Aflac
Insurance Plans

Whole Life

Critical Illness

Accident

Underwritten by:
Continental American Insurance Company (CAIC)

In California, coverage is underwritten by
Continental American Life Insurance Company.

This plan does not contain comprehensive adult wellness benefits as defined by law.

New Group Accident Benefit for All Active Local 19 Members in Good Standing

Effective January 1, 2018 Local 19 will insure all of our Members under an AFLAC Group Accident Insurance Policy "Member Tier". This Local 19 paid benefit will be reviewed by the Local 19 Executive Board and approved on a yearly basis. This is only part of a package, which is a result of years of ancillary benefits research and negotiations for All Local 19 and United Airlines Members. Throughout the months of January and February, I will be out with your Business Agents to explain the new benefit, along with enrollment specialists sharing the other AFLAC Benefits that are available. You will have an opportunity to enroll at that time.

The enrollment for United Airlines Local 19 Members will start January 9, 2018 and will last approximately six weeks as we enroll at the different locations. Once we complete United Airlines, we will visit the remaining properties we represent for their enrollments. Look for posters in your areas that will include dates.

Your Group Accident policy has a wellness benefit for covered persons having their yearly checkup, starting at $25/year and growing to $75/yr. This money goes directly to you and if you elect to cover your spouse or children, the wellness benefit amount is the same for them.

Our United Airlines CBA has a negotiated payroll deduction slot for these additional benefits. Our other Local 19 Members will need to establish electronic draft for premium payments.

In January or February a Certificate of Coverage for the Local 19 paid Accident Policy will be sent to your home. It is very important that, at the very least, you meet with a Benefits Representative, during the initial enrollment, to ensure they have your current address for this important document.

I cannot express enough how important it is to understand this opportunity. Participating in the initial enrollment offers special pricing and significant guaranteed issue amounts, with no medical questions asked for yourself or your family members.

Thank you,

Your Local 19 Executive Board

AFLAC INSURANCE

Health changes. Your lifestyle shouldn't.

When health changes for you or a loved one, it can change everything. Aflac can help you make sure you can keep the life you love. Aflac is different from major medical insurance. It's insurance for daily living. If you're sick or injured, Aflac pays cash benefits directly to you (unless otherwise assigned) to help address out-of-pocket medical costs, everyday expenses—whatever you choose. More than 50 million people worldwide have chosen Aflac voluntary insurance products for the added comfort of being better prepared for whatever life may bring.

Why Aflac?

- Cash benefits paid directly to you, unless otherwise assigned
- Benefits paid regardless of any other insurance you may have
- No deductibles or copayments
- Freedom to choose any provider
- Plan stays with you if you leave your job (with certain stipulations)

During this enrollment, the following Aflac plans are available:

- Whole Life Insurance
- Critical Illness Insurance
- Accident Insurance

What you need, when you need it.

Aflac pays cash benefits that you can use any way you see fit.

For enrollment information go to www.aflac.com/airlinemechanics or call 800-330-7735.

WHOLE LIFE INSURANCE Policy Form C60100TX

Benefits:

- Benefit amounts are available up to $300,000 for members, up to $100,000 for spouses and up to $25,000 for dependent children.
- Guaranteed Issue Face amount is $100,000 for members, $50,000 for spouses, and $25,000 for children.
- Waiver of Premium Benefit (employee only).
- Accidental-Death Benefit (employee and spouse only).
- Accelerated Benefit Rider (employee and spouse only)

Features:

- Premiums will never increase.
- Benefits may be paid directly to your named beneficiary.
- Coverage is portable (with certain stipulations), which means you can take it with you if you change jobs or retire.
- Premiums are paid through convenient payroll deduction.
- Policy builds cash value for you and your family.

Benefits Overview

WHOLE LIFE BENEFIT (Employee, Spouse, Child and Grandchild (see eligibility) coverage available)
The Whole Life Benefit pays proceeds upon the insured's death. Proceeds are defined as the total of the benefits payable upon the insured's death. Proceeds will be the sum of the amount of insurance in force, any insurance on the life of the insured provided by benefit riders, any premium paid that applies to a period of time beyond the certificate month in which the insured dies, less any certificate loan and loan interest, and any unpaid premium, except the first premium, that applies to a period before and including the certificate month in which the insured dies.

ACCELERATED BENEFIT RIDER (Employee and Spouse only)
The Accelerated Benefit Rider pays a lump sum benefit up to one-half of the eligible death benefit when the insured is diagnosed with one or more Qualifying Life Events.

The insured may choose the amount of the Accelerated Benefit, subject to these limitations: The maximum Accelerated Benefit is 50% of the eligible death benefit subject to state limitations. Refer to your certificate for benefit details. The insured may also choose to take the Accelerated Benefit as a monthly benefit. See certificate for details.

ACCIDENTAL DEATH BENEFIT RIDER (Employee and Spouse only)
The Accidental Death Benefit Rider provides an additional benefit equal to the face amount if the insured dies within 90 days of direct accidental bodily injuries. The maximum coverage available under this rider is $300,000. Employees and spouses, ages 18-60, are issued this benefit, which terminates at age 65.

WAIVER OF PREMIUM BENEFIT RIDER (Employee only)
The Waiver of Premium Benefit Rider waives entire premium amount for employee coverage after the insured has been totally disabled due to bodily injury or disease for 4 consecutive months and continues throughout the duration of the disability. Any recurrence of a prior disability will be covered, provided the prior disability continued for at least 6 consecutive months, began within 30 days of recovery, and was due to the same or related causes. The Waiver of Premium Benefit Rider is also available for loss of sight or loss of limbs even though the employee may be able to engage in an occupation. Only employees, ages 18–55, are eligible to be issued this benefit, which terminates at age 60.

CHILDREN'S TERM INSURANCE RIDER (Children only)
The Children's Term Rider pays a benefit upon receipt of due proof of death of an insured child if coverage is in force, it is before the expiration date, and it is before the rider anniversary following the insured child's 26th birthday. The children's term insurance may be converted to a whole life plan without evidence of insurability subject to the maximum shown in the certificate. Refer to your certificate for details.

CRITICAL ILLNESS ADVANTAGE Policy Form C21000TX

Benefits:

- Benefits are paid directly to you, unless otherwise assigned.
- Guaranteed Issue Amounts
- No Waiting Period
- No Pre-Existing Condition Exclusion

Eligible Amounts:

- Member: Up to $50,000
- Spouse: Up to $50,000

Guaranteed-issue Amounts:

- Member: Up to $30,000
- Spouse: Up to $15,000
- Children: Up to $15,000

Benefits Overview

COVERED CRITICAL ILLNESSES:

CANCER (Internal or Invasive)	100%
HEART ATTACK (Myocardial Infarction)	100%
STROKE (Ischemic or Hemorrhagic)	100%
MAJOR ORGAN TRANSPLANT	100%
KIDNEY FAILURE (End-Stage Renal Failure)	100%
SUDDEN CARDIAC ARREST	100%
BONE MARROW TRANSPLANT (Stem Cell Transplant)	100%
SEVERE BURNS*	100%
COMA**	100%
PARALYSIS**	100%
LOSS OF SIGHT / HEARING / SPEECH**	100%
AMYOTROPHIC LATERAL SCLEROSIS[1] (ALS or Lou Gehrig's Disease)	100%
SUSTAINED MULTIPLE SCLEROSIS[1]	100%
BENIGN BRAIN TUMOR[2]	100%
ADVANCED ALZHEIMER'S DISEASE[2]	100%
ADVANCED PARKINSON'S DISEASE[2]	25%
NON-INVASIVE CANCER	25%
CORONARY ARTERY BYPASS SURGERY	25%

*This benefit is only payable for burns due to, caused by, and attributed to, a covered accident.

**These benefits are payable for loss due to a covered underlying disease or a covered accident.

1. These benefits are found in the Progressive Diseases rider. We will pay the benefit shown upon diagnosis of one of the covered diseases if the date of diagnosis is while the rider is in force.

2. These benefits are found in the Optional Benefits rider. We will pay the benefit shown upon diagnosis of one of the covered diseases if the date of diagnosis is while the rider is in force.

INITIAL DIAGNOSIS
We will pay a lump sum benefit upon initial diagnosis of a covered critical illness when such diagnoses is caused by or solely attributed to an underlying disease. Cancer diagnoses are subject to the cancer diagnosis limitation. Benefits will be based on the face amount in effect on the critical illness date of diagnosis.

ADDITIONAL DIAGNOSIS
We will pay benefits for each different critical illness after the first when the two dates of diagnoses are separated by at least 3 consecutive months. Cancer diagnoses are subject to the cancer diagnosis limitation.

REOCCURRENCE
We will pay benefits for the same critical illness after the first when the two dates of diagnoses are separated by at least 3 consecutive months. Cancer diagnoses are subject to the cancer diagnosis limitation.

CHILD COVERAGE AT NO ADDITIONAL COST
Each dependent child is covered at 50 percent of the primary insured's benefit amount at no additional charge. Children-only coverage is not available.

SKIN CANCER BENEFIT
We will pay $250 for the diagnosis of skin cancer. We will pay this benefit once per calendar year.

WAIVER OF PREMIUM
If you become totally disabled due to a covered critical illness prior to age 65, after 90 continuous days of total disability, we will waive premiums for you and any of your covered dependents. As long as you remain totally disabled, premiums will be waived up to 24 months, subject to the terms of the plan.

SUCCESSOR INSURED BENEFIT
If spouse coverage is in force at the time of the primary insured's death, the surviving spouse may elect to continue coverage. Coverage would continue at the existing spouse face amount and would also include any dependent child coverage in force at the time.

HEALTH SCREENING BENEFIT (Employee and Spouse only)
We will pay $50 for health screening tests performed while an insured's coverage is in force. We will pay this benefit once per calendar year.

This benefit is only payable for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. This benefit is payable for the covered employee and spouse. **This benefit is not paid for dependent children.**

COVERED HEALTH SCREENING TESTS INCLUDE:

- Blood test for triglycerides
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- DNA stool analysis
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum cholesterol test to determine level of of HDL and LDL
- Serum protein electrophoresis (blood test for myeloma)
- Spiral CT screening for lung cancer
- Stress test on a bicycle or treadmill
- Thermography

ACCIDENT INSURANCE Policy Form C70100TX

Benefits Overview

	BENEFIT AMOUNT
INITIAL TREATMENT (once per accident, within 7 days after the accident, not payable for telemedicine services)	up to $200
AMBULANCE (once per day, within 90 days after the accident)	up to $900
MAJOR DIAGNOSTIC TESTING (once per accident, within 6 months after the accident)	$150
EMERGENCY ROOM OBSERVATION (within 7 days after the accident	up to $70
PRESCRIPTIONS (2 times per accident, within 6 months after the accident)	$5
BLOOD/PLASMA/PLATELETS (3 times per accident, within 6 months after the accident)	$200
PAIN MANAGEMENT (once per accident, within 6 months after the accident)	$75
CONCUSSION (once per accident, within 6 months after the accident)	$350
TRAUMATIC BRAIN INJURY (once per accident, within 6 months after the accident)	$3,500
COMA (once per accident)	$7,500
EMERGENCY DENTAL WORK (once per accident, within 6 months after the accident)	up to $120
BURNS (once per accident, within 6 months after the accident)	up to $15,000
EYE INJURIES	$175
FRACTURES (once per accident, within 90 days after the accident)	Up to $3,000 based on a schedule
DISLOCATIONS (once per accident, within 90 days after the accident)	Up to $2,000 based on a schedule
LACERATIONS (once per accident, within 7 days after the accident)	up to $600
OUTPATIENT SURGERY AND ANESTHESIA (per day / performed in hospital or ambulatory surgical center, within one year after the accident)	$300
FACILITIES FEE FOR OUTPATIENT SURGERY (surgery performed in hospital or ambulatory surgical center, within one year after the accident)	$75
OUTPATIENT SURGERY AND ANESTHESIA (per day / performed in a doctor's office, urgent care facility, or emergency room; maximum of two procedures per accident, within one year of the accident)	$35
INPATIENT SURGERY AND ANESTHESIA (per day / within one year after the accident)	$750
TRANSPORTATION (greater than 100 miles from the insured's residence, 3 times per accident, within 6 months after the accident)	up to $350

Surgical Procedures may include, but are not limited to, surgical repair of: ruptured disc, tendons/ligaments, hernia, rotator cuff, torn knee cartilage, skin grafts, joint replacement, internal injuries requiring open abdominal or thoracic surgery, exploratory surgery (with or without repair), etc., unless otherwise noted due to an accidental injury.

AFTER CARE BENEFITS	BENEFIT AMOUNT
APPLIANCES (within 6 months after the accident)	up to $300
ACCIDENT FOLLOW-UP TREATMENT (maximum of 6 per accident, within 6 months after the accident provided initial treatment is within 7 days of the accident)	$35
POST-TRAUMATIC STRESS DISORDER (PTSD) (once per accident, within 6 months after the accident)	$150
REHABILITATION UNIT (maximum of 31 days per confinement, no more than 62 days total per calendar year for each insured)	$75 per day
THERAPY (maximum of 10 per accident, beginning within 90 days after the accident provided initial treatment is within 7 days after the accident)	$35
CHIROPRACTIC OR ALTERNATIVE THERAPY (maximum of 6 per accident, beginning within 90 days after the accident provided initial treatment is within 7 days after the accident)	$25
HOSPITALIZATION BENEFITS	
HOSPITAL ADMISSION (once per accident, within 6 months after the accident)	$1,000 per confinement
HOSPITAL CONFINEMENT (maximum of 365 days per accident, within 6 months after the accident)	$225 per day
HOSPITAL INTENSIVE CARE (maximum of 30 days per accident, within 6 months after the accident)	$300 per day
INTERMEDIATE INTENSIVE CARE STEP-DOWN UNIT (maximum of 30 days per accident, within 6 months after the accident)	$150 per day
FAMILY MEMBER LODGING (greater than 100 miles from the insured's residence, maximum of 30 days per accident, within 6 months after the accident)	$150 per day
LIFE CHANGING EVENTS BENEFITS	
DISMEMBERMENT (once per accident, within 6 months after the accident)	up to $17,500
PARALYSIS (once per accident, diagnosed by a doctor within six months after the accident)	up to $7,500
PROSTHESIS (once per accident, one replacement per device per insured)*	$2,000
RESIDENCE/VEHICLE MODIFICATION (once per accident, within one year after the accident)	$1,500
WELLNESS RIDER (once per calendar year)	up to $75
CATASTROPHIC ACCIDENT RIDER (365–day elimination period)	up to $250,000

* We will pay this benefit again once to cover the replacement of a prosthesis for which a benefit has been paid, provided the replacement takes place within three years of the initial benefit payment.

Need help with healthcare?

We've got your lifeline.

Introducing Health Advocacy, Medical Bill Saver™ and Telemedicine services, now part of your Aflac plan.

Plans are enhanced without adding cost.

Now, if you have Aflac Group Critical Illness, Group Accident, or Group Whole Life plans, you also have access to three new services that make it easier to access care, reduce out-of-pocket medical expenses and navigate the healthcare system with greater ease:

- **Get answers and expert help** with Health Advocacy from Health Advocate.
- **Let advocates negotiate** your medical bills with Medical Bill Saver™, also from Health Advocate
- **Connect with health providers** via phone, app or online with MeMD.

These three services are now embedded in your group plan. Best of all, you can start using them as soon as your Aflac coverage starts.

SERVICES AVAILABLE AS SOON AS YOUR COVERAGE STARTS

Start using Health Advocacy and Medical Bill Saver™ from Health Advocate and Telemedicine from MeMD when your coverage begins.

Questions? Call **855-423-8585**

DID YOU KNOW?

You can also use Health Advocate's Health Advocacy and Medical Bill Saver™ services for your spouse, dependent children, parents and parents-in-law, while Telemedicine is available for you and your family.

HealthAdvocate™ MeMD™ Aflac®

Get more without spending more.

More than just peace of mind.

Health Advocacy from Health Advocate

You have 24/7 access to Personal Health Advocates who start helping from the first call:

- Find doctors, dentists, specialists, hospitals and other providers
- Schedule appointments, treatments and tests
- Resolve benefits issues and coordinate benefits
- Assist with eldercare issues, Medicare and more
- Help transfer medical records, lab results and X-rays
- Work with insurance companies to obtain approvals and clarify coverage

More than just cash benefits.

Medical Bill Saver™ from Health Advocate

Aflac already pays claims quickly. Now, with Medical Bill Saver™, Health Advocate professionals also help you negotiate medical bills not covered by health insurance:

- Just send in your medical and dental bills of $400 or more
- They contact the provider to negotiate a discount
- Negotiations can lead to a reduction in out-of-pocket costs
- Once an agreement is made, the provider approves payment terms and conditions
- You get an easy-to-read personal Savings Result Statement, summarizing the outcome and payment terms

More than just care.

Telemedicine from MeMD

You can quickly connect with board-certified, U.S. licensed health providers online for 24/7/365 access to medical care — fast:

- Create your account at www.MeMD.me/Aflac
- When you have a health issue, log on and request a provider consultation
- You can request consultations via webcam, app or phone
- Get ePrescriptions, referrals and more
- Use it for a range of health issues, from allergies and colds to medication refills
- $25.00 per visit!

CAIC's affiliation with the Value-Added Service providers is limited only to a marketing alliance, and CAIC and the Value-Added Service providers are not under any sort of mutual ownership, joint venture, or are otherwise related. CAIC makes no representations or warranties regarding the Value-Added Service Providers, and does not own or administer any of the products or services provided by the Value Added Service providers. Each Value-Added Service Provider offers its products and services subject to its own terms, limitations and exclusions. Value Added Services are not available in Idaho or Minnesota. State availability may vary.

Medical Bill Saver has restrictions for negotiations on in-network deductibles and co-insurance in Arizona, Colorado, District of Columbia, Illinois, Indiana, New Jersey, New York, North Carolina, Ohio, South Dakota, Texas, Utah and Vermont.

When medically necessary, MeMD providers can submit a prescription electronically for purchase and pick-up at your local participating pharmacy; however, MeMD providers cannot prescribe elective medications, narcotic pain relievers, or controlled substances. MeMD's providers are each licensed by the appropriate licensing board for the state in which they are providing services and all have prescriptive authority for each of the states in which they are licensed.

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups situsedin California, group coverage is underwritten by Continental American Life Insurance Company.

aflacgroupinsurance.com | 1.800.433.3036

Continental American Insurance Company | Columbia, South Carolina

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WHOLE LIFE, ACCIDENT, & CRITICAL ILLNESS INSURANCE

LIMITATIONS AND EXCLUSIONS
WHAT IS NOT COVERED, AND TERMS YOU NEED TO KNOW

WHOLE LIFE LIMITATIONS AND EXCLUSIONS

If an insured takes his own life within two years from the date of issue of his certificate, our liability will be limited to all premiums paid, without interest, less any certificate loan and loan interest.

ACCELERATED BENEFIT RIDER EXCLUSIONS

We will not pay the Accelerated Benefit until we receive proof of the insured's qualifying event and the following conditions are met: We have received the owner's written request for an Accelerated Benefit; We have received written consent from all irrevocable beneficiaries waiving their rights to any death benefit required to pay off the lien at the time of death. At our discretion, we may require written consent from a spouse of the insured, or other beneficiaries, or any other person whom we believe to have a potential interest in the proceeds of the certificate; and We have received as assignment form making us the assignee of the certificate for the amount of the lien.

The rider is not intended to provide health, nursing, home or long term care insurance. Benefit payments may affect the insured's eligibility to receive Medicaid and other government benefits or entitlements.

Receipt of accelerated benefits may be taxable. The insured should consult with his personal tax advisor. This benefit is subject to an administrative expense charge not to exceed $150.

We will not pay the Accelerated Benefit: If either the owner or the insured is required by a government agency to use the Accelerated Benefit in order to apply for, obtain, or otherwise keep a government benefit or entitlement; If either the owner or the insured is required by law to use the Accelerated Benefit to meet the claims of creditors, whether in bankruptcy or otherwise; If the qualifying event results from intentionally self-inflicted injuries; If the certificate is in force as either extended term insurance or reduced paid-up insurance; If the certificate is legally or equitably assigned, except to us as security for the lien; If any part of the Death Benefit under the certificate is contestable; If the certificate is not in force or the Death Benefit under the certificate is not payable for any reason. If the amount of the Accelerated Benefit, plus the amount of all Accelerated Benefits on the insured from all certificates issued by us, exceeds $250,000; or If there has already been an Accelerated Benefit paid on the certificate.

ACCIDENTAL DEATH RIDER EXCLUSIONS

The Accidental Death Benefit provided will not be payable if the insured's death results from any of the following causes: War, or an act of war (including any armed aggression resisted by the armed forces of any country or combination of countries), whether such war is declared or undeclared; Suicide; Any bodily or mental infirmity (or disease, except a bacterial infection occurring with or through an accidental injury; Committing or attempting to commit an assault or felony; The voluntary taking of any drug, medication, or sedative unless as prescribed by a physician; or any poison (except for food poisoning), including carbon monoxide; Operating, riding in, or subsequent drowning from, any kind of aircraft, if the insured: Is a pilot, officer, or member of the crew; or Is giving or receiving any kind of training or instructions; or Has any duties aboard such aircraft, Skydiving

WAIVER OF PREMIUM RIDER EXCLUSION

No benefit will be provided by the rider if a total disability is caused by: An intentionally self-inflicted injury; or Results from an act of war (declared or undeclared) while the insured is in the military service of any country.

Approval for Waiver of Premium requires: That the total disability be caused by bodily injury or by disease; That the total disability has continued for four consecutive months; and That the rider and certificate were in force when the total disability began.

CHILDREN'S TERM INSURANCE RIDER EXCLUSIONS

The Children's Term Insurance Rider is part of the certificate and is subject to all certificate provisions that are not inconsistent with it. It is issued in consideration of the application for and the payment of premiums for this rider.

TERMS YOU NEED TO KNOW

Beneficiary means the person (or entity) named in the application, or later changed by the plan owner, who will receive proceeds upon the death of the insured.

Eligible Person means the following individuals who are eligible for coverage: 1. A person who is employed and paid for services by his employer on a regular basis. The eligible person must work for the employer: a. At such person's usual place of work, or such other places as required by the employer in the course of such work; b. For the full number of hours and full rate of pay, as set by the employment practices of the employer. 2. The employed person's spouse. 3. The employed person's child under 26 years of age. 4. A child under 26 years of age the eligible person will be adopting pursuant to an interim court order of adoption. 5. The employed person's grandchild under 26 years of age, who is legally dependent on the employed person. Note: "Child" as used above includes adopted children and stepchildren. However, eligible person will not include a foster child. An eligible child or grandchild must be under age 26 to be issued coverage, but whole life coverage under the certificate does not end after age 26.

Child eligibility definitions vary by state.

Spouse is your legal wife, husband, or partner in a legally recognized union. Refer to your certificate for details.

Total Disability means the incapacity of the primary insured, as a result of bodily injury or disease or mental disease, to engage, for remuneration or profit, in an occupation or profession. During the first 24 months of such disability, occupation or profession means the primary insured's occupation or profession at the time the disability began; thereafter it means any occupation or profession for which he is, or becomes, reasonably suited by education, training, or experience.

Eligible Death Benefit means the death benefit payable under the certificate and any riders by reason of death of the insured, not reduced by certificate loans excluding accidental death benefit riders, and any death benefit that is within five years of its expiration date on the benefit date.

Qualifying Event means one or more of the following: A non-correctable illness or physical condition that, with a reasonable degree of medical certainty, will result in the death of the insured in less than 12 months from the date of a written statement by a physician. A condition that causes the insured to lose the ability to perform, without substantial assistance from another person, at least two activities of daily living due to a loss of functional capacity. This condition must be expected to last for the rest of the insured's life. A condition which causes the Insured to require substantial supervision to protect himself from threats to health and safety due to severe cognitive impairment. This condition must be expected to last for the rest of the insured's life.

YOUR COVERAGE MAY BE CONTINUED

When an employee is no longer a member of an eligible class and coverage would otherwise terminate, coverage may be continued. See certificate for details.

CRITICAL ILLNESS LIMITATIONS AND EXCLUSIONS

Cancer Diagnosis Limitation Benefits are payable for cancer and/or non-invasive cancer as long as the insured: Is treatment-free from cancer for at least 12 months before the diagnosis date; and Is in complete remission prior to the date of a subsequent diagnosis, as evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the cancer.

EXCLUSIONS

We will not pay for loss due to: Self-Inflicted Injuries – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured; Suicide – committing or attempting to commit suicide, while sane or insane; Illegal Acts – participating or attempting to participate in an illegal activity, or working at an illegal job: Participation in Aggressive Conflict: War (declared or undeclared) or military conflicts; Insurrection or riot Civil commotion or civil state of belligerence.Illegal Substance Abuse: Abuse of legally-obtained prescription medication Illegal use of non-prescription drugs. Diagnosis, treatment, testing, and confinement must be in the United States or its territories. All benefits under the plan, including benefits for diagnoses, treatment, confinement and covered tests, are payable only while coverage is in force.

TERMS YOU NEED TO KNOW

Bone Marrow Transplant (Stem Cell Transplant) means a procedure to replace damaged or destroyed bone marrow with healthy bone marrow stem cells. For a benefit to be payable, a Bone Marrow Transplant (Stem Cell Transplant) must be caused by at least one of the following diseases: Aplastic anemia, Congenital neutropenia, Severe immunodeficiency syndromes, Sickle cell anemia, Thalassemia, Fanconi anemia, Leukemia, Lymphoma, Multiple myeloma.

The Bone Marrow Transplant (Stem Cell Transplant) benefit is not payable if the transplant results from a covered critical illness for which a benefit has been paid under this plan.

Cancer (internal or invasive) is a disease that meets either of the following definitions:

A malignant tumor characterized by: The uncontrolled growth and spread of malignant cells, and The invasion of distant tissue.

A disease meeting the diagnostic criteria of malignancy, as established by the American Board of Pathology. A pathologist must have examined and provided a report on the histocytologic architecture or pattern of the tumor, tissue, or specimen.

Cancer (internal or invasive) also includes:

Melanoma that is Clark's Level III or higher or Breslow depth equal to or greater than 0.77mm, Myelodysplastic syndrome – RCMD (refractory cytopenia with multilineage dysplasia), Myelodysplastic syndrome – RAEB (refractory anemia with excess blasts), Myelodysplastic syndrome – RAEB-T (refractory anemia with excess blasts in transformation), or Myelodysplastic syndrome – CMML (chronic myelomonocytic leukemia). The following are not considered internal or invasive cancers: Pre-malignant tumors or polyps Carcinomas in Situ Any superficial, non-invasive skin cancers including basal cell and squamous cell carcinoma of the skin Melanoma in Situ Melanoma that is diagnosed as Clark's Level I or II, Breslow depth less than 0.77mm, or Stage 1A melanomas under TNM Staging.

Non-Invasive Cancer is a cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

For the purposes of the plan, a Non-Invasive Cancer is: Internal Carcinoma in Situ Myelodysplastic Syndrome – RA (refractory anemia), Myelodysplastic Syndrome – RARS

(refractory anemia with ring sideroblasts).

Skin Cancer, as defined in this plan, is not payable under the Non-Invasive Cancer Benefit.

Skin Cancer is a cancer that forms in the tissues of the skin. The following are considered skin cancers: Basal cell carcinoma, Squamous cell carcinoma of the skin Melanoma in Situ Melanoma that is diagnosed as Clark's Level I or II, Breslow depth less than 0.77mm, or Stage 1A melanomas under TNM Staging.

These conditions are not payable under the Cancer (internal or invasive) Benefit.

Cancer, non-invasive cancer, or skin cancer must be diagnosed in one of two ways: Pathological Diagnosis is a diagnosis based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This diagnosis must be made by a certified pathologist and conform to the American Board of Pathology standards. Clinical Diagnosis is based only on the study of symptoms. A clinical diagnosis will be accepted only if: A doctor cannot make a pathological diagnosis because it is medically inappropriate or life-threatening, Medical evidence exists to support the diagnosis, and A doctor is treating you for cancer or carcinoma in situ Complete Remission is defined as having no symptoms and no signs that can be identified to indicate the presence of cancer.

Coronary Artery Bypass Surgery means open heart surgery to correct the narrowing or blockage of one or more coronary arteries with bypass grafts and where such narrowing or blockage is attributed to coronary artery disease or acute coronary syndrome. This excludes any non-surgical procedure, such as, but not limited to, balloon angioplasty, laser relief, or stents.

Critical Illness is a disease or a sickness as defined in the plan that first manifests while your coverage is in force. In Illinois, critical illness is a sickness or disease that began while the insured's coverage is in force. In South Dakota, critical illness is a disease or a sickness that manifests while your coverage is in force.

Date of Diagnosis is defined as follows: Bone Marrow Transplant (Stem Cell Transplant): The date the surgery occurs. Cancer: The day tissue specimens, blood samples, or titer(s) are taken (diagnosis of cancer and/or carcinoma in situ is based on such specimens). Coronary Artery Bypass Surgery: The date the surgery occurs. Coma: The first day of the period for which a doctor confirms a coma that is due to one of the underlying diseases and that has lasted for at least seven consecutive days. Heart Attack (Myocardial Infarction): The date the infarction (death) of a portion of the heart muscle occurs. This is based on the criteria listed under the heart attack (myocardial Infarction) definition. Kidney Failure (End-Stage Renal Failure): The date a doctor recommends that an insured begin renal dialysis. Loss of Sight, Speech, or Hearing: The date the loss due to one of the underlying diseases is objectively determined by a doctor to be total and irreversible. Major Organ Transplant: The date the surgery occurs. Non-Invasive Cancer: The day tissue specimens, blood samples, or titer(s) are taken (diagnosis of cancer and/or carcinoma in situ is based on such specimens). Paralysis: The date a doctor diagnoses an insured with paralysis due to one of the underlying diseases as specified in this plan, where such diagnosis is based on clinical and/or laboratory findings as supported by the insured's medical records. Severe Burn: The date the burn takes place. Skin Cancer: The date the skin biopsy samples are taken for microscopic examination. Stroke: The date the stroke occurs (based on documented neurological deficits and neuroimaging studies). Sudden Cardiac Arrest: The date the pumping action of the heart fails (based on the sudden cardiac arrest definition).

Dependent means your spouse or your dependent child. Spouse is your legal wife or husband, who is listed on your application. Dependent children are your or your spouse's natural children, step-children, legally adopted children, or children placed for adoption, who are younger than age 26 (in Indiana, this includes children subject to legal guardianship). Newborn children are automatically covered from the moment of birth.

There is an exception to the age-26 limit listed above. This limit will not apply to any dependent child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent (in Arkansas, chiefly dependent) on a parent for support. The employee or the employee's spouse must furnish proof of this incapacity and dependency to the company within 31 days (in Indiana, 120 days) following the dependent child's 26th birthday.

In Texas, this limit will not apply to any dependent child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support and maintenance. Dependent Children may also include grandchildren, who are unmarried, under age 26, and if they are your dependents for federal income tax purposes, or if you must provide medical support under an order issued under Chapter 154, Family Code, or enforceable by a court in this state.

Diagnosis (Diagnosed) refers to the definitive and certain identification of an illness or disease that: Is made by a doctor and Is based on clinical or laboratory investigations, as supported by your medical records.

Doctor is a person who is: Legally qualified to practice medicine, Licensed as a doctor by the state where treatment is received, and Licensed to treat the type of condition for which a claim is made.

A doctor does not include you or any of your family members.

For the purposes of this definition, family member includes your spouse as well as the following members of your immediate family: Son, Daughter, Mother, Father, Sister, Brother.

This includes step-family members and family-members-in-law.

Employee is a person who meets eligibility requirements and who is covered under the plan. The employee is the primary insured under the plan.

Heart Attack (Myocardial Infarction) is the death of a portion of the heart muscle (myocardium) caused by a blockage of one or more coronary arteries due to coronary artery disease or acute coronary syndrome.

Heart Attack (Myocardial Infarction) does not include: Any other disease or injury involving the cardiovascular system. Cardiac arrest not caused by a heart attack (myocardial infarction).

Diagnosis of a Heart Attack (Myocardial Infarction) must include the following: New and serial electrocardiographic (ECG) findings consistent with heart attack (myocardial infarction), and Elevation of cardiac enzymes above generally accepted laboratory levels of normal. (In the case of creatine physphokinase (CPK) a CPK-MB measurement must be used.)

Confirmatory imaging studies, such as thallium scans, MUGA scans, or stress echocardiograms may also be used.

Kidney Failure (End-Stage Renal Failure) means end-stage renal failure caused by end-stage renal disease, which results in the chronic, irreversible failure of both kidneys to function.

Kidney Failure (End-Stage Renal Failure) is covered only under the following conditions: A doctor advises that regular renal dialysis, hemo-dialysis, or peritoneal dialysis (at least weekly) is necessary to treat the kidney failure (end-stage renal failure); or The kidney failure (end-stage renal failure) results in kidney transplantation.

Maintenance Drug Therapy is a course of systemic medication given to a patient after a cancer goes into complete remission because of primary treatment. Maintenance Drug Therapy includes ongoing hormonal therapy, immunotherapy, or chemo-prevention therapy. Maintenance Drug Therapy is meant to decrease the risk of cancer recurrence; it is not meant to treat a cancer that is still present.

Major Organ Transplant means undergoing surgery as a recipient of a covered transplant of a human heart, lung, liver, kidney, or pancreas. A transplant must be caused by one or more of the following diseases: Bronchiectasis, Cardiomyopathy Cirrhosis Chronic obstructive pulmonary disease, Congenital Heart Disease, Coronary Artery Disease, Cystic fibrosis, Hepatitis Interstitial lung disease, Lymphangioleiomyomatosis, Polycystic liver disease, Pulmonary fibrosis, Pulmonary hypertension, Sarcoidosis Valvular heart disease.

A Major Organ Transplant benefit is not payable if the major organ transplant results from a covered critical illness for which a benefit has been paid.

Party to a Civil Union: In Illinois, a person who has established a civil union pursuant to the Illinois Religious Freedom Protection and Civil Union Act.

Pathologist is a doctor who is licensed: To practice medicine, and By the American Board of Pathology to practice pathologic anatomy.

A Pathologist also includes an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Signs and/or symptoms are the evidence of disease or physical disturbance observed by a doctor or other medical professional. The doctor (or other medical professional) must observe these signs while acting within the scope of his license.

Stroke means apoplexy due to rupture or acute occlusion of a cerebral artery. The apoplexy must cause complete or partial loss of function involving the motion or sensation of a part of the body and must last more than 24 hours. Stroke must be either: Ischemic: Due to advanced arteriosclerosis or arteriosclerosis of the arteries of the neck or brain, or vascular embolism, or Hemorrhagic: Due to uncontrolled hypertension, malignant hypertension, brain aneurysm, or arteriovenous malformation.

The stroke must be positively diagnosed by a doctor based upon documented neurological deficits and confirmatory neuroimaging studies.

Stroke does not include: Transient Ischemic Attacks (TIAs) Head injury Chronic cerebrovascular insufficiency Reversible ischemic neurological deficits unless brain tissue damage is confirmed by neurological imaging.

Stroke will be covered only if the Insured submits evidence of the neurological damage by providing: Computed Axial Tomography (CAT scan) images, or Magnetic Resonance Imaging (MRI).

Sudden Cardiac Arrest is the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction due to coronary artery disease, cardiomyopathy, or hypertension.

Sudden Cardiac Arrest is not a heart attack (myocardial infarction). A sudden cardiac arrest benefit is not payable if the sudden cardiac arrest is caused by or contributed to by a heart attack (myocardial infarction).

Total Disability or Totally Disabled means you are: Not working at any job for pay or benefits,

Under the care of a doctor for the treatment of a covered critical illness, and Unable to Work, which means either: During the first 365 days of total disability, you are unable to work at the occupation you were performing when your total disability began; or After the first 365 days of total disability, you are unable to work at any gainful occupation for which you are suited by education, training, or experience.

Treatment or Medical Treatment is the consultation, care, or services provided by a doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines.

Treatment-Free From Cancer refers to the period of time without the consultation, care, or services provided by a doctor. This includes receiving diagnostic measures and taking prescribed drugs and medicines. Treatment does not include maintenance drug therapy or routine follow-up visits to verify whether cancer or carcinoma in situ has returned.

Severe Burn or Severely Burned means a burn resulting from fire, heat, caustics, electricity, or radiation. The burn must: Be a full-thickness or third-degree burn, as determined by a doctor. A Full-Thickness Burn or Third-Degree Burn is the destruction of the skin through the entire thickness or depth of the dermis (or possibly into underlying tissues). This results in loss of fluid and sometimes shock. Cause cosmetic disfigurement to the body's surface area of at least 35 square inches. Be caused solely by or be solely attributed to a covered accident.

Coma means a state of continuous, profound unconsciousness, lasting at least seven consecutive days, and characterized by the absence of: Spontaneous eye movements, Response to painful stimuli, and Vocalization.

Coma does not include a medically-induced coma. To be payable as an Accident benefit, the coma must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, the coma must be caused solely by or be solely attributed to one of the following diseases: Brain Aneurysm, Diabetes Encephalitis, Epilepsy, Hyperglycemia, Hypoglycemia, Meningitis.

Paralysis or Paralyzed means the permanent, total, and irreversible loss of muscle function to the whole of at least two limbs. To be payable as an Accident benefit, the paralysis must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, paralysis must be caused solely by or be solely attributed to one or more of the following diseases: Amyotrophic lateral sclerosis, Cerebral palsy, Parkinson's disease, Poliomyelitis.

The diagnosis of paralysis must be supported by neurological evidence.

Loss of Sight means the total and irreversible loss of all sight in both eyes. To be payable as an Accident benefit, loss of sight must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, loss of sight must be caused solely by or be solely attributed to one of the following diseases: Retinal disease, Optic nerve disease, Hypoxia.

Loss of Speech means the total and permanent loss of the ability to speak. To be payable as an Accident benefit, loss of speech must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, loss of speech must be caused solely by or be solely attributable to one of the following diseases: Alzheimer's disease , Arteriovenous malformation.

Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of hearing does not include hearing loss that can be corrected by the use of a hearing aid or device. To be payable as an Accident benefit, loss of hearing must be caused solely by or be solely attributed to a covered accident. To be considered a critical illness, loss of hearing must be caused solely by or be solely attributed to one of the following diseases: Alport syndrome, Autoimmune inner ear disease, Chicken pox, Diabetes, Goldenhar syndrome, Meniere's disease, Meningitis, Mumps.

PROGRESSIVE DISEASES RIDER

All limitations and exclusions that apply to the critical illness plan also apply to the rider unless amended by the rider. Date of Diagnosis is defined for each specified critical illness as follows: Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease): The date a Doctor Diagnoses an Insured as having ALS and where such Diagnosis is supported by medical records. Sustained Multiple Sclerosis: The date a Doctor Diagnoses an Insured as having Multiple Sclerosis and where such Diagnosis is supported by medical records.

Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease) means a chronic, progressive motor neuron disease occurring when nerve cells in the brain and spinal cord that control voluntary movement degenerate, causing muscle weakness and atrophy, eventually leading to paralysis.

Sustained Multiple Sclerosis means a chronic degenerative disease of the central nervous system in which gradual destruction of myelin occurs in the brain or spinal cord or both, interfering with the nerve pathways. Sustained Multiple Sclerosis results in one of the following symptoms for at least 90 consecutive days: Muscular weakness, Loss of coordination, Speech disturbances, or Visual disturbances.

OPTIONAL BENEFITS RIDER

All limitations and exclusions that apply to the critical illness plan also apply to the rider unless amended by the rider.

Date of Diagnosis is defined as follows: Advanced Alzheimer's Disease: The date a doctor diagnoses the insured as incapacitated due to Alzheimer's disease. Advanced Parkinson's Disease: The date a doctor diagnoses the insured as incapacitated due to Parkinson's disease. Benign Brain Tumor: The date a doctor determines a benign brain tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.

Optional Benefit is one of the illnesses defined below and shown in the rider schedule:

Advanced Alzheimer's Disease means Alzheimer's Disease that causes the insured to be incapacitated. Alzheimer's Disease is a progressive degenerative disease of the brain that is diagnosed by a psychiatrist or neurologist as Alzheimer's Disease.

To be incapacitated due to Alzheimer's Disease, the insured must: Exhibit the loss of intellectual capacity involving impairment of memory and judgment, resulting in a significant reduction in mental and social functioning, and Require substantial physical assistance from another adult to perform at least three ADLs.

Advanced Parkinson's Disease means Parkinson's Disease that causes the insured to be incapacitated. Parkinson's Disease is a brain disorder that is diagnosed by a psychiatrist or neurologist as Parkinson's Disease. To be incapacitated due to Parkinson's Disease, the insured must: Exhibit at least two of the following clinical manifestations: Muscle rigidity, Tremor, Bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses), and Require substantial physical assistance from another adult to perform at least three ADLs.

Benign Brain Tumor is a mass or growth of abnormal, noncancerous cells in the brain. The tumor is composed of similar cells that do not follow normal cell division and growth patterns and develop into a mass of cells that microscopically do not have the characteristic appearance of a Cancer. Benign Brain Tumor must be caused by Multiple Endocrine Neoplasia, Neurofibromatosis, or Von Hippel-Lindau Syndrome. Multiple Endocrine Neoplasia is a genetic disease in which one or more of the endocrine glands are overactive or form a tumor. Neurofibromatosis is a genetic disease in which the nerve tissue grows tumors that may be benign and may cause serious damage by compressing nerves and other tissue. Von Hippel-Lindau Syndrome is a genetic disease that predisposes a person to have benign or malignant tumors.

Activities of Daily Living (ADLs) are activities used in measuring levels of personal functioning capacity. These activities are normally performed without assistance, allowing personal independence in everyday living. For the purposes of this plan,

ADLs include the following: Bathing – the ability to wash oneself in a tub, shower, or by sponge bath. This includes the ability to get into and out of the tub or shower with or without the assistance of equipment; Dressing – the ability to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs; Toileting – the ability to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene with or without the assistance of equipment; Transferring – the ability to move in and out of a bed, chair, or wheelchair with or without the assistance of equipment; Mobility – the ability to walk or wheel on a level surface from one room to another with or without the assistance of equipment; Eating – the ability to get nourishment into the body by any means once it has been prepared and made available with or without the assistance of equipment; and Continence – the ability to voluntarily maintain control of bowel and/or bladder function. In the event of incontinence, the ability to maintain a reasonable level of personal hygiene.

YOU MAY CONTINUE YOUR COVERAGE

Your coverage may be continued with certain stipulations. See certificate for details.

TERMINATION OF COVERAGE

Your insurance may terminate when the plan is terminated; the 31st day after the premium due date if the premium has not been paid; or the date you no longer belong to an eligible class. If your coverage terminates, we will provide benefits for valid claims that arose while your coverage was in force.

ACCIDENT LIMITATION AND EXCLUSIONS

INITIAL ACCIDENT EXCLUSIONS

EXCLUSIONS

Plan exclusions apply to all riders unless otherwise noted.

We will not pay benefits for accidental injury, disability or death contributed to, caused by, or resulting from*:

War – voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the insured is in such service.) War also includes voluntary participation in an insurrection, riot, civil commotion or civil state of belligerence. War does not include acts of terrorism. Suicide – committing or attempting to commit suicide, while sane or insane. Sickness – having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for: Allergic

reactions; Any bacterial, viral, or microorganism infection or infestation or any condition resulting from insect, arachnid or other arthropod bites or stings. In Illinois: any bacterial infection, except an infection which results from an accidental injury or an infection which results from accidental, involuntary or unintentional ingestion of a contaminated substance; any viral or microorganism infection or infestation; or any condition resulting from insect, arachnid or other arthropod bites or stings. In North Carolina: any viral or microorganism infestation or any condition resulting from insect, arachnid or other arthropod bites or stings; An error, mishap or malpractice during medical, diagnostic, or surgical treatment or procedure for any sickness; Any related medical/surgical treatment or diagnostic procedures for such illness. Self-Inflicted Injuries – injuring or attempting to injure oneself intentionally. Racing – riding in or driving any motor-driven vehicle in a race, stunt show or speed test in a professional or semi-professional capacity. Illegal Occupation – voluntarily participating in, committing or attempting to commit a felony or illegal act or activity, or voluntarily working at or being engaged in, an illegal occupation or job. Sports – participating in any organized sport in a professional or semi-professional capacity for pay or profit. Cosmetic Surgery – having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of a covered accident. Felony (In Idaho only) – participation in a felony. For 24-Hour Coverage, the following exclusions will not apply: An injury arising from any employment. An injury or sickness covered by worker's compensation.

DEFINITIONS

Accidental Injury means accidental bodily damage to an insured resulting from an unforeseen and unexpected traumatic event. This must be the direct result of an accident and not the result of disease or bodily infirmity. A Covered Accidental Injury is an accidental injury that occurs while coverage is in force. A Covered Accident is an accident that occurs on or after an insured's effective date while coverage is in force, and that is not specifically excluded by the plan.

Ambulatory Surgical Center is defined as a licensed surgical center consisting of an operating room; facilities for the administration of general anesthesia; and a post-surgery recovery room in which the patient is admitted and discharged within a period of less than 24 hours.

Dependent Child or Dependent Children means your or your spouse's natural children, step-children, grandchildren who are in your legal custody and residing with you, foster children, children subject to legal guardianship, legally adopted children, or children placed for adoption, who are younger than age 26 (and in Louisiana, unmarried). Newborn children may be automatically covered from the moment of birth for 60 days. Newly adopted children (and foster children in North Carolina and Florida) may also be automatically covered for 60 days. See certificate for details.

Doctor is a person who is duly qualified as a practitioner of the healing arts acting within the scope of his license, and is licensed to practice medicine; prescribe and administer drugs; or to perform surgery, or is a duly qualified medical practitioner according to the laws and regulations in the state in which treatment is made.

A Doctor does not include the insured or an insured's family member. In South Dakota however, a doctor who is an employee's family member may treat the insured if that doctor is the only doctor in the area and acts within the scope of his practice. For the purposes of this definition, family member includes the employee's spouse as well as the following members of the employee's immediate family son, daughter, mother, father, sister, and brother. This includes step-family members and family-members-in-law.

The term Hospital specifically excludes any facility not meeting the definition of hospital as defined in this plan, including but not limited to: A nursing home, An extended-care facility, A skilled nursing facility, A rest home or home for the aged, A rehabilitation facility, A facility for the treatment of alcoholism or drug addiction, or An assisted living facility.

Spouse is your legal wife, husband, or partner in a legally recognized union. Refer to your certificate for details.

Telemedicine Service means a medical inquiry with a doctor via audio or video communication that assists with a patient's assessment, diagnosis, and consultation.

Treatment is the consultation, care, or services provided by a doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines. Treatment does not include telemedicine services.

Urgent Care is a walk-in clinic that delivers ambulatory, outpatient care in a dedicated medical facility for illnesses or injuries that require immediate care but that are not serious enough to require a visit to an emergency room.

Hospital Intensive Care Unit means a place that meets all of the following criteria: Is a specifically designated area of the hospital called a hospital intensive care unit; Provides the highest level of medical care; Is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care; Is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement; Is permanently equipped with special life-saving equipment for the care of the critically ill or injured; Is under close observation by a specially trained nursing staff assigned exclusively to the hospital intensive care unit 24 hours a day; and Has a doctor assigned to the hospital intensive care unit on a full-time basis.

The term Hospital Intensive Care Unit specifically excludes any type of facility not meeting the definition of hospital intensive care unit as defined in this plan, including but not limited to private monitored rooms, surgical recovery rooms, observation units and the following step-down units: A progressive care unit; A sub-acute intensive care unit; or An intermediate care unit.

Intermediate Intensive Care Step-Down Unit means any of the following: A progressive care unit; A sub-acute intensive care unit; An intermediate care unit; or A pre- or post-intensive care unit. An intermediate intensive care step-down unit is not a hospital intensive care unit as defined in this plan.

Psychiatrist is a doctor of medicine who specializes in the diagnosis and treatment of mental disorders.

Psychologist is a clinical, mental health professional who works with patients. A psychologist is not a doctor of medicine who typically provides medical interventions and drug therapies, but provides analysis and counseling.

Rehabilitation Facility is a unit or facility providing coordinated multidisciplinary physical restorative services. These services must be provided to inpatients under a doctor's direction. The doctor must be knowledgeable and experienced in rehabilitative medicine.

Beds must be set up in a unit or facility specifically designated and staffed for this service. This is not a facility for the treatment of alcoholism or drug addiction.

CATASTROPHIC ACCIDENT EXCLUSIONS

We will pay the Catastrophic Accident Benefit once per lifetime for each insured covered under the rider.

Please refer to the the Initial Accident Treatment insert for other exclusions applicable to this coverage.

DEFINITIONS

Catastrophic Accident Elimination Period is the period of days after the date of a Covered Accident for which no benefits are payable under this rider.

Catastrophic Loss refers to an injury from a covered accident that causes total and irrecoverable: Loss of both hands or both feet; or Loss or loss of use of both arms or both legs; or Loss of one hand and one foot; or Loss of use of one arm and one leg; or Loss of sight of both eyes; or Loss of hearing in both ears; or Loss of the ability to speak.

Note: The loss of use of an arm means the functional loss of the entire arm from the shoulder to the hand. The loss of use of a leg means the functional loss of the entire leg from the hip to the foot. The loss of sight means both eyes are totally blind and that no sight can be restored. The loss of hearing means deafness in both ears, such that it cannot be corrected to any functional degree by any procedure, aid or device. The loss of the ability to speak means loss of audible communication, such that it cannot be corrected to any functional degree by any procedure, aid or device.

Your coverage may be continued with certain stipulations. See certificate for details.

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