THE STANDARD LIFE INSURANCE COMPANY OF NEW YORK

A Stock Life Insurance Company
360 Hamilton Avenue, Suite 210
White Plains, New York 10601-1871
(914) 989-4400

GROUP SPECIFIED DISEASE INSURANCE CERTIFICATE

Policyholder:	New York State Correctional Officers and Police Benevolent Association, Inc.
Employer(s):	New York State Correctional Officers and Police Benevolent Association, Inc.
Group Policy Number:	645228-E
Group Policy Effective Date:	12/01/2017
State of Issue:	New York

The Group Policy has been issued to the Policyholder. We certify that you will be insured as provided by the terms of the Group Policy. If your insurance is changed by an amendment to the Group Policy, we will provide the Policyholder or Employer with a revised Certificate or other notice that will be available to you.

Possession of this Certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this Certificate.

"You" and "your" mean the Member. "We", "us" and "our" mean The Standard Life Insurance Company Of New York. Other defined terms appear with the initial letters capitalized. Section and provision headings, and references to them, appear in boldface type.

Your Certificate describes the insurance under the Group Policy. Please read your Certificate carefully.

THIS IS A LIMITED BENEFIT CERTIFICATE. IT PAYS BENEFITS FOR ALZHEIMER'S DISEASE, CANCER (CARCINOMA IN SITU AND SKIN CANCER INCLUDED) END-STAGE RENAL FAILURE, MAJOR ORGAN FAILURE, MYOCARDIAL INFARCTION, SEVERE CORONARY ARTERY DISEASE, AND STROKE. READ IT CAREFULLY WITH THE REQUIRED DISCLOSURE STATEMENT.

THE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED DOES NOT PROVIDE COMPREHENSIVE HEALTH INSURANCE COVERAGE. IT IS NOT INTENDED TO SATISFY THE INDIVIDUAL MANDATE OF THE AFFORDABLE CARE ACT (ACA) OR PROVIDE THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE ACA (OFTEN REFERRED TO AS "MAJOR MEDICAL COVERAGE"). IT DOES NOT PROVIDE COVERAGE FOR HOSPITAL, SURGICAL OR MAJOR MEDICAL EXPENSES.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT POLICY. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE "GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE" AVAILABLE FROM US.

THE STANDARD LIFE INSURANCE COMPANY OF NEW YORK

By

Chairman, President and CEO

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COVERAGE FEATURES

Employer(s)

New York State Correctional Officers and Police Benevolent Association, Inc.

Member

You are a Member if you are one of the following:

1. A NYSCOPBA Employees' Association (NEA) union employee of the Policyholder who retired under the Policyholder's retirement program; or
2. A member in associate (retired) membership in good standing of the NYSCOPBA Retiree Chapter.

You are not a Member if you are:

- A temporary or seasonal employee.
- A full time member of the armed forces of any country.
- A leased employee.
- An independent contractor.

Class(es)

Class 3: Retired Members

Eligibility Waiting Period

If you are a Member on the Group Policy Effective Date, you are eligible on that date.

If you become a Member after the Group Policy Effective Date, you are eligible on the date you become a Member.

Your Eligibility Waiting Period will be reduced by any continuous period as an employee of the Employer immediately prior to the date you become a Member.

Premium Contributions

For you and your Child:	Contributory
For your Spouse:	Contributory

Contributory means you pay all or part of the premium for insurance.

Coverage Amount

The Coverage Amount is the amount of insurance under the Group Policy. The Guarantee Issue Amount is the amount of insurance you may apply for without submitting Evidence Of Insurability. Coverage Amounts requiring Evidence Of Insurability are not effective until approved by us.

For Member:	The amount you elect and we approve in increments of $5,000 from $5,000 - $50,000. You may not be insured as both an active Member and a retired Member.
For Child(ren):	25% of your Coverage Amount.

For Spouse:	The amount you elect for your Spouse and we approve in increments of $5,000 from $5,000-$50,000. Not to exceed 100% of your Coverage Amount.
Guarantee Issue Amount	
For Member:	$20,000
For Spouse:	$10,000

Amount Payable

Table of Specified Disease Benefits

Subject to the Maximum Group Policy Amount, the amount payable is the percentage of the Coverage Amount or dollar amount in effect on the date you or your Dependent incur a Specified Disease. Subject to the Maximum Group Policy Amount, a benefit for each Specified Disease is payable only once for each covered person. Once benefits for a covered person reach the Maximum Group Policy Amount no further Specified Disease or Additional Benefit will be paid for that covered person.

The total of all benefits payable for a covered person under the Group Policy will not exceed the Maximum Group Policy Amount. The Maximum Group Policy Amount is:

For Member:	500% of your Coverage Amount
For Spouse:	500% of your Spouse's Coverage Amount
For Child(ren):	500% of your Child's Coverage Amount

Specified Disease Benefit Amounts:

Alzheimer's Disease	100% of Coverage Amount
Cancer, other than Carcinoma in Situ and Skin Cancer	100% of Coverage Amount
Carcinoma in Situ, other than Skin Cancer	25% of Coverage Amount
Skin Cancer	$250 per insured, per lifetime
End-Stage Renal (Kidney) Failure	100% of Coverage Amount
Major Organ Failure	100% of Coverage Amount
Myocardial Infarction (Heart Attack)	100% of Coverage Amount
Severe Coronary Artery Disease	25% of Coverage Amount
Stroke	100% of Coverage Amount

Additional Benefit

You may select the Health Maintenance Screening Benefit for you and your Dependents.

Health Maintenance Screening Benefit	$50

Additional Features

Reinstatement

Continuity of Coverage

ELIGIBILITY AND ENROLLMENT

Becoming Insured

To become insured you must:

- Be a Member.
- Complete your Eligibility Waiting Period.
- Meet the requirements shown in **When Your Insurance Becomes Effective** and **Active Work Requirement** unless you are a Retired Member.
- Submit Evidence Of Insurability, if required.

When Your Insurance Becomes Effective

The **Coverage Features** states whether insurance is Contributory or Noncontributory. Subject to the **Active Work Requirement,** your insurance becomes effective as follows:

Insurance Subject to Evidence Of Insurability

Insurance subject to Evidence Of Insurability becomes effective on the date we approve your Evidence Of Insurability.

Insurance Not Subject to Evidence Of Insurability

Contributory insurance

You must apply in writing for Contributory insurance and agree to pay premiums. Contributory insurance not subject to Evidence Of Insurability becomes effective on:

- The date you become eligible if you apply on or before that date.
- The date you apply if you apply within 31 days after you become eligible.
- If you have a Family Status Change the later of:
  - The date of the Family Status Change if you apply on or before the date of the Family Status Change.
  - The date you apply if you apply within 31 days of the Family Status Change.

Family Status Change means any of the following events:

- Your marriage or divorce or dissolution of your Civil Union or Domestic Partner relationship.
- The birth of your Child.
- The adoption of a Child by you.
- The death of your Dependent.
- The commencement or termination of your Spouse's employment.
- A change in employment from full-time to part-time by your Spouse.
- A loss of specified disease insurance through your Spouse’s employment.

Evidence Of Insurability

Evidence Of Insurability will be required as follows:

- For Contributory insurance if you apply more than 31 days after you become eligible.
- For reinstatements, if required.

- If you were required to provide Evidence Of Insurability during a prior period of eligibility under the Group Policy and either:
  - You did not provide Evidence Of Insurability; or
  - We disapproved your Evidence Of Insurability.
- For any Coverage Amount in excess of the Guarantee Issue Amount.

Evidence Of Insurability will be waived to become insured for the Guarantee Issue Amount if:

- You have a Family Status Change; and you apply within 31 days of the Family Status Change.
- The Employer has an Annual Enrollment Period; and you apply during the Annual Enrollment Period following the date you become a Retired Member.

However, we will not waive Evidence Of Insurability if you previously submitted Evidence Of Insurability and it was not approved by us.

Changes in Your Insurance

You may apply in writing for any increase in your insurance.

Evidence Of Insurability for Contributory insurance will be required as follows:

- For increases in Coverage Amounts.
- If you were required to provide Evidence Of Insurability during a prior period of eligibility under the Group Policy and either:
  - You did not provide Evidence Of Insurability; or
  - We disapproved your Evidence Of Insurability.

Evidence Of Insurability will be waived for any increase in Coverage Amount not to exceed the Guarantee Issue Amount if you have a Family Status Change, and you apply for the increase within 31 days of the Family Status Change. However, we will not waive Evidence Of Insurability if you previously submitted Evidence Of Insurability that was not approved by us.

Subject to the **Active Work Requirement**, increases in your insurance become effective as follows:

Increases Subject to Evidence Of Insurability

Increases subject to Evidence Of Insurability become effective on the date we approve your Evidence Of Insurability.

Decreases in Coverage Amounts become effective on the date the Policyholder or Employer receives your written request for the decrease.

Active Work Requirement

If you are incapable of Active Work because of sickness, injury, or pregnancy on the day before the scheduled effective date of your insurance or increase in Coverage Amount under the Group Policy, such insurance will not become effective until the day after you complete 1 full day(s) of Active Work as an eligible Member.

Active Work and Actively At Work mean performing the material duties of your own occupation at your Employer's usual place of business.

You will also meet the Active Work requirement if you meet all of the requirements shown below:

- You were absent from Active Work because of a regularly scheduled day off, holiday, or vacation day.
- You were Actively At Work on your last scheduled work day before the date of your absence.
- You were capable of Active Work on the day before the scheduled effective date of your insurance.

When Your Insurance Ends

Insurance ends automatically on the earliest of the following:

- For Contributory insurance, the date you notify the Policyholder or your Employer in writing that coverage is to be terminated.

- The date the last period ends for which the premium was paid for your insurance.
- The date the Group Policy terminates or your Employer's coverage under the Group Policy terminates.
- The first day of the calendar month coinciding with or next following the date your employment terminates, unless you become insured as a Retired Member.
- The date benefits paid for your Specified Diseases reach the Maximum Group Policy Amount. Insurance for your Dependents will remain in effect, subject to the Maximum Group Policy Amount for your Dependents.
- The date you reach age 80.
- The date you cease to be a Member. However, if you cease to be a Member because you are not working the required minimum number of hours, your insurance will be continued with payment of premium:
  - During the first 60 days of a temporary or indefinite administrative leave of absence.
  - During any other scheduled leave of absence approved by your Employer in advance and in writing and lasting not more than 60 days.
  - During a leave of absence which is required by the federal or a state-mandated family or medical leave act or law.

CHILD INSURANCE

When Child Insurance Becomes Effective

Insurance for your Child becomes effective as follows:

- The date your insurance becomes effective if you have a Child on that date.
- The date you first acquire a Child, if you are insured on that date.

If you have more than one Child on the effective date, all are insured as of that date. While your insurance is in effect, each new Child becomes insured immediately.

A Member may not be insured as both a Member and a Child. A Child may not be insured by more than one Member.

Changes in Child Insurance

Increases or decreases resulting from changes in your Coverage Amounts will become effective for a Child on the effective date of your change.

When Child Insurance Ends

Your insurance for a Child ends automatically on the earliest of:

- The date your insurance ends. If benefits paid for your Specified Diseases reach the Maximum Group Policy Amount, insurance for your Child will continue, subject to the Maximum Group Policy Amount applicable to your Child.
- With respect to each Child, the date benefits paid for that Child’s Specified Diseases reach the Maximum Group Policy Amount.
- The date the Child insurance terminates under the Group Policy.
- The date a Child ceases to meet the definition of Child.
- The date the Group Policy terminates.

SPOUSE INSURANCE

Eligibility for Spouse Insurance

You become eligible to insure your Spouse on the later of:

- The date you become eligible for insurance if you have a Spouse on that date.
- The date you acquire a Spouse, if you are insured on that date.

A Member may not be insured as both a Member and a Spouse.

When Spouse Insurance Becomes Effective

The **Coverage Features** states whether your Spouse insurance is Contributory or Noncontributory. You must apply in writing for Contributory Spouse insurance and agree to pay premiums.

Spouse Insurance Subject to Evidence Of Insurability

Spouse insurance subject to Evidence Of Insurability becomes effective on the later of:

- The date we approve Evidence Of Insurability for your Spouse;

Spouse insurance will not become effective if you were required to submit Evidence Of Insurability and either:

- You did not submit Evidence Of Insurability.
- We disapproved your Evidence Of Insurability.

Spouse Insurance Not Subject to Evidence Of Insurability

Contributory Spouse insurance becomes effective on:

- The date your insurance becomes effective if you apply on or before that date to insure your Spouse.
- The date you apply to insure your Spouse.
- If you have a Family Status Change, the later of:
  - The date of the Family Status Change if you apply on or before the date of the Family Status Change.
  - The date you apply, if you apply within 31 days of the Family Status Change.

Evidence Of Insurability

Evidence Of Insurability will be required for your Spouse as follows:

- For Contributory insurance if you apply more than 31 days after you become eligible for Spouse insurance.
- If your Spouse was eligible for more than 31 days under the Prior Plan but not insured.
- For reinstatements, if required.
- If Evidence Of Insurability was required for your Spouse during a prior period of eligibility under the Group Policy and either:
  - Evidence Of Insurability was not provided for your Spouse; or
  - We disapproved Evidence Of Insurability for your Spouse.
- For any Coverage Amount in excess of the Spouse Guarantee Issue Amount.

Evidence Of Insurability will be waived to become insured for the Guarantee Issue Amount if:

- You have a Family Status Change; and you apply within 31 days of the Family Status Change.
- The Employer has an Annual Enrollment Period; and you apply during the Annual Enrollment Period following the date you become a Retired Member.

However, we will not waive Evidence Of Insurability if you previously submitted Evidence Of Insurability for your Spouse and it was not approved by us.

Changes in Spouse Insurance

You may apply in writing for any increase in your Spouse insurance.

Evidence Of Insurability for Contributory insurance will be required as follows:

- For increases in Coverage Amounts.
- If Evidence Of Insurability was required for your Spouse during a prior period of eligibility under the Group Policy and either:
  - Evidence Of Insurability was not provided for your Spouse; or
  - We disapproved Evidence Of Insurability for your Spouse.

Evidence Of Insurability will be waived in the following instances:

- For additional insurance due to a plan change
- For any increase in your Spouse's Coverage Amount not to exceed the Spouse Guarantee Issue Amount if:
  - You have a Family Status Change; and you apply for the increase within 31 days of the Family Status Change.

However, we will not waive Evidence Of Insurability for your Spouse if you previously submitted Evidence Of Insurability that was not approved by us.

Subject to your Spouse being gainfully employed or capable of performing the material duties of an occupation, increases in your Spouse's insurance become effective as follows:

Spouse Insurance Increases Subject to Evidence Of Insurability

Increases in your Spouse's insurance subject to Evidence Of Insurability become effective on the later of:

- The date we approve Evidence Of Insurability for your Spouse.
- The date we approved Evidence Of Insurability for your Spouse due to a Family Status Change.

Spouse Insurance Increases Not Subject to Evidence Of Insurability

Increases in your Spouse's insurance not subject to Evidence Of Insurability becomes effective on the latest of:

- The date you apply for the increase.
- The date of your Family Status Change.

Decreases in your Spouse's Coverage Amounts become effective on:

- The date your Coverage Amount decreases.
- The date the Policyholder or Employer receives your written request for the decrease.

When Spouse Insurance Ends

Your insurance for a Spouse ends automatically on the earliest of:

- The date your insurance ends. If benefits paid for your Specified Diseases reach the Maximum Group Policy Amount, insurance for your Spouse will continue, subject to the Maximum Group Policy Amount applicable to your Spouse.

- The date benefits paid for your Spouse's Specified Diseases reach the Maximum Group Policy Amount.
- The date Spouse insurance terminates under the Group Policy.
- The date a Spouse ceases to meet the definition of Spouse.
- The date the last period ends for which the premium was paid for your Spouse insurance.
- The date the Group Policy terminates or the date your Employer's coverage under the Group Policy terminates.
- The date your Spouse reaches age 80.

SPECIFIED DISEASE BENEFITS

Insuring Clause

If you or your Dependent incur a Specified Disease or meet the requirements for the Additional Benefit while insured under the Group Policy, we will pay benefits according to the terms of the Group Policy after we receive Proof Of Loss satisfactory to us.

Specified Disease Definitions

Alzheimer's Disease means the development of multiple, progressive cognitive deficits manifested by memory impairment (impaired ability to learn new information or to recall previously learned information) and one or more of the following cognitive disturbances:

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

The initial diagnosis of Alzheimer's Disease must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as a neurologist.

Dementia due to the root cause of vascular dementia (including stroke), drug or alcohol abuse are not included.

Cancer means an initial diagnosis of any malignant tumor or neoplasm with histological confirmation, characterized by the uncontrolled growth of malignant cells and invasion of tissue beyond the initial tissue (invasive).

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as a pathologist or oncologist.
- Be based on pathological or clinical evidence.

Cancer includes:

- Leukemia
- Lymphoma
- Sarcoma

- Melanoma and other skin malignancies that have been histologically classified as having caused invasion beyond the epidermis with a Clark's level III or greater, Breslow's depth of 0.75mm or greater, or AJCC TNM stage II or greater are included.

Conditions that are not invasive Cancer are not included. Such conditions include, but are not limited to:

- All cancers which are histologically classified as pre-malignant, non-invasive, carcinoma in situ, having borderline malignancy, or having low malignant potential.
- Benign tumors or polyps.
- Early prostate cancer that is histologically classified as T1N0M0 or equivalent staging.
- Chronic lymphocytic leukemia that is histologically classified as Rai Stage 0 or Binet Stage A.
- Any skin cancer not previously incorporated in this definition, including:
  - Cutaneous lymphoma.
  - Melanoma that is histologically classified as Clark's level I or II; Breslow's depth of less than 0.75mm; or AJCC TNM stage 0 or I.

Carcinoma in Situ means an initial diagnosis of cancer in which the tumor or cells still lie within the tissue of origin without invading neighboring tissue or regional lymph nodes.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as a pathologist or oncologist.
- Be based on pathological or clinical evidence.

Carcinoma in Situ includes, but is not limited to:

- Early prostate cancer that is histologically classified as T1N0M0 or equivalent staging.
- Chronic lymphocytic leukemia that is histologically classified as Rai Stage 0 or Binet Stage A.
- Cutaneous lymphoma.
- Melanoma not invading the reticular (lower) dermis that is histologically classified as one of the following:
  - Clark's level I or II.
  - Breslow's depth of less than 0.75mm.
  - AJCC TNM stage 0 or I.

Conditions that are not Carcinoma in Situ are not included. Such conditions include, but are not limited to:

- Lesser skin malignancies (such as basal cell and squamous cell carcinomas).
- Invasive Cancer as defined above.
- Pre-malignant lesions.
- Intraepithelial neoplasia.
- Benign tumors or polyps.

Skin Cancer means an initial diagnosis of basal cell carcinoma of the skin or squamous cell carcinoma of the skin with histological confirmation.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as a pathologist, oncologist or dermatologist.
- Be based on pathological or clinical evidence.

Conditions that are not Skin Cancer are not included. Such conditions include, but are not limited to:

- Carcinoma in situ
- Invasive Cancer as defined above.
- Pre-malignant tumors or polyps.
- Any conditions which may be considered pre-cancerous, such as: leukoplakia; actinic keratosis; carcinoid; hyperplasia; polycythemia; non-malignant melanoma; moles; or similar diseases or lesions.

End-Stage Renal Failure means an initial diagnosis of chronic and end-stage irreversible failure of both kidneys to function, as a result of which the need for regular, at least weekly, kidney dialysis or kidney transplant is recommended to sustain life.

The diagnosis and recommendation must:

- Be made while insured under the Group Policy.
- Be made by a board certified nephrologist.

Major Organ Failure means an initial diagnosis of irreversible failure of the heart, liver, lung, small intestine, or pancreas as a result of a disease and, for which a transplantation of the organ(s) or tissue from a suitable human donor is required.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician.
- Be based on clinical evidence of major organ failure of an organ(s) or tissue.

If your or your Dependent's condition is too far advanced or you or your Dependent are too ill to proceed with a transplant, the transplantation requirement will not apply.

Myocardial Infarction is commonly known as a heart attack and means an episode of rapid onset of chest pain that required immediate medical attention and with an initial diagnosis of death of a portion of the heart muscle as a result of inadequate blood supply to the heart.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician.
- Be based on new changes consistent with an evolving infarction on electrocardiogram (EKG) and concurrent with elevation of infarction specific enzymes, troponins or other biochemical markers accepted to be indicative of an acute Myocardial Infarction. In the event of death, an autopsy or death certificate indicating Myocardial Infarction as the cause will apply.

Myocardial Infarction does not include a heart attack that occurred during a medical procedure or due to alcohol or drug abuse. Other acute coronary syndromes, including but not limited to angina, are not included.

Severe Coronary Artery Disease means a 70% or more narrowing or blockage of the arteries and vessels that provide oxygen and nutrients to the heart that result in an initial diagnosis of severe coronary artery disease.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as a cardiologist or cardiac surgeon.
- Be based on a clinical diagnosis.

Severe Coronary Artery Disease does not include: angioplasty, stenting, percutaneous coronary intervention, or laser procedures.

Stroke means an initial diagnosis of: a cerebrovascular accident or infarction (death) of brain tissue caused by hemorrhage, embolism or thrombosis producing measurable, neurological deficit, which is expected to be permanent.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician.
- Be based on objective clinical evidence of brain tissue damage using current neuroimaging tests, including but not limited to: Computed Tomography scan (CT); Magnetic Resonance Imaging (MRI); Positron Emission Tomography scan (PET); arteriography; or angiography.

Stroke does not include Transient Ischemic Attack (TIA) and traumatic injury to brain tissue or blood vessels.

Additional Benefit

Health Maintenance Screening Benefit

We will pay a Health Maintenance Screening Benefit if you or your Dependent meet all of the following requirements:

- You or your Dependent were insured under the Group Policy for at least 1 months.
- A Health Maintenance Screening Procedure is performed.

Health Maintenance Screening Procedures are limited to the following:

- Abdominal aortic aneurysm ultrasound.
- Ankle Brachial Index (ABI) screening for peripheral vascular disease.
- Biopsies for cancer.
- Bone density screening.
- Breast ultrasound.
- Cancer antigen 125 blood test for ovarian cancer (CA 125).
- Cancer antigen 15-3 blood test for breast cancer (CA 15-3).
- Carcinoembryonic antigen blood test for colon cancer (CEA).
- Colonoscopy.
- Complete Blood Count (CBC).
- Comprehensive Metabolic Panel (CMP).
- Electrocardiogram (EKG).
- Hemocult stool analysis.
- Hemoglobin A1C.
- Human Papillomavirus (HPV) vaccination.
- Lipid panel.
- Mammography.
- Pap smears or thin prep pap test.
- Prostate specific antigen (PSA) test.
- Stress test on a bicycle or treadmill.

We will pay a Health Maintenance Screening Benefit per insured person per Calendar Year.

Calendar Year means the period from January 1 through December 31 of the same year.

EXCLUSIONS

General Exclusions

Benefits are not payable if Specified Disease is caused or contributed to by any of the following:

- War or act of War. War whether declared or undeclared.
- Suicide or other intentionally self-inflicted injury.
- Participating in a felony, riot, or insurrection. Participating does not include being at the scene of a felony, riot, or insurrection while performing official duties.
- Alcoholism and drug addiction. We shall not be liable for any Specified Disease sustained or contracted in consequence of you or your Dependent being intoxicated or under the influence of any narcotic unless administered on the advice of a Physician.
- Initial diagnosis outside of the United States.
- Cosmetic surgery or other procedure which:
  - Does not promote the proper function of your or your Dependent's body or prevent or treat sickness or injury.
  - Is directed at improving your or your Dependent's appearance, unless such cosmetic surgery or procedure is necessary to correct a deformity resulting from a congenital abnormality or disfigurement.

  This exclusion will not apply to a Specified Disease caused or contributed to by your or your Dependent's donation of an organ or tissue.

ADDITIONAL FEATURES

Reinstatement

If your insurance ends, you may become insured again as a new Member. However, the following will apply:

- If your insurance ends because you cease to be a Member and if you become a Member again within 90 days, the Eligibility Waiting Period will be waived.
- If your insurance ends because you fail to make the required premium contribution, you and your Spouse must provide Evidence Of Insurability to become insured again.

In no event will insurance be retroactive.

Continuity of Coverage

Waiver of Active Work Requirement

If you were insured under the Prior Plan on the day before the effective date of the Policyholder's coverage under the Group Policy, you can become insured on the effective date of the Policyholder's coverage without meeting the Active Work requirement. See the **Active Work Requirement**.

CLAIMS AND BENEFIT PAYMENT

Notice of Claim

Written notice of claim must be provided to us within 20 days after the date of the Specified Disease or within 20 days after meeting the requirements for a Specified Disease Insurance Benefit, or as soon thereafter as is reasonably possible.

Filing a Claim

Claims should be filed on our forms. If we do not provide our forms within 15 days after they are requested, the claim may be submitted in a letter to us. The letter should include the nature and extent of the benefit claimed as required in the Proof Of Loss provision. Subject to the time period in the Notice of Claim provision, such letter will constitute notice.

Time Limits on Filing Proof Of Loss

Proof Of Loss must be provided within 120 days after the date of the Specified Disease. For Additional Benefit, Proof Of Loss must be provided within 120 days after meeting the requirements for the Additional Benefit. If that is not possible, it must be provided as soon as reasonably possible.

If Proof Of Loss is filed outside these time limits, the claim will be denied. These limits will not apply while the claimant lacks legal capacity.

Proof Of Loss

Proof Of Loss means written proof that a Specified Disease or entitlement to an Additional Benefit occurred:

- For which the Group Policy provides benefits.
- Which is not subject to any exclusions.
- Which meets all other conditions for benefits.

Proof Of Loss includes any other information we may reasonably require in support of a claim. Proof Of Loss must be in writing and must be provided at the expense of the claimant. No benefits will be paid until we receive Proof of Loss satisfactory to us.

Investigation of Claim

We reserve the right to investigate a claim at any time at our expense, including an examination conducted by specialists of our choice. In case of death, we have the right and opportunity to request an autopsy, except where prohibited by law.

Notice of Decision on Claim

We will evaluate a claim for benefits promptly after we receive it. Within 60 days after we receive the claim we will send the claimant: (a) a written decision on the claim; or (b) a notice that we are extending the period to decide the claim for an additional 60 days.

If we extend the period to decide the claim, we will notify the claimant of the following: (a) the reasons for the extension; and (b) when we expect to decide the claim.

If we deny any part of the claim, we will send the claimant a written notice of denial containing:

- The reasons for our decision.
- Reference to the parts of the Group Policy on which our decision is based.
- A description of any additional information needed to support the claim.
- Information concerning the claimant's right to a review of our decision.

Review Procedure

If all or part of a claim is denied, the claimant may request a review. The claimant must request a review in writing within 60 days after receiving notice of the denial of the claim.

The claimant may send us written comments or other items to support the claim. The claimant may review and receive copies of any non-privileged information that is relevant to the request for review. There will be no charge for such copies. Our review will include any written comments or other items the claimant submits to support the claim.

We will review the claim promptly after we receive the request. With respect to all claims, within 45 days after we receive the request for review we will send the claimant: (a) a written decision on review; or (b) a notice that we are extending the review period for 45 days.

If an extension is due to the claimant's failure to provide information necessary to decide the claim on review, the extended time period for review of the claim will not begin until the claimant provides the information or otherwise responds.

If we extend the review period, we will notify the claimant of the following: (a) the reasons for the extension; and (b) when we expect to decide the claim on review.

If we request additional information, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, we may conclude our review of the claim based on the information we have received.

If we deny any part of the claim on review, the claimant will receive a written notice of denial containing:

- The reasons for our decision.
- Reference to the parts of the Group Policy on which our decision is based.
- Information concerning the claimant's right to receive, free of charge, copies of non-privileged documents and records relevant to the claim.

Time of Payment

We will pay benefits within 30 days after Proof Of Loss is satisfied.

Payment of Benefits

Benefits will be paid to you. Any benefits remaining unpaid at your death will be paid as shown below.

Benefits will be paid in equal shares to the first surviving class of the classes below.

- Your Spouse.
- Your children.
- Your parents.
- Your brothers and sisters.
- Your estate.

Reimbursement

We reserve the right to recover any benefits that you or your Dependent or a claimant were paid but not entitled to under the terms of the Group Policy, state or federal law.

You or your Dependent, or a claimant or beneficiary must reimburse us in full. We will determine the method by which repayment is to be paid.

Unpaid Premium

Any unpaid premium due for your or your Dependent's Specified Disease Insurance under the Group Policy may be recovered by us. Any Specified Disease Benefits payable to you or your Dependent, a claimant, a beneficiary or legal representative will be applied to reduce the amount of any unpaid premiums prior to paying you or your Dependent, a claimant, a beneficiary or a legal representative.

GENERAL PROVISIONS

Assignment

The rights and benefits under the Group Policy may not be assigned.

Time Limits on Legal Actions

No action at law or in equity may be brought until 60 days after we have been given Proof Of Loss. No such action may be brought more than two years after the earlier of:

- The date we receive Proof Of Loss.
- The time within which Proof Of Loss is required to be given.

Incontestability of Insurance

Any statement made to obtain insurance or to increase insurance is a representation and not a warranty. No misrepresentation will be used to reduce or deny a claim or contest the validity of insurance unless:

- The insurance would not have been approved if we had known the truth.
- We have given you or any other person claiming benefits a copy of the signed written instrument which contains the misrepresentation.

After insurance has been in effect for two years during the lifetime of the insured, we will not use a misrepresentation to reduce or deny the claim, unless it was a fraudulent misrepresentation.

Clerical Error

Clerical error by the Policyholder, your Employer, or their respective employees or representatives will not:

- Cause a person to become insured.
- Invalidate insurance under the Group Policy otherwise validly in force.
- Continue insurance under the Group Policy otherwise validly terminated.

Agency

The Policyholder and your Employer act on their own behalf as your agent, and not as our agent. Individuals selected by the Policyholder or by your Employer to secure coverage under the Group Policy or to perform their administrative function under it, represent and act on behalf of the person selecting them, and do not represent or act on behalf of us. The Policyholder and your Employer have no authority to alter, expand or extend our liability or to waive, modify or compromise any defense or right we may have under the Group Policy.

Misstatement of Age

If a person's age has been misstated, we will make an equitable adjustment of premiums, benefits, or both. The adjustment will be based on the following:

- The amount of insurance based on the correct age.
- The difference between the premiums paid and the premiums which would have been paid if the age had been correctly stated.

Misstatement of Tobacco Use

If a person’s use of tobacco has been misstated, we have the right to make an equitable adjustment of premiums, benefits, or both. The adjustment will be based on the following:

- The amount of insurance based on the correct tobacco use status.

- The difference between the premiums paid and the premiums which would have been paid if the tobacco use status had been correctly stated.

DEFINITIONS

Child

Child means one of the following:

- Your child from live birth until age 26.
- Your adopted child and a child placed in your home pending adoption until age 26. A child dependent on you while residing with you during any waiting period prior to the finalization of the adoption is considered an adopted child.
- Your stepchild, foster child, dependent grandchild, and the child of your Spouse until age 26.
- A child for whom you are the court appointed legal guardian until age 26.
- Your child, stepchild, foster child, dependent grandchild, and the child of your Spouse who is continuously incapable of self-sustaining employment because of mental illness, developmental disability, mental retardation as defined in the mental hygiene law or physical handicap; and chiefly dependent upon you for support and maintenance or institutionalized because of mental or physical handicap.

Child does not include a person who is eligible for insurance as a Member. A Child does not include a full-time member of the armed forces of any country.

Dependent(s**)**

Your Spouse, your Child, or your Spouse or Child, or your Spouse and Child.

Eligibility Waiting Period

The period you must be a Member before you become eligible for insurance. Your Eligibility Waiting Period is shown in the **Coverage Features**.

Employer

An employer for which coverage under the Group Policy is approved in writing by us.

Evidence Of Insurability

You or your Spouse must:

- Complete and sign our medical history statement.
- If required by us, sign our form authorizing us to obtain information about the applicant's health.
- Undergo a physical examination, if required by us, which may include blood testing.
- Provide any additional information about the applicant's insurability that we may reasonably require.

Group Policy

The group specified disease insurance policy issued by us to the Policyholder and identified by the Group Policy Number, the Policyholder's attached application, group specified disease insurance certificates with the same Group Policy Number, and any amendments to the policy or certificates.

Physician

An individual who is licensed by the state as an M.D. or D.O., including a legally qualified practitioner of the healing arts and acting within the scope of the license. Physician does not include you or your Spouse, or an employee partner or owner of the Policyholder, or the brother, sister, parent or child of either you or your Spouse.

Prior Plan

A specified disease insurance plan which is replaced by coverage under the Group Policy and which is the Employer’s group specified disease insurance plan in effect on the day before the effective date of your Employer’s coverage under the Group Policy and which is replaced by the Group Policy.

Spouse

Spouse means:

- A person to whom you are legally married.
- A person who is party to a Civil Union with you. Civil Union means a civil union established according to applicable law.
- Your Domestic Partner. Domestic Partner means an individual with whom you have established a domestic partnership in accordance with the laws or regulations of a jurisdiction that recognizes domestic partnerships; or an individual you have identified as a domestic partner under the Policyholder’s domestic partnership policy.

Spouse does not include a full-time member of the armed forces of any country.