GROUP CRITICAL ILLNESS INSURANCE
CERTIFICATE OF COVERAGE

FOR

LOUISIANA STATE UNIVERSITY AND
AGRICULTURAL AND MECHANICAL COLLEGE

POLICY NUMBER: 303972
EFFECTIVE DATE: January 1, 2015

If there is a discrepancy between the provisions of the Employer’s on-line or printed Certificates and the provisions of the Certificates furnished by the Company, the provisions of the Group Policy will prevail.

LA – UHIC/2011
(12-14)
Important notice about your Critical Illness plan

What is a Critical Illness Plan?
A Critical Illness plan is not health insurance that pays for medical expenses. This is a plan that pays a set amount of money when you have a critical illness. See your policy for information on what illnesses are covered.

What do I need to know?
The Affordable Care Act (health care reform) requires insurance companies to provide minimum coverage for certain medical benefits. This is called essential health benefits.

Why is this important to me?
You need to know that your critical illness plan is not a substitute for health insurance that pays medical expenses. This plan doesn’t provide essential health benefits. This is why you also need health insurance with medical benefits.

What happens if I don’t have health insurance?
The Affordable Care Act requires everyone to have health insurance with essential health benefits. This critical illness plan is not enough to meet the requirement. You must also have health insurance with medical benefits.
Policyholder: Louisiana State University and Agricultural and Mechanical College
Effective Date: January 1, 2015
Policy Number: 303972
Policy Anniversary Date: January 1
Beneficiary: As on file with the Administrator

We, UnitedHealthcare Insurance Company, issue this Certificate to the Covered Person as evidence of insurance under the Policy We issued to the Policyholder shown above. This Certificate describes the benefits and other important provisions of the Policy.

The Policy is a legal contract between the Policyholder and Us and it may be changed or discontinued without the consent of the Covered Person or the Covered Person’s beneficiary. The Policy may be inspected at the office of the Policyholder.

The benefits described in this Certificate insure the Covered Person and, if applicable, Dependents, provided the person is eligible, has become covered, and the required premium has been paid to Us.

**Read the Group Certificate Carefully.** If the Policyholder has any questions or problems with the Policy, We will be ready to help the Policyholder. The Policyholder may call upon his agent or Our Home Office for assistance at any time. If the Covered Person has questions, needs information about their insurance, or needs assistance in resolving complaints, call 1-888-299-2070.

The Certificate is signed at the Home Office of UnitedHealthcare Insurance Company by:

[Signature]
Secretary

[Signature]
President

Administrative Office:
9900 Bren Road East
Minnetonka, MN  55343

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**Group Critical Illness Insurance Certificate**

**THE POLICY PROVIDES A LIMITED BENEFIT FOR CERTAIN CRITICAL ILLNESSES.**
**THE POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.**

UHICI-CERT-1-LA
Printed in U.S.A.
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SCHEDULE OF BENEFITS

Eligible Class: All Active Salaried Academic, Unclassified and Classified Employees working at 75% full-time employment or greater per pay period with an appointment of more than 120 days or one regular academic semester and their eligible Dependents

Description of Class: All Eligible Employees working an average of 30 hours per week

Employee Waiting Period: An Employee is eligible for insurance on the first day of the month following the date he completes 30 days of continuous employment with the Policyholder.

Benefit Waiting Period: None

Maximum Benefit Amount: (Payable per Category below)

<table>
<thead>
<tr>
<th>Category</th>
<th>Maximum Benefit Amount</th>
<th>Percentage of Maximum Benefit Amount payable per Covered Person or Dependent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$10,000 or $20,000</td>
<td>100%</td>
</tr>
<tr>
<td>Spouse</td>
<td>$5,000 or $10,000</td>
<td>100%</td>
</tr>
<tr>
<td>Child</td>
<td>$2,500</td>
<td>100%</td>
</tr>
</tbody>
</table>

Category 1: Percentage of Maximum Benefit Amount payable per Covered Person or Dependent

- Level 1 Cancer: 100%
- Level 2 Cancer: 25%

Category 2: Percentage of Maximum Benefit Amount payable per Covered Person or Dependent

- Heart Attack: 100%
- Heart Transplant: 100%
- Ruptured Aneurysm: 100%
- Stroke: 100%
- Coronary Artery Bypass: 25%

Category 3: Percentage of Maximum Benefit Amount payable per Covered Person or Dependent

- Coma: 100%
- Chronic Renal Failure: 100%
- Major Organ Transplants: 100%
- Permanent Paralysis: 100%
- Severe Brain Damage: 100%
- Severe Burns: 100%
SCHEDULE OF BENEFITS (continued)

Portability

Included

Benefit Rider:

Wellness Benefit

$100 per calendar year

The Restoration Benefit is applicable to
the Covered Person and Dependent if
elected at the time of enrollment

Restoration Rider:

Restoration Benefit

Employee: Payable up to 100% of the Maximum
Benefit Amount for each Category

Spouse: Payable up to 100% of the Maximum
Benefit Amount for each Category

Child: Payable up to 100% of the Maximum
Benefit Amount for each Category

Coverage Reduction at Age 70: The Critical Illness and Restoration of Benefit Amounts
reduce by 50% upon attainment of Age 70. If Age 70 or over at time of application, the amounts
will not be more than 50% of the amounts applicable to persons in the same Class who are
under Age 70.

Maximum Age for Dependent Child: 26 years

Premium Rate Change: The Covered Person and Dependent premiums may change on any
Premium Due Date if rates for the person’s Class are changed under the group Policy.
GENERAL DEFINITIONS

The male pronoun, whenever used in the Policy, includes the female.

Active Work or Actively at Work: the Covered Person reports for work at his usual place of employment or any other business location where he is required to travel and is able to perform his regular occupation for the entire normal workday. The Covered Person must be working at least the minimum number of hours per week in an Eligible Class, as shown in the Schedule of Benefits.

Unless disabled on the prior workday or on the day of absence, a Covered Person will be considered Actively at Work on the following days:
1. a Saturday, Sunday or holiday which is not a scheduled workday;
2. a paid vacation day, or other scheduled or unscheduled non-workday; or
3. an excused or emergency leave of absence (except medical leave).

Benefit Waiting Period: an exclusionary period immediately following the effective date of a person’s insurance, during which benefits are not payable. When a Critical Illness has a Date of Diagnosis within the Benefit Waiting Period, benefits are not payable on the basis of that diagnosis.

Change in Family Status:
1. a change in marital status (marriage, divorce, legal separation, annulment);
2. a change in the number of Dependents for tax purposes (birth, legal adoption of a Child, placement of a Child with the Covered Person for adoption, or death of a Dependent);
3. certain changes in employment status that affect benefits eligibility for the Covered Person, Spouse or Child, such as termination of employment, a strike or lockout, the start of or return from an unpaid leave of absence, a change in worksite, a change in work schedule (between full-time and part-time work, decrease or increase in hours);
4. a change of residence for the Covered Person, Spouse or Child;
5. a significant increase in the cost of coverage or a significant reduction in the benefit coverage under the Covered Person’s insurance or his Spouse’s insurance;
6. the addition, elimination, or significant curtailment of, a coverage option;
7. a change in the Covered Person’s, Spouse’s or Child’s coverage during another employer’s Annual Enrollment, Re-Enrollment period when the other plan has a different period of coverage.

Contributory or Non-Contributory Insurance: Contributory Insurance is insurance for which the Covered Person must apply and agree to make the required premium contributions. Non-Contributory Insurance is insurance for which the Covered Person does not have to make any premium contributions.

Covered Person: the Employee insured under the Policy. References to “Covered Person,” “Covered Persons” and “Covered Person’s” throughout this Certificate are references to a Covered Person.
GENERAL DEFINITIONS (continued)

**Dependent:** the Covered Person’s Spouse or Child, as defined below.

Spouse means a legal Spouse.

Child means a Child under the Maximum Age for Dependent Child shown in the Schedule and who is:

1. a natural Child;
2. a stepchild;
3. a legally adopted Child;
4. a Child placed in the Covered Person’s home for adoption or following execution of an act of voluntary surrender in favor of the Covered Person or his legal representative;
5. a Covered Person’s grandchild who is in legal custody of and residing with him; or
6. a Child for whom legal guardianship has been awarded to the Covered Person or the Covered Person’s Spouse.

The Child will cease to be an eligible Dependent on the last day of the month following the date the Child reaches the Maximum Age for Dependent Child unless the Child is an Incapacitated Child.

A Child is an Incapacitated Child if he is:

1. unmarried and, with respect to a Covered Person’s grandchild, in the legal custody of and residing with the Covered Person;
2. physically handicapped or mentally retarded; and
3. incapable of self-sustaining employment.

No one can be a dependent of more than one Covered Person.

**Employee:** a person who is authorized to work and reside in the United States and is:

1. directly employed in the normal business of the Employer; and
2. Actively at Work for the Employer, or any subsidiary or affiliate insured under the Policy.

No director or officer of an Employer will be considered an Employee unless he meets the above conditions.

**Employer:** the Policyholder and includes any division, subsidiary, or affiliated company named in the Policy. Employer does not include Employers of other related areas of practice for which the Covered Person may also work.

**Enrollment:**

- **Enrollment Period** - the Initial Enrollment Period or Re-Enrollment Period.
- **Initial Enrollment Period** - the period during which the Employee may first apply in writing for insurance.
- **Re-Enrollment Period** - the period of time following the Initial Enrollment Period determined by the Employer and Us during which the Covered Person may apply in writing for insurance under the Policy or change his insurance under the Policy.

**Hospital or Medical Facility:** a legally operated, accredited facility licensed to provide full-time care and Treatment for the condition for which benefits are payable under the Policy. It is operated by a full-time staff of licensed physicians and registered nurses. It does not include facilities that primarily provide custodial, education or rehabilitative care, or long-term institutional care on a residential basis.
Injury: a bodily injury resulting directly from an accident and independently of all other causes and the accident occurs while covered under the Policy.

Physician: a medical doctor or doctor of osteopathy who is:
   1. duly licensed in the state or Province in which the Treatment is received; and
   2. practicing within the scope of that license.
For the purposes of the Policy, the term Physician does not include the Covered Person, the Covered Person’s Spouse, or any family members.

Policy Anniversary Date: the annual renewal date of the group insurance contract between Us and the Policyholder.

Policyholder: the group named as the Policyholder on the face page of this Certificate.

Sickness: an illness, or disease, pregnancy or complication of pregnancy.

Treatment: as used in the Policy refers to any consultation, advice, tests, attendance or observation, supplies or equipment, including the prescription or use of prescription drugs or medicines.

We, Our and Us: UnitedHealthcare Insurance Company or its Administrator.
BENEFITS PAYABLE AND BENEFIT DEFINITIONS

Benefit Payable: We will pay up to a total of 100% of the Maximum Benefit Amount for each of the Categories shown on the Schedule of Benefits for which the Covered Person or Dependent:
1. receives a Diagnosis of a Critical Illness; and
2. for which he is insured on the Date of Diagnosis.

If the benefit paid for a Critical Illness within a specific category is less than 100%, the remainder of the Maximum Benefit Amount will be an available benefit for another Critical Illness for which a benefit has not already been paid within the specific Critical Illness category.

The benefit payable will be paid as a single per diem amount in one lump sum payment following receipt of a Proof of Claim.

Critical Illness: The Diagnosis of an illness or condition as defined in this section.

Diagnosis: The diagnosis by a Physician that is all of the following:
1. in writing;
2. made while the Covered Person’s insurance under the Policy is in force and is subject to all provisions of the in force Policy; and
3. based on objective clinical findings and/or laboratory investigations and supported by medical records and any diagnostic requirements stated in the Policy.

Date of Diagnosis, based on objective clinical or pathological findings, is:
1. for Cancer, the date that the tissue specimen, blood sample(s) and/or titer(s) are taken on which the diagnosis of Cancer is based;
2. for Coronary Artery Bypass, the date that heart disease has been clinically diagnosed and requires the Covered Person or Dependent to undergo a surgical procedure to open a blockage of one or more coronary arteries using venous or arterial grafts;
3. for Heart Attack, the date the Physician confirms that a Heart Attack (myocardial infarction) has occurred;
4. for Heart Transplant, the date the Physician recommends that the Covered Person or Dependent undergo a heart transplant, or results in the Covered Person or Dependent being placed on the United Network of Organ Sharing (UNOS) transplant list. If the Covered Person or Dependent is determined by the Physician to be too ill for a transplant, but otherwise meets the criteria for placement on the UNOS list, the network requirement will be waived;
5. for Ruptured Aneurysm, the date the Physician confirms that a Ruptured Aneurysm occurred;
6. for Stroke, the date the Physician confirms that a Stroke occurred;
7. for Chronic Renal Failure, the date the Physician recommends that the Covered Person or Dependent undergo hemodialysis or peritoneal dialysis at least weekly, or results in the Covered Person or Dependent being placed on the United Network of Organ Sharing (UNOS) transplant list, whichever occurs first;
8. for Coma, the date the Physician confirms that the Covered Person or Dependent has been in a Coma for a continuous period of at least 30 days;
9. for Major Organ Transplant, due to documented major organ failure, the date the Physician recommends that the Covered Person or Dependent undergo transplant surgery, or results in the Covered Person or Dependent being placed on the United Network of Organ Sharing (UNOS) transplant list for the organ that has failed, whichever occurs first. If the Covered Person or Dependent is determined by the Physician to be too ill for a transplant, but otherwise meets the criteria for placement on the UNOS list, the network requirement will be waived;
10. for Paralysis, the date the Physician confirms the complete loss of functional use of two or more limbs for a continuous period of at least 30 days;
11. for Severe Brain Damage, the date the Physician confirms that the Severe Brain Damage has lasted for a continuous period of at least 90 days; and
12. for Severe Burns, the date the Physician confirms the presence of Severe Burns.
BENEFITS PAYABLE AND BENEFIT DEFINITIONS

Category 1 Critical Illness: means a Level 1 or Level 2 Cancer as stated below.

Cancer: a pathological diagnosis of cancer. However, a clinical diagnosis of Level 1 Cancer that is based on symptoms will be recognized if:
1. a pathological diagnosis cannot be made because it is medically inappropriate or life threatening;
2. there is medical evidence to support the diagnosis; and
3. a Physician is treating the Covered Person or Dependent for Cancer.

Level 1 Cancer means a malignant tumor which has:
1. uncontrolled growth of malignant cells; and
2. invaded normal tissue.

It must be positively diagnosed with histopathological confirmation.

The term does not include the tumors listed below:
1. Chronic lymphocytic leukemia that has not progressed to at least:
   a. Rai stage II; or
   b. Binet Stage B.
2. All tumors that are histologically described as:
   a. premalignant;
   b. noninvasive;
   c. carcinoma in situ (including cervical dysplasia: CIN-1; CIN-2; and CIN-3);
   d. borderline malignant; or
   e. low malignant potential.
3. All skin cancers, unless:
   a. there is evidence of metastasis; or
   b. the tumor is a malignant melanoma of greater than 1.0 mm maximum thickness (regardless of Clark level or ulceration) as determined by histological examination using the Breslow method.
4. Prostate cancer; unless histologically classified as:
   a. Gleason score 7 or greater; or
   b. TNM classification T1bN0M0 or greater.
5. Papillary carcinoma of the thyroid that is:
   a. 1 cm or less in diameter; and
   b. limited to the thyroid.
6. Noninvasive papillary cancer of the bladder histologically described as TNM classification TaN0M0 or lower.

Level 2 Cancer means a malignant tumor which has not yet become invasive but is confined only to the superficial layer of cells from which it arose (i.e. malignant cells confirmed to the epithelium without penetration of the basement membrane).

The term does include:
1. carcinoma in-situ;
2. prostate cancer; or
3. papillary carcinoma of the thyroid, and noninvasive papillary cancer of the bladder; that is not covered under Level 1 Cancer.

Level 2 Cancer does not include the tumors listed below:
1. pre-malignant conditions or conditions with malignant potential;
2. Basal cell carcinoma and squamous cell carcinoma of the skin; or
3. Melanoma or melanoma in situ.
Category 2 Critical Illness: means Coronary Artery Bypass, Heart Attack, Heart Transplant, Ruptured Aneurysm or Stroke as defined below.

Coronary Artery Bypass: Heart disease that has been clinically diagnosed and requires the Covered Person or Dependent to undergo a surgical procedure to open a blockage of one or more coronary arteries using venous or arterial grafts. Coronary artery bypass does not include balloon angioplasty, placement of intravascular stent, laser relief or other like procedures.

Heart Attack (myocardial infarction): means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. Heart Attack results in some permanent functional loss of heart contraction detectable by a regional contraction abnormality study on an imaging study.

The diagnosis must include all of the following criteria concurrently:
1. typical clinical symptoms such as central chest pain;
2. acute diagnostic increase of specific cardiac markers; and
3. new electrocardiographic changes of infarction.

Heart Attack does not include any other disease or injury involving the cardiovascular system. Heart Attacks that occur during a medical procedure are not included. Cardiac Arrest not caused by a Myocardial Infarction is not a Heart Attack. Established (old) myocardial infarction prior to the Effective Date is excluded.

Heart Transplant: a clinical diagnosis of heart failure of such severity that the Physician recommends the Covered Person or Dependent undergo a heart transplant, or results in the Covered Person or Dependent being placed on the United Network of Organ Sharing (UNOS) transplant list. If the Covered Person or Dependent is determined by the Physician to be too ill for a transplant, but otherwise meets the criteria for placement on the UNOS list, the network requirement will be waived.

Ruptured Aneurysm (Ruptured Cerebral, Carotid or Aortic Aneurysm): the diagnosis of a Ruptured Aneurysm must be supported by:
1. Medical records; including
2. Radiographically specific diagnostic studies to objectively support the diagnosis as established by the American Academy of Radiologists.

Stroke: a cerebrovascular event resulting in measurable permanent neurological damage or impairment, including infarction of brain tissue, hemorrhage and embolism from an extra cranial source. The diagnosis must be based on objective clinical evidence of brain tissue damage for a continuous period of at least 30 days, using a current neuro imaging test such as:
1. a CT Scan (Computed Tomography);
2. MRI (Magnetic Resonance Imaging);
3. MRA (Magnetic Resonance Angiography);
4. PET Scan (Positron Emission Tomography); or
5. Arteriography or Angiography.

Stroke does not include Transient Ischemic Attacks (TIA) or attacks of Vertebrobasilar Ischemia.
Category 3 Critical Illness:

**Chronic Renal Failure:** the chronic irreversible failure to function of both kidneys of such severity that the Physician recommends the Covered Person or Dependent undergo hemodialysis or peritoneal dialysis at least weekly, or results in the Covered Person or Dependent being placed on the United Network of Organ Sharing (UNOS) transplant list.

**Coma:** the diagnosis of a state of unconsciousness for a continuous period of at least 30 days and which is not a result of Stroke. The Coma diagnosis must be supported by:
- a Glasgow Coma Scale Score of eight or below throughout the 30 day period; and
- an Electroencephalogram (EEG).

**Major Organ Transplant:** a clinical diagnosis of a major organ failure of a kidney, liver, both lungs, or pancreas of such severity that the Physician recommends the Covered Person or Dependent undergo transplant surgery, or results in the Covered Person or Dependent being placed on the United Network of Organ Sharing (UNOS) transplant list for the organ that has failed. If the Covered Person or Dependent is on the UNOS list for a combined transplant, only one benefit will be paid. If the Covered Person or Dependent is determined by the Physician to be too ill for a transplant, but otherwise meets the criteria for placement on the UNOS list, the network requirement will be waived.

**Permanent Paralysis:** total and permanent loss of the use of two or more limbs (arms or legs or combination) due to Injury or Sickness for a continuous period of at least 30 days, and which is not a result of Stroke.

**Severe Brain Damage:** accidental cranial trauma that:
- results in permanent loss of cognitive ability for a continuous period of at least 90 days;
- renders the Covered Person or Dependent unable to safely and completely perform three or more of the following Activities of Daily Living without another person’s active assistance or verbal cueing:
  - Bathing – the ability to wash oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower;
  - Dressing – the ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs;
  - Toileting – the ability to get to and from the toilet, get on and off the toilet and perform associated personal hygiene;
  - Transferring – the ability to move into or out of a bed, chair or wheelchair;
  - Continence – the ability to maintain control of bowel and bladder functions; or, when unable to maintain control of bowel and bladder function, the ability to perform associated personal hygiene including caring for catheter or colostomy bag;
  - Eating – the ability to feed oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

The diagnosis must be based on objective laboratory and clinical findings, including a score of seven or less on the Rancho Los Amigos Scale throughout the 90 day period.

**Severe Burns:** the diagnosis of third degree burns covering at least 20% of the surface area of the body. Third degree burns means the destruction of the skin through the entire thickness or depth of the dermis and the layer of tissue below the skin (subcutaneous tissue).
ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

**Covered Person’s Eligibility:** Employees who are Actively at Work are eligible for insurance after completion of the required Employee Waiting Period provided:
1. they are in a class of Employees who are included; and
2. customarily working at least the number of hours per week shown in the Schedule of Benefits.

An Employee will become eligible for insurance on the latest of the following dates:
1. the Effective Date of the Policy;
2. the end of the Employee Waiting Period shown in the Schedule of Benefits;
3. the date the Policy is changed to include the Employee’s class; or
4. the date the Employee enters a class eligible for insurance.

**Dependent Eligibility:** Dependents are eligible for insurance on the latest of the following dates:
1. the date the Covered Person becomes eligible for Dependent Insurance;
2. the date a person becomes a Dependent; or
3. the date the Policy is amended to include the Covered Person’s class as being eligible for Dependent Insurance.

The Dependent will not be eligible for Dependent Insurance if he:
1. is eligible for insurance under the Policy as a Covered Person; or
2. is a member of the armed forces on active duty, except for duty of 30 days or less for training in the Reserves or National Guard; or
3. has been diagnosed as having a life expectancy of less than 12 months.

**Enrolling in or Changing Insurance for Covered Person Insurance Under the Policy:** The Employee may enroll in or change his insurance only under the following situations:
1. during the Initial Enrollment Period:
   a. if the Employee is eligible for insurance on the Effective Date, he may enroll for insurance during the Initial Enrollment Period. If an Employee fails to enroll, then he will not be insured under the Policy.
   b. if the Employee becomes eligible for insurance after the Effective Date, he may enroll for insurance during his Initial Enrollment Period.
2. during a Re-enrollment Period: The Employee may choose:
   a. to keep his same insurance;
   b. no insurance under the Policy;
   c. to enroll for insurance if not currently insured under the Policy;
   d. to change any benefit or amount that is optional;
3. within 31 days of a Change in Family Status, as defined, the Employee may choose to enroll or change the insurance for which he is eligible.

During a Re-enrollment Period, if the Covered Person does not re-enroll for insurance, he will continue to be insured for the same insurance.
ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS (continued)

Enrolling in or Changing Dependent Insurance Under the Policy:
The Employee may elect or change Dependent Insurance only under the following situations:

1. during the Initial Enrollment Period:
   a. if the Dependents are eligible for insurance on the Effective Date of the Policy, the Employee may enroll for Dependent insurance during the Initial Enrollment Period. If an Employee fails to enroll his Dependents, then the Dependents will not be insured under the Policy.
   b. if the Dependents become eligible for insurance after the Effective Date of the Policy, the Employee may enroll for Dependent Insurance during his Initial Enrollment Period.

2. during a Re-enrollment Period: The Employee may choose:
   a. to keep the same Dependent Insurance;
   b. no Dependent insurance under the Policy;
   c. to apply for Dependent Insurance under the Policy;
   d. to change any benefit or amount of Dependent Insurance that is optional;

3. within 31 days of a Change in Family Status, as defined, the Employee may choose to enroll or change his Dependent Insurance provided the Dependent is eligible.

The Employee may enroll for:

1. Dependent Insurance for Spouse only;
2. Dependent Insurance for Children only; or
3. Dependent Insurance for both Spouse and Children.

During a Re-enrollment Period, if the Covered Person does not re-enroll for Dependent Insurance, his Dependents will continue to be insured for the same insurance until the next Re-enrollment Period.

Dependents will not be insured until the Employee is insured. Dependents are not eligible for any benefit or amount that is more than the Covered Person’s.

Effective Date of Covered Person Initial Insurance: If an Employee is not Actively at Work on the date his insurance is scheduled to take effect, it will take effect on the day after the date he returns to Active Work. If the Employee’s insurance is scheduled to take effect on a non-working day, his Active Work status will be based on the last working day before the scheduled Effective Date of his insurance.

An Employee must use forms provided by Us when applying for insurance.

The Employee’s insurance will be effective at 12:01 A.M. Eastern Standard time as follows:

1. if it is Non-contributory, on the date the Employee becomes eligible for insurance, regardless of when he applies, or
2. if it is Contributory, and the Employee makes application within 31 days after the date he first became eligible, on the later of:
   a. the date the Employee is eligible for insurance, regardless of when he applies; or
   b. the date the Employee’s application is approved by Us if evidence of insurability is required.

Evidence of insurability is required if an Employee applying for Contributory Insurance:

1. does not apply for insurance within 31 days after the date he first became eligible; or
2. he has previously terminated his insurance while in an eligible class; or
3. applies for an amount of insurance other than during an Enrollment Period.
Effective Date of Dependent Initial Insurance: No insurance will take effect on any day the Dependent is confined in a Hospital or Medical Facility. Insurance will take effect on the day following discharge from the Hospital or Medical Facility.

A Covered Person must use forms provided by Us when applying for Dependent Insurance.

The Dependent Insurance will be effective at 12:01 A.M. Eastern Standard time:
1. if it is Non-contributory, on the date the Dependent becomes eligible for insurance regardless of when application was made; or
2. if it is Contributory and the Covered Person makes application within 31 days after the date the Dependent first became eligible, on the later of:
   a. the date the Dependent becomes eligible for insurance, regardless of when application is made; or
   b. the date the Dependent’s application is approved by Us, if evidence of insurability is required.

Dependents will not be insured until the Employee is insured.

Evidence of insurability is required, at the Covered Person’s expense, if a Covered Person applying for Contributory Insurance:
1. does not apply for Dependent Insurance within 31 days after the date the Dependent first became eligible; or
2. has previously terminated Dependent Insurance while in an eligible class.

Effective Date of Change in Covered Person or Dependent Insurance: A change in insurance that is made during a Re-enrollment Period will be effective at 12:01 a.m. Eastern Standard time on the later of:
1. the date of application;
2. the date We approve the Covered Person’s or Dependent’s evidence of insurability form, if evidence of insurability is required;
3. the first day of the pay period for which contributions for his insurance are deducted; or
4. the date the Covered Person or Dependent becomes eligible for the change in insurance, regardless of when application is made.

If the Covered Person is not Actively at Work due to Injury or Sickness, or is on a layoff or leave of absence, any increase in or addition to the Covered Person or Dependent insurance will be effective on the date the Covered Person returns to Active Work.
ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS (continued)

Termination of Covered Person's Insurance: The Covered Person’s insurance will terminate at 12:00 midnight Eastern Standard time on the earliest of the following dates:

1. the last day of the period for which a premium payment is made, if the next payment is not made;
2. the date he becomes a member of the armed forces on active duty, except:
   a. for duty of 30 days or less for training in the Reserves or National Guard; or
   b. to the extent coverage is continued under the Leave of Absence Continuation provision;
3. the last day of the month during which he ceases to be a member of a class eligible for insurance;
4. the date the Policy terminates, or with respect to a specific benefit, the date that such benefit terminates;
5. the last day of the month during which he ceases to be Actively at Work, unless Active Work ceases during an approved medical leave of absence, then the insurance will continue for up to 3 months from the date he stopped Active Work;
6. the last day of the month during which he ceases to be Actively at Work, unless Active Work ceases during an approved layoff or non-medical leave of absence, then the insurance will continue for up to 12 months from the date he stopped Active Work;
7. the date he is no longer Actively at Work due to a labor dispute, including but not limited to strike, work slow down or lock out; or
8. the date the Maximum Benefit Amount for a Critical Illness for each Category shown on the Schedule of Benefits is paid to the Covered Person or on his behalf.

Termination of Dependent Insurance: Insurance on a Dependent will terminate at 12:00 midnight Eastern Standard time on the earliest of the following dates:

1. the last day of the month during which he ceases to be a Dependent as defined in the Policy;
2. the last day of the month during which he ceases to be a member of a class eligible for Dependent insurance;
3. the last day of the month during which the Covered Person’s insurance under the Policy terminates;
4. the date the Dependent becomes a member of the armed forces on active duty, except:
   a. for duty of 30 days or less for training in the Reserves or National Guard; or
   b. to the extent coverage is continued under the Leave of Absence Continuation provision;
5. the last day of the period for which a Dependent’s required premium payment is made, if the next payment is not made;
6. the date the Policy terminates, or with respect to a specific benefit, the date that such benefit terminates; or
7. the date the Maximum Benefit Amount for a Critical Illness for each Category shown on the Schedule of Benefits is paid on behalf of that Dependent. However, payment of a Critical Illness benefit for one Dependent will not affect the insurance of other Dependents.
CONTINUATION AND REINSTATEMENT PROVISIONS

Continuation during Grace Period: A Grace Period of 60 days will be allowed for the payment of each premium after the first premium payment. During the Grace Period, the insurance will continue in effect provided the premium is paid by the Policyholder before the end of the Grace Period. The Grace Period will not continue the insurance beyond a date stated in a Termination Provision.

Continuation during Leave of Absence: If the Covered Person is on Family or Medical Leave of Absence, or other leave of absence required by an applicable state or federal law, continuation of his insurance will be governed by his Employer’s policy on such leave not to exceed the greater of:
1. the leave period required by the Family and Medical Leave Act of 1993 (FMLA); or
2. the minimum leave period required by applicable state law.

We will continue the Covered Person’s insurance if the cost of his insurance continues to be paid.

If the Covered Person’s insurance does not continue during such Leave of Absence, then when he returns to Active Work:
1. he will not have to meet a new Employee Waiting Period including a Waiting Period for insurance of a Pre-Existing Condition, if applicable; and
2. he will not have to give Us evidence of insurability to reinstate the insurance he had in effect before his Leave of Absence began.

However, time spent on a Leave of Absence, without insurance, does not count toward satisfying his Employee Waiting Period.

Continuation of an Incapacitated Child: If, on the date a Child reaches the Maximum Age for Dependent Child as shown in the Schedule, he is:
1. covered under the Policy; and
2. an Incapacitated Child, as defined;
his coverage will not terminate solely due to age. The Covered Person must give Us notice of the incapacity within 31 days of the termination date.

The Child's coverage will continue as long as:
1. the Child qualifies as an Incapacitated Child; and
2. the required premium is paid.

We may, from time to time, require proof of continued incapacity and dependency. After the first two years, We cannot require proof more than once each year.

Reinstatement of Rehired Employees: If a Covered Person ends employment and is rehired within a year, he may be insured on his eligibility date for the insurance that he had under the Policy on the date his employment ended.
CONTINUATION AND REINSTATEMENT PROVISIONS

Reinstatement following Military Service: If the Covered Person’s or Dependent’s insurance under the Certificate terminates due to active duty in one of the uniformed services of the United States military, he will have the right to renew coverage on the same basis as before the suspension in the coverage took place, provided:

1. he is in the service for a period of five years or less;
2. he applies for reinstatement of coverage and pays the required premium within 60 days of his discharge from the service; and
3. the Policy is still in force, he is eligible for coverage, and he is Actively at Work.

As used above, uniformed services includes service in the uniformed services as defined in Chapter 43 of Title 38. Coverage will be reinstated without evidence of insurability or regard to Pre-existing Conditions except any that may have been previously excluded on the date coverage was suspended. The coverage will become effective on the first day of the month after military service terminates. However, the Policy will not cover a Critical Illness, loss or other disability resulting from the military service.
PORTABILITY

Portability: If the Covered Person’s and his insured Dependent’s insurance under the Policy ends because his employment with the employer ends, he may choose to continue his and his insured Dependent’s Group Critical Illness coverage under the Policy without providing evidence of insurability.

The Covered Person must be insured under the Policy for at least 6 months prior to the date his employment ends.

The Covered Person may port his insurance or his insured Dependent’s insurance if coverage ends for any reason other than:
1. he failed to pay premium for the cost of his insurance;
2. he is on an approved leave of absence;
3. he Retires;
4. the group policy is terminating;
5. he is or becomes insured under another group critical illness policy;
6. he resides outside of the United States or in a state where the coverage is not available; or
7. he is actively in military service or entering active military service.

To apply for Portability insurance, within 31 days of the date the Covered Person’s insurance ends he must:
1. submit a written application to Us; and
2. pay the first month’s premium.

If the above conditions are met, such insurance will:
1. be issued without evidence of insurability; and
2. continue in effect provided the Covered Person continues to pay the cost of his and his insured Dependent’s insurance.

The Portability insurance will end on the earliest of:
1. the date the Covered Person fails to pay the required premium;
2. the date he Retires;
3. the date he becomes insured under any other group critical illness policy;
4. the date a benefit for a Critical Illness for each Category shown on the Schedule of Benefits is paid to the Covered Person or on his behalf; or
5. the date he attains any Policy Age Limit stated in the Portability policy.

Covered Persons rehired after porting insurance must either lapse his and his insured Dependent’s ported insurance or provide evidence of insurability.

The Portability coverage will be issued under the Policy for Critical Illness Portability purposes.

The Portability coverage may differ from Your coverage under the Policy. The premium for the Portability coverage will be based on the coverage, as well as Your age and risk class.

Retire means, for purposes of Portability, the Covered Person has concluded his working career on a Full-time basis and:
1. he is receiving payments from a governmental retirement plan or any employer; or
2. he is receiving Social Security Retirement benefits.
GENERAL EXCLUSIONS AND LIMITATIONS

General Exclusions: We will not cover a Critical Illness under the Policy if it is due to:

1. an act or accident of war, declared or undeclared, whether civil or international, and any substantial armed conflict between organized forces of a military nature;
2. loss sustained while on active duty as a member of the armed forces of any nation except during any time period coverage is extended under the Continuation during Leave of Absence provision;
3. any intentionally self-inflicted Injury;
4. active participation in a riot;
5. committing or attempting to commit a felony, or participating or attempting to participate in a felony;
6. use of alcohol or the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance, unless administered on the advice of a Physician;
7. cosmetic or elective surgery; or
8. attempted suicide, while sane or insane.

We also will not pay a benefit for a Critical Illness:

9. for which the Covered Person’s or Dependent’s Date of Diagnosis for any type of Critical Illness, as defined in the Policy, was prior to his Effective Date of insurance;
10. that was diagnosed outside of the United States or Canada, unless the diagnosis was confirmed by a Physician practicing within the United States or Canada; or
11. with respect to a Dependent who is a Child, that is caused by or contributed to by a congenital defect.
CLAIM INFORMATION

Notice of Claim: Written notice of a claim must be given to Us at Our Home Office by the Covered Person, or his authorized representative, within 30 days after the date of the Diagnosis of a Critical Illness. If it is not possible, written notice must be given as soon as it is reasonably possible to do so.

The claim form is available from the Covered Person’s employer, or can be requested from Us. If the Covered Person does not receive the form from Us within 15 days of his request, written proof of claim should be sent to Us without waiting for the form. Written proof should establish facts about the claim such as nature of illness and Date of Diagnosis.

Filing a Claim: The Covered Person must fill out the claim form and then give it to the attending Physician. The Physician should fill out his section of the form and send it directly to Us.

Proof of Claim: Written proof of claim must be filed within 90 days after the date of the Diagnosis of a Critical Illness. However, if it is not possible to give proof within 90 days, it must be given no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

Proof of claim must include, at the Covered Person’s expense:
   1. the Date of Diagnosis;
   2. a completed claim form signed by the Covered Person and Physician(s) including documentation furnished by the Physician and supported by clinical, radiological, histological, pathological and/or laboratory evidence of the Critical Illness. If the claim is for the Covered Person’s Spouse, then the Spouse must also sign the claim form; and
   3. the name and address of any Hospital or Medical Facility where Treatment was received and any Physician who provided Treatment prior to the Diagnosis.

In the event of death, an autopsy confirmation identifying the cause of death:
   1. will be required for Myocardial Infarction; and
   2. may also be required for other Critical Illnesses;
where allowed by law.

Payment of Claim: All benefits are payable to the Covered Person within 30 days after We receive Proof of Claim. If he dies before a benefit is paid, We will pay any amount due to his beneficiary if he designated a beneficiary, otherwise in the following order:
   1. to his legal Spouse;
   2. to his natural or legally adopted children in equal shares; or
   3. to his estate.

Overpayment of Claim: We have the right to recover any overpayments due to fraud or any error We make in processing a claim.

The Covered Person must reimburse Us in full. We will determine the method by which the repayment is to be made. We have the right to recover overpayment from the Covered Person’s Spouse if living, otherwise Child under the age 26 or estate.

Legal Action: The Covered Person or his Dependent, if applicable, may not bring suit to recover under this section until 60 days after he has given Us written proof of loss. No suit may be brought more than three years after the date of loss.
CLAIM INFORMATION

Physical Examination and Autopsy: We have the right to have a Physician of Our choice examine the Covered Person or his Dependent, if applicable, as often as reasonably necessary while the claim is pending. We may also have an autopsy made in case of death, unless not allowed by law. We will pay for the cost of the exam or autopsy.

In the event of a dispute or disagreement regarding the accuracy or appropriateness of a Diagnosis, We have the right to also request an examination of the evidence used in arriving at a Diagnosis by an independent expert that We select in the applicable field of medicine. We will pay the cost.

Fraud: We will focus on all means necessary to support fraud detection, investigation, and prosecution. It may be a crime if the Covered Person or the employer knowingly, and with intent to injure, defraud or deceive Us, files a claim containing any false, incomplete, or misleading information. These actions, as well as submission of false information, will result in denial of the Covered Person’s claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

Incontestability: No statement made by any Covered Person relating to his insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person’s lifetime, nor unless it is contained in a written instrument signed by him.

Misstatement Of Age: If a Covered Person’s age has been misstated, premiums will be subject to an equitable adjustment. If the amount of the benefit depends upon age, then the benefit will be that which would have been payable, based upon the person’s correct age.

Workers’ Compensation: The Policy is not to be construed to provide benefits required by Worker’s Compensation laws.
WELLNESS BENEFIT

We will pay the amount shown on the Schedule of Benefits per calendar year for any one of the following health screening tests performed on either the Covered Person or Spouse provided the Covered Person elected coverage under the benefit.

Health screening test is defined as:

- Stress test on a bicycle or treadmill
- Fasting blood glucose test
- Blood test for triglycerides
- Serum cholesterol test to determine level of HDL and LDL
- 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
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum Protein Electrophoresis (blood test for myeloma)
- Thermography
- Virtual Colonoscopy

This benefit will be paid as long as the Policy is in force and the Covered Person or Spouse remains insured under this Benefit of the Policy. The benefit will be paid regardless of the results of the test. The Wellness Benefit is paid in addition to any other payments the Covered Person or Spouse receives under the Policy.

Only one health screening test will be covered upon receipt by Us of adequate documentation to support the performance of the test on the Covered Person or Spouse.
RESTORATION BENEFIT

We will pay the Restoration Benefit for the Covered Person or Dependent for a Critical Illness under each Category as defined provided the Covered Person elected coverage under the benefit.

Under the Restoration Benefit, We will reinstate 100% of the Maximum Benefit Amount and will cover the recurrence of the same Critical Illness or an occurrence of another covered Critical Illness within each benefit category. The Maximum Benefit Amount payable, as shown on the Schedule of Benefits, will be paid in a lump sum amount.

**Restoration Benefit Payable**: The Restoration Benefit will be payable up to 100% of the Maximum Benefit Amount if the Covered Person or Dependent is diagnosed with a covered Critical Illness and:

1. the subsequent specified covered Critical Illness is diagnosed following a 12-month consecutive period free of any previously diagnosed and additional Critical Illness; and
2. the subsequent Date of Diagnosis is while coverage under this Policy is in force.

If a Restoration Benefit for a Critical Illness within a specific category has been paid at less than 100% of the Maximum Benefit Amount, the remainder of the Restoration Benefit for a Critical Illness in that specific category, for which benefits have not already been paid under this Rider, will be available.

**Reduction**: Any remaining rider benefit (Maximum Benefit Amount less any partial benefit payments) will be reduced by 50% at age 70 as noted on the Schedule of Benefits.

**Termination**: The Termination of Covered Person’s Insurance provision in the Policy is amended to read as follows:

8. The date the Restoration Benefit totaling 100% of the Maximum Benefit Amount for each Category is paid to the Covered Person, or on his behalf.

The Termination of Dependent Insurance provision in the Policy is amended to read as follows:

8. The date a Restoration Benefit totaling 100% of the Maximum Benefit Amount for each Category shown on the Schedule of Benefits is paid on behalf of that Dependent. However, payment of the Restoration Benefit for one Dependent will not affect the insurance of other Dependents.

The Benefit Waiting Period provisions will not apply to the insurance for a Restoration Benefit. All other provisions of the Policy not specifically changed by the provisions of this Rider apply to this benefit.
IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

• hospitalization

• physician services

• hospice

• outpatient prescription drugs if you are enrolled in Medicare Part D

• other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program SHIP.
CERTIFICATE MODIFICATIONS RIDER

Certificate Modification(s) to the Certificate

Policyholder: Louisiana State University and Agricultural and Mechanical College
Policy Number: 303972

It is agreed that the Certificate is amended as follows:

Effective January 1, 2015, with respect to residents of the states as shown on the subsequent pages, the following provisions amend or are added to the Certificate:

Signed for the Company by:

Secretary

President

UnitedHealthcare Insurance Company
Hartford, Connecticut
CERTIFICATE MODIFICATIONS RIDER
STATUTORY PROVISIONS

ALASKA

Residents of the state of Alaska the following provisions are included to bring your Certificate into conformity with Alaska state law:

**Dependent Definition**

When dependent coverage is included in the Certificate of Coverage and Domestic Partners are described in the definition of a Dependent, Any references to gender (i.e., "of the opposite or same sex" or "of the same sex") in the Domestic Partner and Domestic Partnership definitions are deleted and do not apply to you.

**Overpayment of Claim**

The Overpayment of Claim section as contained in the Claim Information section is hereby changed to read as follows:

**Overpayment of Claim:** We have the right to recover any overpayments due to any error that We or the plan administrator make in processing a claim within 180 calendar days of payment of a benefit.

The Covered Person must reimburse Us in full. We will determine the method by which the repayment is to be made. We have the right to recover overpayment from the Covered Person's Spouse if living, otherwise Child under the age 26 or estate.

ARKANSAS

Residents of the state of Arkansas, the following provisions are included to bring your Certificate into conformity with Arkansas state law:

**Insurer Information Notice**

Any questions regarding the Policy may be directed to:
UnitedHealthcare Insurance Company
Administrative Offices
9900 Bren Road East
Minnetonka, MN 55343
1-866-615-8727

If the question is not resolved, you may contact the Arkansas Insurance Department:
Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 77201-1904
Telephone: 1-800-852-5494 or 501-371-2640

**Continuation of an Incapacitated Child:**

When dependent coverage is included, the section entitled Continuation of an Incapacitated Child has been changed to remove the 31 day notice requirement.
Residents of the state of Florida:

**The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida**

The following provisions are included to bring your Certificate into conformity with Florida state law:

**Pre-existing Conditions Exclusion**

The section entitled Pre-existing Conditions Exclusions as contained on the page entitled General Exclusions and Limitations is hereby replaced with the following (reference to Dependent only applies if dependent coverage is included):

**Pre-existing Conditions Exclusion:** We will not cover any Critical Illness that begins during the first 12 months after the Covered Person’s or Dependent’s Effective Date of insurance that is caused or contributed to by a Pre-Existing Condition.

**Pre-Existing Condition** means any condition for which the Covered Person or Dependent within 6 months prior to his Effective Date of insurance:

1. was diagnosed by or received Treatment from a legally qualified Physician; or
2. had symptoms for which a reasonably prudent person would have sought Treatment.
CERTIFICATE MODIFICATIONS RIDER

Pre-Existing Condition does not include routine follow up care to determine whether a breast cancer has recurred in a person who has been previously determined to be free of breast cancer, unless evidence of breast cancer is found during or as a result of the follow up care.

If the Covered Person’s or Dependent’s insurance is increased, then a benefit based on the increased amount of insurance is not payable for a Critical Illness which is first diagnosed during the 18 months following the Effective Date of his increase in insurance, if it is caused by or contributed to by a Pre-Existing Condition. For purposes of applying this provision, Effective Date of insurance as used in the definition of Pre-Existing Condition also includes the Effective Date of the Covered Person’s or Dependent’s increase in insurance.

Time Payment of Claim
The section entitled Time Payment of Claim is hereby added to the page entitled Claim Information.

Time Payment of Claim: Benefits for loss covered by the Policy are paid immediately upon receipt of Proof of Claim. If special circumstances require an extension, We will notify the Covered Person within 45 days of receipt of the initial proof. Our notice will provide the Covered Person with:

1. a description of any further proof needed to perfect the claim; and
2. an explanation of why such material is needed.

Benefits for a covered loss will then be paid upon receipt of all proper Proof of Claim. If any benefit of the Policy is due on a periodic basis, it will be paid monthly.

Legal Action:
The section entitled Legal Action as contained on the page entitled Claim Information is hereby changed to read as follows:

Legal Action: The Covered Person or his Dependent, if applicable, may not bring suit to recover under this section until 60 days after he has given Us written proof of loss. No suit may be brought after the expiration of the statute of limitations from the time Proof of Claim is required.

IDAHO
Residents of the state of Idaho, the following provisions are included to bring your Certificate into conformity with Idaho state law:

Insurer Information Notice
Any questions regarding the Policy may be directed to:
UnitedHealthcare Insurance Company
Administrative Offices
9900 Bren Road East
Minnetonka, MN 55343
1-866-615-8727

If the question is not resolved, you may contact the Idaho Department of Insurance:
Idaho Department of Insurance
Consumer Affairs
700 W State Street, 3rd Floor
PO Box 83720
Boise ID 83720-0043

1-800-721-3272 or www.DOI.Idaho.gov

UHI-POLMOD
Printed in U.S.A. 08/2013
CERTIFICATE MODIFICATIONS RIDER

IDAHO (continued)

The following Outline of Coverage is included:

CRITICAL ILLNESS COVERAGE
AS PROVIDED BY POLICY FORM UHICI-POL-1
THIS CERTIFICATE PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE

(1) This coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. Persons covered under Medicaid should not purchase it. Read the Buyer’s Guide to Specified Disease Insurance to review the possible limits on benefits in this type of coverage.

(2) Read Your Certificate Carefully—This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR CERTIFICATE CAREFULLY!

(3) Critical Illness coverage is designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of a critical illness. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

(4) A fixed percentage of the maximum benefit is payable for a critical illness. The critical illnesses are listed in the certificate schedule. The maximum benefit for an employee is $20,000; a spouse is $10,000 and each child is $2,500. When you or your spouse attains age 70, the maximum benefit reduces by 50%.

The fixed percentage is 25% of the maximum benefit for a Level 2 Cancer (defined in the certificate) or a Coronary Artery Bypass. For all other critical illnesses, the fixed percentage is 100%.

No benefit is payable for a critical illness that: is due to war or an act of war; is due to loss sustained while on active duty as a member of the armed forces; is due to any intentionally self-inflicted injury, active participation in a riot, participation in a felony, alcoholism, drug addiction, cosmetic or elective surgery, or attempted suicide; is diagnosed outside of the US or Canada (unless the diagnosis was confirmed by a physician practicing in the US or Canada). No benefit is payable for a pre-existing condition for the first 12 months of coverage.

Coverage terminates on the first to occur of: the last day of the period for which premium is paid; the date you or your dependent enter active duty of the armed forces; the date you cease to be in a class eligible for coverage; the date the master policy under which this certificate is issued terminates; or the date you cease to be actively at work.

Your coverage may be continued during leave of absence or during a strike or layoff if the certificate includes such continuation provisions. When your coverage terminates because you are no longer eligible, you will have the option to continue your coverage under the portability privilege explained in your certificate.

Your dependent’s coverage will terminate when you are in a class that is no longer eligible for dependent coverage or if the dependent no longer meets the definition of a dependent as explained in the certificate. Coverage may be continued for children who reach the age limit and are incapacitated on that date.

UHICI-OOC-ID-1
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IDAHO (continued)

**Date of Diagnosis**

The Date of Diagnosis as contained on the page entitled Benefits Payable and Benefit Definitions is hereby replaced with the following:

**Date of Diagnosis**, based on objective clinical or pathological findings, is:

1. for Cancer, the date that Cancer was detected by a medical professional in any tissue specimen, blood sample(s) and/or titer(s) provided the Diagnosis is confirmed by a Physician;
2. for Coronary Artery Bypass, the date that a coronary arterial blockage is detected by a medical professional provided the severity of the blockage results in a Physician’s recommendation to surgically bypass the blockage using venous or arterial grafts;
3. for Heart Attack, the date of the Heart Attack (myocardial infarction) provided that the Heart Attack meets the definition of the Policy and is confirmed by a Physician;
4. for Heart Transplant, the date the Covered Person or Dependent is placed on the United Network of Organ Sharing (UNOS) transplant list. If the Covered Person or Dependent is determined by the Physician to be too ill for a transplant, but otherwise meets the criteria for placement on the UNOS list, the network requirement will be waived;
5. for Ruptured Aneurysm, the date the Ruptured Aneurysm occurred provided a Physician confirms that a Ruptured Aneurysm occurred;
6. for Stroke, the date of the Stroke, provided the Physician confirms that a Stroke occurred;
7. for Chronic Renal Failure, the earlier of the date the Covered Person or Dependent is placed on the United Network of Organ Sharing (UNOS) transplant list; or the earliest date that a Physician recommends the Covered Person or Dependent begin hemodialysis or peritoneal dialysis at least weekly;
8. for Coma, the date the Coma commenced provided the Covered Person or Dependent has been in a Coma for a continuous period of at least 30 days and a Physician confirms the person is and has been in a Coma for such period of time;
9. for Major Organ Transplant, due to documented major organ failure, the date the Covered Person or Dependent is placed on the United Network of Organ Sharing (UNOS) transplant list for the organ that has failed. If the Covered Person or Dependent is determined by the Physician to be too ill for a transplant, but otherwise meets the criteria for placement on the UNOS list, the network requirement will be waived;
10. for Paralysis, the earliest date the Covered Person or Dependent suffers a complete loss of functional use of two or more limbs provided such loss continues for a period of at least 30 days and a Physician confirms the person is and has been paralyzed for such period of time;
11. for Severe Brain Damage, the date Severe Brain Damage occurred provided it has lasted for a continuous period of at least 90 days and a Physician confirms the person suffered such damage for such period of time; and
12. for Severe Burns, the date the burns occurred provided a Physician confirms the presence of Severe Burns.

**Severe Brain Damage**

The definition of Severe Brain Damage as contained on the page entitled Benefits Payable and Benefit Definitions is hereby replaced with the following:

**Severe Brain Damage**: accidental cranial trauma that, based on objective laboratory and clinical findings, results in a severe and permanent loss of cognitive ability for a continuous period of at least 90 days. The loss must render the person unable to care for their physical needs and result in a score of IV or less on the Rancho Los Amigos Scale throughout the 90 day period.
CERTIFICATE MODIFICATIONS RIDER

IDAHO (continued)

Definition of Dependent
When dependent coverage is included in the Certificate of Coverage, the definition of Dependent will not include a Domestic Partner. The state of Idaho does not recognize a Domestic Partner as a Dependent eligible for Critical Illness Insurance.

Dependent Eligibility
When dependent coverage is included, the section entitled Dependent Eligibility as contained on the page entitled Eligibility, Effective Date and Termination Provisions is hereby replaced with the following:

Dependent Eligibility: Dependents are eligible for insurance on the latest of the following dates:
1. the date the Covered Person becomes eligible for Dependent Insurance;
2. the date a person becomes a Dependent; or
3. the date the Policy is amended to include the Covered Person’s class as being eligible for Dependent Insurance.

The Dependent will not be eligible for Dependent Insurance if he:
1. is eligible for insurance under the Policy as a Covered Person; or
2. is a member of the armed forces on active duty, except for duty of 30 days or less for training in the Reserves or National Guard.

Enrolling in or Changing Dependent Insurance Under the Policy
When dependent coverage is included, the section entitled Enrolling in or Changing Dependent Insurance Under the Policy as contained on the page Eligibility, Effective Date and Termination Provisions is hereby replaced with the following:

Enrolling in or Changing Dependent Insurance Under the Policy:
The Employee may elect or change Dependent Insurance only under the following situations:
1. during the Initial Enrollment Period:
   a. if the Dependents are eligible for insurance on the Effective Date of the Policy, the Employee may enroll for Dependent insurance during the Initial Enrollment Period. If an Employee fails to enroll his Dependents, then the Dependents will not be insured under the Policy.
   b. if the Dependents become eligible for insurance after the Effective Date of the Policy, the Employee may enroll for Dependent Insurance during his Initial Enrollment Period.
2. during a Re-enrollment Period: The Employee may choose:
   a. to keep the same Dependent Insurance;
   b. no Dependent insurance under the Policy;
   c. to apply for Dependent Insurance under the Policy;
   d. to change any benefit or amount of Dependent Insurance that is optional;
3. within 31 days of a Change in Family Status, other than a change to add a newborn or newly adopted child, the Employee may choose to enroll or change his Dependent Insurance provided the Dependent is eligible; or
4. within 60 days of a Change in Family Status to enroll in coverage for a newborn or newly adopted child.

The Employee may enroll for:
1. Dependent Insurance for Spouse only;
2. Dependent Insurance for Children only; or
3. Dependent Insurance for both Spouse and Children.
IDAHO (continued)

During a Re-enrollment Period, if the Covered Person does not re-enroll for Dependent Insurance, his Dependents will continue to be insured for the same insurance until the next Re-enrollment Period.

Dependents will not be insured until the Employee is insured. Dependents are not eligible for any benefit or amount that is more than the Covered Person’s.

**General Exclusions and Limitations**

The section General Exclusions as contained on the page entitled General Exclusions and Limitations is hereby replaced with the following:

**General Exclusions:** We will not cover a Critical Illness under the Policy if it is due to:

1. an act of war, declared or undeclared, whether civil or international;
2. loss sustained while on active duty as a member of the armed forces of any nation except during any time period coverage is extended under the Continuation during Leave of Absence provision;
3. any intentionally self-inflicted Injury;
4. active participation in a riot;
5. participation in a felony;
6. alcoholism or drug addiction;
7. cosmetic or elective surgery, except that cosmetic surgery shall not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a Dependent Child; or
8. attempted suicide, while sane or insane.

We also will not pay a benefit for a Critical Illness that was diagnosed outside of the United States or Canada, unless the diagnosis was confirmed by a Physician practicing within the United States or Canada.

**Pre-existing Conditions Exclusion**

The section entitled Pre-existing Conditions Exclusions as contained on the page entitled General Exclusions and Limitations is hereby replaced with the following (reference to Dependent only applies if dependent coverage is included):

**Pre-existing Conditions Exclusion:** We will not cover any Critical Illness that begins during the first 12 months after the Covered Person’s or Dependent’s Effective Date of insurance that is caused or contributed to by a Pre-Existing Condition.

**Pre-Existing Condition** means any condition except a congenital anomaly of a Dependent Child for which the Covered Person or Dependent within 6 months prior to his Effective Date of insurance, was diagnosed by or received Treatment from a legally qualified Physician.

If the Covered Person’s or Dependent’s insurance is increased, then a benefit based on the increased amount of insurance is not payable for a Critical Illness which is first diagnosed during the 12 months following the Effective Date of his increase in insurance, if it is caused by or contributed to by a Pre-Existing Condition. or purposes of applying this provision, Effective Date of insurance as used in the definition of Pre-Existing Condition also includes the Effective Date of the Covered Person’s or Dependent’s increase in insurance.
IDAHO (continued)

Time of Claim Payment
The section entitled Time of Claim Payment is hereby added to the page entitled Claim Information.

Time of Claim Payment: Benefits for loss covered by the Policy are paid upon receipt of Proof of Claim. If special circumstances require an extension, We will notify the Covered Person within 45 days of receipt of the initial proof. Our notice will provide the Covered Person with:
1. a description of any further proof needed to perfect the claim; and
2. an explanation of why such material is needed.
Benefits for a covered loss will then be paid upon receipt of all proper Proof of Claim. If any benefit of the Policy is due on a periodic basis, it will be paid monthly.

MINNESOTA
Residents of the state of Minnesota, the following provisions are included to bring your Certificate into conformity with Minnesota state law:

General Exclusions
The alcohol and drug exclusion as contained on the page General Exclusions and Limitations has been replaced with:

• the use of narcotics, unless administered on the advice of a Physician

Effective Date of Dependent Initial Insurance
The following has been added to the page entitled Eligibility, Effective Date and Termination Provisions:

The Covered Person’s newborn Child will become covered by the Policy from the moment of birth. The newborn Child will be covered for the Critical Illness amount that applies to other Children covered under the Policy.

NEW HAMPSHIRE
Residents of the state of New Hampshire, the following provisions are included to bring your Certificate into conformity with New Hampshire state law:

The following disclosures are included:

This is a Limited Policy - Read the Certificate Carefully.

30 Day Free Look: The Covered Person has the right to return this certificate within 30 days of its delivery and to have any premium paid, refunded if after examination, he is not satisfied for any reason.
CERTIFICATE MODIFICATIONS RIDER

NEW HAMPSHIRE (continued)
The following Outline of Coverage is included: GROUP CRITICAL ILLNESS POLICY

SPECIFIED DISEASE COVERAGE

THIS CERTIFICATE PROVIDES LIMITED BENEFITS

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL
MEDICAL EXPENSES

OUTLINE OF COVERAGE

1. This coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. Persons covered under Medicaid should not purchase it. Read the Buyer’s Guide to Specified Disease Insurance to review the possible limits on benefits in this type of coverage.

2. Read Your Outline of Coverage Carefully. This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR CERTIFICATE CAREFULLY!

3. Specified disease coverage is designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of specified diseases. Coverage is not provided for basis hospital, basic medical-surgical, or major medical expenses.

4. Amount and Duration of Benefits – The coverage pays up to a total of 100% of the Maximum Benefit Amount for each of the Categories shown on the Certificate Schedule of Benefits for which you or Dependent, receive a Diagnosis of a Critical Illness; and for which you are insured on the Date of Diagnosis. The benefit payable will be paid in a lump sum amount.

The following Critical Illness Benefits are available under your coverage:

Maximum Benefit Amount
- Employee: $20,000
- Spouse: $10,000
- Child: $3,000

Category 1:
- Level 1 Cancer 100%
- Level 2 Cancer 25%

Category 2:
- Coronary Artery Bypass 25%
- Heart Attack; Heart Transplant; Ruptured Aneurysm; Severe Stroke 100%

Category 3:
- Coma; Chronic Renal Failure; Major Organ Transplants; Permanent Paralysis; Severe Brain Damage; Severe Burns 100%

Benefit Riders
- Health Screening Benefit: $100 per calendar year
- Restoration Benefit: For each Category, not to exceed:
  - 100% of Employee’s Maximum Benefit Amount
  - 100% of Spouse’s Maximum Benefit Amount
  - 100% of Child’s Maximum Benefit Amount whichever applies

NEW HAMPSHIRE (continued)
Definition of Dependent
When dependent coverage is included in the Certificate of Coverage the definition Incapacitated Child is modified to delete the term "unmarried".

Severe Brain Damage
The definition of Severe Brain Damage as contained on the page entitled Benefits Payable and Benefit Definitions is hereby replaced with the following:

Severe Brain Damage: accidental cranial trauma that, based on objective laboratory and clinical findings, results in a severe and permanent loss of cognitive ability for a continuous period of at least 90 days. The loss must render the person unable to care for their physical needs and result in a score of IV or less on the Rancho Los Amigos Scale throughout the 90 day period.

General Exclusions and Limitations
The section General Exclusions as contained on the page entitled General Exclusions and Limitations is hereby replaced with the following (reference to Dependent only applies if dependent coverage is included):

General Exclusions: We will not cover a Critical Illness under the Policy if it is due to:
1. an act or accident of war, declared or undeclared, whether civil or international, and any substantial armed conflict between organized forces of a military nature;
2. loss sustained while on active duty as a member of the armed forces of any nation except during any time period coverage is extended under the Continuation during Leave of Absence provision;
3. any intentionally self-inflicted Injury;
4. active participation in a riot;
5. committing or attempting to commit a felony, or participating or attempting to participate in a felony;
6. use of non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance, whether or not prescribed by a Physician;
7. cosmetic or elective surgery, except that cosmetic surgery does not include reconstructive surgery when service is incidental to or follows surgery resulting from trauma, infection, or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent Child that has resulted in a functional defect; or
8. attempted suicide, while sane or insane.

We also will not pay a benefit for a Critical Illness:
1. for which the Covered Person’s or Dependent’s Date of Diagnosis for any type of Critical Illness, as defined in the Policy, was prior to his Effective Date of insurance; or
2. that was diagnosed outside of the United States or Canada, unless the diagnosis was confirmed by a Physician practicing within the United States or Canada.

Pre-existing Conditions Exclusion
The section entitled Pre-existing Conditions Exclusions as contained on the page entitled General Exclusions and Limitations is hereby replaced with the following (reference to Dependent only applies if dependent coverage is included):

Pre-existing Conditions Exclusion: We will not cover any Critical Illness that begins during the first 6 months after the Covered Person’s or Dependent’s Effective Date of insurance that is caused or contributed to by a Pre-Existing Condition.
NEW HAMPSHIRE (continued)

Pre-Existing Condition means any condition for which the Covered Person or Dependent within 6 months prior to his Effective Date of insurance:

1. was diagnosed by or received Treatment from a legally qualified Physician; or
2. had symptoms for which a reasonably prudent person would have sought Treatment.

If the Covered Person’s or Dependent’s insurance is increased, then a benefit based on the increased amount of insurance is not payable for a Critical Illness which is first diagnosed during the 6 months following the Effective Date of his increase in insurance, if it is caused by or contributed to by a Pre-Existing Condition. For purposes of applying this provision, Effective Date of insurance as used in the definition of Pre-Existing Condition also includes the Effective Date of the Covered Person’s or Dependent’s increase in insurance.

Proof of Claim

The provision entitled Proof of Claim Payment as contained on the page entitled Claim Information is hereby replaced with the following:

Proof of Claim: Written proof of claim must be filed within 90 days after the date of the Diagnosis of a Critical Illness. However, if it is not possible to give proof within 90 days, it must be given as soon as reasonably possible.

Proof of claim must include, at the Covered Person’s expense:

1. the Date of Diagnosis;
2. a completed claim form signed by the Covered Person and Physician(s) including documentation furnished by the Physician and supported by clinical, radiological, histological, pathological and/or laboratory evidence of the Critical Illness. If the claim is for the Covered Person’s Spouse, then the Spouse must also sign the claim form; and
3. the name and address of any Hospital or Medical Facility where Treatment was received and any Physician who provided Treatment prior to the Diagnosis.

In the event of death, an autopsy confirmation identifying the cause of death:

1. will be required for Myocardial Infarction; and
2. may also be required for other Critical Illnesses;
where allowed by law.

Benefits for loss covered by the Policy are paid upon receipt of Proof of Claim. If special circumstances require an extension, We will notify the Covered Person within 45 days of receipt of the initial proof. Our notice will provide the Covered Person with:

1. a description of any further proof needed to perfect the claim; and
2. an explanation of why such material is needed.

Benefits for a covered loss will then be paid upon receipt of all proper Proof of Claim. If any benefit of the Policy is due on a periodic basis, it will be paid monthly.
NORTH CAROLINA

Residents of the state of North Carolina, the following provisions are included to bring your Certificate into conformity with North Carolina state law.

The following disclosure has been added (reference to Dependent only applies if dependent coverage is included):

NO RECOVERY FOR PRE-EXISTING DIAGNOSED CANCER AND CRITICAL ILLNESS – READ CAREFULLY. Benefits are not payable for any Cancer or Critical Illness that begins during the first 12 months after the Covered Person’s or Dependent’s Effective Date of insurance that is caused or contributed to by a Pre-Existing Condition as defined in the Certificate.

General Definitions

When included, the Change in Family Status definition is hereby replaced with the following (reference to Dependent only applies if dependent coverage is included):

Change in Family Status:
1. a change in marital status (marriage, divorce, legal separation, annulment);
2. a change in the number of Dependents (birth, legal adoption of a Child, placement of a Child with the Covered Person for adoption, or death of a Dependent);
3. certain changes in employment status that affect benefits eligibility for the Covered Person, Spouse or Child, such as termination of employment, a strike or lockout, the start of or return from an unpaid leave of absence, a change in worksite, a change in work schedule (between full-time and part-time work, decrease or increase in hours);
4. a change of residence for the Covered Person, Spouse or Child;
5. a significant increase in the cost of coverage or a significant reduction in the benefit coverage under the Covered Person’s insurance or his Spouse’s insurance;
6. the addition, elimination, or significant curtailment of, a coverage option;
7. a change in the Covered Person’s, Spouse’s or Child’s coverage during another employer’s Annual Enrollment, Re-Enrollment period when the other plan has a different period of coverage.

Dependent

The term "child" within the definition of Dependent is hereby changed to read as follows. All other conditions of the Dependent definition will apply:

Child means an unmarried Child under the Maximum Age for Dependent Child shown in the Schedule who is a natural Child, a stepchild, a legally adopted Child, a Child placed for adoption, a foster Child from the date he is placed in a foster home; a non custodial Child, a Child for whom the Covered Person is required to provide insurance due to a court or administrative order, or a Child for whom legal guardianship has been awarded to the Covered Person or the Covered Person’s Spouse.

An adopted Child’s coverage is effective from the date of placement for the purpose of adoption and continues unless placement is disrupted prior to legal adoption and the child is removed from placement.
CERTIFICATE MODIFICATIONS RIDER

NORTH CAROLINA (continued)

Hospital or Medical Facility

The definition of Hospital or Medical Facility is hereby replaced with the following:

Hospital or Medical Facility: a legally operated, accredited facility licensed to provide full-time care and Treatment for the condition for which benefits are payable under the Policy. It is operated by a full-time staff of licensed physicians and registered nurses. In North Carolina, the term also means a duly licensed State tax-supported institution which may be a specialty facility for one particular type of illness or one that may not have an operating room and related equipment for surgery. It does not include facilities that primarily provide custodial, education or rehabilitative care, or long-term institutional care on a residential basis.

Benefits Payable and Benefit Definitions

The definition of Cancer is hereby amended to include the following sentence:

If the requisite pathological/clinical diagnosis can only be made postmortem, liability will be assumed retroactively.

General Exclusions and Limitations

The exclusion for cosmetic or elective surgery has been modified to allow coverage when cosmetic surgery is performed on a child to correct a congenital defect or anomaly.

Pre-existing Conditions Exclusion: We will not cover any Critical Illness that begins during the first 12 months after the Covered Person’s or Dependent’s Effective Date of insurance that is caused or contributed to by a Pre-Existing Condition.

Pre-existing Conditions Exclusion

The provision entitled Pre-existing Conditions Exclusions as contained on the page entitled General Exclusions and Limitations is hereby replaced with the following (reference to Dependent only applies if dependent coverage is included):

Pre-Existing Condition means any condition for which the Covered Person or Dependent within 12 months prior to his Effective Date of insurance:

1. was diagnosed by or received Treatment from a legally qualified Physician; or
2. had symptoms for which a reasonably prudent person would have sought Treatment.

If the Covered Person’s or Dependent’s insurance is increased, then a benefit based on the increased amount of insurance is not payable for a Critical Illness, which is first diagnosed during the 12 months following the Effective Date of his increase in insurance, if it is caused by or contributed to by a Pre-Existing Condition. For purposes of applying this provision, Effective Date of insurance as used in the definition of Pre-Existing Condition also includes the Effective Date of the Covered Person’s or Dependent’s increase in insurance.
CERTIFICATE MODIFICATIONS RIDER

NORTH CAROLINA (continued)

Notice of Claim:
The provision entitled Notice of Claim as contained on the page entitled Claim Information is hereby changed to read as follows:

Notice of Claim: Written notice of a claim must be given to Us or Our authorized agent at Our Home Office by or on behalf of the Covered Person within 30 days after the date of the Diagnosis of a Critical Illness. If it is not possible, written notice must be given as soon as it is reasonably possible to do so.

The claim form is available from the Covered Person’s employer, or can be requested from Us. If the Covered Person does not receive the form from Us within 15 days of his request, written proof of claim should be sent to Us without waiting for the form. Written proof should establish facts about the claim such as nature of illness and Date of Diagnosis.

Proof of Claim:
The time period in which written proof of claim must be filed has been changed to 180 days.

NORTH DAKOTA
Residents of the state of North Dakota, the following provisions are included to bring your Certificate into conformity with North Dakota state law:

The Covered Person will have 10 days to review this Certificate. If the Covered Person is not satisfied for any reason, he may send the Certificate back to Us within 10 days of its delivery. In that event, We will consider it void and refund all premium paid by the Covered Person.

Pre-existing Conditions Exclusion
The section entitled Pre-existing Conditions Exclusions as contained on the page entitled General Exclusions and Limitations conditions has been modified to delete the prudent person language.

OKLAHOMA
Residents of the state of Oklahoma, the following provisions are included to bring your Certificate into conformity with Oklahoma state law:

The following disclosures have been included:

Certificates delivered in the state of Oklahoma are subject to the terms and conditions of the Certificate and not the Policy. This Certificate is issued in and governed by the laws of the state of Oklahoma.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
CERTIFICATE MODIFICATIONS RIDER

Oklahoma (Continued)

Domestic Partnership
Item 1 of the section entitled Domestic Partnership as contained on the page entitled General Definitions is hereby changed to read as follows:

1. they must not be related;

General Exclusions and Limitations
Item 1 of the section General Exclusions as contained on the page entitled General Exclusions has hereby been changed to read as follows:

1. an act or accident of war, declared or undeclared, while the Covered Person was serving in the military or an auxiliary unit thereto

Time of Claim Payment
The section entitled Time of Claim Payment is hereby added to the page entitled Claim Information.

Time of Claim Payment: Benefits for loss covered by the Policy are paid upon receipt of Proof of Claim. If special circumstances require an extension, We will notify the Covered Person within 45 days of receipt of the initial proof. Our notice will provide the Covered Person with:

1. a description of any further proof needed to perfect the claim; and
2. an explanation of why such material is needed.

Benefits for a covered loss will then be paid upon receipt of all proper Proof of Claim. If any benefit of the Policy is due on a periodic basis, it will be paid monthly.
CERTIFICATE MODIFICATIONS RIDER

TEXAS
Residents of the state of Texas, the following provision is included to bring your Certificate into conformity with Texas state law:

IMPORTANT NOTICE
To obtain information or make a complaint:
You may call UnitedHealthcare Insurance Company’s toll-free telephone number for information or to make a complaint at 1-888-299-2070
You may also write to UnitedHealthcare Insurance Company at:
UnitedHealthcare Insurance Company Administrative Offices
9900 Bren Road East
Minnetonka, MN 55343
You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at: 800-252-3439
You may write the Texas Department of Insurance at:
P.O. Box 149104
Austin, TX 78714-9104
FAX #(512) 475-1771

PREMIUM OR CLAIM DISPUTES:
Should you have a dispute concerning your premium or about a claim you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:
This notice is for information only and does not become a part or condition of the attached document.

Form No. ACN-TX-MP (8/95)

AVISO IMPORTANTE
Para obtener información o para someter una queja:
Usted puede llamar al numero de teléfono gratis de UnitedHealthcare Insurance Company’s para información o para someter una queja al 1-888-299-2070
Usted también puede escribir a UnitedHealthcare Insurance Company's:
UnitedHealthcare Insurance Company Administrative Offices
9900 Bren Road East
Minnetonka, MN 55343
Puede comunicarse con el Departamento de Seguro de Texas para obtener información acerca de compañías, coberturas, derechos o quejas al 800-252-3439
Puede escribir al Departamento de Seguros de Texas
P.O. Box 149104
Austin, TX 78714-9104
FAX #(512)475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS:
Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con la compañía primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

ADJUNTAR ESTE AVISO A SU POLIZA:
Esto aviso es solo para propósituo de información y no se convierte en parte o condición del documento adjunto.
Residents of the state of Vermont, the following provision is included to bring your Certificate into conformity with Vermont state law:

**Vermont Mandatory Civil Union**

**Purpose:** Vermont law requires coverage for parties to a civil union equivalent to that provided married persons. If any terms of the Policy would not be equivalent, the terms are hereby amended to comply. As used in this Notice, Civil Union means one established according to Vermont law.

**Definitions, Terms, Conditions and Provisions:** In Vermont, the word Spouse, as used in the Policy includes a person with whom the Covered Person has received a Certificate of Civil Union under Vermont law. Any terms that refer to a marital relationship such as "marriage," "spouse," "relative," "beneficiary," "survivor," "immediate family," and any other such terms includes the relationship created by a Civil Union.

Terms that refer to the inception or dissolution of a marriage, such as "date of marriage," "divorce decree," "termination of marriage," and any other such terms include the inception or dissolution of a Civil Union.

Terms that refer to a family relationship arising from a marriage such as "family," "immediate family," "dependent," "children," "relative," "beneficiary," "survivor" and any other such terms include the family relationship created by a Civil Union. A child born or brought to a Civil Union will be a Child under the Policy if he meets all other Policy criteria to qualify under the definition of Child.

**CAUTION: FEDERAL LAW RIGHTS MAY OR MAY NOT BE AVAILABLE:** Vermont law grants parties to a Civil Union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to health insurance that are available to married persons under federal law may not be available to parties to a Civil Union. For example, under federal law, the Employee Income Retirement Security Act of 1974 known as “ERISA,” controls the employer /employee relationship with regard to determining eligibility for enrollment in private employer health insurance plans. Because of ERISA, Act 91 of Vermont state law does not state requirements pertaining to a private employer’s enrollment of a party to a civil union in an ERISA employee welfare benefit plan. However, governmental employers (not federal government) are required to provide health benefits to the dependents of a party to a Civil Union if the public employer provides such coverage to the dependents of married persons. Federal law also controls group health insurance continuation rights under “COBRA” for employers with 20 or more employees as well as the Internal Revenue Code treatment of health insurance premiums. As a result, parties to a Civil Union and their families may or may not have access to certain benefits under a Policy or Certificate that derive from federal law. You are advised to seek expert advice to determine your rights under the Policy.

UHICI-CIVUNION-VT
Residents of the state of Washington, the following provisions are included to bring your Certificate into conformity with Washington state law:

The following Outline of Coverage is included:
UnitedHealthcare Insurance Company
185 Asylum Street
Hartford, Connecticut
(Home Office)

IMPORTANT INFORMATION ABOUT THE COVERAGE YOU ARE BEING OFFERED

Save this statement! It may be important to you in the future. The Washington State Insurance Commissioner requires that we give you the following information about fixed payment benefits.

This coverage is not comprehensive health care insurance and will not cover the cost of most hospital and other medical services.

This disclosure provides a very brief description of the important features of the coverage being considered. It is not an insurance contract and only the actual policy provisions will control. The policy itself will include in detail the rights and obligations of both the master policyholder and UnitedHealthcare Insurance Company.

This coverage is designed to pay you a fixed dollar amount regardless of the amount that the provider charges. Payments are not based on a percentage of the provider's charge and are paid in addition to any other health plan coverage you may have.

CAUTION: If you are also covered under a High Deductible Health Plan (HDHP) and are contributing to a Health Savings Account (HSA), you should check with your tax advisor or benefit advisor prior to purchasing this coverage to be sure that you will continue to be eligible to contribute to the HSA if this coverage is purchased.

The benefits under this policy are summarized below:

1. **Type of Coverage: Critical Illness Insurance Coverage.** This certificate is designed to provide, to certificate holders, restricted coverage paying benefits ONLY when certain losses occur as a result of treatment (or diagnosis) of a Critical Illness. This certificate does NOT provide general health insurance.

2. **Benefit Amount:**

   **Maximum Benefit Amount**
   - **Employee:** $20,000
   - **Spouse:** $10,000
   - **Child:** $2,500
WASHINGON (continued)

Percentage of Maximum Benefit Payable:

**Category 1:**
- Level 1 Cancer: 100%
- Level 2 Cancer: 25%

**Category 2:**
- Coronary Artery Bypass: 25%
- Heart Attack: 100%
- Heart Transplant: 100%
- Ruptured Aneurysm: 100%
- Stroke: 100%

**Category 3**
- Coma: 100%
- Chronic Renal Failure: 100%
- Major Organ Transplants: 100%
- Permanent Paralysis: 100%
- Severe Brain Damage: 100%
- Severe Burns: 100%

3. **Benefit Trigger:** A fixed percentage of the maximum benefit is payable for a Critical Illness. We will pay up to a total of 100% of the Maximum Benefit Amount for each of the Categories shown on the Schedule of Benefits for which you or your Dependent:
   1. receives a Diagnosis of a Critical Illness; and
   2. for which you are insured on the Date of Diagnosis (as defined in the Certificate).

   *Benefit Waiting Period:* an exclusionary period immediately following the effective date of a person’s insurance, during which benefits are not payable. When a Critical Illness has a Date of Diagnosis within the Benefit Waiting Period, benefits are not payable on the basis of that diagnosis.

4. **Duration of Coverage:** Your coverage terminates on the first to occur of: the last day of the period for which premium is paid; the date you enter active duty of the armed forces; the date you cease to be in a class eligible for coverage; the date the Policy terminates; the date a benefit for a Critical Illness for each Category shown on the Schedule of Benefits is paid to you; or the date you cease to be actively at work.

   Your dependent’s coverage will terminate when you are in a class that is no longer eligible for dependent coverage or if the dependent no longer meets the definition of a dependent as explained in the certificate. Coverage may be continued for children who reach the age limit and are incapacitated on that date.
CERTIFICATE MODIFICATIONS RIDER

WASHINGTON (continued)

In certain cases insurance may be continued as stated in the section of the Certificate titled CONTINUATION AND REINSTATEMENT PROVISIONS.

5. **Renewability of Coverage:** The Policy will continue in force until it is canceled by either the Policyholder or UnitedHealthcare Insurance Company.

Policy provisions that exclude, eliminate, restrict, limit, delay, or in any other manner operate to qualify payment of the benefits described above include the following:

Coverage may be subject to evidence of good health if you enroll late or if you enroll for an amount of coverage in excess of the guaranteed issue limits that are outlined in your certificate.

We will not cover a Critical Illness under the Policy if it is due to: due to war or act of war, whether declared or undeclared; any intentionally self-inflicted Injury; active participation in a riot; committing or attempting to commit a felony, or participating or attempting to participate in a felony; cosmetic or elective surgery; or attempted suicide, while sane or insane.

No benefit is payable for a critical illness for which you or your Dependent’s Date of Diagnosis for any type of Critical Illness, was prior to his Effective Date of insurance; that was diagnosed outside of the United States or Canada (unless the diagnosis was confirmed by a Physician practicing within the United States or Canada); or with respect to a Dependent who is a Child, that is caused by or contributed to by a congenital defect.

**Pre-existing Conditions Exclusion:** We will not cover any Critical Illness that begins during the first 12 months after you or your Dependent’s Effective Date of insurance that is caused or contributed to by a Pre-Existing Condition.

**Pre-Existing Condition** means any condition for which you or your Dependent’s within 24 months prior to his Effective Date of insurance:

1. was diagnosed by or received Treatment from a legally qualified Physician; or
2. had symptoms for which a reasonably prudent person would have sought Treatment.

When your coverage terminates because you are no longer eligible, you will have the option to continue your coverage under the portability privilege explained in your certificate.

The Critical Illness and Restoration of Benefit Amounts will be reduced by 50% upon attainment of Age 70.

Form UHICI-OOC-WA-1

**General Exclusions and Limitations**

- Item 1 of the section General Exclusions as contained on the page entitled General Exclusions has hereby been changed to read as follows:
  1. due to war or act of war, whether declared or undeclared;
- The alcohol and drug exclusion as contained on the page General Exclusions and Limitations has been removed.
Purpose of this Notice
UnitedHealthcare Insurance Company respects the privacy of personal information and understands the importance of keeping this information confidential and secure. This Notice describes how we protect the confidentiality of the personal information we receive. Our practices apply to current and former members.

Types of Personal Information We Collect
We collect a variety of personal information to administer a member's life or health coverage. Some of this information is provided by members in enrollment forms, surveys and correspondence (such as address, Social Security number, and dependent information). We also receive personal information (such as eligibility and claims information) through transactions with our affiliates and members, employers, insurance agents, other insurers, and health care providers. We retain this information after a member's coverage ends. We limit the collection of personal information to that which is necessary to administer our business, provide quality service and meet regulatory requirements.

How We Protect Personal Information
We treat personal information securely and confidentially. We limit access to personal information to only those persons who need to know that information to provide our products or services to members (for example, our claims processors and care coordinators). These persons are trained on the importance of safeguarding this information and must comply with our procedures and applicable law. We meet strict physical, electronic and procedural security standards to protect personal information and maintain internal procedures to promote the integrity and accuracy of that information.

Disclosure of Personal Information
We may share any of the personal information we collect (as described above) with our affiliates as permitted by law. We may also disclose this information to non-affiliated entities or individuals as permitted or required by law. Non-affiliates with whom we may disclose information as permitted by law include our attorneys, accountants and auditors, a member's authorized representative, health care providers, third party administrators, insurance agents and brokers, other insurers, consumer reporting agencies, and law enforcement or regulatory authorities. We may also disclose any of the personal information we collect (as described above) to companies that perform marketing services on our behalf or to other companies with whom we have joint marketing or disease management agreements. We do not disclose personal information to any other third parties without a member's request or authorization.

Individual Rights to Access and Correct Personal Information
We have procedures for a member to access the personal information we collect, and other than information we collect in connection with, or in anticipation of, a lawsuit or legal claim, we will make this information available to the member upon written request. Our goal is to keep our member information up-to-date and to correct inaccurate information. We have procedures in place to ensure the integrity of our information and for the timely correction of incorrect information. If you believe that any personal information we have about you is not accurate, please let us know by contacting our Compliance Officer at UnitedHealthcare Specialty Benefits, Administrative Offices, 9900 Bren Road East, Minnetonka, MN 55343.

Further Information
We may amend our privacy policy from time to time. In accordance with applicable law, we will send our current customers a Notice describing our privacy policy and practices at least once a year. It will also be available upon request. This Notice is provided on behalf of the following UnitedHealthcare Insurance Company affiliates: