Voluntary
Critical Illness Insurance

Certificate of Coverage

Plan Sponsor: Veros Software Inc.
Policy: L06131
Class: 01
Class Description: All Eligible Employees

anthem.com

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GROUP CRITICAL ILLNESS (SPECIFIED DISEASE) INSURANCE CERTIFICATE

Anthem Blue Cross Life and Health Insurance Company
21555 Oxnard Street
Woodland Hills, CA 91367

Policyholder: Veros Software Inc.
Policy Number: L06131
Policy Effective Date: September 1, 2023
Policy Anniversary: September 1

We have issued the Policy to the Policyholder. The Policy is delivered in and governed by the laws of the state of California, and to the extent applicable, by the Employee Retirement Income Security Act of 1974 (as amended). The provisions of the Policy that are important to the Covered Person(s) are summarized in this Certificate, consisting of this form and any additional forms which have been made a part of this Certificate. This Certificate replaces any other Certificate We may have previously issued to the Primary Insured under the Policy. The Policy alone is the only contract under which payment will be made. Any difference between the Policy and this Certificate will be settled according to the provisions of the Policy on file with Us at Our Home office. The Policy may be inspected at the office of the Policyholder.

Signed for Anthem Blue Cross Life and Health Insurance Company at Woodland Hills, CA.

Beth Andersen
President

THIS IS A LIMITED BENEFIT CERTIFICATE: This Certificate provides limited or supplemental coverage. It pays benefits ONLY upon the occurrence and Diagnosis of a Critical Illness with the exception of the Health Screening Benefit. This Certificate does not provide benefits for any other disease, sickness or incapacity. Benefits provided are supplemental and are not intended to substitute for medical coverage or disability insurance.

THIS CERTIFICATE PAYS A REDUCED AMOUNT FOR NON-INVASIVE CANCER, BENIGN BRAIN TUMOR, CORONARY ARTERY BYPASS GRAFT, COMA, PARALYSIS, LOSS OF VISION, AND LOSS OF SPEECH.

THIS CERTIFICATE PAYS NO BENEFITS FOR EARLY STAGE MELANOMA (CLASSIFIED AS TISN0M0 OR EQUIVALENT STAGING), BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA UNLESS SPECIFICALLY PROVIDED FOR UNDER THE NON-MELANOMA SKIN CANCER BENEFIT, DYSPLASIA, INTRAEPITHELIAL NEOPLASIA, PRE-MALIGNANT GROWTHS, PRE-MALIGNANT LESIONS, BENIGN TUMORS (OTHER THAN BENIGN BRAIN TUMORS) OR BENIGN POLYPS. READ THE DEFINITIONS OF EACH CRITICAL ILLNESS CAREFULLY TO DETERMINE WHAT CONDITIONS ARE INCLUDED AND EXCLUDED.

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

READ YOUR CERTIFICATE CAREFULLY: You have a 30 day right from the Primary Insured's Coverage Effective Date to examine Your Certificate. If You are not satisfied, You may return it to Us within 30 days from the date You received Your Certificate. In that event, We will consider it void from its effective date and any premiums paid will be refunded. Any claims paid under the Policy during the initial 30 day period will be deducted from the refund.

This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal health law.

THIS IS A GROUP CRITICAL ILLNESS CERTIFICATE WHICH PROVIDES STATED BENEFITS ONLY FOR SPECIFIED CRITICAL ILLNESSES OR OTHER BENEFITS THAT MAY BE ADDED.

THIS CERTIFICATE DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.

A note on capitalization in this Certificate:

Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in the Policy or refers to a specific provision contained herein.

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BENEFIT SCHEDULE

Eligible Class(es)
Actively at work Employees who are scheduled to work at least 30 hours per week and who have satisfied any applicable eligibility waiting periods as defined by the policyholder.

Policy Age Limit: 85

Individual Grace Period: 31 days

Cost of Coverage:
Contributory – You must contribute toward the cost of coverage.

Coverage Amount:

Primary Insured:	$20,000
Spouse:	$10,000
Dependent Child(ren):	$10,000

Guaranteed Issue Amount: $20,000

Primary Insured Coverage Maximum:
You may receive multiple Critical Illness Benefit payments and Recurrence Benefit payments until a maximum of 2500% of the Primary Insured's Critical Illness Coverage Amount is reached in Your lifetime under the Policy. The Coverage Maximum does not include any Additional Critical Illness Benefits.

Spouse Coverage Maximum:
Your Spouse may receive multiple Critical Illness Benefit payments and Recurrence Benefit payments until a maximum of 2500% of the Spouse's Critical Illness Coverage Amount is reached in Your Spouse's lifetime under the Policy. The Coverage Maximum does not include any Additional Critical Illness Benefits.

Child(ren) Coverage Maximum:
Each Child may receive multiple Critical Illness Benefit payments and Recurrence Benefit payments until a maximum of 2500% of the Child's Coverage Amount is reached while covered as a Dependent Child under the Policy. The Coverage Maximum does not include any Additional Critical Illness Benefits.

CRITICAL ILLNESS BENEFITS

Critical Illnesses	Percentage of Coverage Amount
Cancer Benefits	
Invasive Cancer	100%
Non-Invasive Cancer	25%
Benign Brain Tumor	100%
Vascular Benefits	
Heart Transplant	100%
Heart Attack (Myocardial Infarction)	100%
Stroke	100%
Coronary Artery Bypass Graft	25%
Other Specified Critical Illness Benefits	
Coma	100%
Paralysis	100%
Major Organ Transplant	100%
End Stage Renal Disease	100%
Loss of Hearing	100%
Loss of Speech	100%
Loss of Vision	100%
Neurological Benefits	
Advanced Parkinson's Disease	100%
Amyotrophic Lateral Sclerosis (ALS or "Lou Gehrig's Disease")	100%
Advanced Multiple Sclerosis	100%
Advanced Alzheimer's Disease	100%

Each covered Critical Illness Benefit listed will only be paid once for each Covered Person.

Recurrence Benefit	Percentage of Original Benefit Amount
Invasive Cancer	50%
Benign Brain Tumor	50%
Heart Transplant	50%
Heart Attack (Myocardial Infarction)	50%
Stroke	50%
Coma	50%
Major Organ Transplant	50%

Subject to the Covered Person's coverage maximum shown above, the Recurrence Benefit is only payable if a Critical Illness Benefit has been paid for the same Critical Illness. In order to receive a Recurrence Benefit, all other conditions stated in the Recurrence Benefit provision must be satisfied. Only one Recurrence Benefit is payable for each covered benefit.

ADDITIONAL CRITICAL ILLNESS BENEFITS

Benefits	Coverage Amount
Health Screening Benefit	$50
Non-Melanoma Skin Cancer Benefit	$250

DEFINITIONS

Actively at Work, Active Work means that an Employee is:

1) performing all the regular duties of his/her job for the Policyholder in the usual way for 30 or more hours each week; and
2) receiving compensation from the Policyholder for work performed.

An Employee is considered actively at work on any day that is not his/her regular scheduled workday (e.g., vacation or holiday) as long as the Employee was actively working on his/her last preceding regular scheduled workday.

Additional Enrollment Event means a period of time designated for enrollment under the Policy, other than an Annual Enrollment Period, as agreed to in writing by Our authorized representative in our Home Office.

Advanced Alzheimer's Disease means a condition Diagnosed as Alzheimer's disease that has progressed to a classification of Stage 6 or greater of the Functional Assessment Staging Test (FAST), or equivalent test. Diagnosis must be supported by neurological examination and cognitive testing for the involved condition/illness. There must be permanent clinical loss of the ability to do all of the following:

1) remember, reason, and perceive; and
2) understand, express and give effect to ideas.

Other types of dementia are not included in this definition. The initial Diagnosis of Alzheimer's disease must occur while the Covered Person is insured under the Policy.

Advanced Multiple Sclerosis ("MS") means a condition Diagnosed as the occurrence of at least two episodes of well-defined neurological abnormalities, with objective evidence of lesions that are characteristic of MS at more than one site within the central nervous system. Advanced Multiple Sclerosis must be Diagnosed by a Physician and the Diagnosis must be supported by modern imaging, investigative techniques and/or analysis of cerebrospinal fluid consistent with the Diagnosis.

The initial Diagnosis of Advanced MS must occur while the Covered Person is covered under the Policy.

Advanced Parkinson's Disease means a condition Diagnosed as Parkinson's Disease which has progressed to a classification of Stage 4 or greater. Diagnosis must be made by a Physician based on abnormal findings from neurological examination, cognitive testing, and results of imaging studies. There must be permanent clinical impairment of motor function with associated tremor, muscle rigidity and postural instability. Other Parkinsonian syndromes are not included in this definition.

The initial Diagnosis of Advanced Parkinson's Disease must occur while the Covered Person is covered under the Policy.

Amyotrophic Lateral Sclerosis (ALS or "Lou Gehrig's Disease") means a condition Diagnosed as progressive degenerative motor neuron disease classified as middle stage, marked by muscular weakness and atrophy with spasticity and hyperreflexia due to a degeneration of anterior horn cells of the spinal cord and cranial nerves. Other motor neuron diseases are not considered to be ALS. ALS must be Diagnosed by a Physician based on generally acceptable principles of medicine.

The initial Diagnosis of ALS must occur while the Covered Person is covered under the Policy.

Aneurysm means a condition Diagnosed as a localized, blood-filled dilation of a blood vessel caused by disease or weakening of the vessel wall in the brain, carotid arteries, or aorta for which surgical correction has been performed. Aorta refers to the thoracic and abdominal aorta, but not its branches. Diagnosis must be supported by medical records which include radiographically specific studies such as, but not limited to, angiography, CT scan, MRI, or ultrasound.

Angioplasty/Stent means a condition Diagnosed as heart disease that has progressed such that reconstitution or recanalization of a blood vessel is recommended by a Physician. Angioplasty surgery may involve balloon dilation, mechanical stripping of intima, forceful injection of fibrinolytics or placement of a stent.

Annual Enrollment Period means a period of time during which annual benefits enrollment occurs each year as determined by the Policyholder.

Benign Brain Tumor means a condition Diagnosed as a non-malignant tumor or cyst in the brain, cranial nerves or meninges within the skull with a minimum size of 1 cm, resulting in either surgical removal or permanent neurological deficit with persisting clinical symptoms. The tumor, including its size, should be documented on an MRI of the brain (with and without contrast) or by pathological diagnosis. If the Covered Person is unable to undergo an MRI of the brain (the study is deemed inappropriate for safety reasons such as the presence of metallic foreign bodies; mechanical reasons such as body habitus; or unavailability), then the tumor should be documented by a CT scan of the head, with and without contrast. Persisting clinical symptoms may include: abnormal reflexes, inability to speak, decreased sensation, loss of balance, mental function problems, vision changes or muscle weakness.

Benign Brain Tumor does not include:

1) tumors in the pituitary gland; or
2) angiomas.

Certificate means this document, which explains the insurance benefits provided, to whom and how benefits are payable and exclusions and limitations that apply to coverage.

Change in Family Status means one of the following events:

1) You get married or enter into a relationship with a person who satisfies the definition of Spouse;
2) You and Your Spouse divorce or legally terminate Your relationship;
3) Your Spouse dies;
4) You acquire a child who satisfies the definition of Dependent Child;
5) Your child no longer satisfies the definition of a Dependent Child or dies; or
6) Your Spouse is no longer employed, which results in a loss of critical illness insurance sponsored by the Spouse's employer for You or any Dependent(s).

Coma means a condition Diagnosed as a continuous state of profound unconsciousness with no reaction to external stimuli which is not the result of a Stroke. The Coma must:

1) be due to disease;
2) be Diagnosed after the Policy Effective Date;
3) last for a period of 7 or more consecutive days; and
4) be rated/classified as one of the following:
    a) Rancho Los Amigos Scale (RLAS) level I or II;
    b) Glasgow Coma Scale value 3 through 5; or
    c) the disability rate scale value 22 through 29.

The condition must require mechanical ventilation for respiratory assistance. For purposes of the Policy, Coma does not include a medically induced coma or a coma caused or contributed to by alcohol or substance abuse.

Contributory Coverage means coverage for which You are required to contribute toward the cost.

Coronary Artery Bypass Graft means a condition Diagnosed as heart disease that necessitates heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts. The surgery must be recommended by a Physician.

Coverage Amount is the dollar amount You or Your Dependents are covered for a Critical Illness.

Covered Person means the Employee and any Dependent(s) who is/are currently insured under the Policy and this Certificate.

Critical Illness means any of the conditions shown in the Benefit Schedule.

Dependent, Dependents means an Employee's Spouse and Dependent Child(ren).

Dependent Child(ren) means:

1) an Employee's or Spouse's natural child, legally adopted child or stepchild;
2) a child placed into the Employee's or Spouse's custody for adoption (regardless of whether the adoption has become final);
3) a child for whom the Employee or Spouse is ordered by a court or administrative order to provide coverage regardless of whether he/she is the custodial or non-custodial parent; any other child for whom the Employee or Spouse has been appointed legal guardian; or who is/are under 26 years of age.

If a child is age 26 or older and is:

1) incapable of self-sustaining employment because of a mental or physical disability;
2) chiefly dependent on the Employee, or Spouse for financial support and maintenance; and proof has been provided of his/her disability upon Our request, that child will continue to be a dependent child until these conditions cease to exist.

Diagnosed, Diagnosis means the definitive establishment of a Critical Illness through the use of clinical or laboratory findings. The Diagnosis must be made by a Physician.

Employee means a person who:

1) is a citizen or legal resident of the United States (including its territories and protectorates); or
2) is lawfully and legally able to work in the United States pursuant to applicable law(s); and
3) works for the Policyholder on a regular basis in the usual course of the Policyholder's business.

This definition does not include a person working for the Policyholder:

1) on a temporary, leased or seasonal basis;
2) subject to the terms of a leasing agreement between the Policyholder and a leasing organization; or
3) who resides outside the United States for a period in excess of 12 months, unless written approval has been received from Us.

End Stage Renal Disease means a condition Diagnosed as kidney disease which has resulted in permanent and irreversible failure of both kidneys requiring regular treatment by either hemodialysis or peritoneal dialysis on a no less than weekly basis, or for which kidney transplant is recommended by a Physician.

Family Member means a Covered Person's Spouse (current and former); domestic partner (or equivalent); child; sibling; parent; grandparent; grandchild; aunt; uncle; first cousin; nephew; niece; or the spouse or domestic partner (or equivalent) of such individuals. This includes adopted, in-law and step-relatives, and anyone living in the Covered Person's household.

Heart Attack means a condition Diagnosed as acute myocardial infarction resulting in the death of a portion of the heart muscle (myocardium) due to a blockage of one or more coronary arteries and resulting in the loss of the normal function of the heart.

The Diagnosis must be made by a Physician. Significant new and serial electrocardiogram (EKG) changes must be seen and the Diagnosis of an acute myocardial infarction (heart attack) with resulting loss of normal heart function must be confirmed by one or both of the following:

1) a clinical picture of myocardial infarction with cardiac enzyme changes found in blood (elevated DK-MB isoenzyme fraction or elevated troponins);
2) confirmatory imaging tests such as a nuclear imaging test or echocardiogram that is consistent with a myocardial infarction.

Heart Attack does not include:
1) congestive heart failure;
2) atherosclerosis;
3) angina;
4) coronary artery disease;
5) or any other dysfunction of the cardiovascular system; or
6) cardiac arrest not caused by a myocardial infarction.

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

Heart Transplant means:
1) a condition Diagnosed as heart failure due to heart disease and for which a Covered Person is placed on a national transplant list such as UNOS; and
2) the irreversible failure of the Covered Person's heart has occurred for which a Physician has determined that the replacement of such organ with a human donor heart is recommended.

If the Covered Person is too ill for a transplant, but otherwise meets the criteria to be placed on the UNOS or other national transplant list, the placement on such list will be waived.

Home Office means Our office at 21555 Oxnard Street, Woodland Hills, CA 91367.

Individual Grace Period means a grace period of 31 days that will be granted for receipt of the payment for each premium falling due after the first premium. During the grace period the Certificate shall continue in force subject to the Termination of Insurance provision.

Invasive Cancer means a condition Diagnosed as the presence of a malignancy characterized by the uncontrolled and abnormal growth and spread of malignant cells with invasion of normal tissue as diagnosed by a Physician. The term "malignancy" includes leukemia, lymphoma and sarcoma.

Invasive Cancer includes any cancer classified as Stage 2 through 4, which has spread to any other part of the Covered Person's body.

Invasive Cancer does not include a Diagnosis of Invasive Cancer for:
1) any non-melanoma skin cancer; or
2) any condition that is considered Non-Invasive Cancer.

Loss of Hearing means a condition Diagnosed as the irreversible loss of hearing for all sounds in both ears, due to disease. The Diagnosis of irreversible loss of hearing must be established by an audiometric and auditory threshold test. The auditory threshold cannot be more than 90 decibels in both ears while utilizing a hearing aid.

The loss of hearing must occur after the Covered Person becomes insured under the Policy.

Loss of Speech means a condition Diagnosed as the irreversible loss of ability to speak, due to disease. The Diagnosis of irreversible loss of speech must include documented evidence of the loss for at least 12 months.

The loss of speech must occur after the Covered Person becomes insured under the Policy.

Loss of Vision means a condition Diagnosed as the irreversible loss of vision in both eyes due to disease. The Diagnosis of irreversible loss of vision must indicate that corrective visual acuity is equal to or worse than 20/200 in both eyes or the field of vision is less than 20 degrees in both eyes.

The irreversible loss of vision must occur after the Covered Person becomes insured under the Policy.

Major Organ Transplant means:

1) a Diagnosis of organ failure due to disease of the affected organ and for which a Covered Person is placed on a national transplant list such as UNOS; and
2) the irreversible failure of the Covered Person's lung, pancreas or any combination thereof, for which a Physician has determined that the complete replacement of such organ with an entire organ from a human donor is recommended; or
3) the irreversible failure of the Covered Person's liver for which a Physician has determined that the complete or partial replacement of the liver with a liver or liver tissue from a human donor is recommended. For this type of transplant, the requirement of placement on a national transplant list, such as UNOS, is specifically null in cases of live donor transplant.

Organs transplanted simultaneously with the heart are covered under Heart Transplant.

If the Covered Person is too ill for a transplant, but otherwise meets the criteria to be placed on the UNOS or other national transplant list, the placement requirement will be waived.

Non-Contributory Coverage means coverage for which You are not required to contribute toward the cost.

Non-Invasive Cancer means a condition Diagnosed as cancer in which the tumor or cells remain within the originating tissue without invasion of neighboring tissue or regional lymph nodes, including:

1) cancer classified as Stage I ; or
2) early cancer classified as TisN0M0 , for which radiotherapy, intravenous chemotherapy, or surgical procedures are recommended to control or cure the disease.

THIS POLICY PAYS NO BENEFITS FOR DYSPLASIA, INTRAEPITHELIAL NEOPLASIA, PRE-MALIGNANT LESIONS, PRE-MALIGNANT GROWTHS, ANY NON-MELANOMA SKIN CANCER (INCLUDING BASAL CELL OR SQUAMOUS CELL CARCINOMA UNLESS SPECIFICALLY PROVIDED FOR UNDER THE NON- MELANOMA SKIN CANCER BENEFIT), OR ANY EARLY STAGE MELANOMA.

THE POLICY PAYS NO BENEFITS FOR BENIGN TUMORS OR BENIGN POLYPS.

Non-Melanoma Skin Cancer means basal cell carcinoma and squamous cell carcinoma.

Paralysis means a condition Diagnosed as the complete and permanent loss of function of two or more limbs due to disease. Paralysis as a result of Stroke is excluded. The Diagnosis of Paralysis must include documented evidence of the illness that caused the Paralysis. As used herein, "limb" means an arm or leg.

The Paralysis must occur after the Covered Person becomes insured under the Policy.

Physician means a person who is:

1) a doctor of medicine, osteopathy, psychology or where required by state law, any other legally qualified practitioner of healing art;
2) licensed to practice in the jurisdiction where care is being given;
3) operating within the scope of his or her license; and
4) not the Covered Person or a Family Member.

Policy means the policy that We issued to the Policyholder under the Policy Number shown on the face page.

Policyholder means the Employer.

Primary Insured means an Employee who is currently insured under the Policy and this Certificate. (See also You, Yours.) This definition also includes a Spouse who has elected to continue coverage under the Extended Continuation provision.

Prior Policy means the Critical Illness insurance policy carried or sponsored by the Employer or an Employer acquired by the Policyholder on the day before the Policy Effective Date and will only include the coverage which is transferred to Us.

Spouse means any individual who, under applicable state law is recognized as a Spouse.

Spouse also includes any individual who is a partner to a civil union, a registered domestic partnership with a government agency or office where such registration is available, or other relationship allowed by state law.

For residents of states that do not offer domestic partner registration: Spouse will include Your affidavit domestic partner provided You have executed a complete domestic partner affidavit, establishing that You and Your partner are domestic partners for purposes of The Policy. You will continue to be considered affidavit domestic partners provided You continue to meet the requirements described in the domestic partner affidavit.

Spouse does not include any person who is insured as an employee.

Stroke means a condition Diagnosed as a cerebrovascular accident including infarction of brain tissue, cerebral and subarachoid hemorrhage, cerebral embolism and cerebral thrombosis.

The diagnosis must be supported by:

1) evidence of persistent neurological deficits confirmed by a neurologist at least 30 days after the event; and
2) confirmatory neuroimaging studies consistent with the diagnosis of a new Stroke. Stroke does not mean a head injury, Transient ischemic attack, or chronic cerebrovascular insufficiency. A transient ischemic attack (also known as “TIA” or “mini-stroke”) is an event with ischemic stroke symptoms that, like a Stroke, is caused by a blood clot. The only difference between a Stroke and TIA is that with TIA the blockage is transient (temporary). TIA symptoms occur rapidly and last a relatively short time. When a TIA is over, there is no permanent injury to the brain, whereas with a Stroke, there is permanent injury to the brain.

Stroke does not include a Diagnosis of Stroke for:

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

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

We, Us, Our means Anthem Blue Cross Life and Health Insurance Company.

You, Yours means an Employee who is currently insured under the Policy and this Certificate. (See also Primary Insured.) This definition also includes a Spouse who has elected to continue coverage under the Extended Continuation provision.

ELIGIBILITY & EFFECTIVE DATES

Eligibility for Coverage

An Employee will become eligible for coverage under the Policy on the latest of:

1) the Policy Effective Date; or
2) the date he/she becomes a member of an Eligible Class

A Dependent will become eligible for coverage under the Policy on the later of:

1) the date the Employee becomes insured under the Policy; or
2) the date You acquire the Dependent.

If more than one person within an immediate family unit is eligible for coverage under the Policy as an Employee of the Policyholder, then:

1) neither Employee may be covered as a Dependent of the other person; and
2) Dependent Child(ren) may only be covered as a Dependent of one Employee.

The date on which an Employee or Dependent becomes eligible for coverage may not be the same date on which insurance begins. The Coverage Effective Date provision describes the date on which insurance begins.

Initial Enrollment

An Employee must enroll for coverage for the Employee and any Dependent(s) within 31 days following the day the Employee or Dependent(s) first become(s) eligible for coverage under the Policy.

If an Employee does not enroll for coverage and/or Dependent's coverage during the Employee's or Dependent's initial enrollment period and later chooses to enroll, the Employee may only enroll for coverage and/or Dependent's coverage:

1) during an Annual Enrollment Period or any Additional Enrollment Event designated by the Policyholder; or
2) within 31 days of the date the Employee has a Change in Family Status.

Coverage Effective Date

Coverage will start on the latest to occur of:

1) the first day of the month following the date an Employee or Dependent becomes eligible as described in the Eligibility for Coverage provision, if enrolled on or before that date;
2) the Policy Anniversary following the last day of an Annual Enrollment Period, if an Employee or Dependent is enrolled during an Annual Enrollment Period;
3) the first day of the month following the last day of an Additional Enrollment Event, if an Employee or Dependent is enrolled during an Additional Enrollment Event; or
4) the first day of the month following the date an Employee or Dependent is enrolled.

In no event will Dependent insurance become effective before an Employee becomes insured.

The Coverage Effective Date for any Employee or Dependent is subject to the Deferred Coverage Effective Date provision.

Deferred Coverage Effective Date

All Coverage Effective Dates and Changes in Coverage effective dates for an Employee will be deferred if an Employee is not Actively at Work on the day coverage would otherwise begin. If deferred, coverage will become effective on the day after the date the Employee has completed one full day of Active Work.

In no event will Dependent insurance become effective before an Employee becomes insured.

This provision does not apply to Employees who are currently eligible for coverage under the Continuity from a Prior Policy provision.

Continuity from a Prior Policy
Coverage under the Policy will begin and will not be deferred if, on the day before the Policy Effective Date, an Employee:

1) was insured under a Prior Policy; and
2) is otherwise eligible under the Policy but is not Actively at Work on the Policy Effective Date and:
   a. is on a leave of absence protected under:
      i. the federal Family and Medical Leave Act (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA); or
      ii. any other applicable federal or state law that allows for continuation of insurance in certain instances; or
   b. was eligible for and insured under a continuation provision of a Prior Policy on the day before the Policy Effective Date; provided the Employee is not insured under any continuation, portability or conversion provision of a Prior Policy after the Policy Effective Date.

If coverage is continued for an Employee under this provision, coverage may also be continued for any eligible Dependent(s) who were insured under the Prior Policy. Insurance under this provision is subject to uninterrupted payment of premium to Us when due.

Coverage provided through this provision ends on the first to occur of:

1) the last day of the 12th month on or next following the Policy Effective Date;
2) the last day the Employee would have been covered under the Prior Policy, had the Prior Policy not terminated;
3) the last day of the continuation period allowed by FMLA, USERRA or applicable federal or state law;
4) the date insurance terminates for any reason shown under the Termination of Coverage provision; or
5) the date the Employee resumes Active Work for the Policyholder or begins full-time employment with any other employer.

If an Employee is eligible for insurance under this provision, the Employee is not eligible for insurance under any Continuation provision of this Certificate. Except as stated in this provision, coverage under this provision is subject to all other terms and provisions of the Policy.

Changes in Coverage
An Employee may elect, drop, increase, decrease or otherwise change coverage only:

1) during an Annual Enrollment Period or any Additional Enrollment Event; or
2) within 31 days of a Change in Family Status.

Any change in coverage requested by an Employee will become effective on:

1) the Policy Anniversary following the last day of an Annual Enrollment Period, if the change is requested during such period;
2) the first day of the month following the last day of an Additional Enrollment Event, if the change is requested during such event; or
3) the first day of the month following the date on which the change is requested following a Change in Family Status; subject to the Deferred Effective Date.

Any change in coverage requested by the Policyholder or as a result of a change in the terms of the Policy will become effective on the first day of the month following the date of the request or change.

TERMINATION OF COVERAGE

Termination of Coverage

Coverage for You and any Dependent(s) will end on the earliest of the following:

1) the date You become no longer eligible for insurance under any provision of the Policy;
2) the date You attain age 85;
3) the date You are no longer in an Eligible Class or the Policy no longer covers Your class;
4) the date You request We terminate coverage, subject to the Changes in Coverage provision;
5) the date the required premium is due but not paid, or
6) the date the Policy terminates.

Coverage for a Dependent will also end on the date a Dependent no longer satisfies the definition of Spouse or Dependent Child(ren), except for a Dependent Child that reaches the limiting age. Coverage for a Dependent Child that reaches the limiting age will end the last day of the month during which the child attains the limiting age.

When coverage would otherwise end, You or an insured Spouse, in certain circumstances may be able to continue insurance for You and any Dependent Child(ren):

1) under a Continuation provision; or
2) under the Extended Continuation provision.

Termination of coverage has no effect on benefits payable for Treatment that is received for a Critical Illness or other loss Diagnosed while a Covered Person was insured under the Policy.

CONTINUATION

Continuation
You may be able to continue coverage for You and any Dependent(s) in certain circumstances when You are no longer Actively at Work. The Continuation Options are explained below.

Any coverage continued under this provision through any of the Continuation Option(s) is subject to the following conditions:

1) We must continue to receive premium payment when due (premiums must be paid by You or paid on Your behalf);
2) the Policyholder must approve the continuation; and
3) if You are eligible for more than one Continuation Option:
   a. the continuation time periods will not be applied consecutively; and
   b. the longest applicable continuation time period from the date You were last Actively at Work will apply.

Coverage continued under this provision will end on the last day of the month on or next following the earliest of the day:

1) the applicable continuation time period has expired, as described in the Continuation Options;
2) You return to Active Work for the Policyholder; or
3) You begin full-time employment with an employer other than the Policyholder.

Coverage continued under this provision will also end in accordance with the Termination of Coverage provision. Except as described in this provision, coverage continued under this provision is subject to all other terms and provisions of the Policy.

Continuation Option(s)
Leave of Absence: If You are on a leave of absence approved by the Policyholder due to any personal reason, coverage may be continued for up to 12 weeks from the date You ceased Active Work.

Federal and/or State Laws: The federal Family and Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto, as well as other applicable federal or state laws, may allow continuation of insurance in certain circumstances for medical leaves of absence, military leaves of absence, other leaves of absence, layoff or termination of employment.

If You are not Actively at Work and are eligible to continue insurance under one of these laws, coverage may be continued for up to the time period allowed by the law that enables the continuation. Contact the Policyholder for additional information regarding continuation options that may be available through federal and/or state laws.

Illness or Injury: If You are not Actively at Work due to Illness or Injury, coverage may be continued for up to 12 weeks from the date You ceased Active Work.

Temporary Layoff: If You are subject to a temporary involuntary layoff by the Policyholder, coverage may be continued for up to 12 weeks from the date You ceased Active Work. If the layoff becomes permanent, this continuation will cease immediately.

Furlough: If You are subject to a temporary work furlough by the Policyholder, coverage may be continued for up to 12 weeks from the date You ceased Active Work. If the furlough ends or becomes permanent (employment is terminated), this continuation will cease immediately.

EXTENDED CONTINUATION

Extended Continuation
You or an insured Spouse, in certain circumstances, may continue coverage under the Policy when insurance would otherwise end under the Termination of Coverage provision.

If You are age 84 or younger, You may be able to continue coverage for You and any insured Dependent(s) under this provision when You:
1) are no longer Actively at Work and are not eligible for coverage under any other Continuation provision in this Certificate; or
2) are no longer employed by the Policyholder, including retirement.

If You are eligible to continue coverage under this provision, then You must elect insurance under this provision in order for any Dependent(s) to remain eligible for coverage.

An insured Spouse who is age 84 or younger may be able to continue coverage under this provision for him/herself and any insured Dependent Child(ren):
1) in the event of Your death; or
2) in the event of divorce, dissolution of partnership or legal separation from You.
3) when You enter active duty service or training in any military for a period of 31 days or more and are no longer eligible under the Policy as an Employee.

If an insured Spouse continues coverage under this provision, the Spouse will become a Primary Insured going forward. Any Dependent Child(ren) may be covered under the Employee or the Spouse, but not both.

Requesting Extended Continuation
When coverage under the Policy would otherwise end, notice of the right to continue coverage under this provision will be given. To elect Extended Continuation, You or Your insured Spouse must send a request to Us.

The request and the initial premium due must be received within 31 days after insurance under the Policy would otherwise end. If timely notice is not given, an extension of the period of time in which to request continued coverage under this provision will be allowed. You or Your Spouse will have 15 days from the date notice is received to submit the request and initial premium. However, in no event will a request be processed if received more than 91 days after the date coverage under the Policy would otherwise end, even if notice is not received.

Coverage continued under this provision:

1) will become effective on the first day of the month following the date coverage under the Policy would otherwise end, so that there is no interruption in coverage; and
2) is subject to continued payment of premium as due, including any portion of the premium that was previously paid for by the Policyholder.

Coverage continued under this provision will end on the last day of the month during which You resume Active Work for the Policyholder.

Coverage continued under this provision will also end in accordance with the Termination of Coverage provision. Except as described in this provision, coverage continued under this provision is subject to all other terms and provisions of the Policy.

CRITICAL ILLNESS BENEFITS

Critical Illness Benefit:
If a Covered Person is Diagnosed with a Critical Illness, while covered under the Policy, We will pay a Critical Illness Benefit. The Critical Illness Benefit is equal to the Coverage Amount multiplied by the Percentage of Coverage Amount for the Critical Illness, as shown in the Benefit Schedule for each Covered Person.

Subject to the Coverage Maximums shown in the Benefit Schedule:

1) Cancer Benefits shown in the Benefit Schedule will only be paid once per Critical Illness for each Covered Person, unless a Recurrence Benefit is available. Following payment of a Cancer Benefit or a Cancer Recurrence Benefit, a period of 30 days must be satisfied before payment of any other Cancer Benefit;
2) Vascular Benefits shown in the Benefit Schedule will only be paid once per Critical Illness for each Covered Person, unless a Recurrence Benefit is available. Following payment of a Vascular Benefit or a Vascular Recurrence Benefit, a period of 30 days must be satisfied before payment of any other Vascular Benefit; and
3) with the exception of Vascular and Cancer Benefits, there is no period of time to be satisfied before payment of any other Critical Illness Benefit.

Recurrence Benefit:
We will pay a Recurrence Benefit as shown in the Benefit Schedule if a Covered Person receives a Diagnosis of a recurrence of a Critical Illness previously paid under the Policy.

Subject to the Coverage Maximums shown in the Benefit Schedule:

1) the condition must be listed as a Recurrence Benefit in the Benefit Schedule; and
2) the Diagnosis of recurrence must be made 12 months or more following the initial Critical Illness Diagnosis.

We will not pay more than one Recurrence Benefit per Critical Illness for the Covered Person during the Covered Person's lifetime.

Non-Melanoma Skin Cancer Benefit:
We will pay the Non-Melanoma Skin Cancer Benefit Coverage Amount if the Covered Person is Diagnosed with Non-Melanoma Skin Cancer.

The Non-Melanoma Skin Cancer Benefit is payable once per each Covered Person's lifetime.

Health Screening Benefit:
For each day a Covered Person has one or more of the screening tests for Critical Illness listed below, not to exceed one day per calendar year, We will pay the Health Screening Benefit stated in the Schedule. The amount stated is the total amount payable in any calendar year regardless of the number of tests or days of tests during that calendar year. A screening test includes any of the following:

1) abdominal aortic aneurysm ultrasound;
2) blood test for triglycerides;
3) bone marrow testing;
4) bone density screening;
5) breast ultrasound;
6) CA 15-3 (blood test for breast cancer);
7) CA 125 (blood test for ovarian cancer);
8) carotid ultrasound;
9) CEA (blood test for colon cancer);
10) cervical cancer screening;
11) chest x-ray;
12) colonoscopy;
13) CT angiography;
14) ECG/EKG;
15) double contrast barium enema;
16) fasting blood glucose test;
17) flexible sigmoidoscopy;
18) hemoccult stool analysis;
19) lipid panel;
20) Mammography;
21) Pap smear;
22) PAD ultrasound
23) PSA (blood test for prostate cancer);
24) serum cholesterol test (for HDL and LDL levels);
25) SPEP (blood test for myeloma);
26) stress test (on a bicycle or treadmill);
27) thermography; or
28) any other generally medically accepted cancer-screening test.

We will pay:

1) regardless of the result of any test; and
2) provided the test was conducted while the Covered Person was covered under the Policy.

LIMITATIONS AND EXCLUSIONS

Exclusions:
No benefits are payable under this Certificate for Critical Illness that results from or is caused by:

1) suicide, attempted suicide or intentionally self-inflicted injury, whether sane or insane;
2) war or act of war, declared or undeclared;
3) the Covered Person's participation in a felony, riot or insurrection;
4) the Covered Person's engaging in any illegal occupation; or
5) the Covered Person's service in the armed forces or units auxiliary to them.

CLAIM PROVISIONS

Notice of Claim
Notice of claim may be given to Us within 20 days after the start of any loss covered by the Policy, or as soon as reasonably possible. Notice given by or on behalf of a Covered Person to Us, or to Our authorized agent, with information sufficient to identify the Covered Person, shall be notice to Us.

Failure to give notice within this time frame will not invalidate nor reduce any claim.

Claim Forms
When We receive Claim Notice, We will send claim forms to the claimant. If the claimant does not receive the forms within 15 days after Claim Notice is sent, the claimant shall be deemed to have complied with the requirements of sending Claim Proof of Loss upon submitting within time fixed in filing the Claim Proof of Loss.

Claim Proof of Loss
The claimant must send proof of loss to Us. This proof must be provided within 90 days after the date of the loss. If it is not reasonably possible to give proof in this time, proof must be provided as soon as reasonably possible. Proof of loss may not be given more than one year after the time proof is otherwise required, unless the claimant is legally incapacitated.

Physical Examinations and Autopsy
We, at our own expense, shall have the right and opportunity to have:
1) a Covered Person for whom a claim is made examined by a Physician or Medical Professional of Our choice during the pendency of a claim as often as reasonably required; and
2) an autopsy conducted for a Covered Person for whom a claim is made in case of death, where not prohibited by law.

Time of Payment of Claims
Benefits payable under the Policy will be paid immediately upon Our receipt of due Claim Proof of Loss. Any other accrued indemnities unpaid at the Covered Person's death may, at the option of Us, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Covered Person.

Payment of Claims
All benefits are payable to You. Any benefits unpaid at the time of Your death will be paid to:
1) Your designated beneficiary(ies); or if none, then to
2) Your estate.

Beneficiary Designation
In the event of Your death, You should designate one or more beneficiaries to receive any benefits under the Policy that are unpaid at the time of Your death. Beneficiary records will be kept by the Policyholder, plan administrator or the office/system where beneficiary records for the Policy are kept. The most current beneficiary designation in effect under a Prior Policy will be accepted as a beneficiary designation under the Policy until changed (if applicable).

Certain states are community property states. If You live in a community property state and designate someone other than Your Spouse as a beneficiary, state law may require that Your Spouse consent to such designation. If spousal consent to the designation is not obtained, then such designation may not be effective. Community property states as of the Policy Effective Date include: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin.

Change of Beneficiary
The beneficiary may be changed at any time by You or Your assignee (if You assigned this insurance). To make a change, a request should be provided to the Policyholder, plan administrator or to the office/system where beneficiary records for the Policy are kept. If it is not known where the records are kept, then the request may be provided to Us. When received by the Policyholder, plan administrator,

office/system where beneficiary records for the Policy are kept or Us, the change will take effect as of the date the request is signed. The change will not apply to any payments or other action taken by Us before the request was received.

The right to change of beneficiary is reserved to You, and the consent of the beneficiary or beneficiaries shall not be requisite to any change in beneficiary, unless the current beneficiary designation is irrevocable.

Claim Denial
If a claim for benefits is wholly or partly denied, the claimant will be furnished with written notification of the decision. This written notification will:

1) give the specific reason(s) for the denial;
2) make specific reference to the Policy provisions on which the denial is based;
3) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
4) provide an explanation of the review procedure.

Claim Appeal
On any claim, the claimant or his or her representative may appeal to Us for a full and fair review. To do so, the claimant:

1) must submit a written request for review within:
   a) 180 days of receipt of Claim Denial if the claim requires Us to make a determination of a Critical Illness or other loss; or
   b) 60 days of receipt of Claim Denial if the claim does not require Us to make a determination of a Critical Illness or other loss; and
2) may request copies of all documents, records, and other information relevant to the claim; and
3) may submit written comments, documents, records and other information relating to the claim.

We will respond in writing with Our final decision on the claim. If You are not satisfied with the decision, You have the right to contact the California Insurance Department to review your dispute.

Overpayment Recovery
We have the right to recover from You or the recipient of benefits any amount that is an overpayment. You or the recipient of benefits has the obligation to refund to Us any such amount.

If benefits are overpaid on any claim, You or the recipient of benefits must reimburse Us within 90 days.

If reimbursement is not made in a timely manner, We have the right to:

1) recover such overpayments from:
   a) You;
   b) any other person to or for whom payment was made; or
   c) Your estate;
2) reduce or offset against any future benefits payable to You or Your survivors until full reimbursement is made;
3) refer the unpaid balance to a collection agency; and
4) pursue and enforce all legal and equitable rights in court.

GENERAL PROVISIONS

Entire Contract
The Policy, the Policyholder's signed application, this Certificate and any riders, endorsements or other attached papers make up the entire contract of insurance between the Policyholder and Us.

Statements
All statements made by the Policyholder and persons insured under the Policy will be deemed representations and not warranties. No statement will be used in any contest unless it is in writing, signed by the person making it and a copy of it is given to the person who made it, or, in the event of the death or incapacity of the Covered Person, to the Covered Person's beneficiary or personal representative.

Time Limit on Certain Defenses
Absent a showing of intentional fraud, no statement concerning insurability made by any Covered Person shall be used to contest the validity of the insurance for which the statement was made after this Policy has been in force for three years. In order to be used, the statement must be in writing and signed by the person making the statement. However, We are not precluded at any time from asserting defenses based upon the person's ineligibility for coverage under this Policy, or upon other provisions in the Policy.

No claim for loss incurred or disability commencing after three years from the effective date of the insurance coverage with respect to which the claim is made shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of the coverage with respect to which the claim is made.

Grace Period
A Grace Period of 31 days will be granted for the payment of each premium falling due after the first premium, during the Grace Period the Policy shall continue in force. If the entire premium is not paid by the end of the Grace Period, this Policy will terminate.

If the Policyholder gives Us written advance notice of an earlier cancellation date, the Policy will terminate on the earlier date; but no such termination will take effect during any period for which the required premium has been paid to us.

Legal Actions
No legal action may start:
1) until 60 days after Claim Proof of Loss has been given;
2) more than 3 years after the time proof of loss is required to be given; unless otherwise required by law in Your or the claimant's jurisdiction of residence.

Misstatement of Age or Tobacco Class
If the age or tobacco class of any Covered Person has been misstated:
1) the premium may be adjusted; and
2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

Assignment
You have the right to absolutely assign Your rights and interest under the Policy including, but not limited to, the following:
1) the right to make any contributions required to keep the insurance in force; and
2) the right to name and change a beneficiary.

We will recognize any absolute assignment made by You under the Policy, provided:
1) it is duly executed; and
2) a copy is acknowledged and on file with Us.

We and the Policyholder assume no responsibility:

1) for the validity or effect of any assignment; or
2) to provide any assignee with notices which We may be obligated to provide to You.

You do not have the right to collaterally assign his/her rights and interest under the Policy.

Conformity with State and Federal Laws
Any provision of the Policy that is contrary to the law of the jurisdiction in which it is delivered or with any other applicable law is amended to meet the minimum requirements of the law.

Time Periods
Unless otherwise specifically stated, all time periods begin and end at 12:01 A.M., Standard Time at the place where the Policy is delivered.

Workers' Compensation
The Policy does not replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

Unpaid Premium
Upon the payment of a claim, any premium then due and unpaid may be deducted from the claim payment.

Eligibility Determination
We, and not your employer or plan administrator, have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine the Covered Person's eligibility for benefits for any claim the Covered Person or the Covered Person's estate make on the policy. We will:

(a) obtain with the Covered Person's cooperation and authorization if required by law, only such information that is necessary to evaluate his/her claim and decide whether to accept or deny his/her claim for benefits. We may obtain this information from the Covered Person's Notice of Claim, submitted proofs of loss, statements, or other materials provided by the Covered Person or others on the Covered Person's behalf; or, at Our expense. We may obtain necessary information, or have the Covered Person physically examined when and as often as We may reasonably require while the claim is pending. In addition, and at the Covered Person's option and at his/her expense, the Covered Person may provide Us and We will consider any other information, including but not limited to, reports from a Physician or other expert of the Covered Person's choice. The Covered Person should provide Us with all information that he/she want Us to consider regarding his/her claim;
(b) as a part of Our routine operations, We will apply the terms of the Policy for making decisions, including decisions on eligibility, receipt of benefits and claims, or explaining policies, procedures and processes;
(c) if We approve the Covered Person's claim, We will review Our decision to approve his/her claim for benefits as often as is reasonably necessary to determine his/her continued eligibility for benefits;
(d) if We deny the Covered Person's claim, We will explain in writing to the Covered Person the basis for an adverse determination in accordance with the Policy as described in the provision entitled **Claim Denial**.

In the event We deny the Covered Person's claim for benefits, in whole or in part, he/she can appeal the decision to Us. If the Covered Person chooses to appeal Our decision, the process he/she must follow is set forth in the Policy provision entitled **Claim Appeal**. If the Covered Person does not appeal the decision to Us, then the decision will be Our final decision.