BlueCross BlueShield
of Illinois

Voluntary Critical Illness Insurance

Employee Benefit Booklet

HIGHLAND COMMUNITY COLLEGE

F020729-0001

Class 1-01

05/21/2021

Dearborn Life Insurance Company

Administrative Office:
701 E. 22nd Street
Lombard IL 60148

(A stock life insurance company, herein called “We” “Us” or “Our”)

Having issued Group Policy No. F020729-0001

(herein called the Policy)

to

HIGHLAND COMMUNITY COLLEGE

(herein called the Policyholder)

GROUP CRITICAL ILLNESS INSURANCE CERTIFICATE

CERTIFIES that You are insured, if You qualify under the ELIGIBILITY AND EFFECTIVE DATES provision, and remain insured in accordance with the terms of the Policy. Your insurance is subject to all the definitions, limitations and conditions of the Policy, and it takes effect as stated in the ELIGIBILITY AND EFFECTIVE DATES provision.

This Certificate describes Your eligibility for benefits and the terms and provisions of the Policy. It replaces and cancels any other Certificate previously issued to You under the Policy.

If the terms and provisions of this Group Insurance Certificate (issued to You) are different from the Policy (issued to the Policyholder), the Policy will govern. Your coverage may be canceled or changed under the terms and provisions of the Policy.

READ THIS CERTIFICATE CAREFULLY

Signed for Dearborn Life Insurance Company

Secretary

President

Voluntary Group Critical Illness Insurance Certificate

with

Dependent Critical Illness Benefits

Non-Participating

THIS IS A LIMITED BENEFIT CERTIFICATE. IT PROVIDES CRITICAL ILLNESS INSURANCE COVERAGE. THERE IS NO COVERAGE FOR HOSPITAL, MEDICAL-SURGICAL OR MAJOR MEDICAL EXPENSES.

THIS TYPE OF PLAN IS NOT CONSIDERED “MINIMUM ESSENTIAL COVERAGE” UNDER THE AFFORDABLE CARE ACT AND THEREFORE DOES NOT SATISFY THE INDIVIDUAL MANDATE THAT YOU HAVE HEALTH INSURANCE COVERAGE. IF YOU DO NOT HAVE OTHER HEALTH INSURANCE COVERAGE, YOU MAY BE SUBJECT TO A TAX PENALTY. PLEASE CONSULT YOUR TAX ADVISOR.

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SCHEDULE OF BENEFITS

POLICYHOLDER:	HIGHLAND COMMUNITY COLLEGE
POLICY NUMBER:	F020729-0001
POLICY EFFECTIVE DATE:	July 1, 2018 (Revised: July 1, 2021)
ENROLLMENT PERIOD:	5/10-6/30

ELIGIBILITY: **Class 01**	ALL ACTIVE FULL TIME EMPLOYEES of the Policyholder working in the United States of America who are Actively at Work for the Policyholder and who have completed the Eligibility Waiting Period are eligible for the insurance. A full-time *Employee* is one who regularly works a minimum of 30 hours per week for the *Policyholder*. Part-time, seasonal and temporary *Employees* of the *Policyholder* are not eligible.	
Eligibility Waiting Period:	Current *Employees*:	None
	New *Employees*:	Date of Hire
Policyholder Contribution:	*Voluntary* Critical Illness	0% of premium

00001-SOB

CRITICAL ILLNESS

***Employee Voluntary* Critical Illness Amount**	Incremental selection from a minimum of $5,000 to a maximum of $10,000 in increments of $5,000
***Employee* Guarantee Issue Amount**	*Voluntary*: $10,000
Reduction of Benefits	Employee and Spouse Voluntary Group *Critical Illness Insurance*. None. Benefits terminate at retirement.
Portability	
Benefit Eligibility	*Voluntary*
Insured Eligibility	*Employee* & *Spouse*
Portability Benefit Duration	Age 65
Maximum Portable Amount	$10,000
DEPENDENT CRITICAL ILLNESS:	
Guarantee Issue Amount	*Dependent Voluntary Child*: $2,500
Guarantee Issue Amount	*Spouse Voluntary*: $5,000
Spouse Amount	Voluntary: Incremental selection from a minimum of $2,500 to a maximum of $5,000 in increments of $2,500, not to exceed 50% of the Employee Amount
Dependent Child Amount	*Voluntary*: $2,500, not to exceed 50% of the Employee Amount

00002-SOB

COVERED CONDITIONS SCHEDULE:

Covered Condition	**Benefit Percentage**
Benign Brain Tumor	100%
Recurrence Benefit	50%
Coma	100%
Recurrence Benefit	50%
End State Renal Failure	100%
Heart Attack	100%
Recurrence Benefit	50%
Major Heart Surgeries	25%
Loss of Speech, Sight or Hearing	100%
Major Burns	100%
Major Organ Transplant	100%
Paralysis	100%
Severe COVID-19 Infection	100%
Stroke	100%
Recurrence Benefit	50%
Carcinoma in situ	25%
Invasive Cancer	100%
Recurrence Benefit	50%
Wellness Benefit	$50 per *Calendar Year* for each insured Employee and covered Dependent Spouse

00003-SOB

ELIGIBILITY AND EFFECTIVE DATE PROVISIONS

Who is eligible for this insurance?

The eligibility for this insurance is as indicated in the Schedule of Benefits.

The *Eligibility Waiting Period* is further defined in the Schedule of Benefits.
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When does Your Contributory insurance become effective?

You may apply for *Voluntary* insurance coverage during the annual Enrollment Period as indicated in the Schedule of Benefits. *Your* coverage will be effective as indicated below, if You are Actively at Work on that date.

Your Contributory coverage for amounts up to the Guarantee Issue Amount will become effective on the latest of the following dates, if You are Actively at Work on that date:

1. If *You* enroll for coverage prior to the *Polic y* effective date, the *Policy* effective date;
2. If *You* enroll for coverage within 31 days of *Your* eligibility date, on the first of the month that falls on or next follows the date *You* sign the *Enrollment Form*;
3. If *You* do not enroll for coverage within 31 days after *Your* eligibility date, *You* must wait until the next *Enrollment Period* to apply, unless *You* qualify because of a *Change in Family Status.*
    a. Initial requests for coverage or requests for changes to existing coverage made during the *Enrollment Period* will become effective on the *Policy* anniversary date.
    b. Coverage requested within 31 days of a *Change in Family Status* will become effective on the first of the month that falls on or next follows the date *You* sign the *Enrollment Form.*

Enrollment Form means the application *You* complete and submit to apply for coverage under the *Policy*.
00003

What is the Enrollment period?

Unless otherwise specified, **Enrollment Period** means a period of time during which Eligible Employees may apply for or request changes to coverage. The Enrollment Period is shown on the Schedule of Benefits.

Eligible Employees may enroll for coverage, apply for additional coverage, or request changes to their current coverage only during the Enrollment Period, unless they qualify because of a Change in Family Status.

Any Employee hired after an Enrollment Period may enroll within 31 days after their eligibility date; otherwise, he must wait for the next Enrollment Period to enroll unless he qualifies because of a Change in Family Status.

Initial requests for coverage or requests for changes to existing coverage made during the Enrollment Period will become effective on the anniversary date.
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If You are not Actively at Work, when does coverage become effective?

If You are absent from Active Work on the date Your coverage would otherwise become effective and Your absence is caused by an Injury, Illness or layoff, Your effective date for any initial coverage or increased coverage will be deferred until the date You return to Active Work.

However, You will be considered Actively at Work on any day that is not Your regularly scheduled work day (including but not limited to a weekend, vacation or holiday) if You were Actively at Work on the immediately preceding scheduled work day and You were:

1. not Hospital Confined, or;
2. disabled due to an Injury or Illness.
00006

What happens if We are replacing a Prior Policy?

Effect on Actively at Work Requirement

If You were insured under the Prior Policy on the day before the Policy effective date, coverage begins for this Policy on the Policy effective date and continues until the earliest of:

1. The end of the month following the date You become Actively at Work;
2. The end of any period of continuance or extension provided under the Prior Policy; or
3. The date coverage would otherwise end, according to the provisions of this Policy.

Your coverage under this provision is subject to payment of premium.

Effect on Benefits

The benefits payable under this Policy will be the benefits which would have been payable under the terms of the Prior Policy if it had remained in force; and the benefits payable under this Policy will be reduced by any benefits payable under the Prior Policy for the same Covered Condition for which the prior carrier is liable.

The ***Prior Policy*** is the group critical illness policy issued to the Policyholder whose coverage terminated immediately before the Policy effective date.

Effect on Pre-existing Conditions

If You have a Diagnosis of Covered Condition due to a Pre-existing Condition after the Prior Policy has been replaced by this Policy, benefits may be payable if:

1. You were insured under the Prior Policy at the time the Policyholder changed coverage from the Prior Policy to this Policy; and
2. You have been continuously insured under this Policy from the Policy effective date until the date Your Covered Condition was Diagnosed.

In order for benefits to be paid, You must satisfy the Pre-existing Condition exclusion under:

1. this Policy; or
2. the Prior Policy, if benefits would have been paid had the Prior Policy remained in force.

If You satisfy the Pre-existing Condition exclusion of this Policy, We will determine Your payments according to the Policy's provisions.

If You do not satisfy the Pre-existing Condition exclusion of this Policy, but You do satisfy the Pre-existing Condition provision under the Prior Policy:

Your benefit will be the lesser of:

a. The benefit that would have been payable under the terms of the Prior Policy if it had remained in force; or
b. The benefit under this Policy.

If You do not satisfy the Pre-existing Condition exclusion under either this Policy or the Prior Policy, We will not make any payments.

We will require Proof that You were insured under the Prior Policy.
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Changes to Your coverage

A change in Your coverage may occur if:

1. You enroll for a different coverage option; or
2. There is a Policy change; or
3. You enter another class and become eligible for a change in benefits; or
4. You experience a qualified Change in Family Status.

If You are eligible for increased coverage due to a Policy change, the increased coverage will be effective on the date the Policy change is effective, as requested by the Policyholder and agreed on by Us.

Increases in coverage for reasons other than a Policy change will be effective the first of the month following the later of:

1. The date You enroll for the increased coverage; or
2. The date You become eligible for the increased coverage, if enrollment is not required; or
3. The date We approve Your coverage if Evidence of Insurability is required.

In order for Your increased coverage to begin, You must be Actively at Work. Increased Contributory coverage is subject to Our receipt of premium.

A decrease in coverage will take effect immediately.

Increases or decreases to Your benefits elected during the Enrollment Period will become effective on the next anniversary date, if You are Actively at Work on that day.
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Eligibility after You Terminate Employment

If Your coverage ends due to termination of employment and You do not elect continued coverage under the Portability Benefit provision, You must meet all the requirements of a new Employee if You are rehired by the Policyholder at a later date.

If Your coverage ends due to termination of employment and You return to Active Work for the Policyholder in an eligible class within 6 months, We will not:

1. apply a new Eligibility Waiting Period; or
2. require Evidence of Insurability.

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CRITICAL ILLNESS INSURANCE

What is Critical Illness Insurance?

Critical Illness Insurance is a percentage of *Your or Your* covered *Dependents* Voluntary *Critical Illness Insurance* as indicated in the Schedule of Benefits, which is payable to *You or Your* covered *Dependents* if *You or Your* covered *Dependents* experience a *Covered Condition*.

We will pay *You or Your* covered *Dependents* on *Diagnosis* of a *Covered Condition* if *You or Your* covered *Dependents* or *Your or Your* covered *Dependents* legal representative submit a claim and provide satisfactory *Proof.*

You or Your covered *Dependents* may receive multiple benefit payments if *You or Your* covered *Dependents* are *Diagnosed* with more than one *Covered Condition*, as long as the sum of all benefits payments does not exceed 300% of the *Critical Illness Insurance* amount under this *Certificate.*
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How do You or Your covered Dependents qualify for the Critical Illness Insurance Benefit?

You or Your covered *Dependents* receive benefits listed in the Schedule of Benefits if a *Covered Condition* occurs after the *Policy* effective date and after the *Waiting Period* and it is *Your or Your* covered *Dependents Initial Diagnosis* of the *Covered Condition*.
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What are Pre-Existing Conditions?

A ***Pre-existing Condition*** is any *Illness* or *Injury* for which *You or Your* covered *Dependents* received medical treatment for, or advice was rendered, prescribed or recommended whether or not it was *Diagnosed* at all or misdiagnosed within 6 months prior to the *Policy* effective date.

A *Pre-existing* condition is not covered within the first 12 months of coverage.
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***How are benefits paid if You or Your* covered *Dependents* experience two or more Covered Conditions?**

Payments are made for each *Covered Condition You or Your* covered *Dependents* suffer. Each benefit payment is based on the percentage listed in the *Covered Conditions* Schedule of Benefits. The sum of all benefit payments is limited to 300% of the *Critical Illness Insurance* amount under this *Certificate.*

If an *Injury* or *Illness* causes more than one *Covered Condition, We* will pay for the *Covered Condition* with the greatest benefit percentage. The occurrence of each new *Covered Condition* must be separated by 180 days to be eligible for benefits. *or Your* covered *Dependents*
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Are Benefits portable?

Yes, subject to the conditions and limitations set forth in the Portability Benefit section of this *Certificate.*
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Are Benefits convertible?

No, benefits are not convertible.
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EXCLUSIONS AND LIMITATIONS

Are there any Exclusions and Limitations for Critical Illness Insurance?

In addition to specific exclusions and limitations for a *Covered Condition:*

1. If an *Injury* or *Illness* causes more than one *Covered Condition* to occur, benefits are only payable under the greatest benefit level percentage and are payable once, up to 300% of the *Critical Illness Insurance* benefit in the Schedule of Benefits.
2. Benefits for a kidney transplant are covered under the *End Stage Renal Failure* benefit only.
3. If benefits are paid due to a kidney-pancreas transplant, those benefits are not payable under the *End Stage Renal Failure* benefit.
4. *You or Your* covered *Dependents* must be registered by the United Network of Organ Sharing (UNOS) in order for a ***Major Organ Transplant***, or kidney transplant necessitated by End Stage Renal Failure to be a *Covered Condition* under this benefit.
5. *Covered Conditions* must be separated by 180 days to be eligible for benefits.
6. Benefits are subject to any *Reduction of Benefits.*
7. No benefits are payable for a *Covered Condition* if it results directly or indirectly from:
    a. the misuse of alcohol or taking of drugs (except those drugs prescribed by a *Physician* and used in the manner prescribed or FDA regulated over-the-counter drugs used as recommended by the manufacturer); or
    b. *Injury* received during active participation in a *Riot,* strike or civil commotion, or any act incidental thereto; or
    c. Commission of or attempt to commit an illegal activity defined under state or federal law; or
    d. *Injury* received from driving while intoxicated or under the influence. Under the influence or intoxication is defined by the laws of the jurisdiction in which the *Accident* causing the *Injury* occurred or .08% blood alcohol content if the jurisdiction in which the *Accident* occurred does not define intoxication. Conviction is not necessary for a determination of under the influence or intoxication.

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PORTABILITY BENEFIT

What is the Portability Benefit?

If Your Voluntary group Critical Illness Insurance, or any portion of it, terminates, You may elect to continue Your Critical Illness Insurance in accordance with the terms of the Policy by paying premiums directly to Us. If You elect Portability, You may also elect to continue Dependent Critical Illness Insurance under the conditions set forth below, but You may not apply for Dependent Critical Illness Insurance at the time You apply for Portability. The coverages eligible for Portability and the Portability Benefit Duration are in the Schedule of Benefits.

The premiums for the coverage continued under the Portability Benefit will not be the same as the premium You are charged for Your group Critical Illness Insurance under the Policy. Portability premium will be based on:

1. Our current rates for the applicant's age and class of risk at the time he elects Portability; and
2. the amount of insurance continued under Portability.

The maximum amount of Critical Illness Insurance which may be continued under Portability is the amount of Critical Illness Insurance in force at the time the Portability Benefit is elected, not to exceed the Portability Benefit amount as set forth in the Schedule of Benefits.

A beneficiary designation on the Application for Portability, if different from the designation on Your Enrollment Form, shall constitute a change of beneficiary under the Policy, and that beneficiary designation will only apply while Your coverage continues under this Portability Benefit provision.

What are Eligibility Requirements for Employee Portability?

To be eligible for Portability, You must meet the following conditions:

1. You must have been insured under the Policy or the Policy it replaced for at least one year prior to electing Portability; and
2. Your Critical Illness Insurance, or a portion of it, must have terminated for reasons other than Illness, Injury, retirement or termination of the Policy; and
3. You must be less than 60 years of age.

You must submit an Application for Portability and the first premium within 31 days after the date Your Critical Illness Insurance terminated.

We reserve the right to rescind any coverage amounts continued under Portability if it can be shown that You misrepresented any of the information provided to support eligibility for Portability.

Can Dependent Critical Illness Insurance be Ported if Your Eligibility Terminates or if Your Spouse's Coverage Terminates?

Yes, You or Your insured Spouse may elect Portability of Dependents' Critical Illness Insurance if Dependents' insurance coverage ceases as follows:

1. You may apply for Portability of Dependent Critical Illness Insurance if You meet the eligibility requirements to port Your Critical Illness Insurance as shown above and You are covered for Dependent Critical Illness Insurance on the date Your coverage ceases.
2. Your insured Spouse may apply for Portability of his group Critical Illness Insurance, and/or Critical Illness Insurance on covered Dependent child(ren) if:
    a. Your Spouse's Critical Illness Insurance terminates because You die or Your eligibility for Dependent Critical Illness Insurance ceases for reasons other than retirement or termination of the Policy and Your Spouse is less than 60 years of age.
    b. Your Spouse had elected Dependent Critical Illness Insurance on Eligible Dependent child(ren) and such coverage is still in force when Your eligibility for Dependent Critical Illness Insurance ceased for reasons other than retirement or termination of the Policy.
    c. Your Spouse must have been insured for such coverage(s) under the Policy for at least one year prior to electing Portability.
    d. Portability is not available if Your Spouse's Critical Illness Insurance terminates because he no longer meets the Policy definition of an Eligible Dependent Spouse.

If these criteria are met, You or Your Spouse, must submit an Application for Portability and pay the first premium within 31 days after the date such Dependent Critical Illness Insurance terminated.

We reserve the right to rescind any coverage amounts continued under Portability if it can be shown that You or Your Spouse misrepresented any information provided to support eligibility for Portability of Dependent Critical Illness Insurance.

An **Application for Portability** means the application You complete and submit to apply for coverage under the Portability Benefit.

When will Portable Coverage Terminate?

Insurance continued under the Portability Benefit provision of the Policy will terminate at the earliest of the following:

1. the date You return to Active Work with the Policyholder while the Policy is still in force; or
2. the date required premiums are not paid when due; or
3. the end of the Portability Benefit Duration in the Schedule of Benefits; or
4. the premium due date following the date a Dependent ceases to meet the definition of an Eligible Dependent.

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DEPENDENT CRITICAL ILLNESS INSURANCE

What is the Dependent Critical Illness Insurance Benefit?

We will pay *You* the amount of *Critical Illness Insurance* set forth in the Schedule of Benefits on *Your Dependent(s)* while *Your* insurance is in force. Payment will be in one lump sum.

If *You* are not living at the time *Dependent Critical Illness Insurance* benefits become payable, *We* will pay the benefit:

1. to *Your Spouse,* if living; if not,
2. in equal shares to *Your* then living natural or legally adopted children, if any; if none,
3. in equal shares to *Your* father and mother, if living; if not,
4. in equal shares to *Your* brothers and sisters, if living; otherwise,
5. to *Your* estate.

Who is eligible for Dependent Critical Illness Insurance?

If *You* or *Your Spouse* are insured for *Critical Illness Insurance* under the *Policy* and belong to a class listed in the Schedule of Benefits as eligible for *Dependent Critical Illness Insurance* benefits, *You* are eligible to enroll for this benefit. If *You* or *Your Spouse* are enrolled for *Dependent Critical Illness Insurance* and subsequently acquire a new *Eligible Dependent,* that *Dependent* will automatically be covered.

Note: No eligible person may be covered more than once under the *Policy.* If a person is covered as an *Employee,* he cannot be covered as a *Spouse* or *Dependent Child* of another *Employee.* If both parents are covered as insured *Employees* under the *Policy,* only one may enroll for *Critical Illness Insurance* coverage on *Eligible Dependent Child(ren).*

When does Dependent Critical Illness Insurance become effective?

If *You:*

1. have completed any required *Employee Eligibility Waiting Period;* and
2. apply for *Dependent Critical Illness Insurance* no later than 31 days after becoming eligible for this benefit; and
3. have paid any applicable premium.

Critical Illness Insurance for *Your Eligible Dependent(s)* will become effective on the later of:

1. the date *Your* group insurance coverage becomes effective;
2. the effective date of the *Dependent Critical Illness Insurance* benefit; or
3. the first of the month that falls on or next follows the date *You* enroll *Your Eligible Dependent(s);*
4. the first of the month that falls on or next follows the date *You* acquire *Your Eligible Dependent(s);*

5. if *Evidence of Insurability* is required, the date *We* determine that evidence is satisfactory and *We* provide written notice to *You* or the *Policyholder* of approval.

If *You* enroll for *Dependent Critical Illness Insurance* more than 31 days after *You* are eligible to do so, *You* must furnish *Evidence of Insurability* satisfactory to *Us* for each *Dependent*, and coverage will become effective as set forth above.

If an *Eligible Dependent* is required to submit satisfactory *Evidence of Insurability* for any reason, insurance in the amount for which *We* require such evidence will become effective on the date *We* determine that the evidence is satisfactory and *We* provide notice of approval to *You* and the *Policyholder*.

When do changes in the Dependent Critical Illness Insurance benefit become effective?

If no *Evidence of Insurability* is required, increases in the amount of *Dependent Critical Illness Insurance* will become effective on the Policy Anniversary Date.

For amounts on which *Evidence of Insurability* is required, increases in the amount of *Dependent Critical Illness Insurance* will be effective on the date *We* determine that evidence is satisfactory and *We* provide written notice of approval date of approval to *You* and the *Policyholder*.

Any decrease in the amount of *Dependent Critical Illness Insurance* will become effective immediately on the date of the change.
00019

TERMINATION PROVISIONS

When does Your coverage under the Policy end?

Unless Critical Illness Insurance is continued under Portability, Your coverage terminates on the earliest of the following dates:

1. the date on which the Policy is terminated; or
2. the date You stop making any required contribution toward payment of premiums; or
3. the effective date of an amendment to the Policy which terminates insurance for the class to which You belong; or
4. the date on which the Participating Employer's participation under the Policy is terminated; or
5. the date You:
    a. die; or
    b. are no longer a member of a class eligible for this insurance; or
    c. request termination of coverage under the Policy; or
    d. the first of the month following the date You reach age 99; or
    e. are no longer Actively at Work as a result of a Disability, layoff, or leave of absence or sabbatical, or military leave.

Termination will not affect Your claim for a covered Loss which occurred while the coverage was in force.

You may continue to be eligible for coverage, as follows:

Disability	Until the end of the twelfth month following the month in which the Disability began, if all premiums are paid when due.
Layoff	Until the end of the month following the month during which the layoff began, if all premiums are paid when due.
Leave of Absence	Until the end of the month following the month during which the leave of absence began, if all premiums are paid when due, as governed by the Policyholder's Human Resource policy on family and medical leaves of absence or in accordance with the FMLA provision below.
Sabbatical	Until the end of the month following the sixth month in which the sabbatical began, if all premiums are paid when due.
Military Leave	Until the end of the twelfth month following the month in which the military leave began, if all premiums are paid when due.

For the purposes of this provision, **Disability** means You are unable to perform all of the Material and Substantial Duties of Your Regular Occupation.
00020

Will coverage be continued if You are eligible for leave under FMLA?

In the event *You* are eligible for and the *Policyholder* approves a leave of absence under the Family and Medical Leave Act of 1993 (FMLA), or any applicable state family and medical leave law (State FML), provided the required premium continues to be paid, *Your* insurance will continue for a period of up to the later of:

1. the leave period permitted by the federal Family and Medical Leave Act of 1993 and any amendments; or
2. the leave period permitted by applicable state law.

You are eligible for leave under this Act in order to provide care:

1. After the birth of a child; or
2. After the legal adoption of a child; or
3. After the placement of a foster child in *Your* home; or
4. To a *Spouse,* child or parent due to their serious *Illness;* or
5. For *Your* own serious health condition; or
6. For any event later added by amendment to the Act.

While granted a Family or Medical Leave of Absence:

1. The *Policyholder* must remit the premium required by the *Policy;* and
2. Coverage will terminate if *You* do not return to work as scheduled according to the terms of *Your* leave of absence agreement with the *Policyholder.*

00021

When does Dependent Critical Illness Insurance coverage end?

Unless *Critical Illness Insurance* is continued under the *Portability Benefit* provision, *Dependent Critical Illness Insurance* coverage will end on the earliest of:

1. the date *You* are no longer *Actively at Work* except in the case of *Disability,* layoff or leave of absence as set forth above; or
2. the date the *Policy* is terminated; or
3. the date *You* stop making any required contribution toward payment of premiums; or
4. the effective date of an amendment to the *Policy* which terminates insurance for the class to which *You* belong; or
5. the date on which the *Participating Employer's* participation under the *Policy* is terminated; or
6. the first of the month following the date:
    a. *You* are no longer a member of a class eligible for this insurance, or
    b. *You* request termination of coverage under the *Policy,* or
    c. *You* reach age 99; or
7. the date a *Dependent* child or *Spouse* no longer meets the *Policy* definition of *Eligible Dependent.*

Coverage will continue past the age limit for *Eligible Dependent* children who are primarily dependent on *You* for support and who cannot work to support themselves due to a physical or mental incapacity which began before the age limit was reached. Written proof of such incapacity must be provided to *Us* on request.
00022

BENIGN BRAIN TUMOR

Benign Brain Tumor means the Diagnosis of a tumor within the brain cavity, known or presumed to be non-malignant, that results in a fixed neurological deficit. These neurological deficits include, but are not limited to:

- Loss of vision;
- Loss of hearing; or
- Balance disruption

Diagnosis of the tumor and neurological deficit must be confirmed by imaging or examination findings conducted by a Physician board-certified as a neurologist.

Tumors of the skull, pituitary adenomas and germanomas are excluded under this Covered Condition.

Also excluded from this Covered Condition is a Benign Brain Tumor Diagnosed with any of the following conditions prior to *Your or Your covered Dependent's* effective date:

- Neurofibromatosis I;
- Neurofibromatosis II;
- Von Hippel Lindau;
- Tuberous Sclerosis;
- Li Fraumani Syndrome;
- Cowden Disease; or
- Turcot Syndrome

The Date of Diagnosis is the date the Physician confirms the existence of the Benign Brain Tumor by examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.
00027

COMA

Coma or ***Comatose*** means the *Diagnosis* of a state of complete loss of consciousness lasting for a period of 14 or more consecutive days from which *You* cannot be aroused and there is no evidence of response to stimulation.

The *Coma* must be characterized by the absence of:

- Eye opening;
- Verbal response; and
- Motor response

The *Coma* must require intubation for respiratory assistance.
00028

END STAGE RENAL FAILURE

End Stage Renal Failure means the *Diagnosis* of a chronic and irreversible failure of both kidneys for which dialysis on a regular basis (weekly or biweekly) is necessary. *Diagnosis* must be made by a *Physician* board-certified in nephrology.

The *Date of Diagnosis* is the date the *Physician* recommends the *Insured* begin renal dialysis.
00030

HEART ATTACK

Heart Attack or acute ***Myocardial Infarction*** means a *Diagnosis* of an acute *Myocardial Infarction* resulting in the death of a portion of the *Insured's* heart muscle (myocardium) due to a blockage of one or more coronary arteries and resulting in the loss of the normal function of the heart. The *Diagnosis* must be made by a *Physician* board-certified as a cardiologist and based on both:

a. New clinical presentation and electro-cardiographic changes consistent with an evolving *Heart Attack*; and

b. Serial measurement of cardiac biomarkers showing a pattern and to a level consistent with a *Diagnosis of Heart Attack.*

An established (old) *Myocardial Infarction* is excluded under this *Covered Condition.*
00031

MAJOR HEART SURGERY

Major Heart Surgery means the Diagnosis of either: Aortic Surgery, Coronary Artery Bypass Surgery or Heart Valve Replacement/Repair Surgery, as defined below.

(a) **Aortic Surgery.** A disease of the aorta that necessitates actually undergoing surgery of the aorta needing excision and surgical replacement of a portion of the diseased aorta with a graft. The Diagnosis must be made by a Physician board-certified as a cardiologist, cardio-vascular thoracic surgeon or vascular surgeon. For this definition, aorta means the thoracic and abdominal aorta but not its branches. Traumatic Injury of the aorta causing Aortic Surgery is excluded under this Covered Condition. If the Insured is determined to be too ill to undergo the surgery, but otherwise meets the criteria for the need for the surgery, the surgery requirement will be waived.

(b) **Coronary Artery Bypass Surgery.** A disease of the coronary artery that necessitates actually undergoing Coronary Artery Bypass Surgery using either a saphenous vein or internal mammary artery graft for the treatment of coronary heart disease deemed medically necessary to correct a narrowing or blockage of one or more coronary arteries. The Diagnosis must be made by a Physician board-certified as a cardiologist. Other surgical or nonsurgical techniques such as laser relief or any other intra-arterial procedures are excluded under this Covered Condition. If the Insured is determined to be too ill to undergo the surgery, but otherwise meets the criteria for the need for the surgery, the surgery requirement will be waived.

(c) **Heart Valve Replacement/Repair Surgery.** A disease of the heart valve that necessitates the actually undergoing open heart surgery to replace or repair one or more valves. The Diagnosis must be made by a Physician board-certified as a cardiologist or cardio-vascular surgeon. If the Insured is determined to be too ill for surgery, but otherwise meets the criteria for the need for the surgery, the surgery requirement will be waived.
00033

LOSS OF SPEECH, SIGHT OR HEARING

Loss of Speech means the Diagnosis of loss of the ability to speak to the extent that the Insured is unintelligible to another person with normal hearing, for at least 12 months.

The Date of Diagnosis for Loss of Speech is the date a Physician certifies Loss of Speech as defined in the definition of Loss of Speech.

Loss of Sight means Diagnosis of clinically proven irreversible reduction of sight in both eyes with:

- Sight in the better eye reduced to a best corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (Snellen or E-Chart Acuity); or
- Visual field restriction to 20 degrees or less in both eyes.

The Date of Diagnosis for Loss of Sight is the date a Physician certifies Loss of Sight as defined in the definition of Loss of Sight.

Loss of Hearing means Diagnosis of permanent reduction in both ears to a point that the Insured is unable to hear sounds at or below 70 decibels. Diagnosis must be made by a board-certified or board-eligible otolaryngologist by audiometric testing.

The Date of Diagnosis for Loss of Hearing is the date the Physician certifies Loss of Hearing as defined in the definition of Loss of Hearing.
00035

MAJOR BURN

Major Burn means the Diagnosis that You or Your covered Dependents have sustained third degree burns covering at least 20% of the surface area of the body.
00036

MAJOR ORGAN TRANSPLANT

Major Organ Transplant means a Diagnosis, supported by clinical evidence of the major organ(s) failure which requires the malfunctioning organ(s) or tissue to be replaced with an organ(s) or tissue from a suitable human donor (excluding the recipient) under generally accepted medical procedures. The organs and tissues covered by this definition are limited to: liver, lung, entire heart, small intestine, pancreas or kidney. Excluded from this Covered Condition is bone marrow transplant. The Insured must be registered by the United Network of Organ Sharing (UNOS) in order for the Major Organ Transplant to be a Covered Condition under the Policy. If the Insured is determined to be too ill for a transplant, but otherwise meets the criteria for being registered by the UNOS, the registration requirement will be waived.

Only one Major Organ Transplant benefit will be paid per Insured.

The Date of Diagnosis is the date the Insured is placed on the UNOS list for transplantation or the NMDP list for marrow donation.
00037

PARALYSIS

Paralysis means the Diagnosis of loss of use without severance of a limb as a result of an Injury to the spinal cord, which has continued for 12 consecutive months. Paralysis must be determined by a Physician to be permanent, total and irreversible. Paralysis includes Hemiplegia, Quadriplegia, Paraplegia and Uniplegia.

Hemiplegia means total Paralysis of one arm and one leg on the same side of the body.

Quadriplegia means total Paralysis of both arms and both legs.

Paraplegia means total Paralysis of both legs.

Uniplegia means total Paralysis of one limb.

The Date of Diagnosis is the date the Injury occurred which caused Paralysis continuing for a period of 12 consecutive months as confirmed by the attending Physician, or immediately if the spinal cord is completely and irreparably transected.
00039

SEVERE COVID-19 INFECTION

Severe COVID-19 Infection means the *Diagnosis* of the *COVID-19* strain of the Human Coronavirus, also known as 2019-nCoV.

Diagnosis means a clinically approved, positive medical test confirmed by a *Physician* showing positive for *COVID-19* and a *Physician* recommends confinement in an Intensive Care Unit and placement on a ventilator due to abnormal oxygen levels in the lungs.

The *Date of Diagnosis* is the date the *Physician* recommends confinement in an Intensive Care Unit and placement on a ventilator due to the *Diagnosis* of *COVID-19*.

Intensive Care Unit means a place which:

- Is a specially designated area of the hospital called an Intensive Care Unit that provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care; and
- Is separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement; and

- Is permanently equipped with special lifesaving equipment for the care of the critically ill or injured; and
- Is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the Intensive Care Unit on a 24-hour basis; and
- Has a Physician assigned to the Intensive Care Unit on a full-time basis.

An Intensive Care Unit is not a progressive care unit, an intermediate care unit, a private monitored room, sub-acute Intensive Care Unit, an observation unit or any facility not meeting the definition of an Intensive Care Unit as defined above.

An Intensive Care Unit that meets the definition above includes hospital units with the following names:

- Intensive Care Unit;

- Coronary Care Unit;

- Neonatal Intensive Care Unit;

- Pulmonary Care Unit;

- Burn Unit; or

- Transplant Unit.

00090 rev.0920

STROKE

Stroke means the Diagnosis of an acute cerebrovascular accident producing neurological impairment, resulting in Paralysis or other measurable objective neurological deficit persisting for at least 96 hours and expected to be permanent, and characterized as Score 3 or higher on the Modified Rankin Scale. Transient ischemic attack (mini-stroke), head Injury, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits are excluded under this Covered Condition.

The Diagnosis must be made by a Physician board-certified as a neurologist.

In the event of death, an autopsy confirmation and/or death certificate identifying Stroke as the cause of death will be accepted.

The Date of Diagnosis is the date a Stroke occurred based on neuroimaging consistent with an acute or subacute abnormality or other neurodiagnostic study and presence of neurological deficits persisting for a period of 30 days or greater.

00040

CARCINOMA IN SITU

Carcinoma in situ means the *Diagnosis* of cancer where the tumor cells still lie within the tissue of origin without having invaded neighboring tissue. *Carcinoma in situ* includes melanoma not invading the dermis.

Carcinoma in situ does not include:

a. Non-malignant or pre-malignant lesions (such as intraepithelial neoplasia); or
b. Benign tumors or polyps.

Carcinoma in situ must be *Diagnosed* pursuant to a *Pathological Diagnosis* or *Clinical Diagnosis.*

Clinical Diagnosis means a *Diagnosis of Carcinoma* in situ based on the study of symptoms and diagnostic test results. *We* will accept a Clinical *Diagnosis* of *Carcinoma* in situ only if the following conditions are met:

a. A *Pathological Diagnosis* cannot be made because it is medically inappropriate or is life threatening;
b. There is medical evidence to support the *Diagnosis*, and
c. A *Physician* is treating the *Insured* for *Carcinoma in situ*.

Pathological Diagnosis means a *Diagnosis* of *Carcinoma in situ* based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of *Diagnosis* must be done by a *Physician* who is a board-

certified pathologist and whose *Diagnosis*of malignancy conforms to the standards set by the American College of Pathology.

The *Date of Diagnosis* is the date the tissue specimen, blood samples and/or titer(s) are taken on which the *Diagnosis* of *Carcinoma in situ* is based. If a *Pathological Diagnosis* cannot be made because it is medically inappropriate or life-threatening, *We* will accept a *Clinical Diagnosis.*
00042

INVASIVE CANCER

Invasive Cancer means a Diagnosis of malignant neoplasm which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue, and which is not specifically otherwise excluded. Leukemias and lymphomas are included.

The following are not considered Invasive Cancer:

a. Non-malignant, noninvasive, dysplasia (all grades), or pre-malignant lesions (such as intraepithelial neoplasia); or

b. Benign tumors or polyps; or

c. Carcinoma in situ; or

d. Any Skin Cancer (other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic).

Invasive Cancer must be Diagnosed pursuant to a Pathological Diagnosis. If a Pathological Diagnosis is not possible, Diagnosis can be made pursuant to a Clinical Diagnosis.

The Date of Diagnosis is the date the tissue specimen, blood samples and/or titer(s) are taken on which the Diagnosis of Cancer is based. If a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening, We will accept a Clinical Diagnosis.

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

a. A Pathological Diagnosis cannot be made because it is medically inappropriate or is life threatening;

b. There is medical evidence to support the Diagnosis, and

c. A Physician is treating the Insured for Invasive Cancer.

Pathological Diagnosis means a Diagnosis of Invasive Cancer based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of Diagnosis must be done by a Physician who is a board-certified pathologist and whose Diagnosis of malignancy conforms to the standards set by the American College of Pathology.
00043

WELLNESS BENEFIT

What is the Wellness Benefit?

If, while insured under the Policy, You or Your covered Dependent Spouse undergo any of the Wellness Tests indicated below, We will pay the amount as set forth in the Schedule of Benefits.

Wellness Tests include:

- Blood test for triglycerides;
- Bone marrow aspiration or biopsy;
- CA 15-3 (blood test for breast cancer);
- CA-125 (blood test for ovarian cancer);
- CEA (blood test for colon cancer);
- Carotid Doppler;
- Chest x-ray;
- Colonoscopy;
- COVID-19 screening;
- Echocardiogram;
- Electrocardiogram;
- Fasting blood glucose test;
- Fasting plasma glucose (FPG);
- Flexible sigmoidoscopy;
- Hemoglobin A1C (HbA1c);
- Hemocult stool analysis;
- Mammography;
- Pap smear;
- PSA (blood test for prostate cancer);
- Serum cholesterol test to determine HDL and LDL levels;
- Serum protein electrophoresis (blood test for myeloma);
- Skin cancer biopsy;
- Stress test on a bicycle or treadmill;
- Thermography;
- Thin prep pap test;
- Two hour post-load plasma glucose; or
- Vaccinations; or
- Virtual colonoscopy.

The Wellness Benefit is payable once per Calendar Year for each insured Employee and covered Dependent Spouse.

For the purposes of the Wellness Benefit**,** Calendar Year is the period beginning January 1st and ending December 31st.

The Wellness Tests must be performed while the Insured's coverage under the Policy is in force. Proof must be provided that the test was performed and the Insured incurred an expense.

00050b 0121

RECURRENCE BENEFIT

Which Conditions are eligible for a Recurrence Benefit?

The Recurrence Benefit is available for a Diagnosis of a Recurrence of the following Covered Conditions:

- Stroke
- Benign Brain Tumor
- Coma
- Heart Attack
- Invasive Cancer

Recurrence means a Recurrence of the same condition after being treatment free for 6 months from the original payment of the Covered Condition. The Recurrence Benefit can only be paid one time per Covered Condition.
00051

GENERAL PROVISIONS

Entire Contract; Changes

The Policy, the Policyholder's Application, the Employee's Certificate of coverage, and Your application, if any, and any other attached papers, form the entire contract between the parties. Coverage under the Policy can be amended by mutual consent between the Policyholder and Us. No change in the Policy is valid unless approved in writing by one of Our executive officers and unless such approval is endorsed hereon or attached hereto. No agent has the right to change the Policy or to waive any of its provisions.

Statements on the Application

In the absence of fraud, all statements made in any signed application are considered representations and not warranties (absolute guarantees). No representation by:

1. the Policyholder in applying for the Policy will make it void unless the representation is contained in his signed Application; or
2. any Employee in applying for insurance under the Policy will be used to reduce or deny a claim unless a copy of the application for insurance, signed by the Employee, is or has been given to the Employee.

Legal Actions

Unless otherwise provided by federal law, no legal action of any kind may be filed against Us:

1. until 60 days after Proof has been given; or
2. more than 3 years after Proof must be filed, unless the law in the state where You live allows a longer period of time.

Clerical Error

Clerical error or omission by Us to the Policyholder will not:

1. Prevent You from receiving coverage, if You are entitled to coverage under the terms of the Policy; or
2. Cause coverage to begin or coverage to continue for You when the coverage would not otherwise be effective.

If the Policyholder gives Us information about You that is incorrect, We will:

1. Use the facts to decide whether You have coverage under the Policy and in what amounts; and
2. Make a fair adjustment of the premium.

Time Limit on Certain Defenses

The validity of the Policy shall not be contested, except for non-payment of premiums, after it has been in force for two years from the date of issue. The validity of the Policy shall not be contested on the basis of a statement made relating to insurability by any person covered under the Policy after such insurance has been in force for two years during such person's lifetime, and shall not be contested unless the statement is contained in a written instrument signed by the person making such statement.

Premium Provisions

Premiums are payable in United States dollars on or before their due dates. The Policyholder has agreed to deduct from Your pay any premiums payable for Your Voluntary/Supplemental coverage. The Policyholder agrees to remit such premiums for the entire time coverage under the Policy is in effect.
Premium charges for increases in insurance amounts becoming effective during a Policy month will begin on the next premium due date. Premium charges for insurance terminating during a Policy month will cease at the end of the month in which such insurance terminates. This method of charging premium is for accounting purposes only. It will not extend any insurance coverage beyond the date it would otherwise have terminated.

Misstatement of Age

If You have misstated Your age or the age of a Dependent, the true age will be used to determine:

1. the effective date or termination date of insurance; and
2. the amount of insurance; and
3. any other rights or benefits.

Premiums will be adjusted to reflect the premiums that would have been paid if the true age had been known.

Conformity with State Statutes and Regulations

Any provision of the Policy which, on its effective date, conflicts with the statutes and regulations of the state in which the Policy was issued, it is automatically changed to meet the minimum requirements of such statutes.

Retention of Discretion
We shall have the exclusive right to interpret the terms of the Policy. The decision about whether to pay any claim is within Our sole discretion and such decisions shall be final and conclusive.
00052 IL

UNIFORM CLAIM PROVISIONS

Initial Notice of Claim

We must receive written notice of Loss within 30 days of the date of Loss, or as soon as reasonably possible. The Policyholder can assist with the appropriate telephone number and address of Our Claim Department. Notice may be sent to Our Claim Department at the address shown on the claim form or given to any authorized agent of Ours.

Claim Forms

Within 15 days of Our being notified in writing of a claim, We will supply the claimant with the necessary claim forms. The claim form is to be completed and signed by the claimant, the Policyholder and the claimant's Physician. If the appropriate claim forms are not received within 15 days, then the claimant will be considered to have met the requirements for written Proof of loss if We receive written Proof, which describes the occurrence, extent and nature of the Loss.

Time Limit for Filing Your Claim

We must receive written Proof within 90 days after the date a Loss is incurred. If it is not possible to give Us written Proof within 90 days, the claim is not affected if the Proof is given as soon as possible. However, unless the claimant is legally incapacitated, written Proof of loss must be given no later than one year after the time Proof is otherwise due.

No benefits are payable for claims submitted more than 1 year after the time Proof is due. However, benefits may be paid if it can be shown that:

1. It was not reasonably possible to give written Proof during the one year period, and
2. Proof satisfactory to Us was given as soon as was reasonably possible.

We will give You written response to Your claim, usually within 45 days. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, We notify You in writing that an extension is necessary due to matters beyond Our control, identify those matters and gives the date by which We expect to render a decision. If the extension is due to Your failure to submit information necessary to decide Your claim, the time for decision shall be tolled from the date on which We send You notice of the extension until the date We receive Your

response to Our request. This period will be no longer than 45 days after We have requested the information. At that time We will decide Your claim based on the information We have at that time.

Physical Examination/Autopsy

On receipt of a claim, We may have an Insured examined, at Our expense, at any reasonable time. We may have an autopsy performed, at Our expense, if it is not prohibited by any applicable local law(s).

Who will receive Your Critical Illness Insurance Benefits?

Critical Illness Insurance benefits are payable to You unless such benefits have been assigned. The Policyholder may not be named as beneficiary. In the event of Your death prior to Critical Illness Insurance benefits being paid, benefits will be paid according to the Facility of Payment provision.

Facility of Payment

If no named beneficiary survives You or if You do not name a beneficiary, We will pay the amount of insurance:

1. to Your Spouse, if living; if not,
2. in equal shares to Your then living natural or legally adopted children, if any; if none,
3. in equal shares to Your father and mother, if living; if not,
4. in equal shares to Your brothers and/or sisters, if living; if not,
5. to Your estate.

00053

Do I have the Right to Appeal a Claim Denial?

If Your claim is denied You will receive a written notice giving the following:

- the reason or reasons for the denial;
- the Policy provisions on which the denial is based;
- an explanation of what other material or information, if any, may be needed to process the claim and why it is needed;
- the steps that You have to follow to have the claim reviewed;
- a statement that You have the right to bring a civil action under section 502(a) of ERISA after You appeal Our decision and after You receive a written denial on appeal; and
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion; or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to You upon request; and
- if denial is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances, or (ii) a statement that such explanation will be provided to You free of charge upon request.

If the claim has been denied You can appeal the denial to Us for a full and fair review. You have at least 180 days to appeal from the claim denial.

You may:

a. request a review upon written application within 180 days of the claim denial;
b. request, free of charge, copies of all documents, records and other information relevant to Your claim; and
c. submit written comments, documents, records and other information relating to Your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

We will make a decision no more than 45 days after We receive Your appeal. The time for decision may be extended for one additional 45 day period provided that, prior to the extension, We notify You in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If Your claim is extended due to Your failure to submit information necessary to decide Your claim on appeal, the time for Your decision shall be tolled from the date on which the notification of the extension is sent to You until the date We receive Your response to the request.

The decision on appeal will provide the following:

- the reason or reasons for the decision;
- the Plan provision on which the decision is based;
- a statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to Your claim for benefits;
- a statement of the claimant's right to bring an action under section 502(a) of ERISA;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision either (i) the specific rule, guideline, protocol or other similar criterion; or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the decision and that a copy will be provided free of charge to You upon request;
- if the decision is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances, or (ii) a statement that such explanation will be provided to You free of charge upon request; and
- the following statement: "You and Your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor Office and Your State insurance regulatory agency."

00054 IL

GENERAL DEFINITIONS

Accident or ***Accidental*** means a sudden, unexpected event that was not reasonably foreseeable.
00055

Actively at Work or Active Work means that *You* must:

1. work for the *Policyholder* on a full-time active basis; or
2. work at least the minimum number of hours set forth in the Schedule of Benefits: and either:
   a. work at the *Policyholder's* usual place of business; or
   b. work at a location to which the *Policyholder's* business requires *You* to travel; and
3. not be a temporary or seasonal *Employee;* and
4. be paid regular earnings by the *Policyholder.*

You will be considered *Actively at Work* if *You* were actually at work on the day immediately preceding:

1. a weekend (except for one or both of these days if they are scheduled days of work);
2. holidays (except when such holiday is a scheduled work day);
3. paid vacations;
4. any non-scheduled work day;
5. excused leave of absence (except medical leave and lay-off); or
6. emergency leave of absence (except emergency medical leave); and

You were not *Hospital Confined* or disabled due to an *Injury* or *Illness.*
00056

Application means the document which sets forth the eligible classes, the amounts of insurance, and other relevant information pertaining to the plan of insurance for which the *Policyholder* applied.
00057

Certificate means this *Critical Illness Insurance Certificate.*
00059

Change in Family Status means a change in status as defined in the regulations under Internal Revenue Code section 125, unless *Your* employer's cafeteria plan document or human resource *Policy* contains more restrictive provisions. In that event, *Your* employer may restrict the situations where *You* can change *Your* coverage.
00060

Civil Union means the legeally recognized union of two eligible individuals of the same or opposite sex established pursuant to the "Religious Freedom Protection and Civil Union Act" (750 ILCS 75/1). Civil unions or same sex civil

unions or marriages recognized by other jurisdictions that provide substantially all of the rights and benefits of marriage are also considered Civil Unions.
00089 IL

Contributory means *You* pay all or a portion of the premium for this insurance coverage.
00061

Covered Conditions means an *Illness* or *Injury* listed in the *Covered Conditions* Schedule.
00062

Date of Diagnosis means the date the *Diagnosis* is made by a *Physician* through the use of clinical and/or laboratory findings as supported by *Your or Your* covered *Dependents* medical records. *Date of Diagnosis* may be further defined for a specific *Covered Condition*; if so, that definition will control over this definition.
00063

Dependent* or *Eligible Dependent means:

1. Your lawful *Spouse* or domestic partner; and/or
2. Your unmarried child(ren) who are less than age 26 and are not in active military service.

Eligible Dependents include:

1. *Your* natural or step child or child of Your domestic partner.
2. a child placed with *You* for adoption from the date of placement or the date *You* are party in a suit in which *You* seek the adoption of the child. Eligibility will continue unless the child is removed from placement.
3. a child of *Your* child who is *Your Dependent* for federal income tax purposes at the time application for coverage of the child of *Your* child is made.

00064a IL

Diagnosis/Diagnosed means the definitive establishment of a *Covered Condition* by a *Physician.*
00065

Employee* or *Eligible Employee means an *Actively at Work*, full-time *Employee* as shown in the Schedule of Benefits whose principal employment is with the *Policyholder*, at the *Policyholder's* usual place of business or such place(s) that the *Policyholder's* normal course of business may require, and who is reported on the *Policyholder's* records for Social Security and withholding tax purposes.
00066

Illness means sickness, disease, pregnancy or complications of pregnancy.
00067

Initial Diagnosis means *You* or Your covered Dependents have never been *Diagnosed* with a specific condition or undergone a specific procedure shown in the *Covered Conditions* Schedule.
00068

Injury means bodily harm resulting directly from an Accident.
00069 IL

Insured means an Employee or Eligible Dependent covered under the Policy.
00070

Male Pronoun whenever used includes the female.
00071

Material and Substantial Duties means duties that are normally required for the performance of Your Regular Occupation and cannot be reasonably omitted or modified.
00072

Physician means a person other than You or Your covered Dependent, a member of Your or Your covered Dependents' immediate family or Your or Your covered Dependents' business associate, who is licensed to and actively practicing medicine in the United States, and is licensed to treat Illness and Injury. The Physician must be providing services within the scope of his license and must be a board certified specialist where required under the terms of a Covered Condition.
00077

Policy means the contract between the Policyholder and Us including the Application, this Certificate and any amendments, riders or endorsements.
00078

Policyholder means the person, firm, or institution to whom the Policy was issued. Policyholder also means any covered subsidiaries or affiliates set forth on the face of the Policy. If the Policyholder is an association the term Participating Employer shall be substituted for Policyholder.
00079

Proof means evidence satisfactory to Us that You or Your covered Dependents has a Covered Condition. We reserve the right to determine, at Our sole discretion, if Proof is acceptable under the terms of the Policy.
00080

Regular Occupation means the occupation that You are routinely performing when Your Critical Illness Insurance terminates due to Disability. We will look at Your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific Policyholder or at a specific location.
00081

Riot means all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether with or without a common intent and whether or not damage to person or property or unlawful act is the intent or the consequence of such disorder.
00082

Spouse means lawful *Spouse* or domestic partner. *Spouse* also means a person who has established a *Civil Union* with the Insured.
00083a IL

Student means an Eligible Dependent child who, on the date of Your death, is:

1. A full-time post-high school Student in a school of higher education; or
2. A Student in the 12th grade but who becomes a full-time post-high school Student in a school of higher education within 365 days after Your death.

00084

Voluntary means coverage for which You pay 100% of the premium.
00086

We, Our and **Us** means Dearborn Life Insurance Company.
00087

You, Your and **Yours** means the Eligible Employee to whom this Certificate is issued and whose insurance is in force under the terms of the Policy.
00088

NOTICE OF
PROTECTION PROVIDED BY
ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** description of the Illinois Life and Health Insurance Guaranty Association ('the Association') and the protection it provides for policyholders. This safety net was created under Illinois law which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity, health maintenance organization or health insurance company becomes financially unable to meet its obligations and is placed into Receivership by the Insurance Department of the state in which the company is domiciled. If this should happen, the Association will typically arrange to continue coverage, pay claims, or otherwise provide protection in accordance with Illinois law, with funding from assessments paid by other insurance companies and health maintenance organizations.

The basic protections provided by the Association per insured in each insolvency are:

- Life Insurance
  - $300,000 for death benefits
  - $100,000 for cash surrender or withdrawal values
- Health Insurance
  - $500,000 for health benefits plan*
  - $300,000 for disability insurance benefits
  - $300,000 for long-term care insurance benefits
  - $100,000 for other types of health insurance benefits
- Annuities
  - $250,000 for withdrawal and cash values

*The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except special rules apply with regard to health benefit plan benefits for which the maximum amount of protection is $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also residency requirements and other limitations under Illinois law.

To learn more about these protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ilhiga.org or contact:

Illinois Life and Health *Insurance Guaranty Association* *901 Warrenville Road, Suite 400* *Lisle, Illinois 60532-4324*	*Illinois Department of Insurance* *4th Floor* *320 West Washington Street* *Springfield, Illinois 62767*

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

The Association is not an insurance company or health maintenance organization. If you wish to contact your insurance company or health maintenance organization, please use the phone number found in your policy or contact the Illinois Department of Insurance at DOI.InfoDesk@illinois.gov.

END OF CERTIFICATE

Administrative Office:

701 E. 22nd Street

Lombard Illinois 60148

Principal Office:

300 E. Randolph Street

Chicago Illinois 60601