Alabama and Kentucky Residents:

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Alaska Residents:

If the Master Policy is issued in a state other than Alaska, Alaska law prevails over conflicting provisions between the out of state policy and the Alaska certificate.

Arkansas Residents:

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

Arkansas Insurance Department
1 Commerce Way, Suite 102, Little Rock, AR 72202

Arizona Residents:

If the Policy is issued in a jurisdiction other than Arizona, this Certificate of Insurance may not provide all benefits and protections provided by law in Arizona. Please read this Certificate carefully.

Colorado Residents:

THIS IS A LIMITED BENEFIT HEALTH COVERAGE POLICY AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

District of Columbia Residents:

Limited Benefit, Please Read Carefully.

Florida Residents:

QUESTIONS OR COMPLAINTS TELEPHONE NUMBER: If an Insured has any questions concerning the benefits available under this Certificate or needs to express a complaint, they may contact us at our toll-free Customer Service telephone number, 1-888-763-7474.

If the Policy is issued to a jurisdiction other than Florida, the benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida.

Indiana Residents:

QUESTIONS REGARDING YOUR POLICY OR COVERAGE SHOULD DIRECTED TO:
TRANSAMERICA LIFE INSURANCE COMPANY
Toll-free Customer Service telephone number, 1-888-763-7474.

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: (800) 622-4461; (317) 232-2395
Complaints can be filed electronically at www.in.gov/idoi.

TITLE PAGE (COVER PAGE) - Continued

Kansas Residents:

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Louisiana Residents:

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Maine Residents:

Notice to Buyer: This is a supplemental health certificate. This certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.

Montana Residents:

If the Master Policy is issued in a state other than Montana, Montana law prevails over conflicting provisions between the out of state policy and the Montana certificate.

Nebraska Residents:

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Nevada Residents:

YOU HAVE THE RIGHT TO PROVIDE AN ORAL COMPLAINT OR TO FILE A WRITTEN COMPLAINT.
Any time that we deny a claim for a health care service or we limit coverage of such service to you, we will notify you in writing within 10 working days after denial of such coverage. Such notice will provide the reason for denying coverage of the service. We will provide the criteria used in determining whether to authorize or deny coverage of the health care service. You have the right to provide an oral complaint or to file a written complaint to our Administrator listed on the Policy's cover page.

CONTACT INFORMATION

If you have any questions or concerns, please contact our Administrative Office. If you wish to contact the Nevada Department of Insurance, you may contact them online for instructions on submitting a Consumer Complaint Form:

Nevada Division of Insurance – Consumer Services Section
http://doi.nv.gov

New Hampshire Residents:

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

THIS POLICY DOES NOT PROVIDE COMPREHENSIVE HEALTH INSURANCE COVERAGE. IT IS NOT INTENDED TO SATISFY THE INDIVIDUAL MANDATE OF THE AFFORDABLE CARE ACT (ACA) OR PROVIDE THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE ACA (OFTEN REFERRED TO AS "MAJOR MEDICAL COVERAGE"). IT DOES NOT PROVIDE COVERAGE FOR HOSPITAL. MEDICAL. SURGICAL. OR MAJOR MEDICAL EXPENSES.

North Carolina Residents:

IMPORTANT CANCELLATION INFORMATION – PLEASE REFER TO THE "TERMINATION OF INSURANCE" SECTION OF THIS CERTIFICATE.

If the Master Policy is issued in a state other than North Carolina, this Certificate of Insurance provides all of the benefits mandated by the North Carolina Insurance Code, but is issued under a group master policy located in another state and may be governed by that state's laws.

Ohio Residents:

THIS CERTIFICATE IS NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE. IT DOES NOT QUALIFY AS MINIMUM ESSENTIAL HEALTH COVERAGE UNDER THE FEDERAL AFFORDABLE CARE ACT. TO BE ELIGIBLE FOR COVERAGE UNDER THIS CERTIFICATE, YOU MUST HAVE PROOF OF MINIMUM ESSENTIAL HEALTH COVERAGE.

Oklahoma Residents:

NOTICE: If the Master Policy is issued in a state other than Oklahoma, then the Certificates delivered in Oklahoma in conjunction with such Policy are subject to the terms and conditions of the Certificates and not the Policy.

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

Pennsylvania Residents:

This Is A Limited Policy – Read It Carefully. THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE.

South Dakota Residents:

This limited health benefits plan does not provide comprehensive medical coverage. It is a basic or limited benefits policy and is not intended to cover all medical expenses. This plan is not designed to cover the costs of serious or chronic illness.

Utah Residents:

Notice to Buyer: This is a limited benefit health certificate. This certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.

Vermont Residents:

THIS POLICY DOES NOT MEET THE MINIMUM COVERAGE REQUIREMENTS OF THE AFFORDABLE CARE ACT. YOU SHOULD NOT PURCHASE THIS POLICY UNLESS YOU ARE ALREADY COVERED BY COMPREHENSIVE MAJOR MEDICAL INSURANCE.

IN THE EVENT OF A CONFLICT BETWEEN THE LAWS OF THE STATE WHERE THE POLICY IS ISSUED AND THE LAWS OF VERMONT, THE LAWS OF VERMONT WILL CONTROL.

TITLE PAGE (COVER PAGE) - Continued

Virginia Residents:

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions, you may contact the insurance company issuing this insurance at the following address and telephone number:

Administrative Office: PO Box 219, Cedar Rapids, IA 52406-0219
Customer Service: 1-888-763-7474

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

State Corporation Commission
Virginia Bureau of Insurance
P.O. Box 1157 Richmond, VA 23218
www.scc.virginia.gov/boi
National toll-free #1-877-310-6560 or Virginia-only toll free #800-552-7945. or the local #804-371-9741
Fax no.: 804-371-9944

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

Wyoming Residents:

The insurance policy under which this Certificate is issued does not include Comprehensive Adult Wellness Benefits.

CONTACT US

If you have any questions about this Certificate, you may:

Write us at our Administrative Office: PO Box 219, Cedar Rapids, IA 52406-0219
Call our toll-free telephone number at: 1-888-763-7474
Write us at our E-Mail Address: TEBcustresp@Transamerica.com
Visit our website: www.transamerica.com

TABLE OF CONTENTS

Certificate Section	**Page**
Schedule of Benefits (Who Pays What)	1
Title Page (Cover Page)	3
Contact Us	8
Eligibility	9
Benefits/Coverage (What is Covered)	11
Limitations/Exclusions (What is Not Covered)	16
Insured Payment Responsibility	17
Information on Policy and Rate Changes	18
Claims Procedures (How to File a Claim)	19
General Policy Provisions	25
Termination/Nonrenewal/Continuation	27
Conversion Option	28
Definitions	28

ELIGIBILITY

Insurance will start at 12:01 a.m. on the Effective Date at the main place of business of the Policyholder.

Insured Eligibility – To be eligible for insurance under the Policy, you must:

1. Meet the eligibility requirements listed on the Policyholder Application;
2. Be in Active Service (does not apply for **New Hampshire and Ohio residents**); and
3. Provide satisfactory Evidence of Insurance to us, if required.

Insured Effective Date – Coverage for eligible Insureds who have completed an Enrollment Form, if required, will take effect on the latest of the following dates, provided that we have received your first premium payment:

1. The Group Master Policy Effective Date; or
2. The New Entrants Effective Date as selected on the Policyholder Application which coincides with or next follows the date you are hired or first become eligible for this coverage.

If you do not meet the eligibility requirements on the date your insurance is to take effect, your insurance will take effect on the date you satisfy the requirements.

Dependent Eligibility, if available under the Policy – To be eligible under the Policy, a Dependent must:

1. Meet the definition of a Dependent;
2. Not be eligible as an Insured under the Policy; and
3. Provide satisfactory Evidence of Insurability to us, if required.

A Dependent will be eligible for such coverage on the later of the following dates:

1. The day you become eligible for coverage; or
2. The day the Dependent first meets the definition of Dependent.

A child may be insured as a Dependent of only one Insured.

Dependent Effective Date – Coverage for eligible Dependents for which you have completed an Enrollment Form, if required, will take effect on the latest of the following dates, provided that we have received any additional premium for such Dependent:

1. The date your insurance becomes effective; or
2. The first day of the New Entrants Effective Date as selected on the Policyholder Application which coincides with or next follows the date the Dependent first becomes eligible for this coverage.

If a Dependent does not meet the eligibility requirements on the date his or her insurance would otherwise take effect, insurance on that Dependent will take effect on the date the Dependent satisfies the eligibility requirements.

> **Indiana residents:** Insurance for Newborn Child or Newly Adopted Child – Coverage for a newborn of any Covered Person, a newly adopted Child, or a Child for whom you are appointed the legal guardian, will become effective automatically on the day he or she is born, or the earlier of the day the Child is placed for adoption or the day a court enters an order appointing you the legal guardian of the Child. The Child will be automatically covered for 31 days. In order to continue the Child's coverage, you must notify us by the end of the 31-day period and pay any additional premium, if applicable.

Late Enrollee – You must enroll for coverage for yourself and any Dependents within 31 days of the date such person first becomes eligible under the Policy. Otherwise, such person will be considered a Late Enrollee and may be required to submit satisfactory Evidence of Insurability and be approved for coverage.

Late Enrollee Effective Date – Coverage for Late Enrollees for which you have completed an Enrollment Form, if required, will take effect on the New Entrants Effective Date as selected on the Policyholder Application which coincides with or next follows the date you are accepted for coverage, provided that we have received your first premium payment.

Covered Charges for Late Enrollees will only include those charges that are incurred more than 30 days after the Effective Date of coverage.

This Late Enrollees section also applies to a former Covered Person who applies for reinstatement after his or her insurance has terminated.

Insurance for Newborn Child or Newly Adopted Child – Insurance for a newborn, a newly adopted Child, or a Child for whom you are appointed the legal guardian, will become effective automatically on the day he or she is born, the day the Child is placed for adoption with you, or the day a court enters an order appointing you the legal guardian of the Child. The Child will be automatically insured for 31 days. In order to continue the Child's insurance, you must notify us by the end of the 31-day period and pay any additional premium, if applicable.

Arkansas residents: Insurance for a newborn, a newly adopted Child, or a Child for whom you are appointed the legal guardian, will become effective automatically on the day he or she is born, the day the Child is placed for adoption with you, or the day a court enters an order appointing you the legal guardian of the Child, as long as you have Single Parent Family or Family coverage in force on that date.

If this Certificate was issued as Individual Type of Coverage, the Child's coverage will not continue past the 90-day period following birth or placement, unless:
1. You have Single Parent Family or Family Type of Coverage in force;
2. You have notified us by the end of the 90-day period of the addition of such Child; and
3. You have paid any applicable additional premium.

Minnesota residents: Insurance for Newborn Child or Newly Adopted Child – Insurance for a newborn, a newly adopted Child, or a Child for whom you are appointed the legal guardian, will become effective automatically on the day he or she is born, the day the Child is placed for adoption with you, or the day a court enters an order appointing you the legal guardian of the Child, as long as you have Single Parent Family or Family coverage in force on that date.

If this Certificate was issued as Individual coverage, the Child will be automatically covered without notification requirements, insurability or health underwriting approval. Additional premium will be due from the first premium due date following the date of birth or adoption placement.

If we are not notified of the newborn including a newborn grandchild, adopted child or child placed for adoption, and a claim is filed on that Child while this Policy is still in force as Individual coverage, we may withhold payment of any benefits for the new dependent until we receive all premiums owed as if we had been informed of the additional dependent immediately from the first premium due date following the date of birth or adoption placement.

North Carolina residents: Insurance for a newborn, a newly adopted Child, or a Child or foster Child for whom you are appointed the legal guardian, will become effective automatically on the day he or she is born, the day the Child is placed for adoption with you, the day a court enters an order appointing you the legal guardian of the Child, or the day the Child is placed in the foster home. The Child will be automatically insured for 31 days. In order to continue the Child's insurance, you must notify us by the end of the 31-day period and pay any additional premium, if applicable.

Wyoming residents:
1. Insurance for a newborn will become effective automatically on the day he or she is born.
2. Insurance for a newly adopted Child will become effective on the earlier of the date the petition for adoption is filed or entry of the child in the adoptive home, except that when the child is in the custody of the state, coverage shall begin at the date of entry of a final decree of adoption. Coverage for an adopted child shall continue unless the petition is denied.
3. Insurance for a Child for whom you are appointed the legal guardian will become effective on the day a court enters an order appointing you the legal guardian of the Child.

The Child will be automatically insured for 31 days. In order to continue the Child's insurance, you must notify us by the end of the 31-day period and pay any additional premium, if applicable.

BENEFITS/COVERAGE (WHAT IS COVERED)

Critical Illness Benefit

First Occurrence – If a Covered Person is diagnosed with the First Occurrence of a Critical Illness, we will pay a lump sum Critical Illness Benefit. The Critical Illness Benefit is shown in the Schedule of Benefits.

To be eligible for a First Occurrence Critical Illness Benefit the positive diagnosis must be made:

1. After the Effective Date of this Certificate and while this Certificate is in force; and
2. The First Occurrence Benefit Separation Period shown on the Schedule of Benefit must be satisfied.

Recurrent Critical Illness - If a Covered Person is diagnosed with a Recurrent Critical Illness, we will pay a lump sum Critical Illness Benefit. The Critical Illness Benefit is shown in the Schedule of Benefits.

To be eligible for a Recurrent Critical Illness Benefit the positive diagnosis must be made:

1. After the Effective Date of this Certificate and while this Certificate is in force; and
2. The Recurrent Benefit Separation Period shown on the Schedule of Benefit must be satisfied.

For each Critical Illness, only one Recurrent Critical Illness Benefit may be paid per Covered Person.

First Occurrence Benefit Separation Period – The First Occurrence Benefit Separation Period must be met in order for another Critical Illness Benefit to be payable for any other Critical Illness that would otherwise qualify as a First Occurrence.. The other Critical Illness must be medically unrelated as determined by a Physician. The First Occurrence Benefit Separation Period is the number of days that must elapse between the date of diagnosis of one Critical Illness and the date of diagnosis of a different Critical Illness. The First Occurrence Benefit Separation Period is specified in the Schedule of Benefits.

Recurrent Benefit Separation Period - The Recurrent Benefit Separation Period must be met in order for a Critical Illness Benefit to be payable for a Recurrent Critical Illness. The other Critical Illness must be medically unrelated as determined by a Physician. The Recurrent Benefit Separation Period is the number of days that must elapse between the date of diagnosis of a First Occurrence Critical Illness and the date of diagnosis of a Recurrent Critical Illness. The Benefit Separation Period is specified in the Schedule of Benefits.

Medically Related Conditions During the Benefit Separation Period - If a Covered Person is diagnosed with multiple Covered Conditions that are medically related, as determined by a Physician, during the First Occurrence Benefit Separation Period or Recurrent Benefit Separation Period, we will only pay one benefit which will be the higher Critical Illness Benefit amount as shown in the Schedule of Benefits.

If the last Critical Illness benefit payment under this Certificate was less than 100% of the applicable Benefit Amount, we will waive the First Occurrence Benefit Separation Period or Recurrent Benefit Separation Period.

Lifetime Category Maximum – The sum of all Critical Illness Benefits paid for a First Occurrence and Recurrent Critical Illness will not exceed the Lifetime Category Maximum shown in the Schedule of Benefits per Covered Condition Category for each Covered Person.

Benefit Payments – Benefit payments will be made directly to you. Proof of any Critical Illness diagnosis must be submitted to us in writing (refer to the CLAIMS PROCEDURE (HOW TO FILE A CLAIM) section.

CRITICAL ILLNESS

A **Critical Illness** means an illness or condition listed in one of the Covered Condition Categories, and for which positive diagnosis is made by a Physician. Such diagnosis must be based on diagnostic criteria generally accepted by the medical profession, and as defined below.

Covered Condition Category - Cancer

Invasive Cancer means the presence of one or more malignant tumors with invasion of normal tissue and characterized by the uncontrollable and abnormal growth and spread of malignant cells to lymph nodes and/or a body part different from the site of cancer origin. Invasive Cancer includes the following:

a. a malignant melanoma for which a pathology report shows a maximum thickness greater than 0.80 millimeters using the Breslow method of determining tumor thickness;
b. a cancer that is a leukemia or lymphoma; or
c. where a Covered Person has terminal cancer and has a life expectancy of 24 months or less from the date of diagnosis and will not benefit from, or has exhausted, curative therapy.

Non-Invasive Cancer (including Carcinoma in Situ) means the presence of a malignant tumor and characterized by the abnormal growth of malignant cells which are confined to the site of origin without spread to lymph nodes and/or a body part different from the site of cancer origin. Non-Invasive Cancer includes the following:

a. a malignant melanoma, for which a pathology report shows a maximum thickness less than or equal to 0.80 millimeters using the Breslow method of determining tumor thickness;
b. a tumor of the prostate classified as T1bN0M0, or T1cN0M0; or
c. a Carcinoma in Situ classified as TisN0M0.

Non-Invasive Cancer does not include Skin Cancer.

Carcinoma in Situ means a group of abnormal cells that remain in the location where the cells first formed.

Skin Cancer means any malignant growth that arises on the surface of the skin that is any of the following:
a. basal cell carcinoma;
b. squamous cell carcinoma; or
c. malignant melanoma that remains confined to the epidermis.

Cancer Covered Condition Exclusion - A Cancer Covered Condition does not include other conditions which may be considered precancerous including, but not limited to, leukoplakia, hyperplasia, polycythemia vera, moles, lesions, or similar diseases.

Related Diagnosis for a Cancer Covered Condition

In the event we pay a Critical Illness Benefit for a Cancer Covered Condition that is not an Invasive Cancer, and the Covered Condition is subsequently diagnosed as a Cancer Covered Condition for which we would pay a higher benefit, as shown in the Schedule of Benefits, we will pay the difference between what we paid and the applicable higher First Occurrence Critical Illness Benefit amount. The First Occurrence Benefit Separation Period or Recurrent Benefit Separation Period does not apply to payment of the First Occurrence Benefit for a related diagnosis for a Cancer Covered Condition as described in this provision.

Additional Definitions applicable to a Cancer Covered Condition

North Carolina residents: A Cancer Covered Condition requires a pathological diagnosis or clinical diagnosis as described below.

We will accept a clinical diagnosis in lieu of a pathological diagnosis when:
1. A pathological diagnosis cannot be made because it is medically inappropriate or life-threatening;
2. There is medical evidence to support the diagnosis; and
3. A Physician is treating a Covered Person for Cancer.

A postmortem diagnosis will be accepted if the pathological diagnosis can only be made after death.

A "pathological diagnosis" of Cancer is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a certified pathologist whose diagnosis of malignancy is in keeping with the standards set up by the American Board of Pathology. A "clinical diagnosis" of Cancer is based on the study of symptoms. A '"postmortem diagnosis" is based on the study of the cause of death.

Covered Condition Category - Cardiovascular

Coronary Artery Disease Requiring Angioplasty/Stent means coronary artery disease requiring a balloon angioplasty or other forms of catheter-based percutaneous transluminal coronary artery therapy to correct the narrowing or blockage of one or more coronary arteries, as confirmed in writing by a board-certified cardiologist. This benefit is confined to the heart; therefore, a narrowing or blockage of renal arteries, carotid arteries, or other peripheral arteries is not coronary artery disease and does not qualify for this benefit.

Coronary Artery Disease Requiring Bypass Grafts means coronary artery disease requiring a surgical operation to correct narrowing or blockage of one or more coronary arteries with bypass grafts, as confirmed in writing by a board-certified cardiologist. Angiographic evidence to support the necessity for this surgery will be required. For the purposes of this benefit, a surgical operation to correct narrowing or blockage does not include the following procedures: balloon angioplasty; laser embolectomy; atherectomy; stent placement; or any non-surgical procedures. Also, this benefit is confined to the heart; therefore, a narrowing or blockage of renal arteries, carotid arteries, or other peripheral arteries is not coronary artery disease and does not qualify for this benefit.

Multiple Diagnoses for a Cardiovascular Covered Condition

If the Covered Person is diagnosed with more than one Cardiovascular Disease Covered Condition at the same time, or on the same day, for which a benefit is payable, We will pay the applicable benefit shown on the Schedule for one Cardiovascular Disease Covered Condition, which will be for the Covered Condition that pays the highest Benefit Amount.

Covered Condition Category – Functional Loss

Sensory Loss means Loss of Sight, Hearing or Speech

a. Loss of Sight means the total and irreversible loss of all sight in both eyes. Loss of Sight that can be corrected by the use of any visual aid or device will not be considered an irreversible loss.
b. Loss of Speech means the total and permanent loss of the ability to speak.
c. Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of Hearing that can be corrected by the use of a hearing aid or device will not be considered an irreversible loss.

Functional Loss Covered Condition Exclusions

We will not pay benefits for a Functional Loss Covered Condition for any of the following:

a. a Functional Loss Covered Condition that is associated with the total and irreversible loss of all brain function (brain death);
b. a Functional Loss Covered Condition that is a dismemberment of an extremity;
c. a Functional Loss Covered Condition caused by a congenital birth defect; or
d. any Functional Loss Covered Condition for which, in general medical opinion or practice, surgery, an adaptive device or other corrective measure could restore function.

Covered Condition Category – Heart Attack

Myocardial Infarction means the ischemic death of a portion of the heart muscle as a result of obstruction of one or more of the coronary arteries. A positive diagnosis must be supported by either of the following criteria:

a. The presence of three or more of the following indicators:
   i. pain, pressure, fullness, discomfort, or squeezing in the center of the chest;
   ii. radiating pain to the shoulder, neck, back, arm or jaw;
   iii. new EKG changes indicative of myocardial infarction;
   iv. diagnostic increase of specific cardiac markers typical for Heart Attack; or
   v.confirmatory imaging studies.
b. In the event of death, an autopsy confirmation identifying Heart Attack as the cause of death will be accepted.

Additional Proof of Loss Requirements for Heart Attack Covered Condition

Proof of a Heart Attack Covered Condition requires a pathological diagnosis or clinical diagnosis as described below.

a. For a pathological diagnosis of a Heart Attack Covered Condition, the following additional documentation must be provided:

i. for Myocardial Infarction, documentation that shows an elevation of enzymes, troponins or other biochemical cardiac markers, and two of the following three criteria associated with the Myocardial Infarction:

1. Confinement in a Hospital as an inpatient;
2. documentation of electrocardiograph (EKG) changes on one or a series of electrocardiograms taken at the time the Covered Person experiences the Myocardial Infarction that are indicative of an acute Myocardial Infarction; however, if the Covered Person had any prior electrocardiogram(s), the electrocardiogram(s) presented as Proof of Myocardial Infarction must show changes from the Covered Person's last electrocardiogram, and such changes must be indicative of an acute Myocardial Infarction; or
3. documentation of imaging studies such as thallium scans, or echocardiograms which are indicative of an acute Myocardial Infarction; however, if the Covered Person had any prior imaging studies, the imaging studies presented as Proof of Myocardial Infarction must show changes from the Covered Person's last imaging studies, and such changes must be indicative of a Myocardial Infarction.

b. We will accept a Clinical Diagnosis of a Heart Attack Covered Condition only if a pathological Diagnosis cannot be made because it would be medically inappropriate or life-threatening under generally accepted medical standards.

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

Covered Condition Category – Infectious Disease

Infectious Disease Covered Condition means each of the following diseases:

Anthrax

Cholera

Rocky Mountain Spotted Fever

Encephalitis

Bacterial Meningitis

Typhoid Fever

Tuberculosis

Covered Condition Category – Kidney Failure

End Stage Renal Failure means the end stage failure which presents a chronic, irreversible failure of both kidneys, and requires treatment by renal dialysis.

The date of diagnosis of a Kidney Failure Covered Condition will be the earlier of:

i. the date a Covered Person receives the first kidney dialysis treatment; or
ii. the date a Covered Person is placed on the Transplant List.

Covered Condition Category – Major Organ Transplant

Bone Marrow Transplant means the irreversible failure of a Covered Person's Bone Marrow for which a Physician has determined that replacement of the Bone Marrow (stem cells) from a human donor is medically necessary.

Major Organ Failure Requiring Transplant (other than Bone Marrow) means the irreversible failure of a Covered Person's heart, lung, pancreas, kidney (entire renal function), or any combination of such organs, for which a Physician has determined that there is medical evidence to support the complete replacement of such organ with an entire organ from a human donor. It can also be the irreversible failure of a Covered Person's liver for which a Physician has determined that there is medical evidence to support the complete or partial replacement of the liver or liver tissue from a human donor. The need for a transplant must be due to severe organ disease.

To be eligible for payment of a Critical Illness Benefit for a Major Organ Transplant Covered Condition, documentation of the diagnosis must be provided showing that the Covered Person has either:

i. been placed on the Transplant List; or
ii. such Major Organ Transplant Procedure has been performed.

The date of diagnosis of a Major Organ Transplant Covered Condition will be the earlier of:

a. the date a Covered Person is placed on the Transplant List; or
b. the date a Covered Person undergoes a Major Organ Transplant Procedure.

Multiple Diagnoses for a Major Organ Transplant Covered Condition

a. If a Covered Person is placed on the Transplant List and then subsequently undergoes a Major Organ Transplant procedure of the same organ for which the Covered Person was on the Transplant List, we will treat this as a single diagnosis of a Major Organ Transplant Covered Condition.
b. Two or more organs transplanted on the same day, or during the same Surgery, shall be deemed one diagnosis of a Major Organ Transplant Covered Condition.

Exclusions Applicable to Major Organ Transplant Covered Conditions

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

a. if We have paid an Initial Benefit for a Kidney Failure Covered Condition to the Covered Person and the organ for which a Major Organ Transplant Procedure for such Covered Person is performed is a kidney;
b. if We have paid an Initial Benefit for Invasive Cancer for the same cancer condition for which a Major Organ Transplant of Bone Marrow replacement is performed;
c. if prior to the Covered Person's coverage becoming effective under this Certificate, the Covered Person had been placed on a Transplant List for the same organ for which the Major Organ Transplant Procedure is performed;
d. for a transplant involving organs received from non-human donors;
e. for a transplant involving implantation of mechanical devices or mechanical organs; or
f. for a transplant involving islet cell transplants.

Additional Definitions Applicable to Major Organ Transplant Covered Condition

a. **Bone Marrow** means the soft, sponge-like tissue within the bone that produces white blood cells, red blood cells and platelets.
b. **Transplant List** means the Organ Procurement and Transportation Network (OPTN) list.

Covered Condition Category – Progressive Disease

Progressive Disease Covered Condition means any of the following:

Alzheimer's Disease means a clinically established diagnosis of Alzheimer's Disease by a psychiatrist or neurologist that is based upon a severe cognitive impairment of such progressive nature that it results in a Covered Person's inability to independently perform (without hands-on assistance) 2 or more of the Activities of Daily Living.

Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's) means a neurodegenerative neuromuscular disease that results in the progressive loss of motor neurons that control voluntary muscles. A clinically established diagnosis of ALS must be made by a Physician based upon a detailed history of the symptoms and signs observed during physical examination along with a series of diagnostic tests and criteria generally accepted by the medical profession.

Primary Sclerosing Cholangitis (Walter Payton's Disease) means a chronic, long-term, disease that slowly damages the bile ducts. Primary Sclerosing Cholangitis must be diagnosed by a Physician and based upon a series of examinations and diagnostic tests commonly accepted by the medical profession.

Additional Definitions Applicable to Progressive Disease Covered Conditions.

Activities of Daily Living means, for the purposes of this Certificate, the following activities:

i. **Bathing** - The Insured's ability to wash himself or herself by sponge bath; or in a tub or shower, including the task of getting into and out of the tub or shower.

ii. **Continence** – The Insured's ability to maintain control of bowel or bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

iii. **Dressing** - The Insured's ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.

iv. **Eating** - The Insured's ability to feed himself or herself by getting food into his or her body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

v. **Toileting** – The Insured's ability to get to and from the toilet, to get on and off the toilet, and to perform associated personal hygiene.

vi. **Transferring** - The Insured's ability to move into or out of a bed, chair or wheelchair.

Covered Condition Category – Stroke

Stroke means a cerebrovascular event resulting in permanent neurological damage, including infarction, hemorrhage, or embolization of brain tissue from an extracranial source. The diagnosis must be based on documented irreversible neurological deficits and confirmatory neuroimaging studies.

Stroke does not include cerebral symptoms due to:

i. Transient Ischemic Attack (TIA);
ii. Reversible neurological deficit;
iii. Migraine;
iv. Cerebral injury resulting from trauma or hypoxia; or
v. Vascular disease affecting the eye, optic nerve or vestibular functions.

LIMITATIONS / EXCLUSIONS (WHAT IS NOT COVERED)

Exclusions – We do not cover losses caused by, or as a result of, the following:

1. As a result of the Covered Person voluntarily participating or attempting to participate in an illegal occupation.

   (does not apply for **Illinois residents**)

   Michigan residents: As a result of the Covered Person willfully participating or attempting to participate in an illegal occupation.

   Nevada residents: As a result of the Covered Person's conviction for voluntarily participating or attempting to participate in an illegal occupation.

2. As a result of the Covered Person intentionally causing a self-inflicted injury.

   (while sane for **Colorado residents**)

   (does not apply for **Michigan** and **Minnesota residents**)

3. As a result of the Covered Person committing or attempting to commit suicide, whether sane or insane.

   (while sane for **Colorado** and **Missouri residents**)

   (does not apply for **Michigan** and **Minnesota residents**)

   Vermont residents: As a result of the Covered Person committing or attempting to commit suicide.

4. As a result of a Covered Person's participation in a war or any act of war, declared or undeclared, riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority.

   Michigan residents: As a result of a Covered Person's participation in a war or any act of war, declared or undeclared. This does not include a loss which occurs while acting in a lawful manner within the scope of authority.

   Minnesota residents: voluntary involvement in any period of Armed Conflict. "Armed Conflict" means war or a conflict involving the armed forces of any country, group of countries, governments, or international organizations.

   North Carolina residents: As a result of a Covered Person's participation in a war or any act of war, declared or undeclared, riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority. Undeclared war does not include acts of terrorism.

Oklahoma residents: As a result of a Covered Person's participation in:

1) a war or act of war (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer, or;

2) as a result of a Covered Person's participation in a riot, civil commotion, civil disobedience, or unlawful assembly.

This does not include a loss which occurs while acting in a lawful manner within the scope of authority.

5. For any loss that occurred while on active duty status in the armed forces of any country. If you notify us of such active duty, we will refund any premiums paid for any period for which no coverage is provided as a result of this exclusion.

6. As a result of a Covered Person's commission of a felony.

Montana residents: As a result of a Covered Person's commission and conviction of a felony.

Nebraska residents: As a result of a Covered Person's commission of a felony or attempt to commit a felony.

Nevada residents: As a result of a Covered Person's commission of a felony other than an act that constitutes domestic violence regardless of whether the Covered Person contributed to any loss or injury.

7. As a result of a Covered Person's participation in a contest of speed in power driven vehicles, parachuting, or hang gliding.

(does not apply for **Illinois residents**)

8. As a result of a Covered Person's traveling in or descending from any vehicle or device for aerial navigation, unless as a fare paying passenger on a scheduled or a charter flight operated by a scheduled airline.

9. As a result of a Covered Person's being intoxicated as defined by the laws of the jurisdiction in which the loss occurred or under the influence of a controlled substance unless administered by a Physician or taken according to the Physician's instructions.

Michigan residents: As a result of a Covered Person's being intoxicated while driving a motor vehicle as defined by the laws of the jurisdiction in which the loss occurred.

Montana residents: As a result of a Covered Person's being intoxicated while driving a motor vehicle as defined by the laws of the jurisdiction in which the loss occurred or under the influence of a controlled substance unless administered by a Physician or taken according to the Physician's instructions.

Nevada, South Dakota and **Vermont residents:** This exclusion does not apply.

Under no condition will we pay any benefits for losses incurred prior to the Effective Date.

INSURED PAYMENT RESPONSIBILITY (PREMIUMS)

All premiums are payable on or before the date they are due.

Louisiana residents: We will give the Policyholder at least a 45-day advance written notice before an increase of 20 percent or more in the premium rates.

Grace Period – A Grace Period of 31 days will be allowed for each premium payment after the first premium. Insurance will stay in force during the Grace Period. The insurance under the Policy and/or Certificate will terminate on the day after the Grace Period ends if the premium due has not been paid in full. You must still pay us all premium due through the termination date, including the premium due for the time the Certificate was in force during the Grace Period.

If insurance is terminated on a premium due date and the premium has been paid through that date, the Grace Period will not apply. If termination is during the Grace Period, you will be liable for any unpaid premium including the pro rata premium for that part of the Grace Period during which insurance was in force. Benefits may be reduced by the amount of any due but unpaid premiums.

Nevada residents: A Grace Period of 31 days will be allowed for each premium payment after the first premium. Coverage will stay in force during the Grace Period. This Policy will terminate retroactively to the end of the day next preceding the Grace Period.

The Grace Period will not apply if coverage is terminated on a premium due date and the premium has been paid through that date. We will not be required to pay claims incurred during the Grace Period while a required premium remains unpaid and may seek reimbursement for any such claim erroneously paid during the Grace Period. We are liable for any claims incurred during the Grace period if the required premium payment is received during the Grace Period.

The Grace Period will not apply if coverage is canceled on a premium due date and the premium has been paid through that date.

Pennsylvania residents: A Grace Period of 31 days will be allowed for each premium payment after the first premium. Insurance will stay in force during the Grace Period. The insurance under the Certificate will terminate on the day after the Grace Period ends if the premium due has not been paid in full. You must still pay us all premium due through the termination date, including the premium due for the time the Certificate was in force during the Grace Period.

If insurance is terminated on a premium due date and the premium has been paid through that date, the Grace Period will not apply. If termination is during the Grace Period, you will be liable for any unpaid premium. Upon the payment of a claim under this Certificate, any premium due and unpaid may be deducted from the claim payment.

Virginia residents: A Grace Period of 31 days will be allowed for each premium payment after the first premium. Insurance will stay in force during the Grace Period. The insurance under the Policy and/or Certificate will terminate on the day after the Grace Period ends if the premium due has not been paid in full. You must still pay us all premium due through the termination date, including the premium due for the time the Certificate was in force during the Grace Period.

If insurance is terminated on a premium due date and the premium has been paid through that date, the Grace Period will not apply. If termination is during the Grace Period, you will be liable for any unpaid premium including the pro rata premium for that part of the Grace Period during which insurance was in force.

INFORMATION ON POLICY AND RATE CHANGES

Premium Changes – We have the right to change the premium rates on any premium due date in accordance with the terms of the Policy. If the rates are changed, we will give at least a 60-day advance written notice to the Policyholder.

Mississippi residents: We have the right to change the premium rates on any premium due date in accordance with the terms of the Policy. If the rates are changed, we will give at least a 75-day advance written notice to the Policyholder.

If the premiums increase because a change in benefits increases our liability, premium rates may be changed on the date that our liability is increased, without regard to any premium rate guarantee. If such premium increase takes place on a date other than a premium due date, a pro rata premium for the increase will be due on the next premium due date. The pro rata premium will be for the period from the date of the increase to the next premium due date. If such premium is not paid when due, subject to the grace period, the insurance will automatically be terminated as of the date the pro rata premium was due. Any partial payment of premium will be refunded.

Montana residents: We will not increase the premiums more frequently than once during a 12-month period.

New Hampshire and **Virginia residents:** If the premiums increase because a change in benefits increases our liability, premium rates may be changed on the date that our liability is increased, without regard to any premium rate guarantee. If such premium increase takes place on a date other than a premium due date, a pro rata premium for the increase will be due on the next premium due date. The pro rata premium will be for the period from the date of the increase to the next premium due date.

Premium Refunds – If your Dependent is covered and you divorce or legally terminate the relationship or such Dependent dies and we are notified in writing at our Administrative Office, we will refund premiums for the period of time following the date of divorce/dissolution or death of such Dependent. Premiums will not be refunded for any period prior to 30 days before such notification is received in our Administrative Office.

If your Dependent children are covered and coverage for all Children ends, we will refund premiums for the period of time following the last day of coverage. We must be notified in writing at our Administrative Office. Premiums will not be refunded for any time period prior to 30 days before such notification is received in our Administrative Office.

Reinstatement - If any renewal premium is not paid within the time granted for payment, a subsequent acceptance of premium by us or by any of our authorized agents, without requiring an application for reinstatement, will reinstate the Certificate. However, if we or our agent require an application for reinstatement and issue a conditional receipt, the Certificate will be reinstated upon our approval of such application, or, lacking such approval, upon the 45th day following the date of such conditional receipt; unless we have previously notified the Insured in writing of our disapproval of such application. The reinstated Certificate will only cover loss resulting from an Accident sustained after the date of reinstatement (Michigan residents: This sentence does not apply).. The reinstated Certificate will only cover loss due to a covered Critical Illness that begins more than 10 days after the reinstatement date. In all other respects you and the Company will have the same rights as each had under the Certificate immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement will be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

Maine residents: Termination for Nonpayment of Premium/Reinstatement - If coverage is to terminate due to nonpayment of premium, we will provide a notification of the termination to you and another person, if you have designated such a person to receive a copy of the Termination Notice.

Within 90 days after cancellation for nonpayment of premium, you, a person authorized to act on your behalf or a covered Dependent may request reinstatement on the basis that the loss of coverage was a result of your cognitive impairment or functional incapacity. We may require a medical demonstration that you suffered from such impairment or incapacity at the time of cancellation. If we waive the medical demonstration or the medical demonstration substantiates the existence of a cognitive impairment or functional incapacity at the time of cancellation to our satisfaction, we will reinstate your Certificate.

The reinstated Certificate will cover any loss or claim occurring from the date of cancellation. Within 15 days after our request for same, you must pay any unpaid premium from the date of the last premium payment at the rate that would have been in effect had your Certificate remained in force. If the premium is not paid as required, this Certificate may not be reinstated and we are not responsible for claims incurred after the initial date of cancellation.

CLAIMS PROCEDURE (HOW TO FILE A CLAIM)

Notice of Claim – Written notice of claim must be given to us at the address shown on the first page of this Certificate. Such notice should be made within 30 days after any loss covered by the contract. If it is not reasonably possible to give notice within that time, the claim may not be denied or reduced due to the delay, so long as notice is given as soon as reasonably possible.

North Carolina residents: Written notice of claim must be given to us within 20 days after the occurrence or commencement of any loss covered by the Certificate, or as soon thereafter as reasonably possible. Notice given by or on behalf of the Insured or the Beneficiary to us at our Administrative Office, or to our authorized agent, with information sufficient to identify the Insured, will be deemed notice to us.

Montana residents: Written notice of claim must be given to us at the address shown on the first page of this Certificate. Such notice should be made within 6 months after any loss covered by the contract. If it is not reasonably possible to give notice within that time, the claim may not be denied or reduced due to the delay, so long as notice is given as soon as reasonably possible. Notice given by or on behalf of the Insured to us or to our insurance producer with information sufficient to identify the Insured is considered notice of claim.

Pennsylvania residents: Such Notice should include sufficient information to identify the Covered Person.

Claim Forms – Claim forms should be used for filing Proof of Loss. We will furnish such form to the claimant within 15 days (10 days for **Alaska** and **Georgia residents**) of receipt of notice of claim. If we fail to furnish the proper claim forms within 15 days (10 days for **Alaska** and **Georgia residents**), you can give proof in writing, setting forth the nature and extent of the loss within the time stated in the Proof of Loss provision. You or a personal representative may obtain a claim form by calling our toll-free telephone number listed on the cover page.

Minnesota, Missouri and **Virginia residents:** **Claim Forms** – Claim forms should be used for filing Proof of Loss. We will furnish such form to the claimant, or to the Policyholder for delivery to the claimant, within 15 days of receipt of notice of claim. If we fail to furnish the proper claim forms within 15 days, you will be deemed to have complied with the requirements as to Proof of Loss upon submitting, within the time fixed in the contract for filing Proof of Loss, written proof covering the occurrence, character, and the extent of the loss for which claim is made. You or a personal representative may obtain a claim form by calling our toll-free telephone number listed on the cover page.

New Hampshire residents: Claim forms should be used for filing Proof of Loss. We will send such form to the claimant within 15 days of receipt of Notice of Claim. If we fail to supply the proper claim forms within 15 days, you can give proof in writing, setting forth the nature and extent of the loss within the time stated in the Proof of Loss provision.

Proof of Loss – Due written Proof of Loss must be given to us at the address shown on the first page of this Certificate. In case of a claim for loss for which a periodic payment is provided contingent upon continuing loss, such satisfactory written Proof of Loss must be sent within 90 days (180 days for **North Carolina residents**) after the termination of the period for which we are liable. For any other loss, proof must be sent within 90 days (180 days for **North Carolina residents**) after the date of such loss.

Failure to furnish proof within such time will not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof and it was furnished as soon as reasonably possible. In any event, the proof required must be given no later than one year (15 months for **Hawaii residents**) from the time proof of loss is otherwise required, unless the claimant was legally incapacitated.

Utah residents: Failure to furnish proof within such time will not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof and it was furnished as soon as reasonably possible.

Payment of Claim Benefits – All benefits payable under your Certificate will be paid to you, unless you have assigned such benefits. Any benefits due that have not been paid at the time of your death will be paid either: (1) to your spouse; or (2) if there is no spouse, to your estate. Such payment fully discharges us to the extent of the payment.

Arizona residents: **Reimbursement to Medicaid** – If the state Medicaid program (pursuant to title XIX of the Social Security Act) pays for expenses or treatment covered by this Certificate, the state has the right to reimbursement by us for those expenses or treatment. If the state provides us proof of payment for covered services or treatment, we will reimburse the state Medicaid program according to the coverage provided in this Certificate, including any Riders.

Montana residents: Indemnity for loss will be payable to the Insured in accordance with the provisions respecting such payment which may be prescribed herein and effective at the time of payment. Any indemnities unpaid at the Insured's death may, at the option of the Insurer, be paid either to a named beneficiary or to the Insured's estate.

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

Missouri residents: All benefits payable under your Certificate will be paid to you, unless you have assigned such benefits. Any benefits due that have not been paid at the time of your death will be paid either: (1) to your spouse; or (2) if there is no spouse, to your estate.

New Hampshire residents: All benefits payable under your Certificate will be paid to you. Benefits payable under this Certificate cannot be assigned to a health care provider. Any benefits due that have not been paid at the time of your death will be paid either: (1) to your spouse; or (2) if there is no spouse, to your estate.

Utah residents: All benefits payable under your Certificate will be paid to you, unless you have assigned such benefits. Indemnity for loss of life is paid in accordance with the beneficiary designation effective at the time of payment. If no valid beneficiary designation exists, the indemnity is paid to the insured's estate. Any other accrued indemnities unpaid at the insured's death are paid to the insured's estate. Such payment fully discharges us to the extent of the payment.

Virginia residents: We may pay up to $5,000 of such benefit to one of your relatives by blood or connection by marriage of the person who is deemed by us to be equitably entitled to the benefit.

Department of Medical Assistance Services - The Department of Medical Assistance Services will be the payor of last resort to any insurer, including a group health plan as defined in §607(1) of the Employee Retirement Income Security Act of 1974, a health services plan, a service benefit plan and a health maintenance organization which contracts to pay health care costs for persons eligible for medical assistance in the Commonwealth.

Michigan residents only:

Change of Beneficiary - The insured has the right to change the beneficiary under this certificate. Consent of a beneficiary is not required to surrender this certificate, for the assignment of the certificate, to change a beneficiary, or to make any other changes in the certificate.

Physical Examinations – We have the right to have a Covered Person examined by a Physician of our choice, at our expense, as often as reasonably necessary while a claim is pending.

Autopsy – In case of death, we may request an autopsy at our expense where it is not forbidden by law.

This provision does not apply for **Mississippi residents**.

South Carolina residents: The autopsy must be performed in South Carolina.

Vermont residents: In case of death, we may request an autopsy at our expense where it is not forbidden by law or your religion.

Time of Payment of Claims – Benefits for a covered loss will be paid promptly after we receive due written Proof of Loss.

Alabama residents: Benefits payable under the Certificate for any covered loss will be paid within 30 days after receipt of due written Proof of Loss in the form of a clean claim where claims are submitted electronically. Claims submitted in paper format will be paid within 45 days after receipt of due written Proof of Loss. As used in this provision, a clean claim means a claim which contains substantially all of the required data elements necessary for accurate adjudication, without obtaining additional information from the provider of the service or a third party.

We will notify you if a claim is being denied or pended and what, if any, additional information is required to process the claim not more than 30 days after receipt of a claim that is filed electronically or 45 days after receipt for a claim that is filed in paper format. Any undisputed portion of a claim will be paid as if it were a clean claim. If we fail to give notice why a claim is being denied or pended in the time required, then any such claim, if and when determined to be payable, will be paid with interest from the date notice should have been given. Upon receipt of the necessary information, the claim must be paid, denied, or otherwise adjudicated within 21 calendar days from the receipt of the requested information.

Alaska residents: Benefits for a covered loss will be paid not later than 30 calendar days after we receive due written Proof of Loss in the form of a clean claim. As used in this provision, a clean claim means a claim that does not have a defect or impropriety, including a lack of any required substantiating documentation, or a particular circumstance requiring special treatment that prevents timely payment of the claim. If the claim is not paid, denied or additional information requested to adjudicate a claim, notice will be given to the Covered Person within 30 calendar days after the claim is received. If notice is not given, the claim will be considered a clean claim and interest will accrue at a rate of 15 percent annually and will continue to accrue until the date the claim is paid. When additional information needed to adjudicate a claim has been received, we will then have 15 calendar days to pay the claim or within 30 calendar days after receipt of the claim. If we fail to pay the claim within the required time period, the claim will be considered a clean claim and interest will accrue at a rate of 15 percent annually and will continue to accrue until the date the claim is paid. If only a portion of a claim is covered under the terms of the insurance policy, interest accrues based only on the portion of the claim that is covered.

Arizona and **Kentucky residents:** Benefits for a covered loss will be paid immediately, but no later than 30 days after we receive due written Proof of Loss. If benefits are not paid within such 30-day period, the Insured will be entitled to interest at a legal rate from the date the claim is received by the Insurer. The interest will be calculated on the amount the Insurer is legally obligated to pay according to the terms of this contract.

Colorado residents: Benefits for a covered loss will be paid immediately after we receive due written Proof of Loss in the form of a clean claim that was submitted electronically. A Claim submitted in paper format will be paid within 45 days after we receive due written Proof of Loss. As used in this provision, a clean claim means the claim form is submitted with all required fields completed with correct and complete information, including all required documents.

We will notify you of any deficiencies in a submitted claim not more than 30 days after receipt. We may deny the claim if the required information is not received within 30 days of our request. If we fail to pay or deny a clean claim in the time required and we subsequently pay the claim, we will pay you interest on the amount paid at the rate of 10% annually. Such interest will accrue beginning 31 days after the date the claim is received, when filed electronically, or 46 days after the date the claim is received when filed in paper format. Interest stops accruing on the date the claim is paid.

All claims must be paid, denied, or settled within 90 days after receipt. If we fail to pay or deny a claim within 90 days, we will pay you interest on the amount paid at the rate of 20% annually. Such interest will accrue beginning 91 days after the date the claim is received. Interest stops accruing on the date the claim is paid.

Delaware, South Carolina and **Virginia residents:** Benefits for a covered loss will be paid immediately, but no later than 60 days after we receive due written Proof of Loss.

District of Columbia, Kansas, North Carolina and **Oregon residents:** Benefits for a covered loss will be paid immediately upon receipt of due written proof of such loss.

Florida and **Wyoming residents:** Benefits for a covered loss will be paid not more than 45 days after we receive due written Proof of Loss.

Georgia residents: Benefits for a covered loss will be paid promptly after we receive due written Proof of Loss. If we fail to pay the benefits payable upon receipt of due written proof of loss, we will mail a letter to you within 15 working days that states the reasons we have for failing to pay the claim in whole or in part, and include a written itemization of any documents or other information needed to process the claim or any portions thereof that are not being paid. When all documents or other information needed to process the claim has been received, we will then have 15 working days within which to process and either pay the claim or deny it, in whole or in part, giving you the reasons we have for denying the claim or any portion thereof. If we fail to pay the claim or send a letter denying the claim, or any portion thereof, within 15 working days of receiving due written proof of any documents or other information needed to pay the claim, we will pay interest to you equal to interest at the percentage rate set by the state per annum on the benefits due and payable under the terms of the Policy.

Illinois residents: Benefits for a covered loss will be paid within 30 days after we receive due written Proof of Loss. If benefits are not paid within such 30-day period, the Insured will be entitled to interest at the rate of 9 per cent per annum from the 30th day after receipt of such Proof of Loss to the date of late payment, provided that interest amounting to less than one dollar will not be paid.

Indiana residents: Benefits payable under the Certificate for any covered loss will be paid within 30 days after receipt of due written Proof of Loss in the form of a clean claim where claims are submitted electronically. Claims submitted in paper format will be paid within 45 days after receipt of due written Proof of Loss. As used in this provision, a clean claim means a claim that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

We will notify you of any deficiencies in a submitted claim not more than 30 days after receipt of a claim that is filed electronically or 45 days after receipt for a claim that is filed in paper format. If we fail to pay or deny a clean claim in the time required and we subsequently pay the claim, we will pay you interest on the allowable amount of the claim paid. Such interest will accrue beginning 31 days after the date the claim is received when filed electronically or 46 days after the date the claim is received when filed in paper format. Interest stops accruing on the date the claim is paid.

Maine and New Hampshire residents: Benefits for a covered loss will be paid within 30 days after we receive due written Proof of Loss.

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

Minnesota residents: **Time of Payment of Claims** – In case of a claim for loss for which a periodic payment is provided, benefits will be paid within 30 days after we receive written Proof of Loss. For any other covered loss, benefits will be paid immediately after we receive written Proof of Loss.

Mississippi residents:
1. All benefits payable under this policy for any loss, other than loss for which this policy provides any periodic payment, will be paid within twenty-five (25) days after receipt of due written proof of such loss in the form of a clean claim where claims are submitted electronically, and will be paid within thirty-five (35) days after receipt of due written proof of such loss in the form of clean claim where claims are submitted in paper format. Benefits due under the policies and claims are overdue if not paid within twenty-five (25) days or thirty-five (35) days, whichever is applicable, after the Company receives a clean claim containing necessary medical information and other information essential for the Company to administer preexisting condition, coordination of benefits and subrogation provisions. A "clean claim" means a claim received by the Company for adjudication and which requires no further information, adjustment or alteration by the provider of the services or the Insured in order to be processed and paid by the Company. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected. Errors, such as system errors, attributable to the Company, do not change the clean claim status.

A clean claim does not include any of the following:

a. A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within thirty (30) days of the original claim;
b. Claims which are submitted fraudulently or that are based upon material misrepresentations;
c. Claims that require information essential for the Company to administer preexisting condition, coordination of benefits or subrogation provisions; or
d. Claims submitted by a provider more than thirty (30) days after the date of service; if the provider does not submit the claim on behalf of the Insured, then a claim is not clean when submitted more than thirty (30) days after the date of billing by the provider to the Insured.

Not later than twenty-five (25) days after the date the Company actually receives an electronic claim, the Company shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the Insured (where the claim is owed to the insured) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Not later than thirty-five (35) days after the date the Company actually receives a paper claim, the Company shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the Insured (where the claim is owed to the Insured) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by the Company shall be paid within twenty (20) days after receipt.

For purposes of this provision, the term "pay" means that the Company shall either send cash or a cash equivalent by United States mail, or send cash or a cash equivalent by other means such as electronic transfer, in full satisfaction of the appropriate benefit due the provider (where the claim is owed to the provider) or the Insured (where the claim is owed to the Insured). To calculate the extent to which any benefits are overdue, payment shall be treated as made on the date a draft or other valid instrument was placed in the United States mail to the last known address of the provider (where the claim is owed to the provider) or the Insured (where the claim is owed to the Insured) in a properly addressed, postpaid envelope, or, if not so posted, or not sent by United States mail, on the date of delivery of payment to the provider or Insured.

2. Subject to due written proof of loss, all accrued benefits for loss for which this policy provides periodic payment will be paid monthly, and any balance remaining unpaid upon the termination of liability will be paid within thirty (30) days after receipt of due written proof.

3. If the claim is not denied for valid and proper reasons by the end of the applicable time period prescribed in this provision, the Company must pay the provider (where the claim is owed to the provider) or the Insured (where the claim is owed to the Insured) interest on accrued benefits at the rate of three percent (3%) per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. Whenever interest due pursuant to this provision is less than One Dollar ($1.00), such amount shall be credited to the account of the person or entity to whom such amount is owed. The provisions of this subparagraph 3 shall not apply to any claims or benefits owed under Medicare Advantage plans or Medicare Advantage Prescription Drug plans.

4. In the event the Company fails to pay benefits when due, the person entitled to such benefits may bring action to recover such benefits, any interest which may accrue as provided in subparagraph 3 and any other damages as may be allowable by law. If it is determined in such action that the Company acted in bad faith as evidenced by a repeated or deliberate pattern of failing to pay benefits and/or claims when due, the person entitled to such benefits (health care provider or Insured) shall be entitled to recover damages in an amount up to three (3) times the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated.

Missouri residents: Benefits for a covered loss other than benefits for loss of time will be paid within 30 days after we receive satisfactory written Proof of Loss. All accrued benefits payable under the Policy for loss of time shall be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period shall be paid as soon as possible after receipt of such proof.

Nevada residents: Benefits for a covered loss will be approved or denied within 30 days after we receive Proof of Loss. If the claim is approved, we will pay the claim within 30 days after approval. If the approved claim is not paid within that period, we will pay interest on the claim at a rate of interest equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus 6 percent. The interest will be calculated from 30 days after the date on which the claim is approved until the date on which the claim is paid. The payment of interest may be waived only if the payment was delayed because of an act of God or another cause beyond our control.

If additional information is required to determine whether to approve or deny the claim, we will notify you of this request within 20 days after we receive the claim. We will notify the provider of health care of all the specific reasons for the delay in approving or denying the claim. After receiving the additional information, we will approve or deny the claim within 30 days. If the claim is approved, we will pay the claim within 30 days. If the approved claim is not paid within that period, we will pay interest on the claim.

Oklahoma residents: Benefits for a covered loss will be paid immediately after we receive satisfactory written Proof of Loss. Claims for which no additional information is required and which are not excluded or limited under this contract will be paid no later than 45 calendar days after receipt of Proof of Loss. If there is a delay in payment of the claim, we will notify the Covered Person in writing of the cause for delay in payment of the claim within 30 calendar days after receipt of Proof of Loss. The Company will pay interest at the rate mandated by the State of Oklahoma on any claim paid later than 45 calendar days and interest will accrue beginning on the 46th day.

Rhode Island and **Virginia residents:** Benefits for a covered loss will be paid within 60 days after we receive due written Proof of Loss.

Vermont residents: Benefits for a covered loss will be paid immediately, but no later than 30 days after we receive due written Proof of Loss.

Alaska residents only:

Notice of Appeal Rights – You have a right to appeal any decision we make that denies payment of your claim or your request for coverage of a health care service or treatment. Please review the Grievance Procedures notice provided with this Certificate.

GENERAL CERTIFICATE PROVISIONS

Clerical Error - A clerical error by us will not invalidate insurance otherwise in force, nor continue insurance otherwise not validly in force.

Conformity with State or Federal Laws – Any provision of the Policy or the Certificate that conflicts with the requirements of any state or federal law of the governing jurisdiction is hereby automatically changed to meet the minimum standards of such laws.

Alaska, Missouri, Nebraska, and **Vermont residents:** Any provision of the Policy or Certificate that conflict with the law of the state in which the Covered Person resides is hereby automatically changed to meet the minimum standards of such laws.

Mississippi and **Pennsylvania residents:** Any provision of the Policy or Certificate which, on its Effective Date, is in conflict with the statutes of the state in which the Insured resides on such date, is amended to conform to meet the minimum standards of that law.

Montana residents: Conformity with Montana Statutes – The provisions of the Policy or Certificate that conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the Covered Person resides on or after the Effective Date.

Entire Contract; Changes – The entire contract consists of the Policy as issued to the Policyholder, the Policyholder Application, the Certificate Provisions, and any attached Amendments, Endorsements, and Riders. Changes to the Policy or this Certificate may only be made in writing signed by an executive officer of the Company. No agent or Policyholder has authority to change the Policy or this Certificate or to waive any of its provisions. Any changes are subject to the laws of the governing jurisdiction.

Alaska residents: We will provide written notice to a Covered Person at least 45 days before the effective date of the change in coverage, or change in premium, or cancellation of coverage.

Maine residents: No changes to the Policy or this Certificate shall be valid unless approved by an executive officer of the Company and evidenced by endorsement on the Policy, or by amendment to the Policy signed by the Policyholder and the Company.

Tennessee residents: The entire contract consists of the Policy as issued to the Policyholder, the Policyholder Application, the Insured's Application or Enrollment Form, the Certificate Provisions, and any attached Amendments, Endorsements, and Riders.

Virginia residents: Any individual applications of the persons insured are added to documents that constitute the entire contract. A copy of the Policyholder Application shall be attached to the Policy when issued. Only our President, Vice President, Secretary, or an Assistant Secretary may make any changes to the Policy or Certificate and then only in writing.

Inspection of Policy – The Insured may inspect a copy of the Policy by contacting the Policy holder at reasonable time during normal business hours.

Legal Action – No legal action may be brought to recover under the Policy or Certificate within 60 days (90 Days for **Delaware residents**) after written Proof of Loss has been provided to us as required nor more than three years (five years for **Kansas residents**) (six years for **Alabama** and **South Carolina residents**) from the time written Proof of Loss is required to be furnished.

Florida residents: No legal action may be brought to recover under the Policy or Certificate within 60 days after written Proof of Loss has been provided to us as required. No such action may be brought after the expiration of the applicable statute of limitations from the time written proof of loss is required to be given.

Misstatement of Age – If the Insured's age has been misstated, all benefits payable under the Policy for any Covered Person will be such amount as the premium paid would have purchased at the Insured's correct age.

Misstatement of Tobacco Use Status – If the Covered Person's tobacco use status has been misstated on the Application, all benefits payable under the Policy for any Covered Person will be such amount as the premium paid would have purchased had the use of tobacco been correctly stated.

District of Columbia and **Mississippi residents:** This provision does not apply.

Other Insurance With Us – If a Covered Person has more than one Specified Disease health policy, certificate, or similar coverage with us, only one, chosen by you or your estate, will be effective. We will refund all premiums paid for all other such coverage from the date of duplication, less any benefits paid from such date.

Time Limit on Certain Defenses / Right to Contest / Contestability

Misstatements in the Application – We will not use any statement, except fraudulent statements, to void or reduce benefits after your insurance has been in effect for two years (three years for District of Columbia and Vermont residents) from the Effective Date of coverage. Any such statement would have to be in a signed form. This also applies to all Riders.

Georgia residents: Fraudulent statement are statements made with the intent to misrepresent material fact in applying for or procuring coverage under the terms of the Policy.

Hawaii residents: Fraudulent statement are statements made with the intent to deceive and which materially affected our acceptance of the risk.

Missouri residents: We will not use any statement, except fraudulent statements, to void or reduce benefits after your insurance has been in effect for two years from the Effective Date of coverage. Any such statement would have to be in a signed form.

North Carolina residents: We will not use any statement to void or reduce benefits after your insurance has been in effect for two years from the Effective Date of coverage. Any such statement would have to be in a signed form. This also applies to all Riders.

Utah and **Virginia residents:** Misstatements in the Application – We will not use any statement to void or reduce benefits after your insurance has been in effect for two years from the Effective Date of coverage. Any such statement would have to be in a signed form. This also applies to all Riders.

All statements made are considered representations and not warranties. No such statement will be used in any contest, unless a copy of such statement has been furnished to you.

Montana residents: In the absence of fraud, all statements made are considered representations and not warranties. No such statement will be used in any contest, unless a copy of such statement has been furnished to you.

South Carolina and **Virginia residents:** No such statement will be used in any contest, unless a copy of such statement has been furnished to you or to your beneficiary or personal representatives.

Any increase in benefit amounts is subject to a new two-year (three years for **Vermont residents**) contestable period for the increased amount only, (but only in regard to statements made on the Application for the increase for **Nebraska residents**). (This sentence does not apply for **Missouri residents**.)

Pennsylvania residents: We will not use any statement, except fraudulent statements, in your Application to void or reduce benefits after coverage has been in force during your lifetime for two years from its Effective Date. Any such statement would have to be in a signed form. This also applies to all Riders.

In the absence of fraud, all statements made by you shall be deemed representations and not warranties and no statement for the purpose of insurance shall void such insurance or reduce benefits unless contained in a written application signed by you a copy of which has been furnished to you or your beneficiary.

Michigan residents:

Contestability - Misstatements in the Application – We will not use any statement, except fraudulent statements, to void or reduce benefits after your insurance has been in effect for three years from the Effective Date of coverage. Any such statement would have to be in a signed form. This also applies to all Riders.

All statements made are considered representations and not warranties. No such statement will be used in any contest, unless a copy of such statement has been furnished to you.

A claim for a loss incurred or disability, as defined in the policy, beginning after three years from the date of issue of this policy will not be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss existed before the effective date of coverage of this policy.

Rhode Island residents:

Contestability - The validity of the contract will not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue. No statement made by the Policyholder or an Insured in an Application for coverage under the contract, with respect to a Covered Person, will be used to void the contract or to deny a claim for loss after this insurance has been in force for a period of two years during a Covered Person's lifetime. Such statement must be contained in a written Application signed by the person making the statement and a copy of the Application is or has been furnished to him.

Notice – Any notice to you will be sent to your last known address.

TERMINATION / NONRENEWAL / CONTINUATION

Your insurance will terminate on the earliest of the following dates:

1. The date the Policy terminates;
2. The date you cease to be eligible for insurance;
3. The date of your death;
4. The premium due date on which we fail to receive your premium, subject to the Grace Period provision; or

    Virginia residents: 4. The day after the Grace Period ends; or

5. The date we receive your request to terminate your insurance, or the effective date of termination you request, if later.

The insurance on a Dependent will terminate on the earliest of the following dates:

1. The date your insurance terminates;
2. The premium due date on which we fail to receive your premium from the Policyholder, subject to the Grace Period provision;

    Virginia residents: 2. The day after the Grace Period ends;

3. The date your Dependent no longer satisfies the requirements under Dependent Eligibility provision;
4. The date of the Dependent's death;
5. The date the Policy is modified so as to exclude Dependent insurance; or
6. The date we receive your request to terminate your Dependent insurance, or the effective date of termination you request, if later.

We may terminate the insurance of any Covered Person who submits a fraudulent claim under the Policy.

Termination of your insurance will not affect any claim which begins before the date of termination, except in the case of fraud.

Missouri residents: The Policy may be amended or canceled as stated in its provisions. Such an action may be taken without the consent of or notice to any Covered Person. Premiums are subject to change. However, except for non-payment of premiums or failure to meet continued underwriting standards, we may not terminate the Policy prior to the first anniversary date of the Policy. We will notify the Policyholder 60 days prior to the effective date of any such termination. If we should terminate the Policy, it will be without prejudice to any loss originating prior to the effective date of termination.

Montana residents: Ninety-day advance written notice of termination will be given to you if we intend to terminate your insurance for any reason other than nonpayment of premium. Thirty-day advance written notice of termination will be given to you if we intend to terminate your insurance for nonpayment of premium. Insurance will terminate on the date specified in that notice. Notice will be mailed to the last-known address shown in the records of the company.

Virginia residents: Cancellation by Insured - The Insured may cancel this contract at any time by written notice delivered or mailed to the Company effective upon receipt or on such later date as may be specified in the notice. In the event of cancellation, the Company will return promptly the unearned portion of any premium paid. The earned premium will be computed pro rata.

Cancellation will be without prejudice to any claim originating prior to the effective date of cancellation.

Louisiana residents: Premium rates will not be increased during the initial 12 months of coverage and not more than once in any six-month period following the initial 12-month period. We will notify the Policyholder in writing at least 45 days before any increase of 20 percent or more in the premium rates.

Nevada residents: We may terminate the insurance of any Covered Person who submits a fraudulent claim under the Policy. We will notify the Policyholder 30 days prior to the effective date of any such termination.

Termination of your insurance will not affect any claim which begins before the date of termination.

CONVERSION OPTION

If you lose eligibility for this insurance for any reason other than nonpayment of premium, you will have the option to convert this group coverage to a policy we are issuing for the purpose of conversions. You will receive notification of this Option from the Group Policyholder at the time your insurance terminates.

You must complete a written request to exercise this option and pay the first premium to us no later than 31 days after the date of your termination under the Policy. If you are interested, please request an application from the Policyholder and submit to us within 31 days of your termination date. The converted policy will be issued, without Evidence of Insurability, on a policy form then available for conversions, which is most comparable to this Certificate. The premium you pay for the converted policy will be determined on your resident state, age, and class of risk, at the time of conversion and the type and amount of insurance provided.

The effective date of the converted policy will be the day following the termination of insurance under this Certificate.

This Conversion Option is only available for the Insured and the Insured's covered Dependents. It is not available for the Insured's Dependents without the Insured.

Conversion is not available if coverage is terminating due to fraud (not applicable for Alaska residents).

GENERAL DEFINITIONS

Terms important to understanding this Certificate are defined in this section and are capitalized in this Certificate.

Active Service means performing in the usual manner all the regular duties of your occupation on a scheduled work day at the normal place of business or other location as directed by your employer.

If you are not working on a day your insurance would otherwise take effect, you will be considered to be in Active Service on that day only if: (a) you are capable of performing in the usual manner all the regular duties of your occupation, and (b) you were in Active Service on the last preceding regular workday.

Active Service does not apply if employment is not an eligibility requirement.

New Hampshire and **Ohio residents:** Active Service definition does not apply.

Amendment, Endorsement, or Rider means any form issued by us which adds, modifies, changes, or deletes any Policy or Certificate provision or benefit.

Application or Enrollment Form means the form completed and signed to apply for this insurance coverage.

Certificate means this document that describes your insurance coverage.

Child means
A Child of yours who is under the age of 26 and is:
1. A natural Child;
2. A legally adopted Child or a Child who has been placed for adoption with you;
3. A stepchild or foster Child;
4. A grandchild who lives with you;
5. A Child for whom you have been appointed legal guardian; or
6. A Child for whom you are legally required to provide support.

If applicable, Child will also include children of your Other Adult Dependent in the same manner as a stepchild.

Louisiana residents:
An unmarried Child who is placed in the home of an Insured following execution of an act of voluntary surrender in favor of the Insured or the Insured's legal representative shall be considered a dependent Child of the Insured effective on the date on which the act of voluntary surrender becomes irrevocable.

If a Child covered under this Certificate has reached age 26, but is incapable of self-support because of mental or physical impairment*, we will continue the Child's insurance under the following conditions:

***(Minnesota residents:** because of developmental disability, mental illness or disorder, or physical disability)
***(North Dakota residents:** because of intellectual or physical disability)

1. The Child must be incapacitated;
2. We must receive proof of incapacity within 31 days after insurance would otherwise terminate;
3. We may require proof of continued incapacity from time to time, but not more often than once a year after the two-year period following the date the Child attains age 26; and
4. Your insurance must remain in force.

Arkansas residents:
If a Child covered under this Certificate has reached age 26, but is incapable of self-support because of mental or physical impairment, we will continue the Child's insurance at the premium rate in effect for Child's insurance, under the following conditions:

1. The Child must be incapacitated;
2. To obtain the continuation, you must submit proof of the Child's incapacity to us, at our expense. If proof that the Child was incapacitated from the date the Child attained the limiting age is not submitted before or at the time Proof of Loss is submitted for a claim, benefits will not be paid until proof is received by us;
3. We may require proof of continued incapacity from time to time, at our expense, but not more often than once a year after the two-year period following the date the Child attains age 26; and
4. Your insurance must remain in force.

North Carolina residents:
If a Child covered under this Certificate has reached age 26, but is incapable of self-support because of mental or physical impairment, we will continue the Child's insurance under the following conditions:

1. The Child must be incapacitated;
2. We must receive proof of incapacity within 31 days after insurance would otherwise terminate;
3. We may require proof of continued incapacity from time to time, but not more often than once a year after the date the Child attains age 26; and
4. Your insurance must remain in force.

Indiana residents:

Child means
A Child means an individual who is under the age of 26, covered under a Comprehensive Medical Plan, and is:

1. A natural Child;
2. A legally adopted Child or a Child who has been placed for adoption with you;
3. A stepchild or foster Child;
4. A Child for whom you have been appointed legal guardian; or
5. A Child for whom you are legally required to provide support.

If applicable, Child will also include children of your Spouse or Other Adult Dependent in the same manner as a stepchild. The term Child does not include the Insured's grandchild, unless required by law.

Child also includes a Child who is incapable of self-support due to a mental or physical impairment. If a Child covered under this Certificate has reached age 26 but is incapable of self-support because of mental or physical impairment, we will continue the Child's insurance under the following conditions:

1. The Child must be incapacitated;
2. We must receive proof of incapacity within 120 days after the insurance would otherwise terminate;
3. We may require proof of continued incapacity from time to time, but not more often than once a year after the two-year period following the date the Child attains age 26; and

4. Your insurance must remain in force.

Clinical Diagnosis means a Diagnosis based on the study of symptoms and diagnostic test results.

Confined or Confinement mean that period of time the Covered Person is admitted into a Hospital as a resident bed patient as established by the records of the Hospital. Confinement does not include that period of time during which a Covered Person is in a Hospital emergency room, an Observation Unit for less than 20 hours or recovery room, a freestanding surgical facility or an outpatient facility.

Covered Person means you and your Dependents who have been accepted for insurance by us.

Dependent means your Spouse, Other Adult Dependent, or Child

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

Effective Date means the date the Covered Person's insurance starts under this Certificate as noted on the Certificate Cover Page.

Enrollment Qualifying Event – The occurrence of a specified event that would allow an Eligible Insured and his or her Eligible Dependent(s) to enroll under the Policy after being first eligible without Evidence of Insurability being required. A specified event means any of the following:

1. An individual becomes an Eligible Dependent of the Eligible Insured through marriage, birth, adoption, or placement for adoption; or
2. The Eligible Insured or Dependent loses coverage under another critical illness policy.

Evidence of Insurability means the complete and truthful answers to the questions in the Application and medical history, if necessary, which will be used by us to base our acceptance of an applicant under the Policy.

First Occurrence means the first time a covered Critical Illness, as specified in the Schedule of Benefits, is diagnosed on or after the Covered Person's Effective Date. (Diagnosis can occur after death if death is due to a Critical Illness.)

> **Mississippi residents:** Any reference to **First Occurrence** is changed to **Initial Occurrence**.
>
> **Initial Occurrence** means the first time a covered Critical Illness, as specified in the Schedule of Benefits, is diagnosed on or after the Covered Person's Effective Date. (Diagnosis can occur after death if death is due to a Critical Illness.)

Grace Period means the period of 31 days after the premium due date allowed for each premium payment after the first premium.

Group Master Policy or Policy means the insuring contract that is issued to the Policyholder.

Hospital means a licensed institution that has on its premises or in facilities available to the Hospital on a contractually prearranged basis and under the supervision of a staff of one or more duly licensed Physicians:

1. Laboratory, X-ray equipment and operating rooms where major surgical operations may be performed by licensed Physicians;
2. Permanent and full-time facilities for the care of overnight resident bed patients under the supervision of a licensed Physician;
3. 24-hour-a-day nursing service by graduate registered nurses; and
4. A patient's written history and medical records.

Notwithstanding the above, Hospital does not include an institution or that part of an institution operated as:

1. A nursing home;
2. An extended care facility;
3. A skilled nursing facility;
4. A mental institution or a facility for the treatment of mental disorders;
5. A rest home or home for the aged;

6. A rehabilitation center; or
7. A place for alcoholics or drug addicts.

Missouri residents: Hospital means a legally constituted institution (or an institution which operates pursuant to law) having organized facilities for the care and treatment of sick and injured persons on a resident or inpatient basis including facilities for diagnosis and surgery under the supervision of a staff of one (1) or more licensed physicians and which provides twenty-four (24)-hour nursing service by registered nurses on duty or call. It does not mean convalescent, nursing, rest or extended care facilities or facilities operated exclusively for treatment of the aged, drug addict or alcoholic, even though the facilities are operated as a separate institution by a hospital.

North Carolina residents: A State tax-supported institution will be considered a Hospital even if it does not have an operating room and related equipment for surgery on its premises or in facilities available on a contractually prearranged basis.

Pennsylvania residents: Hospital means an institution operated pursuant to law which is licensed or approved as a Hospital by the responsible state agency, be primarily engaged in providing medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made, and provides 24-hour nursing service by or under supervision of registered graduate professional nurses (RN).

Vermont residents: Hospital will include an institution, approved by the secretary of human services, which provides a program for the treatment of a mental health condition or alcohol or substance dependency pursuant to a written plan.

Immediate Family Member means anyone related to a Covered Person in the following manner: spouse, daughter, son, stepchild, father, mother, stepparent, sister, brother, stepsister, stepbrother, grandchild, grandparent, father-in-law, mother-in-law, or the spouse of any of these.

Hawaii residents: Immediate Family Member means anyone related to a Covered Person in the following manner: spouse, daughter, son, stepchild, father, mother, stepparent, sister, brother, stepsister, stepbrother, grandchild, grandparent, father-in-law, mother-in law, or the spouse of any of these. The term “spouse” includes a reciprocal beneficiary.

Nevada residents: Immediate Family Member means anyone related to a Covered Person in the following manner: spouse, daughter, son, stepchild, father, mother, stepparent, sister, brother, stepsister, stepbrother, grandchild, grandparent, father-in-law, mother-in law, or the spouse of any of these. The term “spouse” includes a domestic partner.

New Hampshire residents: Immediate Family Member means you, your Dependents, mother, father, brother, sister, or Spouse or domestic partner of same.

Pennsylvania residents: Immediate Family Member means anyone related to a Covered Person in the following manner: spouse, daughter, son, parent, sister, brother, or persons who ordinarily reside in the Covered Person’s household. The term “spouse” includes a common law marriage partner, domestic partner, or civil union partner, if the status of the relationship is legally recognized in the governing jurisdiction.

Virginia residents: Immediate Family Member means anyone related to a Covered Person as a blood relative, relation through marriage or domestic partnership in the following manner: Spouse or Other Adult Dependent, daughter, son, stepchild, father, mother, stepparent, sister, brother, stepsister, stepbrother, grandchild, grandparent, father-in-law, mother-in-law, or the Spouse or Other Adult Dependent of any of these family members if legally recognized in the governing jurisdiction.

Insured, you, or your means the employee or member covered under the Policy for this insurance.

Other Adult Dependent means Your common law marriage partner, domestic partner, or civil union partner, if the status of such relationship is legally recognized in the governing jurisdiction or as otherwise agreed upon between the Policyholder and us.

New Hampshire residents: Other Adult Dependent means your common law marriage partner, or domestic partner, if legally required in the governing jurisdiction or as otherwise agreed upon between the Policyholder and us.

Virginia residents: Other Adult Dependent means your common law marriage partner, or domestic partner, if the status of such relationship is legally recognized in the governing jurisdiction or as otherwise agreed upon between the Policyholder and us.

Plan Year means the 12-month period beginning on the Plan Year Start Date of each year. The Plan Year Start Date is specified in the Schedule of Benefits.

Physician means a person who is a practitioner of the healing arts, providing services within the scope of his or her license. A Physician must not be an Immediate Family Member of any Covered Person (this does not apply to residents of Arizona). Practitioners of homeopathic, naturopathic and related medicines are not considered Physicians under this Policy.

Alaska residents: Practitioners of homeopathic and related medicines are not considered Physicians under this Policy.

Montana residents: Practitioners of homeopathic and related medicines are not considered Physicians under this Policy. Practitioners of naturopathic medicines are considered Physicians under this Policy.

New Hampshire residents: A Physician means all providers of medical care and treatment when the services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws. The term Physician includes Advanced Practice Registered Nurses and Physician's Assistants. The term Physician does not include the Covered Person or an Immediate Family Member of any Covered Person.

South Dakota residents: A Physician can be an Immediate Family Member when the Immediate Family Member is the only Physician in the area and acting within the scope of his or her normal employment.

Vermont residents: A Physician is required to be recognized, according to the insurance statutes or regulations of the state of Vermont.

Policyholder means the entity named on the Schedule of Benefits to whom the Policy is issued.

Policyholder Application means the form completed and signed by the Policyholder to apply for this insurance coverage.

Recurrent Critical Illness means an Illness that is not eligible for payment under the Critical Illness Benefit in the contract as a First Occurrence.

Spouse means Your legally married Spouse.

District of Columbia residents: A person of the same or opposite sex who is legally married to the insured under the laws of the state or jurisdiction in which the marriage took place. Whenever the term Spouse appears in the Certificate, this provision includes the Definition of Other Adult Dependent.

Hawaii residents: Your legally married Spouse or reciprocal beneficiary.

New Hampshire residents: Your legally married Spouse named in the Application. If You are not legally married, "Spouse" may include Your common law spouse if named in the Application and if legally recognized in the state in which You reside.

Transamerica Life Insurance Company, the Company, we, us, or our means the insurer that underwrites this insurance.

Treatment Free means the Covered Person is no longer receiving care from a Physician, nor regular office visits, or being prescribed medication for a Critical Illness, other than routine checkups or maintenance medication for that Critical Illness.

TRANSAMERICA LIFE INSURANCE COMPANY

HEALTH SCREENING BENEFIT RIDER

This Rider is attached to and made part of the Certificate as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the Certificate not in conflict with the provisions of this Rider apply to this Rider.

DEFINITIONS

In addition to the definitions contained in the contract, the following definitions apply to this Rider.

Health Screening Test includes, but may not be limited to one of the following tests performed under the supervision of or recommendation by a Physician while this Rider is in force:

Cholesterol and Diabetes	
Blood Test Total Cholesterol	Hemoglobin A1C
Blood Test Total Triglycerides	Serum Cholesterol Test LDL/HDL Levels
Fasting Blood Glucose Test	Two-hour Post-load Plasma Glucose Test
Fasting Plasma Glucose Test	

Cancer	
Biopsies for Cancer	Flexible Sigmoidoscopy
Bone Marrow Testing	Hemoccult Stool Specimen
Breast MRI	Oral Cancer Screening
Breast Ultrasound	PAP Smears or Thin Prep PAP test
Breast Sonogram	Prostate-Specific Antigen (PSA) Test
Cancer Antigen 15-3 Blood Test for Breast Cancer (CA 15-3)	Serum Protein Electrophoresis
Cancer Antigen 125 Blood Test for Ovarian Cancer (CA 125)	Skin Cancer Biopsy
Carcinoembryonic Antigen Blood Test for Colon Cancer (CEA)	Skin Cancer Screening
Colonoscopy	Skin Exam
Doppler Screening for Cancer	Virtual Colonoscopy
Endoscopy	

Cardiovascular Function	
Carotid Doppler	Electrocardiogram (ECG or EKG)
Doppler Screening for Peripheral Vascular Disease	Electroencephalogram (EEG)
Echocardiogram (Echo)	Stress Test on Bicycle or Treadmill

Imaging Studies	
Chest X-Rays	Ultrasounds for Cancer Detection
Mammogram	Ultrasound Screening of the Abdominal Aorta for Abdominal Aortic Aneurysms
Thermography	

Periodic Physical and Blood Examinations	
Routine Health Check-up Exam	Hearing Test
Blood Chemistry Panel	Lipid Panel
Clinical Testicular Exam	Successful Completion of Smoking Cessation Program
Complete Blood Count (CBC)	Tests for Sexually Transmitted Infections (STIs)
Dental Exam	
Digital Rectal Exam (DRE)	
Eye Exams	

Immunizations	
Immunization	Human Papillomavirus Vaccination (HPV)

BENEFITS

We will pay the amount shown on the Schedule of Benefits once per Covered Person per Plan Year in which such Covered Person undergoes a Health Screening Test, regardless of the number of tests the Covered Person undergoes.

RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the Certificate unless we inform the Insured in writing of a different date.

TERMINATION

This Rider will terminate on the earliest of the following dates or events:
1. The date we receive the Policyholder's request to terminate this Rider; or
2. The date the Certificate terminates.

This Rider is signed for the Company at our home office to take effect on the Rider Effective Date.

Karyn S.W. Polak
Secretary

QUESTIONS OR COMPLAINTS TELEPHONE NUMBER: If an Insured has any questions concerning the benefits available under this Rider or needs to express a complaint, they may contact us at our toll-free Customer Service telephone number, 1-888-763-7474.