrhagic***: Due to uncontrolled Hypertension, Malignant Hypertension, Brain Aneurysm, or Arteriovenous Malformation.

The Stroke must be positively Diagnosed by a Doctor based upon documented neurological deficits and confirmatory neuroimaging studies.

Stroke does not include:

- Transient Ischemic Attacks (TIAs)
- Head injury
- Chronic cerebrovascular insufficiency
- Reversible ischemic neurological deficits unless brain tissue damage is confirmed by neurological imaging

Stroke will be covered only if the Insured submits evidence of the neurological damage by providing:

- Computed Axial Tomography (CAT scan) images, or
- Magnetic Resonance Imaging (MRI).

Sudden Cardiac Arrest is the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction due to Coronary Artery Disease, Cardiomyopathy, or Hypertension.

Sudden Cardiac Arrest is not a Heart Attack (Myocardial Infarction). A Sudden Cardiac Arrest benefit is not payable if the Sudden Cardiac Arrest is caused by or contributed to by a Heart Attack (Myocardial Infarction).

Transient Ischemic Attack (TIA) occurs when blood flow to part of the brain is temporarily blocked or reduced. For a benefit to be payable, the TIA must be caused by one or more of the following diseases:

- Advanced Arteriosclerosis
- Arteriosclerosis of the arteries of the neck or brain
- Vascular embolism
- Hypertension
- Malignant Hypertension
- Brain Aneurysm
- Arteriovenous Malformation.

The TIA must be positively Diagnosed by a Doctor based upon documented neurological deficits and confirmatory neuroimaging studies.

Treatment or ***Medical Treatment*** is the consultation, care, or services provided by a Doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines.

Treatment-Free From Cancer refers to the period of time without the consultation, care, or services provided by a Doctor. This includes receiving diagnostic measures and taking prescribed drugs and medicines. Treatment does not include Maintenance Drug Therapy or routine follow-up visits to verify whether Cancer or Carcinoma in Situ has returned.

Type I Diabetes means a form of diabetes mellitus causing total insulin deficiency of an Insured along with continuous dependence on exogenous insulin in order to maintain life. Type I Diabetes excludes Gestational Diabetes and Prediabetes.

SECTION IV - BENEFIT PROVISIONS

The benefit amounts payable under this section are shown in the Certificate Schedule. The Company will pay benefits for a Critical Illness in the order the events occur.

Critical Illness Benefit

Initial Diagnosis Benefit

We will pay the Critical Illness benefit when an Insured is Diagnosed with one of the Critical Illnesses shown in the Benefit Schedule, and when such Diagnosis is caused by or solely attributed to an underlying disease as identified herein. We will pay this benefit if:

- The initial Date of Diagnosis is while the Insured's coverage is in force, and
- The Certificate does not exclude the illness or condition by name or by specific description.

Employee

Benefits will be based on the Face Amount in effect on the Critical Illness Date of Diagnosis.

Additional Diagnosis Benefit

Once benefits have been paid for a Critical Illness, the Company will pay benefits for each different Critical Illness when the Date of Diagnosis for the new Critical Illness is separated from the prior, different Critical Illness by at least 3 consecutive months and the new Critical Illness is not caused or contributed by a Critical Illness for which benefits have been paid.

Reoccurrence Benefit

Once benefits have been paid for a Critical Illness, benefits are payable for that same Critical Illness when the Date of Diagnosis for the Reoccurrence of that Critical Illness is separated from the prior occurrence of that Critical Illness by at least 3 consecutive months and the Critical Illness is not caused or contributed by a Critical Illness for which benefits have been paid.

Non-Invasive Cancer Benefit

We will pay the amount shown in the Certificate Schedule for the Diagnosis of a Non-Invasive Cancer. This benefit is payable in addition to all other applicable benefits.

Metastatic Cancer Benefit

We will pay the amount shown in the Policy Schedule for the Diagnosis of a Metastatic Cancer.

Additional Benefits

Additional Benefits are payable if the Date of Diagnosis is while the Insured's coverage is in force, and the Certificate does not exclude the illness or condition by name or by specific description.

Skin Cancer Benefit

We will pay the amount shown in the Certificate Schedule for the Diagnosis of Skin Cancer. This benefit is payable 1 per calendar year.

Health Screening Benefit

We will pay the amount shown in the Certificate Schedule for Health Screening Tests performed while an Insured's coverage is in force. This benefit is payable 1 per calendar year, per Insured up to the maximum shown on the Certificate Schedule. Benefits are payable for Covered Dependent Children at 100.00% of the Employee benefit amount.

This benefit is only payable for Health Screening Tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations.

Health Screening Tests include, but are not limited to, the following:

- Blood test for triglycerides
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- Non-diagnostic vascular screening
- DNA stool analysis
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum cholesterol test to determine level of HDL and LDL
- Serum protein electrophoresis (blood test for myeloma)
- Spiral CT screening for lung cancer
- Stress test on a bicycle or treadmill
- Thermography
- HIV test performed via nucleic acid test (NAT)
- HPV test performed via Pap smear
- Biopsies
- Genetic Screening Test performed in a medical facility
- Human Coronavirus test
- Dental Exams
- Vision Exams
- Immunizations
- Mental Health Screening

Benign Brain Tumor Benefit
We will pay the amount shown in the Certificate Schedule for the initial Diagnosis of a Benign Brain Tumor.

Accident Benefit
We will pay the amount shown in the Certificate Schedule if an Insured sustains a Covered Accident and suffers any of the following, which is solely due to, caused by, and attributed to, the Covered Accident:

- Coma
- Loss of Sight
- Loss of Speech
- Loss of Hearing
- Severe Burn
- Paralysis

Waiver of Premium Benefit
If you become Totally Disabled as defined in this Plan due to a covered Critical Illness, we will waive premiums for you and any currently covered Dependents (this includes any Riders that are in force).

Total Disability or ***Totally Disabled*** means you are completely unable to perform all the substantial and material duties and functions of your occupation and any other gainful occupation in which you earn substantially the same compensation earned before the disability.

After 90 days of Total Disability, all Plan premiums will be waived if:

- Your Total Disability began before your age of 65;
- Your Total Disability has continued without interruption for at least 90 days, during which time you and/or the Policyholder have paid premiums; and
- You provide proof of Total Disability as required by us. Satisfactory Proof of Loss for Total Disability must be provided at least once every 12 months.

Pending our approval of a claim for the Waiver of Premium Benefit, premiums should be paid as they are due. Premiums that were paid for the first 90 days of Total Disability will be refunded after your claim for this benefit is approved.

Waiver of Premium will continue until the earliest of the following:

- The premium due date following your 65th birthday,
- The date the Company has waived premiums for a total of 24 months of Total Disability,
- The date you refuse to provide proof of continuing Total Disability,
- The date your Total Disability ends, or
- The date coverage ends according to the Termination provisions in **Section I – Eligibility, Effective Date, and Termination.**

If you are still eligible for coverage when you return to Active Work, coverage for any Insured may be continued if premium payments are resumed.

SECTION V – EXCLUSIONS

Exclusions
We will not pay for loss due to any of the following:

- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured
- **Suicide** – committing or attempting to commit suicide, while sane or insane
- **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job
- **Participation in Aggressive Conflict** of any kind, including:
  - War (declared or undeclared) or military conflicts
  - Insurrection or riot
  - Civil commotion or civil state of belligerence
- **Illegal substance abuse, which includes the following:**
  - Abuse of legally-obtained prescription medication
  - Illegal use of non-prescription drugs
- An error, mishap, or malpractice during medical, diagnostic, or surgical treatment or procedure
- Diagnosis of a Critical Illness made by a Family Member.

SECTION VI – CLAIM PROVISIONS

Notice of Claim
Written notice of claim must be given to us:

- Within 60 days after the Date of Diagnosis, or
- As soon as reasonably possible.

When we receive written Notice of Claim, we will send a claim form. If the Claimant does not receive the claim form within 15 days after the notice is sent, written Proof of Loss can be sent to us without waiting for the form. Notice must include your name and Certificate number. Notice can be mailed to the Company at:

P.O. Box 84075, Columbus, GA 31993-9103

Failure to give notice within the time prescribed does not invalidate or reduce any claim if it was not reasonably possible to give the notice within that time and notice was given as soon as was reasonably possible.

Proof of Loss
Proof of Loss refers to documentation that supports a claim. (This information is often found in standardized medical documents, such as hospital bills and operative reports. It includes a statement by the treating Doctor.) Proof of Loss establishes the nature and extent of the loss, the Company's obligation to pay the claim, and the Claimant's right to receive payment.

The Claimant must provide Proof of Loss to the Company at:

P.O. Box 84075, Columbus, GA 31993-9103

Proof of Loss must be given to us within 90 days of the Date of Diagnosis. Failure to give Proof of Loss within such time shall not invalidate or reduce any claim if such Proof of Loss is given as soon as reasonably possible. The Company will not accept Proof of Loss any later than one year and three months after the Date of Diagnosis, except in the absence of the Claimant's legal mental capacity.

The Claimant will be responsible for the cost of obtaining a completed claim form. We may request additional Proof of Loss, such as records from hospitals or Doctors. The Claimant will be responsible for the cost of obtaining these records.

We may require authorizations to obtain medical and psychiatric information as well as non-medical information, including personal financial information.

When we receive the claim and due Proof of Loss, we will review the Proof of Loss. If we approve the claim, we will pay the benefits subject to the terms of the Certificate.

Physical Examination and Autopsy
The Company may have an Insured examined as often as reasonably necessary while a claim is pending. In the case of death, the Company may also require an autopsy, unless prohibited by law. The Company will cover all costs for exams or autopsy.

Prompt Payment of Benefits
For benefits other than for loss of time, the Company will, once we receive the required Proof of Loss, pay, deny, or settle each submitted claim not later than the 60th day after the date Proof of Loss is received. Subject to written Proof of Loss, all accrued benefits payable under the policy for loss of time will be paid at least monthly during the period for which the insurer is liable. Any balance remaining unpaid at the end of that time will be paid as soon as possible after the Proof of Loss is received.

Payment of Claims
We will pay all benefits to you unless otherwise assigned. For any benefits that remain unpaid at the time of death, we will pay those benefits in the following order:
- To your beneficiary or the beneficiary's assignee,
- To your surviving Spouse,
- To your estate.

Special Rules for the Payment of Claims for Dependent Children
When required by law, We will provide for benefits payable for a Dependent Child to be paid to the Texas Health and Human Services Commission if such agency paid, through medical assistance, for the treatment received by the Dependent Child for a Covered Condition.

When required by law, We will provide for benefits payable for a Dependent Child to be paid to the Dependent Child’s possessory or managing conservator if that individual:
1. provides a written notice that the individual is a possessory or managing conservator of the Dependent Child on whose behalf the claim is made; and
2. provides a certified copy of a court order designating the individual as possessory or managing conservator of the Dependent Child or other relevant evidence.

Unpaid Premium
When a claim is paid, we may deduct any premium due and unpaid from the claim payment.

Changing of Beneficiary
A change in beneficiary must be submitted in writing to our Home Office in a form acceptable to us and signed by you. Unless otherwise specified by you, a change in beneficiary will take effect on the date the notice of change is signed. We will not be liable for any action taken before notice is received and recorded at the Home Office.

Claim Review
If a claim is denied, you will be given written notice of:
- The reason for the denial,
- The Plan provision that supports the denial, and
- Your right to ask for a review of the claim.

Appeals Procedure
Before filing any lawsuit—and no later than 60 days after notice of denial of a claim—you, the Claimant, or an authorized representative of either must appeal any denial of benefits under the Plan by sending a written request for review of the denial to our Home Office.

Legal Action
You cannot take legal action against us for benefits under this Plan:
- Within 60 days after you have sent us written Proof of Loss, or
- More than three years from the time written proof is required to be given.

SECTION VII – GENERAL PROVISIONS

Entire Contract Changes
Your insurance is provided under a contract of Group Critical Illness insurance with the Policyholder. The entire Contract of Insurance is made up of:
- The Policy;
- The Certificate of insurance;
- The Application of the Policyholder, a copy of which is attached to and made part of the Policy when issued; and
- Any Riders, Endorsements, or Amendments to the Policy or Certificate.

In the absence of fraud, a statement made by the Policyholder or an Insured is considered a representation and not a warranty. A statement made by the Policyholder or an Insured may not be used in any contest under the Plan, unless a copy of the written instrument containing the statement is or has been provided to:
- The person making the statement; or
- If the statement was made by the Insured and the Insured has died or become incapacitated, the Insured's beneficiary or personal representative.

Changes to this Plan:
- Will not be valid unless approved in writing by an officer of the Company,
- Must be noted on or attached to the Contract, and
- May not be made by any insurance agent (nor can an agent waive any Plan provisions).

Misstatement of Age
If an age has been misstated on the Application, the benefits will be those that the paid premium would have purchased at the correct age.

Successor Insured
If you die while covered under this Certificate and your Spouse is also insured under this Plan at the time of your death, then your surviving Spouse may elect to become the Primary Insured at the current Spouse Face Amount. This would include continuation of any Dependent Child coverage that is in force at that time.

To become the Primary Insured and keep coverage in force, your surviving Spouse must:
- Notify the Company in writing within 31 days after the date of your death; and
- Pay the required premium to the Company no later than 31 days after the date of your death, and on each premium due date thereafter.

If the Certificate does not cover a surviving Spouse, the Certificate will terminate from the date of your death. All unearned premium from the date of your death will be refunded.

Time Limit on Certain Defenses

After two years from your Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on your Application. This does not apply to fraudulent misstatements.

Clerical Error
Clerical error by the Policyholder will not end coverage or continue terminated coverage. In the event of a clerical error, the Company will make a premium adjustment.

Individual Certificates
The Company will give the Policyholder a Certificate for each Employee. The Certificate will set forth:

- The coverage,
- To whom benefits will be paid, and
- The rights and privileges under the Plan.

Required Information
The Policyholder will be responsible for furnishing all information and proofs that the Company may reasonably require with regard to the Plan.

Conformity with State Statutes
This Plan was issued on its Effective Date in the state noted on the Master Application. Any Plan provision that conflicts with that state's statutes is amended to conform to the minimum requirements of those statutes.

BENEFITS SCHEDULE

Critical Illness Benefits

The applicable benefit amount is payable for the following Critical Illnesses, provided such Critical Illness meets all applicable definitions contained in the Plan and is caused by an underlying disease as set forth herein:

- Bone Marrow Transplant (Stem Cell Transplant)
- Cancer (internal or invasive)
- Coma
- Coronary Artery Bypass Surgery
- Heart Attack (Myocardial Infarction)
- Kidney Failure (End-Stage Renal Failure)
- Loss of Sight
- Loss of Speech
- Loss of Hearing
- Major Organ Transplant
- Non-Invasive Cancer
- Paralysis
- Stroke
- Sudden Cardiac Arrest
- Type I Diabetes
- Metastatic Cancer

Additional Benefits

Health Screening Benefit
Skin Cancer Benefit
Benign Brain Tumor Benefit
Accident Benefits
Coma
Loss of Sight
Loss of Speech
Loss of Hearing
Severe Burn
Paralysis
Waiver of Premium Benefit