



**METROPOLITAN LIFE INSURANCE COMPANY  
200 PARK AVENUE, NEW YORK, NEW YORK 10166-0188**

**CERTIFICATE OF INSURANCE PROVIDING GROUP CANCER AND SPECIFIED  
DISEASES INSURANCE**

**This is a Limited Benefit Certificate.**

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

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

Group Policyholder:	State of North Carolina
Group Policy Number:	0119514
Employee Name:	John Doe
Employee Policy ID:	012345678
Effective Date of Insurance:	January 1, 2009
Billing & Eligibility Inquiries:	1-866-232-1518
Claims Inquiries:	1-800-438-6388

**NO RECOVERY FOR PRE-EXISTING DIAGNOSED CANCER – READ CAREFULLY. No benefits will be provided under this certificate for cancer that is diagnosed before the 30th day after the effective date shown above.**

**IF A COVERED PERSON EXPERIENCES ANY COVERED CONDITION BEFORE THE 30TH DAY AFTER THE EFFECTIVE DATE SHOWN ABOVE SOME OR ALL COVERAGE UNDER THIS CERTIFICATE WILL BE VOID AS PROVIDED HEREIN – READ THIS CERTIFICATE CAREFULLY.**

**THERE IS NO RECOVERY UNDER THIS CERTIFICATE FOR A COVERED CONDITION IF THE OCCURRENCE OF THE COVERED CONDITION IS NOT THE FIRST OCCURRENCE – READ THIS CERTIFICATE CAREFULLY.**

We have issued this Certificate to You in consideration of the payment of the Contribution.

**IMPORTANT CANCELLATION INFORMATION: Please read the provision titled “Date Insurance Ends” found on page 24.**

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

## **NOTICE FOR RESIDENTS OF NORTH CAROLINA**

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL:

- (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND
- (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS, IF ANY, TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES.

VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

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## SCHEDULE OF INSURANCE

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

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

### CATEGORY BENEFIT AMOUNT

For You **\$15,000**

### TOTAL BENEFIT AMOUNT

For You **\$45,000**

### BENEFITS FOR COVERED CONDITIONS

#### Covered Condition

Bone Marrow Transplant	100% of the Category Benefit Amount
Heart Attack	100% of the Category Benefit Amount
Heart Transplant	100% of the Category Benefit Amount
Kidney Failure	100% of the Category Benefit Amount
Major Organ Transplant	100% of the Category Benefit Amount
Stroke	100% of the Category Benefit Amount
Full Benefit Cancer	100% of the Category Benefit Amount
Partial Benefit Cancer	25% of the Category Benefit Amount
Coronary Artery Bypass Graft	25% of the Category Benefit Amount

**Waiting Period:** 30 days for all Covered Conditions

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

## DEFINITIONS

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

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

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

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

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

**Benefit Suspension Period** means the 180 day period following the date a Covered Condition, for which this Certificate pays a benefit, Occurs with respect to a Covered Person.

**Bone Marrow Transplant** means the irreversible failure of a Covered Person's bone marrow for which a Physician has determined that the replacement of such Covered Person's bone marrow with bone marrow from the Covered Person, or another human donor is medically necessary.

**Category Benefit Amount** means the maximum aggregate amount, as shown in the Schedule, that We will pay for all Covered Conditions combined in any category of Covered Conditions, per Covered Person, per lifetime, as provided under this Certificate. There are three categories of Covered Conditions and they are shown on page 15 of this Certificate in the Critical Illness Benefits provision. There is only one Category Benefit Amount in effect at any time for each Covered Person.

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

**Clinical Diagnosis** means a Diagnosis of Partial Benefit Cancer or Full Benefit Cancer based on the study of symptoms and diagnostic test results. We will accept a Clinical Diagnosis of Partial Benefit Cancer or Full Benefit Cancer only if the following conditions are met:

- under generally accepted medical standards, a pathological Diagnosis cannot be made because it would be medically inappropriate or life-threatening;
- medical diagnostic testing supports the Diagnosis; and
- a Physician is treating the Covered Person for Partial Benefit Cancer or Full Benefit Cancer.

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

## DEFINITIONS

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

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

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

- Bone Marrow Transplant;
- Heart Attack;
- Heart Transplant;
- Kidney Failure;
- Major Organ Transplant;
- Stroke;
- Full Benefit Cancer;
- Partial Benefit Cancer; or
- Coronary Artery Bypass Graft.

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

**Dependent** means Your Spouse and/or Dependent Child.

**Dependent Child** means the following:

- Your biological, adopted, step child or Foster Child who is under age 19, unmarried and supported by You;
- A child under age 19 for whom You are required to provide health insurance pursuant to a court or administrative order; and
- Your biological, adopted, step child or Foster Child between ages 19 and 26 who is:
  - unmarried;
  - supported by You;
  - not employed on a full-time basis; and
  - a full-time student at an accredited school, college or university that is licensed in the jurisdiction where it is located.

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

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

A Dependent Child cannot be insured as a Dependent Child of more than one employee under the Group Policy. Your adopted child will not be a Dependent Child prior to the date the child is placed in Your home for adoption.

## **DEFINITIONS (continued)**

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

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

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

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

## DEFINITIONS (continued)

**First Occurs** or First Occurrence means, with respect to each Covered Condition, the first time after a Covered Person initially becomes insured under the Group Policy that such Covered Condition Occurs.

**Foster Child** means a child placed with You with the intent that such child will reside with You on more than a temporary or short term basis, for whom you assume the legal obligation for total or partial support, and for whom You are:

- appointed guardian of such child; or
- given primary or sole custody of such child by order of a court of competent jurisdiction.

**Full Benefit Cancer** means the presence of one or more malignant tumors characterized by the uncontrollable and abnormal growth and spread of malignant cells with invasion of normal tissue provided that a Physician has determined that:

- Surgery, radiotherapy, or chemotherapy is medically necessary;
- there is metastasis; or
- the patient has terminal cancer, is expected to die within 24 months or less from the date of Diagnosis and will not benefit from, or has exhausted, curative therapy.

**Full-Time** means Active Work on the Group Policyholder's regular work schedule for the class of employees to which You belong. The work schedule must be at least 20 hours per week.

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

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

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

**Heart Transplant** means the irreversible failure of a Covered Person's heart for which a Physician has determined that the complete replacement of such organ with an entire heart from a human donor is medically necessary, and either such Covered Person has been placed on the Transplant List or such transplant procedure has been performed.

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

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

## DEFINITIONS (continued)

**Hospitalized** means:

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

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

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

**Major Organ Transplant** means:

- the irreversible failure of a Covered Person's lung, pancreas, entire kidney or any combination thereof, for which a Physician has determined that the complete replacement of such organ with an entire organ from a human donor is medically necessary, and either such Covered Person has been placed on the Transplant List or such transplant procedure has been performed; or
- the irreversible failure of a Covered Person's liver for which a Physician has determined that the complete or partial replacement of the liver with a liver or liver tissue from a human donor is medically necessary by a Physician and either such Covered Person has been placed on the Transplant List or such procedure has been performed.

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

**Medicaid** means any state medical assistance program under Title XIX of the Social Security Act as it is now and as it may be amended.

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

## DEFINITIONS (continued)

**Occurs or Occurrence** means:

- with respect to Heart Attack, Kidney Failure, Stroke, Full Benefit Cancer, or Partial Benefit Cancer that the Covered Person:
  1. experiences such Covered Condition; and
  2. is Diagnosed with such Covered Condition.
- with respect to Coronary Artery Bypass Graft, that the Covered Person undergoes a Coronary Artery Bypass Graft.
- with respect to Heart Transplant or Major Organ Transplant, that the Covered Person:
  1. is placed on the Transplant List; or
  2. undergoes such Heart Transplant or Major Organ Transplant.
- with respect to Bone Marrow Transplant, that a Physician has determined that the replacement of the Covered Person's bone marrow with bone marrow from the Covered Person or another human donor is medically necessary to treat the irreversible failure of the Covered Person's bone marrow.

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

- carcinoma in situ classified as TisN0M0, provided that Surgery, radiotherapy or chemotherapy has been determined to be medically necessary by a Physician;
- malignant tumors classified as T1N0M0 or greater which are treated by endoscopic procedures alone;
- malignant melanomas classified as T1N0M0, for which a pathology report shows maximum thickness less than or equal to 0.75 millimeters using the Breslow method of determining tumor thickness; and
- tumors of the prostate classified as T1bN0M0, or T1cN0M0, provided that they are treated with a radical prostatectomy or external beam radiotherapy.

**Physician** means an individual who:

- is validly licensed as a Practitioner Of The Healing Arts in the United States jurisdiction where he or she practices; and
- is acting within the lawful scope of such valid license and of his or her practice when he or she:
  - (1) Diagnoses a Covered Condition for which a claim is made;
  - (2) performs medical services required for a Covered Condition for which a claim is made; or
  - (3) performs any other medical services that are to be performed by a Physician under the terms of this Certificate.

A Physician is not:

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

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

## DEFINITIONS (continued)

**Proof** means Written evidence satisfactory to us that a claimant has satisfied the conditions and requirements for a benefit described in this Certificate. Proof must include all of the information required under the terms of this Certificate and be timely submitted as described in this Certificate. When a claim is made for a benefit described in this Certificate, Proof must establish:

- the nature and extent of the Covered Condition;
- Our obligation to pay the claim; and
- the claimant's right to receive payment.

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

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

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

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

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

- hemorrhage;
- thrombus; or
- embolus from an extracranial source.

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

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

**Total Benefit Amount** means the maximum aggregate amount, as specified in the Schedule of Insurance, that We will pay for any and all Covered Conditions combined, per Covered Person, per lifetime, as provided under this Certificate.

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

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

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

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

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

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

### **Eligible Classes**

#### **CLASS 1**

Any state agency, university or select community college employee working 20 or more hours per week in a permanent, probationary or time-limited position.

### **Date You Are Eligible For Insurance**

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

If You are in an eligible class on the date insurance becomes available for the class, You will be eligible for insurance on that date. If You enter an eligible class after the date insurance is made available to the members of that class, You will be eligible for insurance on the date You enter the eligible class.

### **Date Your Insurance Takes Effect**

Insurance under this Certificate will take effect for You on the date You are first eligible, if on that date You are Actively at Work in an eligible class. If You are not Actively at Work in an eligible class on that date, Your coverage will take effect on the date You return to Active Work in an eligible class.

### **Benefit Increases**

If you are insured under this Certificate at the time a Benefit Increase is offered for Your eligible class, You will be eligible for the Benefit Increase if you have not already attained the Maximum Benefit Amount. Your Benefit Increase will not take effect unless You complete an Enrollment Form and We approve You for the Benefit Increase. You must also give Written permission to deduct Contributions from Your pay for such Benefit Increase.

The Benefit Increase will take effect for You on the date We approve You for such Benefit Increase, if on that date You are Actively at Work in a class that is eligible for the Benefit Increase. If You are not Actively at Work in a class that is eligible for the Benefit Increase on that date, Your Benefit Increase will take effect on the date You return to Active Work in a class that is eligible for the Benefit Increase.

## **ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE**

### **Eligible Classes For Dependent Insurance**

All Class 1 employees of the Group Policyholder as specified in the section titled ELIGIBILITY PROVISIONS: INSURANCE FOR YOU are eligible for Dependent Insurance.

### **Date You Are Eligible For Dependent Insurance**

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

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

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

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

### **Date Dependent Insurance Takes Effect**

Except as provided in the Newborn, Adopted and Foster Children provision below, once You are eligible for Dependent Insurance, it will take effect on the date the Dependent is first eligible if on that date the Dependent meets the following requirement:

The Dependent is not:

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

If the Dependent does not meet this requirement on such date, insurance for the Dependent will take effect on the date they are no longer:

- confined;
- receiving or applying to receive disability benefits from any source; or
- Hospitalized.

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

### **Benefit Increases**

Dependents who are insured under this Certificate at the time a Benefit Increase that is applicable to Dependents is offered for Your eligible class, will be eligible for the Benefit Increase. Such Benefit Increase will not take effect unless You complete an Enrollment Form with respect to such Dependents and We approve such Dependents for the Benefit Increase. You must also give Written permission to deduct Contributions from Your pay for the Benefit Increase.

The Benefit Increase will take effect for each Dependent on the date We approve each Dependent for such Benefit Increase, if on that date the Dependent meets the following requirement:

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

The Dependent is not:

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

If the Dependent does not meet this requirement on such date, the Benefit Increase for the Dependent will take effect on the date such Dependent is no longer:

- confined;
- receiving or applying to receive disability benefits from any source; or
- Hospitalized.

### **Custodial Parent**

If You do not have custody of Your Dependent Child who is insured under this Certificate, We may provide such information to the custodial parent of such Dependent Child as may be necessary for such Dependent Child to obtain benefits under this Certificate.

### **Newborn, Adopted and Foster Children**

A Dependent Child born to You while insurance is in effect under this certificate will be covered for 31 days from the moment of such Dependent Child's birth. The Pre-Existing Condition exclusion will not apply to such Dependent Child. Unless you already have Dependent Insurance in effect for other Dependent Children, to continue coverage beyond the first 31 days you must enroll the child and give Written permission to deduct Contributions from Your pay for Dependent Insurance.

A Dependent Child adopted by You while insurance is in effect under this certificate will be covered for 31 days from the moment of such Dependent Child's birth if You take custody of the Dependent Child upon such Dependent Child's release from the hospital and within 30 days of the date the Dependent Child is born you file a petition to adopt the Dependent Child. The Pre-Existing Condition exclusion will not apply to such Dependent Child. Unless you already have Dependent Insurance in effect for other Dependent Children, to continue coverage beyond the first 31 days you must enroll the child and give Written permission to deduct Contributions from Your pay for Dependent Insurance.

If a Dependent Child is a Foster Child placed with You while insurance is in effect under this certificate, such Dependent Child will be covered for 31 days from the moment of such Dependent Child's birth. The Pre-Existing Condition exclusion will not apply to such Dependent Child. Unless you already have Dependent Insurance in effect for other Dependent Children, to continue coverage beyond the first 31 days you must enroll the child and give Written permission to deduct Contributions from Your pay for Dependent Insurance.

## CRITICAL ILLNESS BENEFITS

Covered Conditions are grouped into three categories, as shown in the table below. If a Covered Condition First Occurs for a Covered Person, while such Covered Person is insured under this Certificate, Proof of the Covered Condition must be sent to Us. When We receive such Proof, We will review the claim and if We approve it, will pay the benefit described below for such Covered Condition, provided, however, that:

- a) We will never pay more with respect to any Covered Person than the Category Benefit Amount shown in the Schedule of Insurance for all of the Covered Conditions listed in any one category; and
- b) We will never pay more with respect to any Covered Person than the Total Benefit Amount shown in the Schedule of Insurance.

Category 1	Category 2	Category 3
Full Benefit Cancer Partial Benefit Cancer Bone Marrow Transplant	Heart Attack Stroke Coronary Artery Bypass Graft Heart Transplant	Kidney Failure Major Organ Transplant

**IMPORTANT NOTE:** Receipt of benefits under this Certificate may affect eligibility for Medicaid or other governmental benefits and entitlements.

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

1. Bone Marrow Transplant;
2. Heart Attack;
3. Heart Transplant
4. Kidney Failure;
5. Major Organ Transplant;
6. Stroke; or
7. Full Benefit Cancer.

**25% of the Category Benefit Amount** is payable for Partial Benefit Cancer that First Occurs for a Covered Person while such Covered Person is insured under this Certificate. Only one benefit for Partial Benefit Cancer is payable per Covered Person, per lifetime.

**25% of the Category Benefit Amount** is payable for a Coronary Artery Bypass Graft that First Occurs for a Covered Person while such Covered Person is insured under this Certificate. Only one benefit for Coronary Artery Bypass Graft is payable per Covered Person, per lifetime.

**Additional Covered Conditions:** We will not pay a benefit for any Covered Condition that First Occurs for a Covered Person during a Benefit Suspension Period if such Covered Condition is in a different category of Covered Conditions from the Covered Condition that started the Benefit Suspension Period. A Benefit Suspension Period will not apply to a Covered Condition that is within the same category of Covered Conditions as the Covered Condition that started the Benefit Suspension Period.

If a Covered Condition First Occurs for a Covered Person during a Benefit Suspension Period, and solely as a result of such Benefit Suspension Period, no benefit is paid for such Covered Condition, We will treat the next Occurrence (if any) of such Covered Condition after the Benefit Suspension Period ends, as the First Occurrence of such Covered Condition.

## CRITICAL ILLNESS BENEFITS (continued)

**Additional Covered Conditions (continued):** For each Covered Person, benefits payable under the Group Policy for all Covered Conditions within any one category of Covered Conditions, as shown in the table on page 15, will not exceed the Category Benefit Amount that applies to that Covered Person. We will reduce what We pay for a claim so that the amount that We pay, when combined with amounts for all claims We have previously paid for the same Covered Person in the same category of Covered Conditions, does not exceed the Category Benefit Amount that was in effect for that Covered Person on the date of the most recent Covered Condition.

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

## **Exclusions that Apply to Specific Covered Conditions**

### **Bone Marrow Transplant**

We will not pay benefits for a Bone Marrow Transplant involving bone marrow received from non-human donors.

### **Heart Transplant**

We will not pay benefits for a Heart Transplant:

- performed outside the United States, unless the Covered Person was placed on the Transplant List prior to the Heart Transplant being performed;
- involving a heart received from non-human donors;
- involving implantation of mechanical devices or mechanical organs; or
- involving stem cell generated transplants.

### **Major Organ Transplant**

We will not pay benefits for a Major Organ Transplant:

- performed outside the United States;
- involving organs received from non-human donors;
- involving implantation of mechanical devices or mechanical organs;
- involving stem cell generated transplants ;
- involving islet cell transplants; or
- involving a heart being transplanted in combination with any other organ.

### **Stroke**

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

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

### **Full Benefit Cancer**

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

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

## **Exclusions that Apply to Specific Covered Conditions (continued)**

### **Partial Benefit Cancer**

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

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

### **Coronary Artery Bypass Graft**

We will not pay benefits for Coronary Artery Bypass Graft:

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

## **Additional Proof Requirements for Each Covered Condition**

### **Bone Marrow Transplant**

Proof of Bone Marrow Transplant requires submission of medical records evidencing that the Bone Marrow Transplant was deemed medically necessary by a Physician.

The Covered Condition for Bone Marrow Transplant will be deemed to Occur on the date the Physician deems the Bone Marrow Transplant to be medically necessary.

### **Heart Transplant**

Proof of Heart Transplant requires submission of medical records evidencing that the Heart Transplant was deemed medically necessary by a Physician and that either:

- the Covered Person has been placed on the Transplant List; or
- the Heart Transplant had been performed.

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

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

### **Heart Attack**

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

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

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

### **Kidney Failure**

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

## **Additional Proof Requirements for Each Covered Condition (continued)**

### **Major Organ Transplant**

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

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

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

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

### **Stroke**

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

### **Full Benefit Cancer**

Unless We accept a Clinical Diagnosis as provided in this Certificate, Diagnosis of Full Benefit Cancer must be based upon microscopic (histologic) examination of fixed tissues or preparations of blood or bone marrow. Such examination must be documented in a Written pathology report by a Physician. It must be made either while the Covered Person is alive or post mortem. The Covered Condition for Full Benefit Cancer will be deemed to Occur upon the date that the Diagnosis of Full Benefit Cancer is made.

### **Partial Benefit Cancer**

Unless We accept a Clinical Diagnosis as provided in this Certificate, Diagnosis of Partial Benefit Cancer must be based upon microscopic (histologic) examination of fixed tissue or preparations of blood or bone marrow. Such examination must be documented in a Written pathology report by a Physician. It must be made either while the Covered Person is alive or post mortem. The Covered Condition for Partial Benefit Cancer will be deemed to Occur upon the date the Diagnosis of Partial Benefit Cancer is made.

### **Coronary Artery Bypass Graft**

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

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

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

## LIMITATIONS

### Waiting Period

On the date a Covered Person's insurance under this Certificate becomes effective, a waiting period starts with respect to such insurance. Such insurance will be void if the Covered Person experiences a Covered Condition during the waiting period.

On the date a Benefit Increase becomes effective, a waiting period starts with respect to the Benefit Increase. Such Benefit Increase will be void with respect to a Covered Person if the Covered Person experiences a Covered Condition during the waiting period.

Contributions You have paid for any insurance that is voided under this section will be returned to You without interest except if Your Dependent Child is the Covered Person whose insurance is void under this provision. If insurance for a Dependent Child is void under this provision, Contributions paid for that insurance will be returned to You only if there is no insurance remaining in effect for any Dependent Child under this Certificate. If You are the Covered Person whose insurance is void under this provision, and as a result You no longer have any insurance in effect under the Group Policy, insurance for Your Dependents will also be void.

If a claim is denied under this Waiting Period provision, at Your option, We will exclude the Covered Condition under the Preexisting Condition Exclusion and insurance that would otherwise be void under this Waiting Period provision will not be void. In order for You to exercise this option, You must notify Us in Writing within 30 days after We notify You that Your claim is denied under this waiting period provision.

The length of the waiting period is shown in the Schedule of Insurance.

## OTHER EXCLUSIONS

### Preexisting Condition Exclusion

**Preexisting Condition** means a sickness or injury for which, in the 12 months before a Covered Person becomes insured under this Certificate, or before any Benefit Increase with respect to such Covered Person medical advice, treatment or care was sought by such Covered Person, or, recommended by, prescribed by or received from a Physician or other Practitioner of the Healing Arts.

We will not pay benefits for a Covered Condition that is caused by or results from a Preexisting Condition if the Covered Condition Occurs during the first 12 months that a Covered Person is insured under this Certificate.

With respect to a Benefit Increase, We will not pay benefits for such Benefit Increase for a Covered Condition that is caused by or results from a Preexisting Condition if the Covered Condition Occurs during the first 12 months after such increase in the Total Benefit Amount.

### Exclusion for Intoxication

We will not pay benefits for any Covered Condition that is caused by, contributed to by, or results from a Covered Person's involvement in an incident, where such Covered Person is intoxicated at the time of the incident and is the operator of a vehicle involved in the incident.

**Intoxicated** means that the Covered Person's alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident happened.

### General Exclusions

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

- participating in a felony, riot or insurrection;
- intentionally causing a self-inflicted injury;
- committing or attempting to commit suicide while sane or insane;
- voluntarily taking or using any drug, medication or sedative unless it is:
  - taken or used as prescribed by a Physician, or
  - an "over the counter" drug, medication or sedative taken according to package directions;
- engaging in any illegal occupation; or
- serving in the armed forces or any auxiliary unit of the armed forces of any country.

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

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

We will not pay benefits for any Covered Condition that does not First Occur for a Covered Person while such Covered Person is insured under this Certificate.

## **WHEN INSURANCE ENDS**

### **Date Your Insurance Ends**

Your insurance will end on the earliest of:

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

### **Date Dependent Insurance Ends**

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

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

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

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

### **For Family And Medical Leave**

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

### **At Your Option: Continuation With Premium Payment**

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

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

- Your employment ends; or
- You cease to be in a class that is eligible for Group Billed Insurance.

However, You cannot obtain Continued Insurance if Group Billed Insurance:

- ends for all employees;
- ends for the class of employees that You are in;
- ends for the class of employees that You were last in before Your Group Billed Insurance ends;
- ends because You failed to pay a required Contribution; or
- ends on a date preceding which You have not been continuously insured for at least 90 days under the Group Policy.

### **Request Period**

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

### **Premiums for Continued Insurance**

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

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

### **End of Continued Insurance**

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

- the date Group Billed insurance ends for all employees;
- the date Group Billed insurance ends for the class of employees that You are in;
- the date Group Billed insurance ends for the class of employees You were last in before obtaining Continued Insurance;
- the date You die;
- the date the Total Benefit Amount has been paid for You;
- if You do not pay a premium that is required for Continued Insurance, the last day of the period for which a required premium payment was made;
- with respect to Dependent Insurance, the date Continued Insurance for You ends for any reason;
- with respect to Dependent Insurance, the date Dependent Insurance ends under the Group Policy for all employees;
- with respect to Dependent Insurance, the date Dependent Insurance ends under the Group Policy for the class of employees that You are in;
- with respect to Dependent Insurance, the date Dependent Insurance ends for the class of employees that You were last in before obtaining Continued Insurance;
- with respect to Dependent Insurance, the date the Dependent no longer meets the definition of a Dependent; or
- with respect to a Dependent's insurance, the date the Total Benefit Amount has been paid for that Dependent.

At the end of any of the continuation periods listed above, Your insurance will be affected as follows:

- if You resume Active Work in an eligible class at that time, You will continue to be insured under the Group Policy;
- if You do not resume Active Work in an eligible class at that time, Your employment will be considered to end and Your insurance will end in accordance with the DATE YOUR INSURANCE ENDS subsection of the section titled WHEN INSURANCE ENDS.

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

## **CLAIMS**

### **Filing A Claim**

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

Notice of claim and Proof must be given to Us by following the steps set forth below:

#### **Step 1**

You must give Us notice by Writing to Us or calling Us at the toll free number shown on the face page of this Certificate within 30 days of the date of the Covered Condition.

#### **Step 2**

We will send a claim form to You and explain how to complete it. You should receive the claim form within 15 days of giving Us notice of claim.

#### **Step 3**

When You receive the claim form You should fill it out as instructed and return it with the required Proof described in this Certificate and the claim form. If You do not receive a claim form within 15 days after giving Us notice of claim, You may send Us Proof using any form sufficient to provide Us with the required Proof.

#### **Step 4**

You must give Us Proof not later than 180 days after the date of the Covered Condition. If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given as soon as is reasonably possible, but in no event other than in the absence of the legal capacity of the claimant, later than 12 months from the date the Covered Condition Occurred.

### **Payment Of Benefits**

When We receive the claim form and Proof We will review the claim and, if We approve it, We will pay benefits subject to the terms and provisions of this Certificate and the Group Policy.

All benefits paid under this Certificate while You are living will be paid to You, unless You have assigned this insurance. But, if You are not legally competent to claim or receive benefits under this Certificate, we may pay up to \$3,000 to anyone related to You by blood or marriage who We believe is entitled to it. If We make such a payment in good faith, We will not be liable to anyone for the amount We pay. Any remaining benefits will be paid to Your legal representative.

If You designated a beneficiary, upon Your death we will pay to Your beneficiary any amount that is or becomes due. You may change Your beneficiary at any time. To do so, You must send a Signed and dated, Written request to the Group Policyholder using a form satisfactory to Us. Your Written request to change the beneficiary must be sent to the Group Policyholder no later than 90 days of the date You Sign such request.

Unless otherwise requested, We may at Our option pay benefits in one sum or by placing the amount in an account that earns interest. The person to whom we pay the benefits will have immediate access to all or any part of the account. We will pay interest on the benefits from the date they become payable until all funds in the account have been withdrawn.

## **CLAIMS**

### **Payment Of Benefits (continued)**

You do not need the beneficiary's consent to make a change. When We receive the change, it will take effect as of the date You Signed it. The change will not apply to any payment made in good faith by Us before the change request was recorded.

If two or more beneficiaries are designated and their shares are not specified, they will share the insurance equally.

If there is no beneficiary designated or no surviving beneficiary at Your death, We may determine the beneficiary to be one or more of the following who survive You, in the order listed below:

1. Your Spouse;
2. Your child(ren);
3. Your parents(s); or
4. Your sibling(s).

Instead of making payment in the order above, We may pay Your estate. Any payment made in good faith will discharge Our liability to the extent of such payment.

### **Authorizations**

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

### **Examinations**

At Our expense, as often as is reasonably necessary, We may require You to have an independent examination by a Physician of Our choice.

At Our expense, as often as is reasonably necessary, We may have Our representatives conduct telephone or in-person interviews with You regarding Your claim.

### **Autopsy**

At Our expense, We have the right to make a reasonable request for an autopsy and/or exhumation where permitted by law. Any such request will set forth the reasons We are requesting the autopsy or exhumation.

### **Time Limit on Legal Actions**

A legal action on a claim may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends three years after the date such Proof is required to be filed.

## **GENERAL PROVISIONS**

### **Changes in Standards**

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

### **Entire Contract**

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

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

### **Incontestability: Statements Made By You**

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

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

We will not use Your statements which relate to insurability to contest this insurance after it has been in force for 2 years during Your lifetime. In addition, We will not use such statements to contest a Benefit Increase after the Benefit Increase has been in force for 2 years during Your lifetime.

### **Misstatements**

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

### **Assignment**

The Benefits under the Group Policy are not assignable prior to a claim for benefits.

### **Conformity with Law**

If the terms and provision of this Certificate do not conform to any applicable law, this Certificate shall be interpreted to so conform.



## Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

### Plan Sponsors and Group Insurance Contract Holders

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This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, or group insurance or annuity contract. In this notice, "you" refers to these individuals.

### Protecting Your Information

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We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

### Collecting Your Information

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We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life, car, and home insurers. They also include a bank, a legal plans company, and securities broker-dealers. In the future, we may also have affiliates in other businesses.

### How We Get Your Information

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We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask for blood and urine tests
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB Group, Inc. ("MIB"). It is a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information that it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, by calling MIB at (866) 692-6901 (TTY (866) 346-3642 for the hearing impaired), or by contacting MIB at [www.mib.com](http://www.mib.com).

### Using Your Information

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We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on

what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- perform business research
- market new products to you
- comply with applicable laws
- process claims and other transactions
- confirm or correct your information
- help us run our business

## Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our “Using Your Information” section above

## HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. If you have dental, long term care, or medical insurance from us, the Health Insurance Portability and Accountability Act (“HIPAA”) may further limit how we may use and share your information.

## Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. Generally, we will provide it as long as it is reasonably retrievable and within our control. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you anything we learned as part of a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

## Questions

We want you to understand how we protect your privacy. If you have any questions about this notice, please contact us. When you write, include your name, address, and policy or account number.

**Send privacy questions to:**

MetLife Privacy Office, P. O. Box 489, Warwick, RI 02887-9954  
[privacy@metlife.com](mailto:privacy@metlife.com)

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of these MetLife companies:

**Metropolitan Life Insurance Company**  
**General American Life Insurance Company**  
**SafeGuard Life Insurance Company**

**MetLife Insurance Company of Connecticut**  
**SafeGuard Health Plans Inc.**