



**METROPOLITAN LIFE INSURANCE COMPANY
NEW YORK, NEW YORK**

CERTIFICATE OF CRITICAL ILLNESS INSURANCE

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You and Your Dependents are insured for the benefits described in this Certificate, subject to the provisions of this Certificate. References to coverage for Your Dependents throughout this Certificate only apply if insurance is in effect for Your Dependents. Please refer to the Covered Person Specifications page and Eligibility Provisions: Dependent Insurance section for details.

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: Western Healthcare Insurance Trust

Group Policy Number: 261389-1-G

MetLife Toll Free Number: 1-800-GETMET8

Important Notice: 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 certain critical illnesses.

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.

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.

Contributions for this coverage may increase as Covered Persons age.

IF THERE IS A CONFLICT OF LANGUAGE AND/OR LAW BETWEEN THE GROUP POLICY AND THE CERTIFICATE, THE CERTIFICATE WILL CONTROL

A handwritten signature of Timothy J. Ring.
Timothy J. Ring
Secretary

A handwritten signature of Michel Khalaf.
Michel Khalaf
President & CEO

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COVERED PERSON SPECIFICATIONS

Certificate Effective Date:

January 1, 2026

Group Policyholder:

Western Healthcare Insurance Trust

Group Policy Number:

261389-1-G

MetLife Contact Information:

1-800-GETMET8

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.

The benefits listed only apply to Dependents if insurance is in effect for Your Dependents under this Certificate. Please refer to the Covered Person Specifications page and the Eligibility Provisions: Dependent Insurance section of this Certificate for details.

BENEFIT AMOUNT

	For You	For Your Spouse	For Your Dependent Children
Benefit Amount	\$20,000	50% of Your Benefit Amount	50% of Your Benefit Amount

BENEFIT SEPARATION PERIOD

For an Initial Benefit for a Covered Person	30 days
For a Recurrence Benefit for a Covered Person	90 days

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

SCHEDULE OF INSURANCE (Continued)

COVERED CONDITION CATEGORY: BENIGN TUMOR		
COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
Benign Brain Tumor	100% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person

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 1 time 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 1 time per Covered Person
Skin Cancer	10% of the Benefit Amount, but not less than \$250; payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount, but not less than \$250, payable no more than 1 time per Covered Person

SCHEDULE OF INSURANCE (Continued)

COVERED CONDITION CATEGORY: CARDIOVASCULAR DISEASE		
COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
Cardiovascular Disease treated with: Aortic Valve or Mitral Valve Repair or Replacement	10% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person
Cardiovascular Disease treated with: Coronary Angioplasty (Percutaneous Coronary Intervention)	10% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person
Cardiovascular Disease treated with: Coronary Artery Bypass Graft	50% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person
Cardiovascular Disease treated with: Internal Cardioverter Defibrillator (ICD)	10% of the Benefit Amount payable no more than 1 time per Covered Person	None
Cardiovascular Disease treated with: Pacemaker Placement	10% of the Benefit Amount payable no more than 1 time per Covered Person	None

SCHEDULE OF INSURANCE (Continued)

COVERED CONDITION CATEGORY: CHILDHOOD DISEASE		
COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
cerebral palsy	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
cleft lip or cleft palate	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
cystic fibrosis	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
diabetes (type 1)	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
down syndrome	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
sickle cell anemia	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
spina bifida	100% of the Benefit Amount payable no more than 1 time per Covered Person	None

SCHEDULE OF INSURANCE (Continued)

COVERED CONDITION CATEGORY: FUNCTIONAL LOSS		
COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
Coma	100% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person
Loss of: Ability to Speak; Hearing; or Sight	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
Paralysis of 2 or more limbs	100% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person

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 1 time per Covered Person
Sudden Cardiac Arrest	50% of the Benefit Amount payable no more than 1 time per Covered Person	None

COVERED CONDITION CATEGORY: INFECTIOUS DISEASE		
COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
anthrax	10% of the Benefit Amount payable no more than 1 time per Covered Person	None
bacterial cerebrospinal meningitis	25% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person
diphtheria	25% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person
encephalitis	25% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person
Legionnaire's disease	25% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person
Lyme disease	10% of the Benefit Amount payable no more than 1 time per Covered Person	None
malaria	25% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person
methicillin-resistant staphylococcus aureus (MRSA)	10% of the Benefit Amount payable no more than 1 time per Covered Person	None

SCHEDULE OF INSURANCE (Continued)

necrotizing fasciitis	25% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person
osteomyelitis	25% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person
pertussis (whooping cough)	10% of the Benefit Amount payable no more than 1 time per Covered Person	None
rabies	25% of the Benefit Amount payable no more than 1 time per Covered Person	None
Rocky Mountain spotted fever	10% of the Benefit Amount payable no more than 1 time per Covered Person	None
sepsis	10% of the Benefit Amount payable no more than 1 time per Covered Person	None
tetanus	25% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person
tuberculosis	25% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person
typhoid fever	10% of the Benefit Amount payable no more than 1 time per Covered Person	None
COVID-19	10% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time 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	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person

COVERED CONDITION CATEGORY: MAJOR ORGAN TRANSPLANT		
COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
Major Organ Transplant	100% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person

SCHEDULE OF INSURANCE (Continued)

COVERED CONDITION CATEGORY: OCCUPATIONAL EXPOSURE DISEASE		
COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
Occupational Hepatitis or Occupational HIV	10% of the Benefit Amount payable no more than 1 time per Covered Person	None

COVERED CONDITION CATEGORY: PROGRESSIVE DISEASE		
COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
ALS	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
Alzheimer's Disease	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
Multiple Sclerosis	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
Muscular Dystrophy	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
Parkinson's Disease	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
systemic lupus erythematosus (SLE)	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 1 time per Covered Person
Transient Ischemic Attack	10% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time 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.

Initial Benefit Separation Period

The Initial Benefit Separation Period is the number of days that must elapse between an Occurrence of a Covered Condition for which a benefit is payable and an Occurrence of a different Covered Condition in order for an Initial Benefit to be payable for the later Covered Condition.

Once a Covered Condition has Occurred for which a benefit is payable, in order for an Initial Benefit to be payable for an Occurrence of any other Covered Condition that would otherwise qualify for an Initial Benefit payment, the Initial Benefit Separation Period must be satisfied. The Initial Benefit Separation Period is set forth on the Schedule.

In the event another Covered Condition Occurs within the Initial Benefit Separation Period, the following rules will apply:

- If the benefit We paid (Initial Benefit or Recurrence Benefit) for the prior Covered Condition(s) is less than the Initial Benefit amount We would pay for the new Covered Condition, We will pay an additional amount equal to:
 - the amount We would have paid for the new Covered Condition had the Initial Benefit Separation Period been satisfied; minus
 - the amount We paid for the prior Covered Condition(s).
- If the benefit We paid (Initial Benefit or Recurrence Benefit) for the prior Covered Condition is equal to or exceeds the Initial Benefit amount We would pay for the new Covered Condition, an additional amount is not payable.

Examples:

The following examples are provided for illustration purposes to explain how the Initial Benefit Separation Period will be applied and an additional amount is calculated as described above. These examples do not necessarily reflect the benefits of Your specific coverage.

Benefit Amount	\$10,000
Initial Benefit Separation Period	90 days
Benefit payable for Covered Condition A, which Occurs on January 1 st	Based on the Schedule, the plan pays 50% of the Benefit Amount = \$5,000
Initial Benefit that applies to Covered Condition B, which Occurs on February 1 st , prior to satisfaction of the Initial Benefit Separation Period	Based on the Schedule, the plan pays 100% of the Benefit Amount = \$10,000
Adjustment Calculation for Occurrence of Covered Condition B	\$10,000 minus \$5,000 (Difference between amount paid for Covered Condition A and amount that would be paid for Covered Condition B). Result: An additional \$5,000 would be payable for the Occurrence of Covered Condition B

LIMITATIONS (Continued)

Benefit Amount	\$10,000
Initial Benefit Separation Period	90 days
Benefit payable for Covered Condition A, which Occurs on January 1 st	Based on the Schedule, the plan pays 100% of the Benefit Amount = \$10,000
Initial Benefit that applies to Covered Condition B, which Occurs on February 1 st prior to satisfaction of the Initial Benefit Separation Period	Based on the Schedule, the plan pays 25% of the Benefit Amount = \$2,500
Adjustment Calculation for Occurrence of Covered Condition B	<p>The amount payable for Covered Condition A (\$10,000) exceeded the amount that would be payable for Covered Condition B (\$2,500).</p> <p>Result: An additional benefit would not be payable for the Occurrence of Covered Condition B</p>

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	<p>The Recurrence Benefit Separation Period is measured from January 1, the date Condition A Occurred.</p> <p>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.</p>

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, riot or terrorist act;
- the Covered Person's engagement in any illegal occupation or activity that constitutes a felony under the laws of the jurisdiction in which the activity took place;
- the Covered Person's intentionally self-inflicted injury;
- the Covered Person's suicide or attempted suicide (while sane or insane);
- war, whether declared or undeclared; or act of war; 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 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.

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 on a Full-Time or a Part-Time basis. This must be done at:

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

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

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

Calendar Year means a period of 12 consecutive months, starting on January 1 and ending on December 31 of the same year.

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.

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

Covered Condition means those conditions or treatments listed in the Schedule for which a benefit is payable as described in this Certificate. A Covered Condition does not include Supplemental Benefits.

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

Dependent means Your Spouse and/or Dependent Child.

Dependent Child means the following:

- Your biological child, while such child is younger than the Dependent Child Age Limit;
- Your adopted child, while such child is younger than the Dependent Child Age Limit;
- Your stepchild, including a child of Your Domestic Partner, while such child is younger than the Dependent Child Age Limit;
- any other child while such child is under the Dependent Child Age Limit as follows: (a) a child for whom You or Your Spouse are a legal guardian, (b) Your or Your Spouse's foster child, (c) a child for whom You or Your Spouse are chiefly responsible to provide support, (d) a child who resides with You as a regular member of Your household, (e) a child for whom You or Your Spouse are legally required to provide insurance, or (f) a child who was able to be claimed by You or Your Spouse as a dependent for Federal Income Tax purposes. Any other child also includes a grandchild who: (a) was able to be claimed by You or Your Spouse as a dependent for Federal Income Tax purposes, (b) resides with You, (c) is in Your or Your Spouse's custody, (d) is supported by You or Your Spouse, or (e) is a child of Your Dependent Child while the Dependent Child is under the Dependent Child Age Limit; or
- a Dependent Child who is a disabled child and whose age exceeds the Dependent Child Age Limit on the Certificate Effective Date who: (a) has been diagnosed with a developmental disability, mental illness or disorder, or physical disability, (b) is incapable of self-sustaining employment, and (c) is chiefly dependent on You or Your Spouse for support and maintenance. Coverage for a disabled child will take effect in accordance with the Eligibility Provisions: Dependent Insurance section of Your Certificate without regard to whether such child is under a Medical Restriction.

The term Dependent Child does not mean an unborn or stillborn child.

DEFINITIONS (Continued)

Dependent Child Age Limit means:

- the end of the calendar month in which the Dependent Child reaches age 26.

Dependent Insurance means insurance under this Certificate for Your Dependents.

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.

Domestic Partner means each of two people, one of whom is You, who:

1. have registered as each other's domestic partner or civil union partner with a government agency where such registration is available; or
2. are of the same or opposite sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:
 - 18 years of age or older;
 - unmarried;
 - the sole Domestic Partner of the other;
 - sharing a Primary Residence with the other; and
 - not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

A Domestic Partner declaration attesting to the existence of an insurable interest in one another's lives must be completed and Signed by You.

Full-Time means Active Work on the Group Policyholder's regular work schedule for the class of employees to which You belong. The work schedule must be at least 30 hours per week.

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

Group Policyholder means Western Healthcare Insurance Trust.

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; 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.

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.

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.

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

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 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;
- anyone with whom You share a business interest; or
- Your employee.

DEFINITIONS (Continued)

Primary Residence means the dwelling where a person lives for the majority of the time, whether the person owns or rents the dwelling.

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, and the Covered Person Specifications page.

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

Spouse means Your lawful spouse or Your Domestic Partner.

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.

Transplant List means the list maintained by the Organ Procurement and Transportation Network (OPTN).

DEFINITIONS (Continued)

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

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS

All Active Full-Time and Part-Time Employees

Employee means any Employee of a Participating Employer or Employer.

Participating Employer or Employer means Please see Your Covered Person Specifications.

DATE YOU ARE ELIGIBLE FOR INSURANCE

You may only become eligible for the Critical Illness Insurance available for Your eligible class as shown in the SCHEDULE OF BENEFITS.

If You are in an eligible class on January 1, 2026, You will be eligible for insurance on the date You complete any applicable eligibility waiting period set by Your Participating Employer.

If You enter an eligible class after January 1, 2026, You will be eligible for insurance as of one of the following dates, based upon Your Contributing Employer's election:

1. the first day of the calendar month following the date You enter an eligible class; or
2. the first day of the calendar month following the date You complete the Waiting Period of 30 days; or
3. the first day of the calendar month following the date You complete the Waiting Period of 60 days.

Please see Your Certificate Confirmation Statement for the date You will be eligible for insurance.

Waiting Period means the period of continuous membership in an eligible class that You must wait before You become eligible for Dependent insurance. This period begins on the date You enter an eligible class and ends on the date You complete the period(s) specified. Your Waiting Period will be 0 days, 30 days, or 60 days, depending on what Your worksite location has elected. Please see Your Certificate Confirmation Statement for the Waiting Period.

ENROLLMENT PROCESS

If You are eligible for insurance, You may enroll for such insurance by completing the required form. You must also provide Written permission to deduct Contributions from Your pay for such insurance, if You are required to make such Contributions.

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.

BENEFIT CHANGES

Once Your insurance takes effect, You may only change Your benefits in accordance with the options available through the Group Policyholder. Please contact Us or the Group Policyholder for more information.

If You are not Actively at Work in an eligible class on the date an increase in benefits would otherwise take effect, the increase will not take effect until You return to Active Work in a class that is eligible for the increase.

ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE

ELIGIBLE CLASS FOR DEPENDENT INSURANCE

All Active Full-Time and Part-Time employees of the Participating Employer as specified in the Eligibility Provisions: Insurance For You section of this Certificate are eligible for Dependent Insurance.

DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE

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

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

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

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

ENROLLMENT PROCESS

If You become eligible for Dependent Insurance, You may enroll for such insurance by providing Us with any information We require for each Dependent to be insured. You must also provide Written permission to deduct Contributions from Your pay for Dependent Insurance, if You are required to make such Contributions.

DATE DEPENDENT INSURANCE TAKES EFFECT

Newborn Children

A Dependent Child born to You while insurance is in effect under the Certificate will be covered:

- from the moment of birth and does not need to be enrolled if Dependent Insurance is already in effect for at least one other Dependent Child; or
- for 60 days from the moment of birth if Dependent Insurance is not already in effect for at least one other Dependent Child. To continue coverage beyond the first 60 days, You must notify Us of the child's birth and give Written permission to deduct Contributions from Your pay for Dependent Insurance for the newborn child if You are required to make such Contributions.

The effective date of insurance for a newborn child will be determined without regard to whether the child is under a Medical Restriction.

ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE (Continued)

Adopted Children

A Dependent Child adopted by You or Placed for Adoption with You while insurance is in effect under the Certificate will be covered:

- from the moment of birth if Placement for Adoption or adoption occurs within 60 days after the child's birth; or
- from the date of adoption or Placement for Adoption if the child is adopted by You or Placed for Adoption with You more than 60 days after the child's birth.

The child does not need to be enrolled if Dependent Coverage is already in effect for at least one other Dependent Child. If Dependent Coverage is not already in effect for at least one other Dependent Child, then to continue the child's coverage beyond the first 60 days of coverage, You must notify Us of the child's adoption or Placement for Adoption and give Written permission to deduct Contributions from Your pay for Dependent Insurance for the adopted child if You are required to make such Contributions. You must do this within 60 days of the date the child is adopted by You or Placed for Adoption with You. Coverage will end if the child's placement is disrupted prior to legal adoption.

The effective date of insurance for a newly adopted child will be determined without regard to whether the child is under a Medical Restriction.

Placed for Adoption or Placement for Adoption means the assumption and retention by You of a legal obligation for total or partial support of a child in anticipation of Your adoption of the child.

Other Dependents

Dependent Insurance for a Dependent who is not under a Medical Restriction will take effect on the later of:

- the date You are enrolled for Dependent Insurance for such Dependent; or
- the date a person becomes Your Dependent.

If a Dependent is under a Medical Restriction on the date insurance for such Dependent would otherwise take effect, insurance for the Dependent will take effect on the date the Dependent is no longer under a Medical Restriction.

BENEFIT CHANGES

Benefit changes with respect to a Dependent are subject to the Benefit Changes provision in the Eligibility Provisions: Insurance for You section of this Certificate.

If a Dependent for whom insurance is in effect under this Certificate is under a Medical Restriction on the date that an increase in benefits would otherwise take effect, the increase will not take effect for the Dependent until such Dependent is no longer under a Medical Restriction.

COVERED CONDITION CATEGORY: BENIGN TUMOR

ADDITIONAL DEFINITIONS THAT APPLY TO BENEFITS FOR THE BENIGN TUMOR COVERED CONDITION CATEGORY

Benign Tumor Covered Condition means the following:

- Benign Brain Tumor.

A Benign Tumor Covered Condition does not include any such tumor resulting from:

- neurofibromatosis I or II;
- Von Hippel Lindau disease;
- tuberous sclerosis; or
- Cowden disease.

Benign Brain Tumor means the presence of a non-cancerous tumor located in the brain, or a non-cancerous Meningioma.

Benign Brain Tumor does not include:

- acoustic neuromas;
- tumors of the skull;
- tumors of the spinal cord; or
- pituitary adenomas.

Meningioma means a tumor located on the membranes that cover the brain.

Occurs or Occurrence, with respect to a Benign Tumor 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 Benign Tumor Covered Condition will be deemed to Occur on the date that the Diagnosis of a Benign Tumor Covered Condition is made.

Permanent Neurological Deficit means the presence of one, or more, of the following deficits:

- impaired cognition;
- impaired or loss of vision;
- impaired or loss of hearing;
- impaired or loss of the ability to speak and communicate;
- balance disruption; or
- impaired or loss of ability to ambulate independently.

INITIAL BENEFIT FOR A BENIGN TUMOR COVERED CONDITION

We will pay the applicable Initial Benefit for a Benign Tumor Covered Condition shown on the Schedule, the first time that the Benign Tumor Covered Condition Occurs for a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

COVERED CONDITION CATEGORY: BENIGN TUMOR (Continued)

RECURRENCE BENEFIT FOR A BENIGN TUMOR COVERED CONDITION

For any Benign Tumor Covered Condition for which the Schedule shows a Recurrence Benefit, We will pay the applicable Recurrence Benefit for another Occurrence of the same Benign Tumor Covered Condition if:

- the subsequent Occurrence of the Benign Tumor happens after the Recurrence Benefit Separation Period has been satisfied; and
- the Covered Person has been Treatment Free for a continuous period of 90 days immediately prior to the subsequent Occurrence of the Benign Tumor Covered Condition.

ADDITIONAL PROOF REQUIREMENTS FOR A BENIGN TUMOR COVERED CONDITION

Proof of a Benign Tumor Covered Condition requires the following additional documentation:

- a pathological or Clinical Diagnosis as described below; and
- submission of medical records evidencing that the Benign Tumor Covered Condition:
 - requires treatment by a Physician that is a Surgery or radiation therapy; or
 - resulted in a Permanent Neurological Deficit that is attributable to the Benign Tumor Covered Condition;

A pathological Diagnosis of a Benign Tumor Covered Condition must include the following:

- microscopic (histologic) examination of fixed tissues, including those taken by a biopsy; and
- magnetic resonance imaging (MRI), computerized tomography (CT scan), or other reliable imaging techniques that have been completed as part of the evaluation to Diagnose a Benign Tumor Covered Condition.

We will accept a Clinical Diagnosis of a Benign Tumor Covered Condition only if the following conditions are met:

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

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

In the event a Covered Person has been paid a benefit for a Benign Brain Tumor based on a Clinical Diagnosis, but later medical evidence establishes that such Covered Condition is malignant and satisfies the Proof requirements for Invasive or Non-Invasive Cancer, We will pay the applicable benefit for a Cancer Covered Condition reduced by the Benefit Amount that We paid for the Benign Brain Tumor. In the event the Benefit Amount We had already paid for Benign Brain Tumor equals or exceeds the amount that would have been payable for a Cancer Covered Condition, We will not pay an additional benefit.

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.

The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

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. The Initial Benefit Separation Period does not apply to payment of the Initial Benefit for a Related Occurrence for a Cancer Covered Condition as described in this provision.

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 90 days immediately prior to the subsequent Occurrence of the Cancer Covered Condition.

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.

In the event a Covered Person was paid a benefit for an Occurrence of a Benign Brain Tumor based on a Clinical Diagnosis, but later medical evidence establishes that such Covered Condition is malignant and meets the Proof requirements for a Cancer Covered Condition, We will pay the appropriate benefit for a Cancer Covered Condition reduced by the benefit amount that We already paid for the Benign Brain Tumor. Please refer to the Covered Condition Category: Benign Tumor section of this Certificate for details.

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;
- 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; or
- any cancer in the presence of human immuno-deficiency virus (HIV) for which there is a known increased risk due to the presence of Acquired Immune Deficiency Syndrome (AIDS) or the presence of HIV.

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 treatment listed below is required to treat the coronary artery disease:
 - Coronary Angioplasty (including Coronary Angioplasty with stent placement); or
 - Coronary Artery Bypass Graft;
- cardiac valve disease where:
 - a heart valve defect exists with regurgitation and stenosis; and
 - an Aortic Valve or Mitral Valve Repair or Replacement is required to treat the cardiac valve disease; or
- cardiac arrhythmias exist:
 - due to electrical conduction abnormalities; and
 - a treatment listed below is required to treat the cardiac arrhythmias:
 - initial Internal Cardioverter Defibrillator (ICD) Placement (not a replacement of an existing Internal Cardioverter Defibrillator); or
 - initial Pacemaker Placement (not a replacement of an existing pacemaker).

Aortic Valve or Mitral Valve Repair or Replacement means, as the result of a covered critical illness or specified disease, the aortic valve or mitral valve is repaired or replaced with a mechanical or bio-prosthetic heart valve by a procedure that is:

- a Surgery in which a Median Sternotomy is performed; or
- a minimally invasive procedure in which a transcatheter valve repair or replacement, or minimal incision valve Surgery is performed.

Coronary Angioplasty (Percutaneous Coronary Intervention or PCI) means, as the result of a covered critical illness or specified disease, a cardiac catheterization procedure to treat Cardiovascular Disease by utilizing a catheter with a balloon, laser, laser-assisted device, rotational device, stent placement or other mechanical means to unblock an occluded coronary artery.

Coronary Artery Bypass Graft means, as the result of a covered critical illness or specified disease, 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; or
- a minimally invasive endoscopic cardiac Surgery procedure is performed.

Coronary Artery Bypass Graft does not include:

- Coronary Angioplasty;
- coronary angiography; or
- any other intra-catheter technique.

Internal Cardioverter Defibrillator (ICD) Placement means a device is placed under the skin to detect and treat cardiac arrhythmias by delivering low-level or high-level electrical pulses to keep the heart at a normal pace and rhythm.

Median Sternotomy means, as the result of a covered critical illness or specified disease, a surgical incision in which the sternum, also known as the breastbone, is divided down the middle from top to bottom.

Pacemaker Placement means a device is placed under the skin to detect and treat heart rate arrhythmias by delivering low-level electrical pulses to keep the heart at a normal pace.

COVERED CONDITION CATEGORY: CARDIOVASCULAR DISEASE (Continued)

Occurs or Occurrence, with respect to a Cardiovascular Disease Covered Condition, means a Covered Person receives the applicable treatment specified in the definition of the term Cardiovascular Disease Covered Condition, and such treatment was performed by a Physician 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 such treatment was performed.

INITIAL BENEFIT FOR A CARDIOVASCULAR DISEASE COVERED CONDITION

We will pay the applicable Initial Benefit for a Cardiovascular Disease Covered Condition treatment shown on the Schedule, the first time that a Cardiovascular Disease Covered Condition Occurs for a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

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 treatment for the Cardiovascular Disease Covered Condition was performed 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;
- for which the treatment required for payment of a benefit is received outside the United States, Canada or Mexico unless confirmation of the Cardiovascular Disease Covered Condition and treatment received is confirmed in the United States, in which case the Covered Condition will be deemed to Occur on the date the treatment was performed outside the United States, Canada or Mexico; or
- for a cardiac catheterization performed for diagnostic purposes only.

COVERED CONDITION CATEGORY: CHILDHOOD DISEASE

ADDITIONAL DEFINITIONS THAT APPLY TO THE CHILDHOOD DISEASE COVERED CONDITION CATEGORY

Childhood Disease Covered Condition means any of the following:

- cerebral palsy;
- cleft lip or cleft palate;
- cystic fibrosis;
- diabetes type 1 (diabetes type 2 is not a Covered Condition);
- down syndrome;
- sickle cell anemia (sickle cell trait is not a Covered Condition); or
- spina bifida (spina bifida occulta is not a Covered Condition).

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

INITIAL BENEFIT FOR A CHILDHOOD DISEASE COVERED CONDITION

We will pay the Initial Benefit shown on the Schedule for a Childhood Disease Covered Condition, the first time that a Childhood Disease Covered Condition Occurs for a Dependent Child who is a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

If more than one Childhood Disease Covered Condition Occurs for a Dependent Child at the same time, We will only pay an Initial Benefit for one Covered Condition which will be for the Childhood Disease Covered Condition that pays the highest Benefit Amount.

ADDITIONAL PROOF REQUIREMENTS FOR A CHILDHOOD DISEASE COVERED CONDITION

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

SPECIAL EXCLUSIONS APPLICABLE TO A CHILDHOOD DISEASE COVERED CONDITION

We will not pay benefits for:

- a suspected or probable Diagnosis of a Childhood Covered Condition; or
- a Childhood Covered Condition that is Diagnosed for a stillborn child.

COVERED CONDITION CATEGORY: FUNCTIONAL LOSS

ADDITIONAL DEFINITIONS THAT APPLY TO THE FUNCTIONAL LOSS COVERED CONDITION CATEGORY

Coma means, as the result of a covered critical illness or specified disease, a continuous state of profound unconsciousness lasting for a period of 14 or more consecutive days, as confirmed by a Physician and characterized by the absence of purposeful response to commands, including:

- eye opening;
- verbal response; and
- motor response.

Coma does not include a medically induced Coma.

Functional Loss Covered Condition means the following:

- Coma;
- Loss of: Ability to Speak; Hearing; Sight; or
- Paralysis.

Loss of: Ability to Speak; Hearing or Sight means, as the result of a covered critical illness or specified disease, the following each of which must last for a continuous period of not less than 90 consecutive days, and is expected to be permanent, as confirmed by a Physician:

- for Loss of Ability to Speak - total loss of audible communication (aphonia), if such loss cannot be corrected to any functional degree by any procedure, air or device;
- for Loss of Hearing - deafness in both ears, such that it cannot be corrected to any functional degree by any procedure, aid or device; or
- for Loss of Sight - loss of sight in both eyes. With correction, visual acuity must be 20/200 or worse in both eyes, or the field of vision must be less than 20 degrees in both eyes. Loss of sight does not include blindness or loss of sight in one eye due to a previous existing blindness in the other eye.

Occurs or Occurrence, with respect to a Functional Loss 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 Functional Loss Covered Condition will be deemed to Occur on the date that a Diagnosis of a Functional Loss Covered Condition is made.

Paralysis means, as the result of a covered critical illness or specified disease, the total and irrevocable loss of extremity movement affecting 2 or more limbs and:

- has lasted for a continuous period of not less than 90 consecutive days, and is expected to be permanent, as confirmed by a Physician; or
- is a result of a transected spinal cord with supporting clinical and radiological evidence and no expectation of a return to function.

INITIAL BENEFIT FOR A FUNCTIONAL LOSS COVERED CONDITION

We will pay the applicable Initial Benefit shown on the Schedule for a Functional Loss Covered Condition, the first time that a Functional Loss Covered Condition Occurs for a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

RECURRENCE BENEFIT FOR A FUNCTIONAL LOSS COVERED CONDITION

For any Functional Loss Covered Condition for which the Schedule shows a Recurrence Benefit, We will pay the applicable Recurrence Benefit for another Occurrence of the same Functional Loss 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: FUNCTIONAL LOSS (Continued)

ADDITIONAL PROOF REQUIREMENTS FOR A FUNCTIONAL LOSS COVERED CONDITION

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

SPECIAL EXCLUSIONS APPLICABLE TO A FUNCTIONAL LOSS COVERED CONDITION

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

- a Functional Loss Covered Condition that is associated with the total and irreversible loss of all brain function (brain death);
- a Functional Loss Covered Condition that is a dismemberment of an extremity; or
- any Functional Loss Covered Condition for which, in general medical opinion or practice, Surgery, an adaptive device or other corrective measure could restore function.

COVERED CONDITION CATEGORY: HEART ATTACK

ADDITIONAL DEFINITIONS THAT APPLY TO THE HEART ATTACK COVERED CONDITION CATEGORY

Heart Attack Covered Condition means the following:

- Myocardial Infarction; or
- Sudden Cardiac Arrest.

Myocardial Infarction means, as the result of a covered critical illness or specified disease, 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.

Sudden Cardiac Arrest means, as the result of a covered critical illness or specified disease, the sudden, unexpected loss of heart function, breathing and consciousness resulting when the heart suddenly, and unexpectedly, stops beating because of an internal electrical disturbance of the heart, which results in a Covered Person being pronounced deceased by a Physician.

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. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

If a Covered Person sustains a Myocardial Infarction and Sudden Cardiac Arrest which Occur at the same time, or on the same day, and for which a Heart Attack Covered Condition benefit is payable, We will pay an Initial Benefit for a single Heart Attack Covered Condition which will be for the Heart Attack Covered Condition that pays the highest Benefit Amount.

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.
 - for Sudden Cardiac Arrest, additional documentation that shows that the Sudden Cardiac Arrest was caused or contributed to by any of the following, or that the Covered Person had a documented medical history of any of the following:
 - coronary artery disease;
 - Myocardial Infarction;
 - myocarditis;
 - cardiomyopathy;
 - valvular heart disease;
 - congenital heart disease; or
 - cardiac electrical conduction abnormalities.

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. We will accept a Clinical Diagnosis of Sudden Cardiac Arrest if the sole cause of death shown on a death certificate and medical records indicates cardiovascular collapse, Sudden Cardiac Arrest, or sudden cardiac death.

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

COVERED CONDITION CATEGORY: INFECTIOUS DISEASE
ADDITIONAL DEFINITIONS THAT APPLY TO THE INFECTIOUS DISEASE COVERED CONDITION CATEGORY

Infectious Disease Covered Condition means each of the following diseases for which a Covered Person was confined in a Hospital as an inpatient for the number of consecutive days as specified below:

- anthrax;
- bacterial cerebrospinal meningitis;
- diphtheria;
- encephalitis;
- Legionnaire's disease;
- Lyme disease;
- malaria;
- methicillin-resistant staphylococcus aureus (MRSA);
- necrotizing fasciitis;
- osteomyelitis;
- pertussis (whooping cough);
- rabies;
- Rocky Mountain spotted fever;
- sepsis;
- tetanus;
- tuberculosis;
- typhoid fever; or
- COVID-19.

Occurs or Occurrence, with respect to an Infectious 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. An Infectious Disease Covered Condition will be deemed to Occur on the date a Diagnosis of an Infectious Disease Covered Condition is made.

INITIAL BENEFIT FOR AN INFECTIOUS DISEASE COVERED CONDITION

We will pay the applicable Initial Benefit shown on the Schedule for an Infectious Disease Covered Condition, the first time that an Infectious Disease Covered Condition Occurs for a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

RECURRENCE BENEFIT FOR AN INFECTIOUS DISEASE COVERED CONDITION

For an Infectious Disease Covered Condition for which the Schedule shows a Recurrence Benefit, We will pay the applicable Recurrence Benefit for another Occurrence of the same Infectious 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.

ADDITIONAL PROOF REQUIREMENTS FOR AN INFECTIOUS DISEASE COVERED CONDITION

Proof of an Infectious Disease Covered Condition requires the following additional documentation:

- a Covered Person was confined in a Hospital as an inpatient for 3 consecutive days for treatment of the Infectious Disease Covered Condition; and
- a Clinical Diagnosis:
 - made in Writing by a Physician; and
 - substantiated in the medical records.

COVERED CONDITION CATEGORY: KIDNEY FAILURE

ADDITIONAL DEFINITIONS THAT APPLY TO THE KIDNEY FAILURE COVERED CONDITION CATEGORY

Kidney Failure Covered Condition means, as the result of a covered critical illness or specified disease, the total, end stage, irreversible failure of all functioning kidneys, provided that a Physician has determined that such failure requires either:

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

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 earlier of:

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

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. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

RECURRENCE BENEFIT FOR A KIDNEY FAILURE COVERED CONDITION

We will pay the Recurrence Benefit shown on the Schedule for another Occurrence of a Kidney Failure Covered Condition for which We have already paid a benefit if the subsequent Occurrence happens after the Recurrence Benefit Separation Period has been satisfied.

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 TRANSPLANT

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

Bone Marrow means the soft, sponge-like tissue within the bone that produces white blood cells, red blood cells and platelets.

Major Organ Transplant Covered Condition means the following:

- Major Organ Transplant.

Major Organ Transplant means, as the result of a covered critical illness or specified disease:

- the irreversible failure of a Covered Person's liver for which a Physician has determined that the complete or partial replacement of the liver with a liver, or liver tissue from a human donor, is medically necessary;
- the irreversible failure of a Covered Person's heart, lung, pancreas, or any combination thereof, for which a Physician has determined that the complete replacement of such organ with an entire organ from a human donor is medically necessary;
- the irreversible failure of a Covered Person's Bone Marrow for which a Physician has determined the replacement of the Bone Marrow (stem cells) from a human donor is medically necessary; and
- for all of the above listed transplants, one of the following additional requirements are met:
 - the Covered Person has been placed on the Transplant List; or
 - such Major Organ Transplant Procedure has been performed.

Major Organ Transplant Procedure means a Covered Person undergoes a procedure for any of the transplant types to which the term Major Organ Transplant Covered Condition applies.

Occurs or Occurrence means, while the coverage is in effect under this Certificate for a Covered Person:

- with respect to Major Organ Transplant, the earlier of:
 - the date a Covered Person is placed on the Transplant List; or
 - the date a Covered Person undergoes a Major Organ Transplant Procedure.

If a Covered Person is placed on the Transplant List and then subsequently undergoes a Major Organ Transplant Procedure of the same organ for which the Covered Person was on the Transplant List, We will treat this as a single Occurrence of a Major Organ Transplant Covered Condition.

COVERED CONDITION CATEGORY: MAJOR ORGAN TRANSPLANT (Continued)

INITIAL BENEFIT FOR A MAJOR ORGAN TRANSPLANT COVERED CONDITION

We will pay the applicable Initial Benefit for a Major Organ Transplant Covered Condition shown on the Schedule, the first time that a Major Organ Transplant Covered Condition Occurs for a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

RECURRENCE BENEFIT FOR A MAJOR ORGAN TRANSPLANT COVERED CONDITION

For a Major Organ Transplant Covered Condition for which the Schedule shows a Recurrence Benefit, once We have paid an Initial Benefit for a Covered Person for a Major Organ Transplant Covered Condition, any subsequent Occurrence of Major Organ Transplant Covered Condition for the same or another organ within the definition of Major Organ Transplant Covered Condition will be considered a Recurrence of the Major Organ Transplant Covered Condition and We will pay the applicable Recurrence Benefit. The Recurrence Benefit Separation Period must be satisfied in order for a Recurrence Benefit to be payable.

SPECIAL LIMITATIONS APPLICABLE TO A MAJOR ORGAN TRANSPLANT COVERED CONDITION

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

- Two or more organs transplanted on the same day, or during the same Surgery, shall be deemed one Occurrence of a Major Organ Transplant.

ADDITIONAL PROOF REQUIREMENTS FOR A MAJOR ORGAN TRANSPLANT COVERED CONDITION

A Clinical Diagnosis of a Major Organ Transplant Covered Condition must be made in Writing by a Physician. In addition, documentation of the following must be provided:

- for Major Organ Transplant:
 - that the Covered Person has been placed on the Transplant List and the date of such placement; or
 - that the Major Organ Transplant has been performed.

SPECIAL EXCLUSIONS APPLICABLE TO A MAJOR ORGAN TRANSPLANT COVERED CONDITION

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

- if prior to the Covered Person's coverage becoming effective under this Certificate, the Covered Person had been placed on a Transplant List for the same organ for which the Major Organ Transplant Procedure is performed;
- for a transplant involving organs received from non-human donors;
- for a transplant involving implantation of mechanical devices or mechanical organs; or
- for a transplant involving islet cell transplants.

COVERED CONDITION CATEGORY: OCCUPATIONAL EXPOSURE DISEASE

ADDITIONAL DEFINITIONS THAT APPLY TO THE OCCUPATIONAL EXPOSURE DISEASE COVERED CONDITION CATEGORY

Hepatitis means hepatitis infection type B or C.

Hepatitis Definitive Test means a test that definitively determines, based on established testing protocols, whether a Covered Person has contracted the type of Hepatitis to which a Covered Person was exposed due to an Occupational Exposure. The test must be approved by the Centers for Disease Control or the Food and Drug Administration, and be performed by a licensed laboratory, with results interpreted in accordance with the manufacturer's specifications and by a Physician.

- For Hepatitis B, a definitive test means a test that establishes the presence of Hepatitis B antibodies or antigens such as any of the following tests: Hepatitis B surface antigen (HSbAg); Hepatitis B surface antibody (anti-HBs); IgM antibody to Hepatitis B core antigen (IgM anti-HBc); or anti-HBc – antibody to Hep B core antibody.
- For Hepatitis C, a definitive test means a test that establishes the presence of Hepatitis C antibodies or antigens such as: confirmation of a positive enzyme immunoassay (EIA) or enhanced chemiluminescence (CIA) with a positive PCR test; or HCV RNA testing.

Hepatitis Positive means the presence of Hepatitis B or Hepatitis C antibodies in a Covered Person's blood (indicating Hepatitis infection or, in the case of Hepatitis B, prior immunization) as substantiated through a positive Hepatitis Definitive Test and a diagnosis by a Physician.

HIV Definitive Test means a test that definitively determines whether a person is HIV Positive, such as the Western Blot, that is approved by the Centers for Disease Control or the Food and Drug Administration, performed by a licensed laboratory, with results interpreted in accordance with the manufacturer's specifications and by a Physician.

HIV Positive means the presence of Human Immunodeficiency Virus (HIV) antibodies in a Covered Person's blood (indicating HIV infection) as substantiated through a positive HIV Definitive Test and a Diagnosis by a Physician.

COVERED CONDITION CATEGORY: OCCUPATIONAL EXPOSURE DISEASE (Continued)

Occupational Exposure means that while insured under this Certificate and during the normal course of the Covered Person's regular occupational duties for which remuneration is earned, that a Covered Person is accidentally exposed to blood or other bodily fluids of another person that are contaminated with Human Immunodeficiency Virus (HIV) and/or the Hepatitis B or C virus through:

- cutaneous exposure through abraded skin;
- percutaneous exposure; or
- mucocutaneous exposure.

Occupational Exposure Disease Covered Condition means the following:

- Occupational Hepatitis; or
- Occupational HIV.

Occupational Hepatitis means that a Covered Person contracts Hepatitis as a direct result of an Occupational Exposure.

Occupational HIV means that a Covered Person becomes HIV Positive as a direct result of an Occupational Exposure.

Occurs or Occurrence, with respect to an Occupational Exposure Disease Covered Condition, means that a Covered Person is Diagnosed with such Covered Condition following an Occupational Exposure that happened while coverage is in effect under this Certificate for such Covered Person. An Occupational Exposure Disease Covered Condition will be deemed to Occur on the date of the Occupational Exposure.

INITIAL BENEFIT FOR AN OCCUPATIONAL EXPOSURE DISEASE COVERED CONDITION

We will pay the Initial Benefit for an Occupational Exposure Disease Covered Condition shown on the Schedule, the first time that an Occupational Exposure Disease Covered Condition Occurs for a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

ADDITIONAL PROOF REQUIREMENTS FOR AN OCCUPATIONAL EXPOSURE DISEASE COVERED CONDITION

A pathological Diagnosis of an Occupational Exposure Disease Covered Condition and the following additional documentation is required:

- Reporting and Investigation:
 - an incident report, which describes the nature of the Occupational Exposure must be filed with the Volunteer Organization within 10 days of the exposure;
 - the Occupational Exposure must be reported in accordance with any applicable legislation, regulations, standards or guidelines that apply to the Covered Person's occupation or profession; and
 - the Covered Person's Occupational Exposure was investigated by the Covered Person's Volunteer Organization and a Written investigation report must be provided to Us by the Volunteer Organization.

COVERED CONDITION CATEGORY: OCCUPATIONAL EXPOSURE DISEASE (Continued)

- Testing and Diagnosis for an Occupational Exposure to Hepatitis:
 - the Covered Person must have, within 26 weeks after the Occupational Exposure, a Hepatitis Definitive Test and the results of such test must show the presence of Hepatitis antibodies and be Diagnosed as having Hepatitis.
- Testing and Diagnosis for an Occupational Exposure to HIV:
 - the Covered Person must have, within 26 weeks after the Occupational Exposure, an HIV Definitive Test, and the results of such test must show the presence of HIV antibodies and be Diagnosed as being infected with HIV.

ADDITIONAL EXCLUSIONS APPLICABLE TO AN OCCUPATIONAL EXPOSURE DISEASE COVERED CONDITION

We will not pay benefits for an Occupational Exposure Disease Covered Condition if a Covered Person:

- becomes HIV Positive or Hepatitis Positive as a result of a transmission other than an Occupational Exposure;
- tested positive for Hepatitis prior to the Occupational Exposure, unless the Covered Person subsequently tested negative for Hepatitis before the Occupational Exposure on a Hepatitis Definitive Test; or
- becomes infected with Hepatitis or becomes HIV Positive as a result of intravenous drug use or sexual transmission.

We will not pay benefits for an Occupational Exposure Disease Covered Condition if the Occupational Exposure takes place outside the United States.

We will not pay for any cost incurred for Hepatitis or HIV tests or any related testing.

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 Cognitive Disturbances that are manifested by memory impairment (impaired ability to learn new information or to recall previously learned information).

Alzheimer's Disease must be confirmed by neuropsychological testing. Results of one or more of the following tests may be provided as confirmation in addition to the neuropsychological testing:

- computed tomography (CT);
- magnetic resonance imaging (MRI); or
- positron emission tomography (PET) documents the presence of abnormal deposits of proteins which have formed amyloid plaques and tau tangles.

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 Disturbances (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 Other Dementia; or
- any form of dementia that is not Clinically Diagnosed as Alzheimer's Disease.

Cognitive Disturbances means the following intellectual impairments:

- aphasia (language disturbance);
- apraxia (impaired ability to carry out motor activities despite intact motor function);
- agnosia (failure to recognize or identify objects despite intact sensory function); or
- disturbance in executive functioning (i.e. planning, organizing, sequencing, or abstracting).

Multiple Sclerosis means a progressive neurological condition with evidence of all of the following:

- well-defined neurological abnormalities lasting more than a continuous period of 6 months confirmed by neurological exam;
- presence of demyelination in at least two separate areas of the central nervous system;
- evidence that such demyelination damage took place at different points in time; and
- diagnostic testing results that document the following:
 - magnetic resonance imaging (MRI) that show T2 – weighted lesions;
 - an abnormal response on evoked potential testing; or
 - oligoclonal antibodies or a high immunoglobulin (IgG) index present in cerebrospinal fluid.

Multiple Sclerosis does not include clinically isolated syndrome (CIS).

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.

Other Dementia means the development of multiple progressive cognitive defects:

- manifested by memory impairment and other Cognitive Disturbances; and
- for which one or more of the following tests document changes to the specific areas of the brain that result in Cognitive Disturbances: electroencephalogram (EEG); or imaging studies, including computed tomography (CT), magnetic resonance imaging (MRI), fluorodeoxyglucose positron emission tomography (FDG Pet Scan) or amyloid positron-emission tomography scan.

Other Dementia includes the following types of neurological conditions:

- 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.

Other Dementia does not include:

- Alzheimer's Disease;
- substance-induced conditions;
- a form of dementia that is a mental and nervous condition, such as schizophrenia or psychoses;
- any form of Parkinson's disease other than Parkinson's disease dementia; or
- reversible dementias such as those cause by thyroid or other hormonal abnormalities, or vitamin deficiencies.

Parkinson's Disease means a chronic, slowly progressive neurological condition affecting the brain's ability to produce dopamine and that is marked by tremor of the muscles, rigidity, slowness of movement, impaired balance, and a shuffling gait which has resulted in a Covered Person requiring 24-hour care and being unable to live independently for a continuous period of 90 days.

Progressive Disease Covered Condition means any of the following:

- Alzheimer's disease;
- amyotrophic lateral sclerosis (referred to as ALS or Lou Gehrig's Disease);
- Multiple Sclerosis;
- muscular dystrophy;
- Parkinson's Disease; or
- systemic lupus erythematosus (SLE).

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. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

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 the following:

- Stroke; or
- Transient Ischemic Attack.

Stroke means a cerebrovascular accident or incident as the result of a covered critical illness or specified disease producing measurable, functional and permanent neurological impairment caused by any of the following which result in an infarction of brain tissue:

- hemorrhage;
- thrombus; or
- embolus from an extra-cranial source.

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, as the result of a covered critical illness or specified disease, 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. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

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

Proof of a Stroke Covered Condition requires the following additional documentation:

- medical records indicating objective evidence of a significant neurological, motor or sensory impairment that is functional and measurable; and
- for a Stroke – a pathological Diagnosis:
 - demonstrated on magnetic resonance imaging (MRI), computerized tomography (CT) or other reliable imaging techniques; and
 - confirmed in Writing by a Physician no earlier than 30 days after the Stroke with such impairments being present and considered permanent on the date that such Written confirmation is made; or
- for a Transient Ischemic Attack – a Clinical Diagnosis which is 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:

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

WHEN INSURANCE ENDS

Please Note: If insurance ends under this section, in certain cases it may be continued as stated in the Continuation of Insurance With Premium Payment section of this Certificate. Please see that section for details.

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 insurance ends for Your class;
- the end of the period for which the last full premium has been paid for Your insurance;
- the end of the calendar month in which You notify Us that You wish to cancel Your insurance;
- the end of the calendar month in which You cease to be in an eligible class, subject to the Change in Class provision of the Eligibility Provisions: Insurance for You section;
- the last day of the calendar month in which Your employment ends;
- the last day of the calendar month in which You retired in accordance with the Employer's retirement plan;
- the date Your Participating Employer no longer participates in the Western Healthcare Insurance Trust; or
- the date Your Participating Employer no longer participates in the Group Policy provided by the Policyholder.

DATE DEPENDENT INSURANCE ENDS

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

- the date Your insurance under this Certificate ends;
- the date Dependent Insurance ends under the Group Policy for all employees or for Your class;
- the end of the calendar month in which the person ceases to be a Dependent;
- the end of the calendar month in which You cease to be in a class that is eligible for Dependent Insurance;
- the end of the calendar month in which the Dependent is no longer eligible as described in the Eligible Classes for Dependent Insurance provision; or
- the end of the period for which the last full premium has been paid for insurance for the Dependent;
- the last day of the calendar month in which Your employment ends;
- the last day of the calendar month in which You retired in accordance with the Employer's retirement plan;
- the date Your Participating Employer no longer participates in the Western Healthcare Insurance Trust; or
- the date Your Participating Employer no longer participates in the Group Policy provided by the Policyholder.

CHANGE IN CLASS

If there is more than one class eligible for insurance under the Group Policy, and each class has its own certificate, instead of receiving a new certificate when You move between classes, You will remain insured under this Certificate if:

- You move to a class that is eligible for Critical Illness Insurance under the Group Policy; and
- the benefits available to Your new class are identical to the benefits available under this Certificate.

In all other cases when You move between classes, Your insurance under this Certificate will end on the date You are no longer a member of the class eligible for insurance under this Certificate.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

AT YOUR OPTION: CONTINUATION WITH PREMIUM PAYMENT

If Your insurance ends under the Date Your Insurance Ends provision of this Certificate, in certain situations, it may be continued for You and Your Dependents, as described in this provision. This is referred to in this provision as "Continued Insurance". For purposes of this provision, insurance in effect under the Group Policy for which the Group Policyholder remits premium is referred to in this provision as "Group Billed Insurance".

Except as described below, Continued Insurance is subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate.

Requirements for Continued Insurance

Continued Insurance will be available to You if:

- Your Group Billed Insurance ends for any reason other than:
 - non-payment of premium or Contribution; or
 - the end of the Group Policy, provided that Continued Insurance will be available to You if You do not become eligible, within 30 days after the end of the Group Policy, for critical illness insurance under another policy of group insurance available through the Group Policyholder;
- We receive Your completed Written request for Continued Insurance on a form approved by Us within 31 calendar days after Your Group Billed Insurance ends; and
- You pay premiums required for Continued Insurance by the due date specified in the premium notice sent to You.

Changes in Continued Insurance

You may elect to decrease Your insurance after the date that Continued Insurance goes into effect for You if a lower benefit option is available. In addition, You may end insurance for any or all of Your Dependents. Please contact Us for information. You may not increase insurance once Continued Insurance goes into effect.

Contributions for Continued Insurance

The Contribution that You must pay for Continued Insurance is the amount of Your Contribution for Your Group Billed Insurance before it ended, plus any amount of premium that the Group Policyholder paid. The Contribution that You must pay for Continued Insurance will be determined on the same basis as premium rates charged for Group Billed Insurance. We have the right to change premium rates in accordance with the terms set forth in the Group Policy. All payments for Continued Insurance must be made directly to Us by the due date specified in the premium notice We send to You.

End of Continued Insurance

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

- the date You die;
- if You do not pay a Contribution that is required for Continued Insurance, the end of the period for which the last full premium has been paid for Your insurance;
- with respect to Continued Insurance for a Dependent:
 - the date Continued Insurance for You ends for any reason;
 - the end of the calendar month in which the Dependent no longer meets the definition of a Dependent; or
 - the end of the calendar month in which the Dependent is no longer eligible as described in the Eligibility Provisions: Dependent Insurance section of this Certificate.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT (Continued)

FOR DEVELOPMENTALLY OR PHYSICALLY DISABLED CHILDREN

Insurance for a Dependent Child may be continued past the age limit if that child is incapable of self-sustaining employment because of a developmental or physical disability as defined by applicable law. Proof of such disability must be sent to Us within 31 days after the date the Dependent Child attains the age limit and at reasonable intervals after such date, but no more often than annually after the two year period following such Dependent Child's attainment of the limiting age.

Except as stated in the Date Dependent Insurance Ends provision of the When Insurance Ends section of this Certificate, insurance will continue while such Dependent Child:

- remains incapable of self-sustaining employment because of a developmental or physical disability; and
- continues to qualify as a Dependent Child, except for the age limit.

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 90 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 \$1,000 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.

CLAIMS (Continued)

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.

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 where permitted by law. Any such request will set forth the reasons We are requesting the autopsy.

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 STANDARDS

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

ENTIRE CONTRACT

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

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

INCONTESTABILITY: STATEMENTS MADE BY YOU

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

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

We will not use Your statements which relate to insurability to contest this insurance after it has been in force for 2 years, unless the statement is fraudulent. In addition, We will not use such statements to contest an increase in benefits after the increase has been in force for 2 years, unless such statement is fraudulent.

MISSTATEMENTS

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

ASSIGNMENT

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

RENEWABILITY OF COVERAGE

The policy is optionally renewable, subject to the provisions of the Group Policy.