CRITICAL ILLNESS PLAN 1

METROPOLITAN LIFE INSURANCE COMPANY
NEW YORK, NEW YORK

CERTIFICATE OF CRITICAL ILLNESS INSURANCE

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You are insured for the benefits described in this Certificate, subject to the provisions of this Certificate.

This Certificate is issued to You under the Group Policy and it includes the terms and provisions of the Group Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.** The Group Policy is a contract between MetLife and the Group Policyholder. It may be changed or ended without Your consent or notice to You.

Group Policyholder:	Independent Drivers Guild
Group Policy Number:	232092-2-G
MetLife Toll Free Number:	1-800-GETMET8

Important Notice: This is a limited Certificate. Subject to the provisions of this Certificate, including limitations, exclusions and Proof requirements, this Certificate provides limited benefits in the event You are Diagnosed with Cancer, Cardiovascular Disease, Heart Attack, Kidney Failure, Major Organ Failure, Progressive Disease or Stroke. Read it carefully with the Outline of Coverage.

30-Day Right to Examine Certificate. Please read this Certificate carefully. If You are not satisfied for any reason, You may notify the Group Policyholder that You are cancelling Your Certificate within 30 days from the date of delivery by calling the Group Policyholder. If You notify the Group Policyholder that You are cancelling within the 30 day period, this Certificate will be void from the beginning. We will refund any premium or Contribution paid within 30 days after We receive Your notice of cancellation.

This is a supplement to health insurance and is not a substitute for Medical Coverage. Lack of Medical Coverage (or other minimum essential coverage) may result in an additional payment with Your taxes. You must have Medical Coverage when You enroll for this insurance.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CONTRACT. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from MetLife.

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SCHEDULE OF INSURANCE

IMPORTANT NOTE: Payment of the benefits listed in this Schedule of Insurance is subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate. PLEASE READ THE ENTIRE CERTIFICATE CAREFULLY.

BENEFIT AMOUNT AND TOTAL BENEFIT AMOUNT

	For You
Benefit Amount	$20,000
Total Benefit Amount	$100,0000

Minimum Benefit Amount

For each Covered Condition, the benefit will be the greater of the amount determined in accordance with this Schedule of Insurance or $250.

BENEFIT SEPARATION PERIOD

For a Recurrence Benefit for a Covered Person **30** days

Please refer to the Benefit Separation Period provision in the Limitations section for additional information.

CERTIFICATE CHANGES

In the event We issue You a revised Certificate under the same Group Policy, without a lapse in coverage, due to:

- a change in benefit provisions made by the Group Policyholder; or
- a change in coverage made by You,

We will treat the new Certificate as a continuation of Your coverage under this Certificate.

SCHEDULE OF INSURANCE (Continued)

COVERED CONDITION CATEGORY: CANCER		
COVERED CONDITION	**INITIAL BENEFIT**	**RECURRENCE BENEFIT**
Invasive Cancer	100% of the Benefit Amount payable no more than 1 time per Covered Person per Occurrence of each Separate and Unrelated Invasive Cancer	100% of the Initial Benefit Amount payable no more than 2 times per Covered Person
Non-Invasive Cancer	25% of the Benefit Amount payable no more than 1 time per Covered Person per Occurrence of each Separate and Unrelated Non-Invasive Cancer	100% of the Initial Benefit Amount payable no more than 2 times per Covered Person
Skin Cancer	5% of the Benefit Amount, payable no more than 1 time per Covered Person	None

COVERED CONDITION CATEGORY: CARDIOVASCULAR DISEASE		
COVERED CONDITION	**INITIAL BENEFIT**	**RECURRENCE BENEFIT**
Coronary Artery Disease	50% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 2 times per Covered Person

SCHEDULE OF INSURANCE (Continued)

COVERED CONDITION CATEGORY: HEART ATTACK		
COVERED CONDITION	**INITIAL BENEFIT**	**RECURRENCE BENEFIT**
Heart Attack	100% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 2 times per Covered Person

COVERED CONDITION CATEGORY: KIDNEY FAILURE		
COVERED CONDITION	**INITIAL BENEFIT**	**RECURRENCE BENEFIT**
Kidney Failure	100% of the Benefit Amount payable no more than 1 time per Covered Person	None

COVERED CONDITION CATEGORY: MAJOR ORGAN FAILURE		
COVERED CONDITION	**INITIAL BENEFIT**	**RECURRENCE BENEFIT**
Major Organ Failure	100% of the Benefit Amount payable no more than 1 time per Covered Person	None

SCHEDULE OF INSURANCE (Continued)

COVERED CONDITION CATEGORY: PROGRESSIVE DISEASE		
COVERED CONDITION	**INITIAL BENEFIT**	**RECURRENCE BENEFIT**
Alzheimer's Disease	100% of the Benefit Amount payable no more than 1 time per Covered Person	None

SCHEDULE OF INSURANCE (Continued)

COVERED CONDITION CATEGORY: STROKE		
COVERED CONDITION	**INITIAL BENEFIT**	**RECURRENCE BENEFIT**
Stroke	100% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 2 times per Covered Person

LIMITATIONS

BENEFIT SEPARATION PERIOD

Benefit Separation Period
The Benefit Separation Period is the number of days that must elapse between Occurrences of Covered Conditions for a Covered Person as described below in order for a benefit to be payable.

Recurrence Benefit Separation Period
The Benefit Separation Period that applies to a Recurrence Benefit for a Covered Person for a subsequent Occurrence of the same Covered Condition is subject to all of the following:

- a benefit must have been payable for the prior Occurrence of the Covered Condition; and
- the Recurrence Benefit Separation Period must be satisfied in order for a Recurrence Benefit to be payable.

The Recurrence Benefit Separation Period is set forth on the Schedule. The Recurrence Benefit Separation Period is measured from the date of the most recent Occurrence of the same Covered Condition for which a benefit was payable.

Example:
The following example is provided for illustration purposes to explain how the Recurrence Separation Period will be applied and a Recurrence Benefit is calculated as described above. This example does not necessarily reflect the benefits of Your specific coverage.

Recurrence Benefit Separation Period	180 days
Covered Condition A Occurs on January 1st	Initial Benefit paid for Covered Condition A
Covered Condition A Occurs again on March 1st	The Recurrence Benefit Separation Period is measured from January 1, the date Condition A Occurred. Result: The Recurrence Benefit for Covered Condition A is not paid because the 180 day Recurrence Benefit Separation Period had not been satisfied when Condition A Occurred again.

LIMITATIONS (Continued)

PREEXISTING CONDITION LIMITATION

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 6 months that a Covered Person is insured under this Certificate. After a Covered Person has been insured for the first 6 months under this Certificate benefits may be payable for an Occurrence of a Covered Condition that is caused by or results from a Preexisting Condition.

We will not pay for an increase in the Benefit Amount for any Covered Condition that is caused by or results from a Preexisting Condition if such Covered Condition Occurs during the first 6 months after such increase in the Benefit Amount. After a Covered Person has been insured for the first 3 months under this Certificate for an increase in Benefit Amount, the increase in benefits may be payable for an Occurrence of a Covered Condition that is caused by or results from a Preexisting Condition.

Preexisting Condition means a sickness or injury for which, in the 3 months before a Covered Person becomes insured under this Certificate, or in the 3 months before any increase in the Benefit Amount for such Covered Person, medical advice, treatment or care was sought by the Covered Person, or, was recommended by, prescribed by or received from a Physician or other Practitioner of the Healing Arts.

For purposes of satisfying the Preexisting Condition Limitation, We will not consider the following to be medical advice, treatment or care received by the Covered Person from a Physician or other Practitioner of the Healing Arts:

- maintenance drug therapy prescribed to the Covered Person during remission of a Covered Condition; or
- routine medical assessments to verify that a Covered Condition is no longer present or remains in remission.

The Preexisting Condition Limitation applies to all Covered Conditions unless otherwise stated in this Certificate.

GENERAL EXCLUSIONS

The exclusions that appear below apply to all Covered Conditions and benefits set forth in this Certificate. Please note that certain Covered Conditions have additional exclusions that are set forth in the benefit provisions of this Certificate.

We will not pay benefits for any Covered Condition for a Covered Person caused by, or that takes place during:

- the Covered Person's active participation in an insurrection, rebellion, or riot ;
- the Covered Person's engagement in any illegal occupation;
- the Covered Person's intentionally self-inflicted injury;
- the Covered Person's suicide or attempted suicide;
- war, or act of war (whether declared or undeclared);
- the Covered Person being intoxicated;
- the Covered Person being under the influence of any narcotic (unless administered on the advice of a Physician); or
- activities required by the Covered Person's service in the armed forces or any auxiliary unit of the armed forces of any country or international authority.

In addition, We will not pay benefits for:

- any Covered Condition for which Diagnosis is made outside the United States, Canada or Mexico 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, Canada or Mexico.

DEFINITIONS

As used in this Certificate, the terms listed below will have the meanings set forth below. Other terms may be defined where they are used. 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.

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

Certificate means this Certificate including any riders attached to it.

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

Covered Condition means those conditions or treatments listed in the Schedule for which a benefit is payable as described in this Certificate.

Covered Person means You.

Diagnosis or Diagnosed means the establishment of a Covered Condition by a Physician through the use of clinical and/or laboratory findings, and using generally accepted medical standards. In the event a pathological or Clinical Diagnosis cannot be made under generally accepted medical standards because it would be medically inappropriate or life-threatening, We will accept a medically appropriate Diagnosis.

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

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

DEFINITIONS (Continued)

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;
- has facilities for major Surgery either on its premises or through a contractual arrangement with another Hospital;
- has a requirement that every patient must be under the care of a Physician or dentist;
- provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- is duly licensed by the agency responsible for licensing such Hospitals;
- if located in New York State, has in effect a hospitalization review plan applicable to all patients that meets at least the standards set forth in section 1861 (k) of United States Public Law 89-97; 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.

Initial Benefit means the benefit, as specified in the Schedule, that is payable for a Covered Condition the first time that such condition Occurs for a Covered Person while coverage is in effect under this Certificate and subject to the terms and conditions of this Certificate.

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.

Medically Necessary means that a treatment stated in the definition of a Covered Condition:

- has been determined by a Covered Person's Physician to be required to treat such Covered Person for such Covered Condition; and
- is not primarily for the convenience of the Covered Person or Physician.

Medically Necessary treatment recommendations by a Covered Person's Physician for such Covered Person must be consistent with generally accepted published standards of medical practice and clinical protocols that are applicable to the Covered Condition.

Medical Restriction means a person is:

- restricted to the person's home under a Physician's care;
- receiving or applying to receive disability benefits from any source;
- an inpatient in a Hospital;
- receiving care in a hospice facility, an intermediate care facility or a long-term care facility; or
- receiving chemotherapy, radiation therapy or dialysis.

Member means (i) a driver who is licensed with the New York City Taxi and Limousine Commission (NYC TLC) as a for hire vehicle driver, is driving a vehicle that is affiliated with a dispatch base that is a member of The Black Car Fund, and who in the prior calendar year (or prior calendar quarter if driving for less than a calendar year) has provided service to passengers averaging at least 10 hours per week, or (ii) a driver not registered with the NYC TLC and qualifies as a transportation network company driver that is working with a member of the Black Car Fund, or is affiliated with a dispatch base that is a member of the Black Car Fund, and in the prior calendar year (or prior calendar quarter if driving for less than a calendar year) has received gross earnings averaging at least $4,000 per month from the provision of service to passengers in the State of New York. Gross revenue is to be determined based on income that will be reported on a driver's Form 1099. In the case of either (i) or (ii) the driver must also be enrolled in The Black Car Fund Drivers Benefits program.

Occurs or **Occurrence** means, for a Covered Person, an Occurrence of a particular Covered Condition as defined in the benefit provision for that Covered Condition while coverage is in effect under this Certificate for such Covered Person.

Physician means:

- a person:
  - who has received a degree of doctor of medicine (M.D.), or doctor of osteopathy (D.O.); or
  - any other person whose services, according to applicable law, must be treated as Physician's services; and
- such person is acting within the scope of a valid license issued in the United States, Canada or Mexico to make a Diagnosis of a Covered Condition or to perform the services required for a Covered Condition for which a claim is made.

The term Physician does not include:

- You;
- Your spouse or anyone to whom You are related by blood or marriage;
- anyone who is a member of Your household;
- Your adopted or stepchild; or
- Anyone else in Your immediate family.

Practitioner of the Healing Arts means any person who holds a valid license in the United States, Canada or Mexico to engage in the Diagnosis or treatment of disease or any ailment of the human body, and is acting within the scope of such license.

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

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

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

Recur or Recurrence means another Occurrence of the same Covered Condition for which We have already paid a benefit.

Recurrence Benefit means a benefit, as specified in the Schedule, that is payable for another Occurrence of the same Covered Condition for the same Covered Person for whom We have already paid a benefit while coverage is in effect under this Certificate and subject to the terms and conditions of this Certificate. The Schedule shows the Covered Conditions for which a Recurrence Benefit is payable.

Schedule means the Schedule of Insurance that appears in this Certificate.

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.

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 or non-invasive procedures.

Total Benefit Amount means the maximum aggregate amount that We will pay, per Covered Person, per lifetime, for any and all of the Covered Conditions to which the Total Benefit Amount maximum applies (each Covered Condition Category states whether the Covered Condition Category is subject to the Total Benefit amount). The Total Benefit Amount is shown on the Schedule.

Treatment Free means that a Covered Person is symptom free and not receiving medical treatment or care from a Physician for the Covered Condition for which We paid an Initial Benefit or Recurrence Benefit. For purposes of this term, medical treatment does not include:

- the Covered Person receiving maintenance drug therapy while in remission; or
- routine medical assessments to verify that a Covered Condition is no longer present or remains in remission.

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 Member who is insured under the Group Policy for the insurance described in this Certificate.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS

All Members

DATE YOU ARE ELIGIBLE FOR INSURANCE

You may only become eligible for the insurance as shown in the SCHEDULE OF BENEFITS if You are a Member.

If You are a Member on August 1, 2023, You will be eligible for the insurance described in this Certificate on that date.

If You become a Member after August 1, 2023, You will be eligible for insurance on the date You become a Member.

ENROLLMENT PROCESS

If You are eligible for insurance, You may enroll for such insurance by completing the required form.

DATE YOUR INSURANCE TAKES EFFECT

Provided that You are Actively at Work in an eligible class, insurance under this Certificate will take effect for You on the Certificate effective date. If You are not Actively at Work in an eligible class on the date insurance would otherwise take effect, insurance will take effect on the date You return to Active Work in an eligible class.

COVERED CONDITION CATEGORY: CANCER

ADDITIONAL DEFINITIONS THAT APPLY TO BENEFITS FOR THE CANCER COVERED CONDITION CATEGORY

Cancer Covered Condition means the following:
- Invasive Cancer;
- Non-Invasive Cancer; or
- Skin Cancer.

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

Chemotherapy means the administration of drugs or biologics that are prescribed by a Physician to either eliminate the cancerous cells, or prevent or slow the growth of the cancerous cells.

Invasive Cancer means the presence of one or more malignant tumors with invasion of normal tissue and characterized by the uncontrollable and abnormal growth and spread of malignant cells to lymph nodes and/or a body part different from the site of cancer origin. Invasive Cancer includes the following:
- a malignant melanoma for which a pathology report shows a maximum thickness greater than 0.80 millimeters using the Breslow method of determining tumor thickness;
- a cancer that is a leukemia or lymphoma; or
- where a Covered Person has terminal cancer and has a life expectancy of 24 months or less from the date of Diagnosis and will not benefit from, or has exhausted, curative therapy.

Occurs or Occurrence, with respect to a Cancer Covered Condition, means a Covered Person is Diagnosed with such Covered Condition while the coverage is in effect under this Certificate for such Covered Person. A Cancer Covered Condition will be deemed to Occur on the date that the Diagnosis of the Cancer Covered Condition is made.

Non-Invasive Cancer (including Carcinoma in Situ) means the presence of a malignant tumor and characterized by the abnormal growth of malignant cells which are confined to the site of origin without spread to lymph nodes and/or a body part different from the site of cancer origin. Non-Invasive Cancer includes the following:
- a malignant melanoma, for which a pathology report shows a maximum thickness less than or equal to 0.80 millimeters using the Breslow method of determining tumor thickness;
- a tumor of the prostate classified as T1bN0M0, or T1cN0M0; or
- a Carcinoma in Situ classified as TisN0M0.

Non-Invasive Cancer does not include Skin Cancer.

Separate and Unrelated with respect to a Cancer Covered Condition means a Cancer Covered Condition that is:
- not a Recurrence of any previously Diagnosed Cancer Covered Condition;
- not a metastasis of a previously Diagnosed Cancer Covered Condition; and
- distinct in the cause and etiology from any previously Diagnosed Cancer Covered Condition.

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

TNM Classification of Malignant Tumors (**"TNM Staging")** means the classification standards for cancer developed by the American Joint Committee on Cancer.

COVERED CONDITION CATEGORY: CANCER (Continued)

INITIAL BENEFIT FOR A CANCER COVERED CONDITION

We will pay the applicable Initial Benefit for a Cancer Covered Condition shown on the Schedule for a Covered Person:

- the first time a Cancer Covered Condition Occurs for such Covered Person; or
- for a Cancer Covered Condition that is Separate and Unrelated from any prior Cancer Covered Condition for which We paid a benefit.

Related Occurrence for a Cancer Covered Condition

In the event a Covered Person has an initial Occurrence of a Cancer Covered Condition that is not an Invasive Cancer, and the Cancer Covered Condition for which We paid a benefit is subsequently Diagnosed as a Cancer Covered Condition for which We would pay a higher benefit as shown on the Schedule, We will pay the difference between what We paid and the applicable higher Initial Benefit amount.

RECURRENCE BENEFIT FOR A CANCER COVERED CONDITION

For any Cancer Covered Condition for which the Schedule shows a Recurrence Benefit, We will pay the applicable Recurrence Benefit for another Occurrence of the same Cancer Covered Condition for which We have already paid a benefit if:

- the subsequent Occurrence of the Cancer Covered Condition happens after the Recurrence Benefit Separation Period has been satisfied; and
- the Covered Person has been Treatment Free for a continuous period of 30 days immediately prior to the subsequent Occurrence of the Cancer Covered Condition.

We will not pay a Recurrence Benefit for a Cancer Covered Condition that is a Skin Cancer.

ADDITIONAL PROOF REQUIREMENTS FOR A CANCER COVERED CONDITION

Proof of an Occurrence of a Cancer Covered Condition requires the following additional documentation:

- A pathological Diagnosis that is based upon microscopic (histologic) examination of fixed tissues, including those taken by a biopsy, or preparations of blood or bone marrow.
- If a pathological Diagnosis cannot be made because it would be medically inappropriate or life-threatening under generally accepted medical standards, We will accept a Clinical Diagnosis based on the following:
  - medical diagnostic testing that supports the Diagnosis; and
  - the Covered Person is being treated for the Cancer Covered Condition by a Physician.

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

COVERED CONDITION CATEGORY: CANCER (Continued)

SPECIAL EXCLUSIONS APPLICABLE TO A CANCER COVERED CONDITION

We will not pay benefits for a Diagnosis of a Cancer Covered Condition for:

- myelodysplastic syndrome;
- any benign tumor, dysplasia, intraepithelial neoplasia or pre-malignant growth;
- any papillary tumor of the bladder classified as a maximum severity of Ta under TNM Staging;
- any tumor of the prostate classified as T1aN0M0 under TNM Staging; or
- any papillary, follicular or medullary tumor of the thyroid that is classified as a T1N0M0 or less under TNM Staging and is one centimeter or less in diameter, unless there is metastasis.

PREEXISTING CONDITION LIMITATION AND A CANCER COVERED CONDITION

We will pay benefits for an Occurrence of Non-Invasive Cancer or Invasive Cancer that results from a Preexisting Condition that is Skin Cancer when a Covered Person is Diagnosed with such Occurrence after the expiration of the Preexisting Condition Limitation period.

We will pay benefits for an Occurrence of Invasive Cancer that results from a Preexisting Condition that is Non-Invasive Cancer when a Covered Person is Diagnosed with such Occurrence after the expiration of the Preexisting Condition Limitation period.

COVERED CONDITION CATEGORY: CARDIOVASCULAR DISEASE

ADDITIONAL DEFINITIONS THAT APPLY TO THE CARDIOVASCULAR DISEASE COVERED CONDITION CATEGORY

Cardiovascular Disease Covered Condition means the following:

- coronary artery disease where:
  - the arteries of the heart are damaged or diseased, valves of the heart are damaged or diseased, or there is impaired cardiac function due to the presence of plaques, or fatty deposit, buildup on the artery walls that has caused narrowing of the coronary arteries resulting in partial or complete blockage of the arteries; and
  - a Physician has determined that a treatment listed below is Medically Necessary to treat the coronary artery disease:
    - Coronary Artery Bypass Graft;

Coronary Artery Bypass Graft means a heart Surgery procedure to bypass a narrowing or blockage of one or more coronary arteries using venous or arterial grafts. Surgical access to the heart may be done by a procedure that is:

- a Surgery in which a Median Sternotomy is performed.

Coronary Artery Bypass Graft does not include:

- Coronary Angioplasty;
- Coronary Angiography;
- any other intra-catheter technique; or
- a cardiac catheterization performed for diagnostic purposes only.

Median Sternotomy means a surgical incision in which the sternum, also known as the breastbone, is divided down the middle from top to bottom.

COVERED CONDITION CATEGORY: CARDIOVASCULAR DISEASE (Continued)

Occurs or **Occurrence**, with respect to a Cardiovascular Disease Covered Condition, means a Covered Person is Diagnosed with such Covered Condition while the coverage is in effect under this Certificate for such Covered Person. A Cardiovascular Disease Covered Condition will be deemed to Occur on the date that the Diagnosis of a Cardiovascular Disease Covered Condition is made, which includes a determination by a Physician that the applicable treatment (as set forth in the definition of the Covered Condition) is Medically Necessary.

INITIAL BENEFIT FOR A CARDIOVASCULAR DISEASE COVERED CONDITION

We will pay the applicable Initial Benefit for a Cardiovascular Disease Covered Condition shown on the Schedule, the first time that a Cardiovascular Disease Covered Condition Occurs for a Covered Person.

RECURRENCE BENEFIT FOR A CARDIOVASCULAR DISEASE COVERED CONDITION

For any Cardiovascular Disease Covered Condition for which the Schedule shows a Recurrence Benefit, We will pay the applicable Recurrence Benefit for another Occurrence of the same Cardiovascular Disease Covered Condition for which We have already paid a benefit if the subsequent Occurrence happens after the Recurrence Benefit Separation Period has been satisfied.

RULE FOR MORE THAN ONE OCCURRENCE OF A CARDIOVASCULAR DISEASE COVERED CONDITION

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

ADDITIONAL PROOF REQUIREMENTS FOR A CARDIOVASCULAR DISEASE COVERED CONDITION

Proof of a Cardiovascular Disease Covered Condition requires a Clinical Diagnosis and the following additional documentation:

- submission of medical records that include test results for at least one of the following:
  - cardiac perfusion scan;
  - cardiac catheterization;
  - doppler ultrasound;
  - echocardiogram;
  - electrocardiogram (EKG);
  - angiogram; or
  - positron emission tomography (PET scan); and
- that the applicable treatment set forth in the definition of a Cardiovascular Disease Covered Condition was deemed Medically Necessary by a Physician.

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

SPECIAL EXCLUSIONS APPLICABLE TO A CARDIOVASCULAR DISEASE COVERED CONDITION

We will not pay benefits for a Cardiovascular Disease Covered Condition:

- for a Heart Attack.

COVERED CONDITION CATEGORY: HEART ATTACK

ADDITIONAL DEFINITIONS THAT APPLY TO THE HEART ATTACK COVERED CONDITION CATEGORY

Heart Attack Covered Condition means the following:

- Myocardial Infarction.

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.

Myocardial Infarction does not include Sudden Cardiac Arrest.

Occurs or **Occurrence**, with respect to a Heart Attack Covered Condition, means a Covered Person is Diagnosed with such Covered Condition while coverage is in effect under this Certificate for such Covered Person. A Heart Attack Covered Condition will be deemed to Occur on the date that a Diagnosis of a Heart Attack Covered Condition is made.

INITIAL BENEFIT FOR A HEART ATTACK COVERED CONDITION

We will pay the applicable Initial Benefit for a Heart Attack Covered Condition shown on the Schedule, the first time a Heart Attack Covered Condition Occurs for a Covered Person.

RECURRENCE BENEFIT FOR A HEART ATTACK COVERED CONDITION

For any Heart Attack Covered Condition for which the Schedule shows a Recurrence Benefit, We will pay the applicable Recurrence Benefit for another Occurrence of the same Heart Attack Covered Condition for which We have already paid a benefit if the subsequent Occurrence happens after the Recurrence Benefit Separation Period has been satisfied.

COVERED CONDITION CATEGORY: HEART ATTACK (Continued)

ADDITIONAL PROOF REQUIREMENTS FOR A HEART ATTACK COVERED CONDITION

Proof of a Heart Attack Covered Condition requires a pathological Diagnosis or Clinical Diagnosis as described below.

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

- for Myocardial Infarction, documentation that shows:
  - an elevation of enzymes, troponins or other biochemical cardiac markers, and
  - two of the three following criteria associated with the Myocardial Infarction:
    - confinement in a Hospital as an inpatient;
    - documentation of electrocardiograph (EKG) changes on one or a series of electrocardiograms taken at the time the Covered Person experiences the Myocardial Infarction that are indicative of an acute Myocardial Infarction; however, if the Covered Person had any prior electrocardiogram(s), the electrocardiogram(s) presented as Proof of Myocardial Infarction must show changes from the Covered Person's last electrocardiogram, and such changes must be indicative of an acute Myocardial Infarction; or
    - documentation of imaging studies such as thallium scans, or echocardiograms which are indicative of an acute Myocardial Infarction; however, if the Covered Person had any prior imaging studies, the imaging studies presented as Proof of Myocardial Infarction must show changes from the Covered Person's last imaging studies, and such changes must be indicative of a Myocardial Infarction.

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

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

PREEXISTING CONDITION LIMITATION AND A HEART ATTACK COVERED CONDITION

The Preexisting Condition Limitation provision does not apply to benefits for Heart Attack.

COVERED CONDITION CATEGORY: KIDNEY FAILURE

ADDITIONAL DEFINITIONS THAT APPLY TO THE KIDNEY FAILURE COVERED CONDITION CATEGORY

Kidney Failure Covered Condition means the total, end stage, irreversible failure of all functioning kidneys, which was Diagnosed by a Physician based on an estimated glomerular filtration rate (eGFR) that is less than 15ml/min/1.73m2.

Occurs or **Occurrence**, with respect to a Kidney Failure Covered Condition, means a Covered Person is Diagnosed with such Covered Condition while coverage is in effect under this Certificate for such Covered Person. A Kidney Failure Covered Condition will be deemed to Occur on the date a Diagnosis of a Kidney Failure Covered Condition is made.

INITIAL BENEFIT FOR A KIDNEY FAILURE COVERED CONDITION

We will pay the Initial Benefit for a Kidney Failure Covered Condition shown on the Schedule, the first time that a Kidney Failure Covered Condition Occurs for a Covered Person.

ADDITIONAL PROOF REQUIREMENTS FOR A KIDNEY FAILURE COVERED CONDITION

A Clinical Diagnosis of a Kidney Failure Covered Condition must be made in Writing by a Physician and must be substantiated in the medical records.

COVERED CONDITION CATEGORY: MAJOR ORGAN FAILURE

ADDITIONAL DEFINITIONS THAT APPLY TO THE MAJOR ORGAN FAILURE COVERED CONDITION CATEGORY

Major Organ Failure Covered Condition means Major Organ Failure.

Major Organ Failure means that a Physician has determined that there is irreversible, permanent end-stage failure of a Covered Person's heart, lung, liver, or any combination thereof and such Major Failure meets the following criteria:

- for end-stage heart failure, such heart failure is classified as Stage D heart disease by the American College of Cardiology (ACC) and the American Heart Association (AHA);
- for end-stage lung failure, such failure is classified as Stage 4 under the Global Initiative for Chronic Obstructive Lung Disease (GOLD) pulmonary classification system; and
- for end-stage liver failure, such failure is scored as greater than or equal to 15 under the Model for End Stage Liver Disease (MELD).

Occurs or **Occurrenc**e, with respect to a Major Organ Failure Covered Condition, means a Covered Person is Diagnosed with such Covered Condition while coverage is in effect under this Certificate for such Covered Person. A Major Organ Failure Covered Condition will be deemed to Occur on the date a Diagnosis of a Major Organ Failure Covered Condition is made.

COVERED CONDITION CATEGORY: MAJOR ORGAN FAILURE (Continued)

INITIAL BENEFIT FOR A MAJOR ORGAN FAILURE COVERED CONDITION

We will pay the applicable Initial Benefit for a Major Organ Failure Covered Condition shown on the Schedule, the first time that a Major Organ Failure Covered Condition Occurs for a Covered Person.

SPECIAL LIMITATION APPLICABLE TO A MAJOR ORGAN FAILURE COVERED CONDITION

Payment of benefits for a Major Organ Failure Covered Condition is subject to the following:

- a Diagnosis of a Major Organ Failure Covered Condition made at the same time, or on the same day, that includes two or more organs described in the definition of a Major Organ Failure Covered Condition shall be deemed one Occurrence of a Major Organ Failure Covered Condition.

ADDITIONAL PROOF REQUIREMENTS FOR A MAJOR ORGAN FAILURE COVERED CONDITION

A Clinical Diagnosis of a Major Organ Failure Covered Condition must be made in Writing by a Physician and include medical records with the following additional documentation:

- for end-stage heart failure – an angiogram;
- for end stage liver failure – laboratory values for serum bilirubin, serum creatine, and the international normalized ration (INR) used to determine the MELD score determined by a Physician; and
- for end-stage lung failure – a pulmonary function test.

SPECIAL EXCLUSIONS APPLICABLE TO A MAJOR ORGAN FAILURE COVERED CONDITION

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

- if at the time the Major Organ Failure Occurs, no treatment of the Major Organ Failure is recommended by a Physician due to the anticipated death of the Covered Person.

COVERED CONDITION CATEGORY: PROGRESSIVE DISEASE

ADDITIONAL DEFINITIONS THAT APPLY TO THE PROGRESSIVE DISEASE COVERED CONDITION CATEGORY

Alzheimer's Disease means the development of multiple, progressive symptoms of cognitive decline, which was Diagnosed by a Physician, and that are manifested by memory impairment (impaired ability to learn new information or to recall previously learned information).

Alzheimer's Disease does not include:

- other central nervous system conditions that may cause deficits in memory and cognition (e.g., cerebrovascular disease, Parkinson's Disease, normal-pressure hydrocephalus);
- systemic conditions that are known to cause cognitive changes (e.g., hypothyroidism, vitamin B12 or folic acid deficiency, niacin deficiency, hypercalcemia, or neurosyphilis);
- substance-induced conditions;
- a form of dementia that is a mental and nervous condition such as schizophrenia or psychoses;
- a form of dementia that is Diagnosed as any of the following:
  - dementia with Lewy bodies;
  - progressive supranuclear palsy;
  - corticobasal degeneration;
  - Parkinson's disease dementia;
  - frontotemporal dementia;
  - primary progressive aphasia;
  - normal-pressure hydrocephalus; or
  - rapidly progressive dementia as in Creutzfeldt-Jakob disease; or
- any form of dementia that is not Clinically Diagnosed as Alzheimer's Disease.

COVERED CONDITION CATEGORY: PROGRESSIVE DISEASE (Continued)

Occurs or **Occurrence**, with respect to a Progressive Disease Covered Condition, means a Covered Person is Diagnosed with a such Covered Condition while the coverage is in effect under this Certificate for such Covered Person. A Progressive Disease Covered Condition will be deemed to Occur on the date the Diagnosis of a Progressive Disease Covered Condition is made.

Progressive Disease Covered Condition means any of the following:

- Alzheimer's Disease.

COVERED CONDITION CATEGORY: PROGRESSIVE DISEASE (Continued)

INITIAL BENEFIT FOR A PROGRESSIVE DISEASE COVERED CONDITION

We will pay the applicable Initial Benefit for a Progressive Disease Covered Disease shown on the Schedule, the first time that a Progressive Disease Covered Condition Occurs for a Covered Person.

ADDITIONAL PROOF REQUIREMENTS FOR A PROGRESSIVE DISEASE COVERED CONDITION

A Clinical Diagnosis of a Progressive Disease Covered Condition must be made in Writing by a Physician and must be substantiated by the current clinical diagnostic criteria for the condition in the medical records.

COVERED CONDITION CATEGORY: STROKE

ADDITIONAL DEFINITIONS THAT APPLY TO THE STROKE COVERED CONDITION CATEGORY

Stroke Covered Condition means a cerebrovascular accident or incident was Diagnosed by a Physician, which was caused by hemorrhage, thrombus or embolus, and resulted in an infarction of brain tissue producing measurable, functional and permanent neurological impairments.

The term Stroke does not include Transient Ischemic Attacks, or prolonged reversible ischemic attacks.

Occurs or **Occurrence**, with respect to a Stroke Covered Condition, means a Covered Person is Diagnosed with such Covered Condition while coverage is in effect under this Certificate for such Covered Person. A Stroke Covered Condition will be deemed to Occur on the date the Diagnosis of the Stroke Covered Condition is made.

Transient Ischemic Attack (TIA) means a temporary ischemic event (including prolonged reversible ischemic attacks) in which:

- there are measurable, functional neurological impairments that are focal and confined to an area of the brain perfused by a specific artery;
- there is no evidence of cerebral tissue damage on diagnostic imaging; and
- the reversible functional neurological impairments are confirmed by a Clinical Diagnosis.

INITIAL BENEFIT FOR A STROKE COVERED CONDITION

We will pay the applicable Initial Benefit for a Stroke Covered Condition shown on the Schedule, the first time that a Stroke Covered Condition Occurs for a Covered Person.

RECURRENCE BENEFIT FOR A STROKE COVERED CONDITION

For any Stroke Covered Condition for which the Schedule shows a Recurrence Benefit, We will pay the applicable Recurrence Benefit for another Occurrence of the same Stroke Covered Condition for which We have already paid a benefit if such subsequent Occurrence happens after the Recurrence Benefit Separation Period has been satisfied.

ADDITIONAL PROOF REQUIREMENTS FOR A STROKE COVERED CONDITION

A Clinical Diagnosis of a Stroke Covered Condition must be made in Writing by a Physician and must be substantiated by the current clinical diagnostic criteria for the condition in the medical records.

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

COVERED CONDITION CATEGORY: STROKE (Continued)

SPECIAL EXCLUSIONS APPLICABLE TO A STROKE COVERED CONDITION

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

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

PREEXISTING CONDITION LIMITATION AND A STROKE COVERED CONDITION

The Preexisting Condition Limitation provision does not apply to benefits for a Stroke Covered Condition.

WHEN INSURANCE ENDS

DATE YOUR INSURANCE ENDS

Your insurance under this Certificate will end on the earliest of:

- the date the Group Policy ends;
- the date You die;
- the date the Total Benefit Amount is exhausted (reduced to zero) for You;
- the date insurance ends for Your class;
- the end of the period for which the last full premium has been paid for Your insurance;
- The date You cease to be a Member.

CLAIMS

NOTICE OF CLAIM

You must give Us notice of a claim under this Certificate by Writing to Us or calling Us at the toll-free number shown on the face page of this Certificate within 30 days or as soon as reasonably possible from the date of the loss.

CLAIM FORM

When We receive notice of a claim under this Certificate, We will provide You or the claimant with a claim form. If We do not provide the claim form within 15 days from the date We received notice of claim, Our claim form requirements will be satisfied if We are provided with the required Proof in support of the claim.

PROOF OF LOSS

Proof must be provided to Us not later than 120 days after the date of the loss. 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 of the loss.

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.

Unless You have assigned this insurance, all benefits paid under this Certificate will be paid to You, except as follows:

- If You are not alive to receive benefits that are payable to You, We will pay benefits in accordance with the provision below titled Your Beneficiary.
- If You are living when benefits are to be paid to You, but You are not legally competent to claim or receive benefits, We may pay up to $10,000 to anyone related to You by blood or marriage who We believe is entitled to payment of the benefits. 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 benefits have been assigned, We will pay benefits in accordance with the Assignment provision of the General Provisions section.

YOUR BENEFICIARY

A beneficiary may be named by You to receive a benefit that becomes payable to You under this Certificate that You are not alive to receive.

You may request to change Your beneficiary at any time. A beneficiary change request must be made to Us in Writing. Once the request is recorded, the change will take effect as of the date You sign the request, whether or not You are living when We receive the request. The change will be subject to any legal restrictions. It will also be subject to any payment We made or action We took before We recorded the change. If You designated two or more beneficiaries and their shares are not specified, they will share the benefit equally.

If there is no beneficiary designated or no surviving beneficiary at Your death, We will determine the beneficiary according to the following order:

1. Your spouse, if alive;
2. Your child(ren), if there is no surviving spouse;
3. Your parent(s), if there is no surviving child;
4. Your sibling(s), if there is no surviving parent; or
5. Your estate, if there is no surviving sibling.

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. If a beneficiary or a Payee is a minor or incompetent to receive payment, We will pay that person's guardian.

A benefit due under this Certificate will be paid in one sum by check to the beneficiary. Unless the beneficiary requests payment by check, when this Certificate states that We will pay benefits in “one sum”, We may pay the full benefits payable:

- by check;
- by establishing an account that earns interest and provides the beneficiary with immediate access to the proceeds; or
- by any other method that provides the beneficiary with immediate access to the full amount of benefits payable.

APPEALING A CLAIM DECISION

If We deny Your claim, You may appeal the decision by Writing to Us at the address indicated on the claim form within 180 days of receiving Our decision. Appeals must be in Writing and must include at least the following information:

- name of the Covered Person;
- name of the Group Policyholder;
- claim number;
- Group Policy number; and
- an explanation why You are appealing the decision.

As part of Your appeal, You may submit any Written comments, documents, records, or other information relating to Your claim. After We receive Your Written request appealing the decision, We will conduct a review of Your claim. We will notify You in Writing within 45 days after Our receipt of Your request for an appeal of: (i) Our decision; or (ii) if additional time will be required to complete the review. If additional time is needed, We will notify You of the reason additional time is required.

AUTHORIZATIONS

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

EXAMINATIONS

With respect to a pending claim, at Our expense and as often as is reasonably necessary, in order to substantiate Our Proof requirements:

- We may require a Covered Person to have an independent examination by a Physician of Our choice; and/or
- We may require a Covered Person to have an interview by phone or in person with Our representative.

Failure of a Covered Person to have an independent exam or to be interviewed at Our request as specified in this provision may result in the denial of the claim to which the exam or interview pertains.

AUTOPSY

With respect to a pending claim, at Our expense, in order to substantiate Our Proof requirements, 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.

REFUND TO US FOR OVERPAYMENT OF BENEFITS

If, at any time, We determine that benefits paid under this Certificate were more than the benefits due:

- You, or any other person, entity or health care provider to whom We overpaid benefits have the obligation to reimburse Us for the amount of such overpayment; and
- We have the right to recover the amount of such overpayment from You, or any other person, entity or health care provider to whom We overpaid benefits, including offsetting future benefits payable under this Certificate to You or such other person, entity or health care provider by an amount equal to the overpayment.

GENERAL PROVISIONS

CHANGES IN CLINICAL STANDARDS

This Certificate includes certain clinical criteria that is required to establish a Diagnosis of a Covered Condition under this Certificate. Should the clinical criteria that is generally accepted by the medical community in the United States change as it applies to establishing a Diagnosis of a Covered Condition, We will accept a Diagnosis made by a Physician based on the current generally accepted clinical criteria for medical practice standards in order to establish a Diagnosis of a Covered Condition.

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);
- the Group Policyholder's application; and
- any amendments and/or endorsements to the Group Policy.

MISSTATEMENTS

If Your 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, except as required by law.

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.

STANDARD OF TIME

All insurance becomes effective and terminates at 12:01 A.M. Eastern Standard Time, or at 12:01 A.M. Eastern Daylight Time if Daylight Savings Time is then being observed.