

EMPLOYER: PIMA COUNTY GOVERNMENT

GROUP NUMBER: 561416

CERTIFICATE OF INSURANCE
Humana Insurance Company

This Certificate is not an insurance policy. It is an outline of the insurance provided by the group policy and it does not extend or change the coverage afforded by such group policy. The insurance described by this Certificate is subject to all the provisions, terms, exclusions and conditions of the group policy.

This Certificate supersedes and replaces any Certificate previously issued under the provisions of the group policy.



Michael B. McCallister
President

GROUP INSURANCE CERTIFICATE

POLICYHOLDER (EMPLOYER): PIMA COUNTY GOVERNMENT

GROUP NUMBER: 561416

BENEFITS

EFFECTIVE DATE

VOLUNTARY LIFE COVERAGE for Employee

07/01/2010

VOLUNTARY LIFE COVERAGE for Covered Spouse

07/01/2010

VOLUNTARY LIFE COVERAGE for Covered Dependent Child

07/01/2010

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SCHEDULE OF BENEFITS

EMPLOYEE VOLUNTARY TERM LIFE INSURANCE

VOLUNTARY TERM LIFE INSURANCE BENEFIT - As shown on Your **Employee's** Schedule of Benefits.

THE TERM LIFE INSURANCE BENEFIT IS REDUCED TO THE FOLLOWING FOR YOUR EMPLOYEES:

Reduced by 35% AT AGE 75 based on the amount of Basic Term Life Insurance in force at age 74
Reduced by 65% AT AGE 80 based on the amount of Basic Term Life Insurance in force at age 74

SCHEDULE OF BENEFITS

DEPENDENT SPOUSE VOLUNTARY TERM LIFE INSURANCE BENEFIT

DEPENDENT SPOUSE VOLUNTARY TERM LIFE INSURANCE BENEFIT - As shown on the Schedule of Benefit in **Your Employee's** Certificate.

SCHEDULE OF BENEFITS

DEPENDENT CHILD VOLUNTARY TERM LIFE INSURANCE BENEFIT

DEPENDENT CHILD VOLUNTARY - FROM BIRTH TO AGE 26 \$2000

DEFINITIONS

The following are definitions of terms as they are used in this Certificate. Defined terms are printed in bold face type wherever found in this Certificate.

A

Active Status means the **Employee** is performing all of the material duties of his/her occupation whether performed at the **Employer's** business establishment or another location of business when required to travel on behalf of the **Employer**:

- On a regular, full-time basis;
- For the number of hours per week shown on the Employer Group Application; and
- For 48 weeks a year.

An **Employee** will be considered in **Active Status** with the **Employer** on a day which is one of the **Employer's** scheduled work days if the **Employee** is performing, in the usual way, all of the material duties of his/her occupation on a full-time basis. The **Employee** will also be considered actively at work on each day of a regular scheduled paid vacation, or any regular non-working holiday, only if the **Employee** was at work on the preceding scheduled work day and was not **Totally Disabled** including a hospital confinement on that day.

B

Bodily Injury means injury due directly to a specific accident, independent of all other causes. Muscle strain due to athletic or physical activity, or bodily damage resulting from infection, is considered a **Sickness**.

C

Confinement means being a resident patient in a **Hospital** or **Qualified Treatment Facility** for at least 15 consecutive hours. **Confinement** does not mean detainment in Observation Status.

Successive **Confinements** are considered to be one **Confinement** if:

- Due to the same **Bodily Injury** or **Sickness**; and
- Separated by fewer than 30 consecutive days when **You** are not confined.

Cosmetic Surgery means Surgery performed to reshape normal structures of the body in order to improve **Your** appearance and self-esteem.

Covered Person means the **Employee** and/or the **Employee's** covered **Dependents**.

DEFINITIONS (continued)

D

Dependent means a covered **Employee's**:

- Legally recognized spouse; or
- Unmarried natural blood related child, step-child, or legally adopted child, or child placed with the **Employee** for the purpose of adoption whose age is less than the limiting age. **Dependent** DOES NOT mean a grandchild, great grandchild, or foster child. Each child must:
 - Meet all of the qualifications of a **Dependent** as determined by the Internal Revenue Service; and
 - Be declared on and legally qualify as a **Dependent** on the **Employee's** federal personal income tax return filed for each year of coverage.

The limiting age for each **Dependent** child is the child's 26th birthday.

You must furnish satisfactory proof to **Us** upon **Our** request that the above conditions continuously exist. If satisfactory proof is not submitted to **Us**, the child's coverage will not continue beyond the last date of eligibility.

A covered **Dependent** child who becomes an employee eligible for other group coverage through employment is no longer eligible as a **Dependent** for coverage under the Policy.

A covered **Dependent** child who attains the limiting age WHILE INSURED under the Policy remains eligible for Benefits if:

- Mentally retarded or permanently physically handicapped;
- Incapable of self-sustaining employment;
- The child meets all of the qualifications of a **Dependent** as determined by the Internal Revenue Service;
- Declared on and legally qualified as a **Dependent** on the **Employee's** federal personal income tax return filed for each year of coverage; and
- Unmarried.

You must furnish satisfactory proof to **Us** upon **Our** request that the above conditions continuously exist on and after the date the limiting age is reached. After two years from the date the first proof was furnished, **We** may not request such proof more often than annually. If satisfactory proof is not submitted to **Us**, the child's coverage will not continue beyond the last date of eligibility.

DEFINITIONS (continued)

E

Employee means a person who is in **Active Status** for the **Employer** on a permanent full-time basis. The **Employee** must be paid a salary or wage by the **Employer** that meets the minimum wage requirements of **Your** state or federal minimum wage law for work done at the **Employer's** usual place of business or some other location which is usual for the **Employee's** particular duties.

Employer means the Policyholder of this Group Insurance Plan, or any subsidiary described in the Employer Group Application.

H

Hospital means an institution which:

- Maintains permanent full-time facilities for bed care of resident patients;
- Has a physician or surgeon in regular attendance;
- Provides continuous 24-hour-a-day nursing services;
- Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;
- Is legally operated in the jurisdiction where located; and
- Has surgical facilities on its premises or has a contractual agreement for surgical services with an institution having a valid license to provide such surgical services; or
- Is a lawfully operated **Qualified Treatment Facility** certified by the First Church of Scientist, Boston, Massachusetts.

Hospital does NOT include an institution which is principally a rest home, nursing home, convalescent home or home for the aged. **Hospital** does NOT include a place principally for the treatment of alcohol or chemical dependency or Mental Disorders.

M

Material And Substantial Duties are the duties that:

Are normally required for the performance of the occupation; and

Cannot be reasonably omitted or changed.

You will no longer be considered **Totally Disabled** or Partially Disabled under this Plan when **You** are able to increase **Your** current earnings by increasing the number of hours **You** work or the number of duties **You** perform in **Your** regular occupation but **You** do not do so.

DEFINITIONS (continued)

P

Policyholder means the **Employer** who is the Legal Entity named as the **Policyholder** on the face page of the Policy.

Q

Qualified Practitioner means a practitioner, professionally licensed by the appropriate state agency to diagnose or treat a **Bodily Injury** or **Sickness**, and who provides services within the scope of that license. A **Qualified Practitioner** does not include a practitioner who resides in **Your** home or is **Your** Family Member.

Qualified Treatment Facility means only a facility, institution, or clinic duly licensed by the appropriate state agency, and is primarily established and operating within the scope of its license.

S

Sickness means a disturbance in function or structure of **Your** body which causes physical signs or symptoms which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of **Your** body.

Surgery means excision or incision of the skin or mucosal tissues or insertion for exploratory purposes into a natural body opening. This includes insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes.

T

Total Disability or **Totally Disabled** means, for the **Employee** that during the disability he or she is at all times prevented by **Bodily Injury** or **Sickness** from performing each and every **Material And Substantial Duty** of his or her occupation as it is generally performed in the economy.

A **Totally Disabled** person may not engage in ANY job or occupation for wage or profit.

W

We, Us, and Our means the Insurance Company as shown on the cover page of this Certificate.

Y

You and Your means any **Covered Person**.

ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE

EMPLOYEE COVERAGE

EMPLOYEE ELIGIBILITY DATE

The **Employee** is eligible for coverage on the date:

- Eligibility requirements stated in the Employer Group Application are satisfied; and
- The **Employee** is in an **Active Status**.

EMPLOYEE ENROLLMENT

The **Employee** must enroll on forms furnished and accepted by **Us**. Depending on the total number of **Employees** covered by the **Employer's** plan, **We** may require any **Employee** to provide evidence of insurability and any applicable evidence of health status whenever an enrollment form is submitted.

If **You** enroll more than 31 days after **Your** eligibility date, **You** are a late applicant and must provide **Us** with evidence of insurability and any applicable evidence of health status. This form is available from the **Employer** or **Us**. **We** have the right to accept or decline coverage. If accepted, **You** will be covered on the date **We** specify.

EMPLOYEE EFFECTIVE DATE

The **Employee's** Effective Date Provision is stated in the Employer Group Application. It may be the date immediately following, or the first of the month following, completion of the probationary period (waiting period), or the date approved by **Us**.

EMPLOYEE DELAYED EFFECTIVE DATE

If the **Employee** is not in **Active Status** on the effective date shown on the Schedule of Benefits, coverage will be effective the day after the **Employee** returns to **Active Status**. The **Employer** must notify **Us** in writing of the **Employee's** return to **Active Status**.

EMPLOYEE BENEFIT CHANGES

Additional or increased insurance will become effective on the approved date of change if the **Employee** is in **Active Status** on that date. Otherwise, the approved change will be effective on the day after the **Employee** returns to **Active Status**.

We may require any **Employee** to provide evidence of insurability and any applicable evidence of health status whenever a benefit change is requested.

A decrease in insurance will be effective immediately on the approved date of change.

ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE (continued)

DEPENDENT COVERAGE

DEPENDENT ELIGIBILITY DATE

Each **Dependent** is eligible for coverage on:

- The date the **Employee** is eligible for coverage, if he or she has **Dependents** who may be covered on that date;
- The date of the **Employee's** marriage for any **Dependents** (spouse or child) acquired on that date;
- The date of birth of the **Employee's** natural-born child; or
- The date the child is legally adopted or placed in the **Employee's** home for the purpose of adoption by the **Employee**.

The **Employee** may cover his or her **Dependents** ONLY if the **Employee** is also covered.

A **Dependent** child who becomes eligible for other group coverage through any employment is no longer eligible for group coverage under the Policy. If a **Dependent** child becomes an **Employee** of the participating **Employer**, he or she is no longer eligible as a **Dependent** and must make application as an eligible **Employee**.

DEPENDENT ENROLLMENT

Check with the **Employer** immediately on how to enroll for **Dependent** Coverage. Late enrollment may result in denial of **Dependent** Coverage by **Us**.

The **Employee** must enroll for **Dependent** Coverage and enroll additional **Dependents** on forms furnished and accepted by **Us**. No **Dependent** will become a **Covered Person** until **We** approve the **Dependent** for coverage.

Depending on the total number of **Employees** covered by the **Employer's** plan, **We** may require any **Dependent** to provide evidence of insurability and any applicable evidence of health status whenever an enrollment form is submitted.

If **You** enroll more than 31 days after **Your** eligibility date, **You** are a late applicant and must provide **Us** evidence of insurability and any applicable evidence of health status. This form is available from the **Employer** or **Us**. **We** have the right to accept or decline coverage. If accepted, **You** will be covered on the date **We** specify.

NEWBORN DEPENDENT ENROLLMENT

Employees who already have full **Dependent** (spouse and children) coverage in force PRIOR to the newborn's date of birth are not required to complete an enrollment form for the newborn child.

All other **Employees** who are changing their current coverage must complete an enrollment form for the newborn **Dependent**. This form is available from **Your Employer** or from **Us**.

ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE (continued)

DEPENDENT EFFECTIVE DATE

Each **Dependent's** effective date of coverage is determined as follows, subject to the **Dependent** Delayed Effective Date provision:

- If **We** receive the enrollment form ON, PRIOR TO or WITHIN 31 days of the **Dependent's** eligibility date, that **Dependent** is covered on the date he or she is eligible;
- If **We** receive the enrollment form MORE THAN 31 days after the **Dependent's** eligibility date, **We** require evidence of insurability and any applicable evidence of health status. **We** have the right to accept or decline coverage for the **Dependent** based upon the evidence of insurability and any applicable evidence of health status. If accepted, the effective date of coverage will be the date **We** specify.

However, NO **Dependent's** effective date will be prior to the **Employee's** effective date of coverage.

Refer to **Your** Schedule of Benefits for benefits available.

NEWBORN DEPENDENT EFFECTIVE DATE

A newborn **Dependent's** effective date is determined as follows:

- If **We** receive the enrollment form ON, PRIOR TO or WITHIN 31 days of the newborn's date of birth, **Dependent** Coverage is effective on the newborn's date of birth. **Pre-Existing Condition** limitations described in this Certificate and on the Schedule of Benefits DO NOT apply to that newborn child.
- If **We** receive the enrollment form MORE THAN 31 days after the newborn's date of birth, **We** require evidence of insurability and any applicable evidence of health status. **We** have the right to accept or decline coverage for the newborn based upon the evidence of insurability and any applicable evidence of health status. If accepted, the newborn will be covered on the date **We** specify. **Pre-Existing Condition** limitations WILL apply to that newborn child.

DEPENDENT DELAYED EFFECTIVE DATE

If the **Dependent**:

- Is confined in a **Hospital** or **Qualified Treatment Facility**; or
- Is receiving Home Health Care or Hospice benefits,

the **Dependent's** effective date of coverage will be delayed.

The **Dependent's** coverage will be effective on the day after:

- Discharge from **Confinement**, if the discharge from **Confinement** is certified by a **Qualified Practitioner**; or
- A **Qualified Practitioner** certifies that Home Health Care is no longer required.

ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE

(continued)

If **Dependent** coverage is in force or applied for within 31 days of the newborn child's date of birth, the Dependent Delayed Effective Date provision will not apply to the newborn child on its date of birth.

DEPENDENT BENEFIT CHANGES

Additional or increased insurance will become effective on the approved date of change, subject to the **Dependent** Delayed Effective Date provision.

We may require any **Dependent** to provide evidence of insurability and any applicable evidence of health status whenever a benefit change is requested.

A decrease in insurance will be effective immediately on the approved date of change.

TERMINATION OF COVERAGE

Termination of Coverage may be immediate or at the end of the period which was selected by **Your Employer** on the Employer Group Application.

Insurance terminates on the earliest of the following:

- The date the Group Policy terminates;
- The end of the period for which required premium was due **Us** and not received by **Us**;
- For an **Employee**, the date he or she terminates employment with the **Employer**;
- For an **Employee**, the date he or she no longer qualifies as an **Employee**;
- The date **You** fail to be in an eligible class of persons as provided in the Insurance Classifications as stated in the Employer Group Application;
- The date **You** enter full-time military, naval or air service except that termination will not occur if **You** are in temporary active duty as a reservist for military training that lasts 30 days or less;
- The date the **Employee** retires, except if the Employer Group Application provides coverage for a retiree class of **Employees** and the retiree is in an eligible class of retirees, selected by the **Employer**, and **We** are notified by the **Employer**;
- The date the **Employee** requests termination of insurance to be effective for the **Employee** or **Dependents**;
- For a **Dependent**, the date the **Employee's** insurance terminates;
- For a **Dependent**, the date he or she no longer qualifies as a **Dependent**; or
- For any benefit, the date the benefit is deleted from the Policy.

YOU AND THE EMPLOYER ARE RESPONSIBLE TO ADVISE US OF ANY CHANGES IN ELIGIBILITY INCLUDING THE LACK OF ELIGIBILITY OF ANY COVERED PERSON. COVERAGE WILL NOT CONTINUE BEYOND THE LAST DATE OF ELIGIBILITY REGARDLESS OF THE LACK OF NOTICE TO US.

SPECIAL PROVISIONS FOR NOT BEING IN ACTIVE STATUS

If the **Employer** continues to pay required premiums and continues coverage under the Policy, **Your** coverage, other than Short Term Disability benefits, if any, will remain in force for:

- No longer than three consecutive months if the **Employee** is:
 - Temporarily laid-off;
 - In part-time status; or
 - On an **Employer** approved leave of absence.

TERMINATION OF COVERAGE (continued)

- No longer than twelve consecutive months if the **Employee** is **Totally Disabled**.

If the **Employee** becomes **Totally Disabled** and wishes to apply for Waiver of Premium, **We** must receive premium for **Employee** Term Life Insurance Coverage for the six consecutive month period while the **Employee** is covered under the Special Provisions for Not Being in Active Status. All premium must be submitted to **Us** through the **Employer**.

YOUR OPTIONS

Employee Voluntary Term Life Coverage:

If this coverage terminates, the **Employee** may exercise the rights under the Portability of Voluntary Term Life Benefit described in this Certificate, if applicable, or the Life Conversion Privilege described in this Certificate. If the **Employee** utilizes the Conversion Privilege, he or she thereby waives the right to Port Voluntary Term Life Coverage. If the **Employee** utilizes any applicable Port Privilege, he or she will have an option to Convert all or part of the coverage if the Port coverage terminates. If the **Employee** returns to an **Active Status**, he or she will be considered a new **Employee** and must re-enroll for **Employee** Coverage.

EMPLOYEE TERM LIFE INSURANCE BENEFITS

BENEFIT

The amount of the **Employee** Term Life Insurance benefit is shown on the Schedule of Benefits. Subject to the terms below, a payment in this amount will be made to the beneficiary named by the **Employee**. Payment is made when **We** receive proof the **Employee's** death occurred while insured for this benefit. The **Employee** Group Term Life Insurance has no cash surrender or loan values.

REDUCTION FOR AGE

Reduction percentage(s) and reduction age(s), if any, are shown on the Schedule of Benefits. If the **Employee's** death occurs on or after a reduction age, the amount of payment will be reduced by the corresponding reduction percentage shown. A reduction in benefits due to age is effective on the first day of the calendar month following the date the **Employee** attains that age.

BENEFICIARY

The **Employee** may name any beneficiary he or she chooses. The **Employee** may also change a named beneficiary at any time by notifying **Us** in writing. The change will be effective on the date the **Employee** signs the form. If **We** make a payment before receiving the change form, **We** are released from further liability to the extent of the payment.

If a payment is to be made to two or more beneficiaries, but the **Employee** has not specified the portions payable to each, the payment will be shared equally. If the **Employee** has not named a beneficiary, or if the beneficiary he or she named is not alive at the **Employee's** death, the payment will be made, at **Our** option, to any one or more of the following:

- **Your** spouse;
- **Your** children;
- **Your** parents;
- **Your** brothers and sisters; or
- **Your** estate.

We will rely upon an affidavit to determine benefit payment, unless **We** receive written notice of a valid claim before payment is made. Payment pursuant to the affidavit will release **Us** from further liability.

Any payment made by **Us** in good faith will fully discharge **Us** to the extent of such payment.

Any amount payable to a minor will be paid to the minor's legal guardian.

EMPLOYEE TERM LIFE INSURANCE BENEFITS (continued)

NOTICE OF DEATH

No payment will be made unless **We** receive written proof of **Your** death. In order to receive benefits, written notice of death must be furnished to **Us** within 12 months after the date of death. If a death claim is filed more than 12 months after the date of death, **We** must have proof that it was not possible for the claim to be filed within 12 months. If a death claim is filed while the Waiver of Premium is in effect, proof of continuous **Total Disability** must accompany the death claim.

LIMITED BENEFITS FOR SELF-INDUCED SICKNESS, SUICIDE OR SELF-INFLICTED BODILY INJURY

In the event of death caused by self-induced **Sickness**, suicide, or intentional self-inflicted **Bodily Injury**, whether sane or insane, within the first two years of **Your** effective date under this Certificate, benefits for Employee Voluntary Term Life Insurance will be limited to the premium paid for the **Employee** Voluntary Term Life Insurance.

EMPLOYEE LIFE INSURANCE CONVERSION PRIVILEGE

The **Employee** is entitled to apply for a Conversion Policy of Life Insurance if any portion of his or her Term Life Insurance Benefit terminates due to:

- Termination of employment or membership in a class eligible for Term Life Insurance. The amount the **Employee** is entitled to apply for is the amount of Term Life Insurance that is terminating, LESS the amount of Term Life Insurance for which he or she becomes eligible under any group coverage within 31 days after such termination; or
- Reduction for Age. The amount the **Employee** is entitled to apply for is the amount of insurance lost due to the reduction, but not more than \$10,000.

If the **Employee's** Term Life Insurance benefit terminates because this coverage terminates, or is amended so as to terminate the eligible class to which the **Employee** belongs, and his or her **Employee** Term Life Insurance has been in effect under the Policy for at least three years, the amount the **Employee** is entitled to apply for is the lesser of:

- The amount of **Employee** Term Life Insurance that is terminating, LESS the amount of any Life Insurance for which he or she becomes eligible under any group coverage within 31 days after such termination; or
- \$10,000.

EMPLOYEE TERM LIFE INSURANCE BENEFITS (continued)

CONVERSION POLICY

The Conversion Policy is issued without evidence of insurability. The **Employee** must apply for and pay the first premium within 31 days of the termination of the **Employee's** coverage under the Group Plan. The Conversion Policy will be effective on the 32nd day following such termination. The Conversion Policy will not include any Accidental Death or **Bodily Injury** benefits. It will be issued on any one of the Policy forms, except term insurance, then being issued by **Us** to individuals of the same age. Premiums for the Conversion Policy will be based on **Our** current rate for the form, amount of insurance and the **Employee's** age on the date of issue of the Conversion Policy.

DEATH DURING CONVERSION PERIOD

If the **Employee** dies during the 31 day period that he or she could have applied for a Conversion Policy, the amount of Life Insurance the **Employee** could have converted will be paid as the death benefit, even if the **Employee** had not applied for the Conversion Policy.

NOTICE OF RIGHT TO CONVERT

If the **Employee** has not received notice of his or her right to convert to an individual policy within 15 days before the end of the 31 day conversion period, the **Employee** will have an additional 15 days from the date the **Employee** is notified in which to convert; provided, however, that the life insurance coverage under the Policy will not extend beyond the 31st day after termination of the **Employee's** employment, nor will the **Employee's** right to convert be extended more than 60 days beyond the **Employee's** initial 31 day conversion period.

THE FOLLOWING EXCLUSIONS ARE APPLICABLE TO VOLUNTARY TERM LIFE BENEFITS

LIMITATIONS

Voluntary Term Life Benefits do not cover loss resulting from:

- Self-induced **Sickness**, attempted suicide or intentionally self-inflicted **Bodily Injury**, whether sane or insane within the first two years of **Your** effective date. Benefits will be limited to the premium paid for this **Employee** Voluntary Term Life Insurance;
- The voluntary taking of any sedative, drug, alcohol, poison or inhalation of any gas unless taken or inhaled as prescribed or administered by a **Qualified Practitioner** within the first year of **Your** effective date. Benefits will be limited to the premium paid for this **Employee** Voluntary Term Life Insurance;
- Travel or flight in a device of any type for aerial navigation, except as a fare-paying passenger of a licensed passenger airline;
- Commission or attempt to commit a civil or criminal battery or felony;
- Service in any armed forces, except if **You** are in temporary active duty as a reservist for military training that lasts 30 days or less;

EMPLOYEE TERM LIFE INSURANCE BENEFITS (continued)

- **Bodily Injury** or **Sickness** contributed to or caused by;
 - War or any act of war, whether declared or not; or
 - Any act of armed conflict, or any conflict involving armed forces of any authority; or
- Participation in a riot, rebellion or insurrection.

Participation means taking an active part in common with others. Riot means any use or threat to use force or violence by three or more persons without the authority of law.

WAIVER OF PREMIUM

If the **Employee** becomes **Totally Disabled** while insured for this **Employee** Term Life Insurance Benefit, **We** will continue the **Employee's** Term Life Insurance Benefit during his or her **Total Disability** without the requirement of premium payment subject to the Waiver of Premium provision. In order for **Us** to approve Waiver of Premium, the **Employee** must:

- Become **Totally Disabled** before age 60;
- Remain **Totally Disabled** throughout the 180 consecutive day Elimination Period; Elimination Period means a period of continuous disability which must be satisfied before **You** are eligible to have **Your** life premium waived by **Us**.
- Request an application for Waiver of Premium and submit such application with proof of **Total Disability**, acceptable to **Us**, no later than 12 consecutive months after the **Employee** first became **Totally Disabled**.

Premium payment must continue until **We** approve the application for Wavier of Premium. Failure to do so will result in forfeiture of **Your** rights to Wavier of Premium.

The Wavier of Premium benefit begins at the end of the Elimination Period.

If the **Employee** dies prior to submitting the initial proof of **Total Disability** as required, proof that the **Total Disability** continued until the date of the **Employee's** death must be given to **Us** no later than 12 months following the **Employee's** death.

We will not approve an application for Waiver of Premium if the **Employee** becomes **Totally Disabled** after the **Employer** terminates coverage under the Policy.

EFFECT OF WAIVER OF PREMIUM

When **We** approve Waiver of Premium, no premium payment will be required for the **Employee's** Term Life Insurance benefit during his or her **Total Disability**. Proof of the **Total Disability** must be received by **Us** within one year from the date the **Total Disability** began.

The **Employee** is required to submit proof of continued **Total Disability** to **Us** three months before each anniversary date of the disability. **We** have the right to have the **Employee** examined for the **Total Disability** at any reasonable time during the first two years he or she is **Totally Disabled**. After that, **We** may have the **Employee** examined only once a year.

AMOUNT CONTINUED

The amount of the **Employee** Term Life Insurance benefit which will be continued under this Waiver of Premium is the amount that was in effect for the **Employee** on the date the **Total Disability** began. This amount will be reduced by the same amount, on the same dates, and for the same reasons that it would have been reduced if the **Employee** had not become **Totally Disabled**.

WAIVER OF PREMIUM (continued)

TERMINATION OF WAIVER OF PREMIUM

The Waiver of Premium terminates on the earliest of:

- The date the **Employee** fails or refuses to furnish proof of **Total Disability** as required;
- The date the **Employee** fails or refuses to be examined as required;
- The date the **Employee** is no longer **Totally Disabled**; or
- The **Employee's** 65th birthday.

If the Waiver of Premium benefit terminates and the **Employee** returns to an **Active Status**, he or she will be insured for the **Employee** Term Life Insurance benefit for which he or she is then eligible. Premium payment will be required for the **Employee** Term Life Insurance benefit.

If this Waiver of Premium terminates because the **Employee** is no longer **Totally Disabled** or attains age 65, and does not return to an **Active Status**, he or she may apply for a Conversion Policy of Life Insurance according to the Conversion Privilege provision in this Certificate.

Termination of the **Employer's** participation under the Policy WILL NOT terminate the **Employee's** Waiver of Premium. If the Waiver of Premium terminates after the **Employer's** participation under the Policy terminates, and if the **Employee** Term Life Insurance Benefit has been in force for at least three years, the **Employee** may apply for a Conversion Policy. The amount of any Conversion Policy is limited to the lesser of:

- The amount of **Employee** Term Life Insurance that is terminating LESS the amount of any Life Insurance for which the **Employee** becomes eligible under any group coverage within 31 days after such termination; or
- \$10,000.

ACCELERATED DEATH BENEFITS

If a covered **Employee** is diagnosed with a Terminal Illness, the **Employee** may request that an accelerated benefit be paid immediately. The amount payable is 50% to a maximum benefit of \$250,000.

DEFINITIONS

Terminal Illness means a **Sickness** or **Bodily Injury** which is diagnosed by a **Qualified Practitioner** as life-threatening with a life expectancy of 12 months or less.

QUALIFICATIONS FOR ACCELERATED BENEFITS

Payment of this benefit does not guarantee that the **Employee's** full death benefit will eventually be paid. The **Employee** must still be insured under the Policy at the time of death for the remainder of the Term Life Insurance benefit to be paid.

To qualify for the Accelerated Death Benefit the covered **Employee** must:

- Be covered under the Policy a minimum of 6 months;
- Provide proof of Terminal Illness acceptable to **Us**;
- Request this benefit in writing on a form acceptable by **Us**; and
- Provide written consent stating any beneficiary has agreed to payment of the Accelerated Death Benefit on the **Employee's** behalf.

PROOF OF TERMINAL ILLNESS

Proof of Terminal Illness requires a **Qualified Practitioner's** written certification that the **Employee** has 12 months or less to live. **We** reserve the right to request any additional medical information **We** believe necessary to confirm the **Employee's** status. If **You** fail to submit proof satisfactory to **Us** that **You** have a Terminal Illness, or refuse to be examined as may be required by **Us**, no Accelerated Death Benefit will be payable.

EXCLUSIONS

- Accelerated Death Benefits are not available for a Terminal Illness which resulted from a self-induced **Sickness**, attempted suicide or intentionally self-inflicted **Bodily Injury**, whether sane or insane; or
- Accelerated Death Benefits are not payable to an **Employee** who is:
 - Required by law to use this benefit to satisfy claims of creditors; or
 - Required by a government agency to use this benefit to apply for, obtain or keep a government benefit or entitlement.

ACCELERATED DEATH BENEFITS (continued)

BENEFITS PAYABLE

Payment will be made in one lump sum to **You** and is payable once during **Your** lifetime. The amount requested must be at least \$5,000.

If the amount of **Your** Term Life Insurance is scheduled to reduce within 6 months following the date **You** apply for the Accelerated Death Benefit, **Your** benefit payable will be based on the reduced amount.

Payment from this benefit may be taxable. Assistance should be sought from **Your** personal tax advisor. **We** are not responsible for any tax or other effects of an accelerated benefit payment or loss of eligibility for any State or Federal program.

EFFECT ON EMPLOYEE TERM LIFE INSURANCE BENEFIT

The amount of Term Life Insurance payable to the beneficiary at the time of death will be reduced by any accelerated benefit amount paid. The remaining Term Life Insurance amount will be paid according to the terms and provisions of the Policy. Any amount **You** could otherwise convert will also be reduced by the accelerated benefit.

FRAUD

If **You** commit fraud and **We** have paid an Accelerated Death Benefit under the Policy, **You** will reimburse **Us** for any such benefit payment.

GENERAL PROVISIONS

NOTICE OF CLAIM

Written notice of claim, other than claim for loss of life, must be given within 30 days after the date of loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice may be given at **Our** address and should include **Your** name and **Your** Group Number.

Written notice of claim for loss of life must be furnished to **Us** within 12 months after the date of death. If a death claim is filed later, **We** must have proof that it was not possible for the claim to be filed within 12 months.

CLAIM FORMS

Upon receipt of notice of claim, **We** will send **You** the forms for filing proof of loss. If the forms are not sent to **You** within 15 days, **You** will have met the proof of loss requirement by sending **Us** a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS

You must give written proof of loss within 90 days after the date of loss, except for loss of life. **Your** claim will not be reduced or denied if it was not reasonably possible to give such proof. In any event, written notice must be given within one year after the date proof of loss is otherwise required, except if **You** were legally incapacitated.

TIME OF PAYMENT OF CLAIMS

Payments due under the Policy will be paid upon receipt of written proof of loss.

CLAIM APPEAL PROCEDURE

If **We** partially or fully deny a claim for benefits submitted by **You**, and **You** disagree or do not understand the reasons for this denial, **You** may appeal this decision. **You** have the right to:

- Request a review of the denial;
- Review pertinent plan documents; and
- Submit in writing, any data, documents or comments which are relevant to **Our** review of this denial.

Your appeal must be submitted in writing within 60 days of receiving written notice of denial. **We** will review all information and send written notification within 60 days of **Your** request.

GENERAL PROVISIONS (continued)

INCONTESTABILITY

After **You** are insured without interruption for two years, **We** cannot contest the validity of **Your** coverage except for:

- Nonpayment of premium;
- **Your** ineligibility under the Policy;
- Any Policy provision;
- Any fraudulent misrepresentation made by **You**; or
- Any defenses **We** may have by law.

No statement made by **You** can be contested unless it is in a written form signed by **You**. A copy of the form must be given to **You** or **Your** beneficiary.

An independent incontestability period begins for each type of change in coverage or when **We** require a new Employee Enrollment Form.

This provision only limits **Our** right to void **Your** coverage after **You** have been insured without interruption for two years.

FRAUD

If **You** commit fraud against **Us** or **Your Employer** commits fraud pertaining to **You** against **Us** as determined by a court of competent jurisdiction, **Your** coverage ends automatically, without notice.

TIME LIMIT ON CERTAIN DEFENSES

A claim will not be reduced or denied after two years from the effective date of the benefit because a disease or physical condition not excluded and causing the loss existed before the benefit effective date.

CLERICAL ERROR, MISSTATEMENT OF AGE OR GENDER

If it is determined that information about **Your** age or gender was omitted or misstated in error, the amount of insurance for which **You** are properly eligible will be in effect. An equitable premium adjustment will be made. This provision applies equally to **You** and to **Us**.

DUPLICATING PROVISIONS

If any charge is described as covered under two or more benefit provisions, **We** will pay only under the provision allowing the greater benefits. This may require **Us** to make a recalculation based upon both the amounts already paid and the amounts due to be paid. **We** have **NO** liability for benefits other than those the Policy provides.

GENERAL PROVISIONS (continued)

WORKERS' COMPENSATION NOT AFFECTED

This Plan is not issued in lieu of, nor does it affect any requirement for coverage by any Workers' Compensation or Occupational Disease Act or Law.

RIGHT TO REQUEST OVERPAYMENTS

We reserve the right to recover any payments made by Us that were made in error.

RIGHT TO COLLECT NEEDED INFORMATION

You must cooperate with Us and when asked, assist Us by:

- Authorizing the release of medical information including the names of all providers from whom **You** received medical attention;
- Obtaining medical information and/or records from any provider as requested by Us;
- Providing information regarding the circumstances of **Your** injury or accident;
- Providing information about other insurance coverage and benefits; and
- Providing information We request to administer the Policy.

PHYSICAL EXAMINATION AND AUTOPSY

We, at **Our** expense, have the right to have **You** examined as often as We deem reasonably necessary. We may also have an autopsy performed unless prohibited by law.

LEGAL ACTIONS

You cannot bring an action at law or equity to recover a claim until 60 days after the date written proof of loss is made. **You** cannot bring such action more than one year after such proof of loss is made.

ASSIGNMENT OF BENEFITS FOR LIFE COVERAGE

Except for the dismemberment benefits under the Accidental Death and Bodily Injury Benefit for Covered Employees. **You** have the right to absolutely assign all of **Your** rights and interest under the Policy including, but not limited to, the following:

- The right to make any contributions required to keep the insurance in force;
- The privilege of converting; and
- The right to name and change a beneficiary.

If an Irrevocable beneficiary has been designated, Assignment of Benefit will not be allowed.

GENERAL PROVISIONS (continued)

No absolute assignment of rights and interest shall be binding on **Us** until and unless the original or certified copy of the form documenting the absolute assignment is received and acknowledged by **Us** at our office.

We have no responsibility:

- For the validity or effect of any assignment; or
- To provide any assignee with notice which **We** may be obligated to provide to **You**.

MODIFICATION OF POLICY

The Policy may be modified at any time by agreement between **Us** and the **Policyholder** without the consent of any **Covered Person** or any beneficiary. No modification will be valid unless approved by **Our** President or Secretary. The approval must be endorsed on or attached to the Policy. No agent has authority to modify the Policy, or waive any of the Policy provisions, to extend the time of premium payment, or bind **Us** by making any promise or representation.

PREMIUM CONTRIBUTIONS

Your Employer must pay the required premium to **Us** as they become due. **Your Employer** may require **You** to contribute toward the cost of **Your** insurance. Failure of **Your Employer** to pay any required premium to **Us** on time will result in the termination of **Your** insurance.

GRACE PERIOD

A grace period of 31 days will be allowed for payment of each premium due. If premium due is not paid within the grace period, **We** will cancel the insurance at the end of the grace period. All due and unpaid premium, including premium for the grace period, must be paid to **Us** by **Your Employer**.

RECOVERY RIGHTS

RIGHT OF SUBROGATION

If, after payments have been made under this Plan, **You** have a right to recover damages from a responsible party, **We** will be subrogated to **Your** rights to recover. **You** will do whatever is necessary to enable **Us** to exercise **Our** right and will do nothing after loss to prejudice it. If **We** are precluded from exercising **Our** Right of Subrogation, **We** may exercise **Our** Right of Reimbursement.

RIGHT OF REIMBURSEMENT

If benefits are paid under this Plan and **You** or **Your** covered **Dependent** recovers from a responsible party by settlement, judgment or otherwise, **We** have a right to recover from **You** or **Your** covered **Dependent** an amount equal to the amount **We** paid.

GENERAL PROVISIONS (continued)

ASSIGNMENT OF RECOVERY RIGHTS

This Plan contains an exclusion for **Sickness** or **Bodily Injury** for which there is Short Term Disability coverage provided or payable under any premises or other similar coverage.

If **Your** claim against the other insurer is denied or partially paid, **We** will process **Your** claim according to the terms and conditions of the Policy. If payment is made by **Us** on **Your** behalf, **You** agree to assign to **Us** any right **You** have against the other insurer for income benefits **We** pay.

SUPPLEMENTAL BENEFIT DEPENDENT TERM LIFE INSURANCE BENEFITS

This benefit is attached to and made a part of **Your** Certificate. The effective date of this change is the latter of the effective date of this Certificate or the date this benefit is added to the Policy. Except as modified below, all Policy terms, conditions, and limitations apply.

The amount of the **Dependent** Term Life Insurance Benefit is shown on the Schedule of Benefits.

BENEFITS

The applicable **Dependent** Term Life Insurance Benefit will be paid to the beneficiary subject to the terms below:

- The covered **Dependent** dies while coverage is in force; and
- Proof of death is received that the **Dependent's** death occurred while insured for this benefit.

Dependent Term Life Insurance has no cash surrender or loan values.

REDUCTION FOR AGE

Reduction percentage(s) and reduction age(s), if any, are shown on the Schedule of Benefits. If the **Dependent's** death occurs on or after a reduction age, the amount of payment will be reduced by the corresponding reduction percentage shown. A reduction in benefits due to age is effective on the first day of the calendar month following the date the **Dependent** attains that age.

BENEFICIARY

The **Employee** will be paid the applicable amount of **Dependent** Term Life Insurance shown on the Schedule of Benefits in the event of death of one of his or her covered **Dependents**.

If the **Employee** does not survive the **Dependent**, the applicable **Dependent** Term Life Insurance amount will be payable, at **Our** option, to one or more of the following;

- **Your** parents;
- **Your** children;
- **Your** brothers and sisters; or
- **Your** estate.

We will rely upon an affidavit to determine benefit payment, unless **We** receive written notice of valid claim before payment is made. Payment pursuant to the affidavit will release **Us** from further liability.

Any payment made by **Us** in good faith will fully discharge **Us** to the extent of such payment.

Any amount payable to a minor will be paid to the minor's legal guardian.

SUPPLEMENTAL BENEFIT

DEPENDENT TERM LIFE INSURANCE BENEFITS (continued)

NOTICE OF DEATH

No payment will be made unless **We** receive written proof of **Your** death. In order to receive benefits, written notice of death must be furnished to **Us** within 12 months after the date of death. If a death claim is filed more than 12 months after the date of death, **We** must have proof that it was not possible for the claim to be filed within 12 months.

LIMITED BENEFITS FOR SELF-INDUCED SICKNESS, SUICIDE OR SELF-INFLICTED BODILY INJURY

In the event of death caused by self-induced **Sickness**, suicide, or intentional self-inflicted **Bodily Injury**, whether sane or insane, within the first year of **Your** effective date under this Certificate, benefits for Voluntary **Dependent** Term Life Insurance will be limited to the premium paid for the Voluntary **Dependent** Term Life Insurance.

DEPENDENT LIFE INSURANCE CONVERSION PRIVILEGE

A covered **Dependent** may apply for a Conversion Policy of Life Insurance if the **Dependent's** Term Life Insurance benefit terminates because:

- The **Employee's** employment terminates;
- The **Employee** dies or transfers to a class of **Employees** not eligible for coverage under the Policy; or
- The **Dependent** ceases to qualify as a **Dependent**.

The amount the **Dependent** is entitled to apply for is the amount of Term Life Insurance in force for the **Dependent** under this Plan at the time coverage terminates.

A covered **Dependent** may also apply for a Conversion Policy of Life Insurance if the **Dependent** Term Life Insurance benefit terminates due to a Policy amendment removing the **Dependent** Life Insurance Benefit or termination of the Policy, and the **Dependent's** Term Life Insurance has been in effect under this Plan for at least three years.

The amount the covered **Dependent** is entitled to apply for is the lesser of:

- The amount of **Dependent** Term Life Insurance that is terminating LESS the amount of any Life Insurance for which that **Dependent** becomes eligible within 31 days after such termination; or
- \$10,000.

SUPPLEMENTAL BENEFIT

DEPENDENT TERM LIFE INSURANCE BENEFITS (continued)

CONVERSION POLICY

The Life Conversion Policy is issued without evidence of insurability. The **Employee**, on behalf of the covered **Dependent**, must apply for and pay the first premium within 31 days of the termination of the **Dependent's** coverage under the group Plan. The Conversion Policy will be effective on the 32nd day following such termination. The Conversion Policy will not include any Disability or Accidental Death or **Bodily Injury** benefits. It will be issued on any one of the policy forms, except term insurance, then being issued by **Us** to individuals of the same age. Premiums for the Conversion Policy will be based on **Our** current rate for the Policy form, amount of insurance and the covered **Dependent's** age on the date of issue of the Conversion Policy.

DEATH DURING CONVERSION PERIOD

If the covered **Dependent** dies during the 31 day period that he or she could have applied for a Conversion Policy, the amount of Life Insurance he or she could have converted will be paid as the death benefit, even if the **Dependent** had not applied for the Conversion Policy.

NOTICE OF RIGHT TO CONVERT

If the covered **Dependent** has not received notice of his or her right to convert to an individual policy within 15 days before the end of the 31 day conversion period, the covered **Dependent** will have an additional 15 days from the date the covered **Dependent** is notified in which to convert; provided, however, that the life insurance coverage under the Policy will not extend beyond the 31st day after termination of the covered **Dependent's** coverage, nor will the covered **Dependent's** right to convert be extended more than 60 days beyond the covered **Dependent's** initial 31 day conversion period.

THE FOLLOWING EXCLUSIONS ARE APPLICABLE TO VOLUNTARY TERM LIFE BENEFITS

LIMITATIONS

Voluntary Term Life Benefits do not cover loss resulting from:

- Self-induced **Sickness**, attempted suicide or intentionally self-inflicted **Bodily Injury**, whether sane or insane within the first two years of **Your** effective date. Benefits will be limited to the premium paid for this Voluntary **Dependent** Term Life Insurance;
- The voluntary taking of any sedative, drug, alcohol, poison or inhalation of any gas unless taken or inhaled as prescribed or administered by a **Qualified Practitioner** within the first year of **Your** effective date. Benefits will be limited to the premium paid for this Voluntary **Dependent** Term Life Insurance;
- Travel or flight in a device of any type for aerial navigation, except as a fare-paying passenger of a licensed passenger airline;

SUPPLEMENTAL BENEFIT
DEPENDENT TERM LIFE INSURANCE BENEFITS (continued)

- Commission or attempt to commit a civil or criminal battery or felony;
- Service in any armed forces, except if **You** are in temporary active duty as a reservist for military training that lasts 30 days or less;
- **Bodily Injury** or **Sickness** contributed to or caused by;
 - War or any act of war, whether declared or not; or
 - Any act of armed conflict, or any conflict involving armed forces of any authority; or
- Participation in a riot, rebellion or insurrection.

Participation means taking an active part in common with others. Riot means any use or threat to use force or violence by three or more persons without the authority of law.

SUPPLEMENTAL BENEFIT - PORTABILITY PRIVILEGE

This benefit is attached to and made a part of **Your** Certificate. The effective date of this change is the latter of the effective date of this Certificate or the date this benefit is added to the Policy. Except as modified below, all Policy terms, conditions, and limitations apply.

APPLICABILITY

This provision applies only to contributory Voluntary Term Life Insurance. It DOES NOT apply to any other coverages.

DEFINITION

As used in this provision, the term Port means to elect a continuation of **Your** contributory Voluntary Term Life Insurance.

ELIGIBILITY TO "PORT"

An **Employee** may elect to continue all or part of the **Employee's** Voluntary Term Life Insurance and **Dependent** Voluntary Term Life Insurance, if applicable, by electing a continuation of coverage, subject to the following terms and restrictions:

1. No **Employee** may elect to continue coverage unless the **Employee** has been covered by this group Plan, or the one it replaced, for Voluntary Term Life Insurance for at least 31 consecutive days prior to the date the **Employee's** coverage under this Plan ends.
2. The **Employee** is not allowed to convert coverage and elect to Port at the same time. If a situation arises in which the **Employee** would be eligible to both convert and Port, he or she may only exercise one of these privileges. **You** may never be insured under both a converted policy and a portable certificate of coverage at the same time.
3. The **Employee** may not Port his or her coverage, or coverage for any **Dependents** if the **Employee** has reached his or her 70th birthday on the day his or her coverage ends under this Plan.
4. An **Employee** may not Port a **Dependent** spouse's coverage if the **Dependent** spouse has reached his or her 70th birthday on the day his or her coverage ends under this Plan.
5. An **Employee** may not Port coverage if he or she has received a benefit under the Accelerated Death Benefit provision.
6. An **Employee** may Port his or her coverage if coverage under this Plan ends for any reason other than:
 - A. Termination of employment due to **Total Disability**;
 - B. Failure to pay any required premium; or
 - C. The **Employer** terminates the Policy.

SUPPLEMENTAL BENEFIT - PORTABILITY PRIVILEGE

(continued)

AMOUNT OF PORTABLE COVERAGE

An **Employee** may Port the full amount of his or her Voluntary Term Life Insurance amount as of the day his or her coverage under this Plan ends, or any lesser amount in increments of \$20,000 equal to a multiple of the **Employee's** basic annual compensation in force on the date employment ends.

An **Employee** may Port the full amount of his or her **Dependent** Voluntary Term Life Insurance amount(s) as of the day the **Employee's** coverage under this Plan ends. The **Employee** may Port any lesser amount of **Dependent** Voluntary Term Life Insurance in increments of \$10,000. In no event will a **Dependent's** amount be more than 50% of the **Employee's** amount.

The amount of the coverage **You** may Port will be reduced or terminated according to the Reduction for Age Schedule, if applicable, shown on **Your** Schedule of Benefits.

An **Employee** may Port:

1. The **Employee's** insurance amount only;
2. The **Employee's** insurance amount and the **Dependent** spouse insurance amount;
3. The **Employee's** insurance amount and insurance amount of all of the covered **Dependents**; or
4. The **Employee's** insurance amount and the insurance amount of the covered **Dependent** children.

No other combinations of Ported insurance amounts will be allowed. To be eligible for portability, a **Dependent** must be covered as of the day the **Employee's** coverage under this Plan ends.

THE PORTABILITY CERTIFICATE OF COVERAGE

The Portability Certificate of Coverage provides group Term Life Insurance. It does not provide any other benefits. The benefits provided by the Portability Certificate of Coverage may not be identical to the benefits provided by this Plan.

HOW TO PORT

The **Employee** must apply to **Us** in writing, and pay the required premium to receive a Portability Certificate of Coverage. The **Employee** has 31 days from the date coverage under this Plan ends to apply. No proof of insurability is required.

DISCOUNT DISCLOSURE

From time to time, **We** may offer or provide access to discount programs to persons who become insureds. In addition, **We** may arrange for third party service providers such as pharmacies, optometrists, dentists and alternative medicine providers, to provide discounts on goods and services to persons who become insureds. Some of these third party service providers may make payments to **Us** when insureds take advantage of these discount programs. These payments offset the cost to **Us** of making these programs available and may help reduce the costs of **Your** plan administration. Although **We** have arranged for third parties to offer discounts on these goods and services, these discount programs are not insured benefits under this Policy. The third party service providers are solely responsible to insureds for the provision of any such goods and/or services. **We** are not responsible for any such goods and/or services, nor are **We** liable if vendors refuse to honor such discounts. Further, **We** are not liable to insureds for the negligent provision of such goods and/or services by third party service providers. Discount programs may not be available to persons who "opt out" of marketing communications and where otherwise restricted by law.

DOMESTIC PARTNER AMENDMENT

COVERAGE FOR DOMESTIC PARTNERS

Your certificate is amended to include coverage for **Domestic Partners** as detailed below. The effective date of this amendment is the latter of the effective date of **Your** certificate or the date this amendment is added to **Your** certificate. **Domestic Partners** are subject to all policy terms, conditions and limitations including, but not limited to, all eligibility requirements and termination provisions.

DEFINITIONS

The following definition is added to the Definitions section of **Your** certificate:

Domestic partner – means a person who is in a domestic partnership. A domestic partnership consists of **You** and another individual of the same or opposite sex who:

- Share the same permanent residence;
- Have a close personal relationship;
- Are jointly responsible for basic living expenses;
- Are single or divorced;
- Are eighteen (18) years of age or older;
- Are not related by blood; and
- Are each other's sole **Domestic Partner** and are responsible for each other's common welfare.

Before a **Domestic Partner** can be covered as a **Dependent**, **You** must complete and sign the Pima County Affidavit of Domestic Partnership. A new Affidavit must be completed during the annual enrollment period of each new plan year in order to continue insurance for **Your Domestic Partner** and/or **Your Domestic Partner's Dependents**.

ELIGIBILITY

In addition to the **Dependent** coverage, **Dependent Eligibility date** section in **Your** certificate, the following applies to **Domestic Partners** and any **Domestic Partner's Dependent Child(ren)**, if any:

1. For the **Employee's Domestic Partner**, the eligibility date will be the earlier of:
 - The date of registration of the Declaration of Domestic Partnership; or
 - The date the **Employee** submits to the **Employer** or **Us** an affidavit attesting that a domestic partnership exists and all requirements of the definition of **Domestic Partner** are met.
2. For a **Domestic Partner's Dependent** child(ren), if any, the eligibility date of the **Employee's Domestic Partner** for any **Domestic Partner's Dependent** child(ren) acquired on that date; or

The effective date of a **Domestic Partner's Dependent** child will not be before the effective date of the **Employee's Domestic Partner**.

TERMINATING COVERAGE

In addition to the **Termination of Coverage** provision in **Your** certificate, the following applies to **Domestic Partners** and any **Domestic Partner's Dependent** child(ren), if any.

The **Employee's Domestic Partner** and any **Dependent** child(ren), if any, allowed eligibility will terminate on:

1. The date one of the **Domestic Partners** dies.

DOMESTIC PARTNER AMENDMENT

2. The date one of the **Domestic Partners** marries.
3. The earliest of the following:
 - The date one **Domestic Partner** gives or sends to the other partner a written notice that he or she is terminating the domestic partnership;
 - The date the **Employee** submits to the **Employer** notification to terminate the domestic partnership;
 - The date indicated on the Notice of Termination of Domestic Partnership or its equivalent, as filed in the city, county or state where the **Domestic Partners** live if it offers the ability to terminate a domestic partnership;
 - The date any of the requirements of the **Domestic Partner** definition is not met; or
 - For any **Domestic Partner's Dependent** child(ren), the date any of the requirements of **Domestic Partner's Dependent** child(ren) definition is not met.

The coverage of any **Domestic Partner's Dependent** child(ren) will terminate upon termination of the **Employee's Domestic Partner**.



Gerald L. Ganoni
President

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Specialty Benefits

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Notices

The following pages contain important information about Humana's claims procedures and certain federal laws. There may be differences between the Certificate of Insurance and this Notice packet. There may also be differences between this notice packet and state law. The Plan participant is eligible for the rights more beneficial to the participant.

This section includes notices about:

Claims and Appeal Procedures

Federal Legislation

Claims Procedures

Appeals of Adverse Determinations

Your Rights Under ERISA

Privacy and Confidentiality Statement

LIFE AND SHORT TERM DISABILITY CLAIMS PROCEDURES

CLAIMS PROCEDURES

Definitions

Humana: Humana Insurance Company

Claimant: A covered person (or authorized representative) who files a claim.

Submitting a Claim

This section describes how a Claimant files a claim for plan benefits.

A request for a waiver of Life Insurance premium due to a short-term disability will be treated as a claim.

A claim must be filed in writing and delivered by mail, postage prepaid, by FAX or e-mail. Claims will be not be deemed submitted for purposes of these procedures unless and until received at the correct address.

Claims submissions must be in a format acceptable to Humana and compliant with any legal requirements. Claims not submitted in accordance with the requirements of applicable federal law respecting privacy of protected health information and/or electronic claims standards will not be accepted by Humana.

Claims submissions must be timely. Claims must be filed as soon as reasonably possible, and in no event later than the period of time described in the benefit plan document.

Claims submissions must be submitted on the claims form provided by Humana and available from your employer. The claim form must be complete.

Authorized Representatives

A covered person may designate an authorized representative to act on his or her behalf in pursuing a benefit claim or appeal. The authorization must be in writing and authorize disclosure of health information. If a document is not sufficient to constitute designation of an authorized representative, as determined by Humana, the plan will not consider a designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.

Covered persons should carefully consider whether to designate an authorized representative. Circumstances may arise under which an authorized representative may make decisions independent of the covered person, such as whether and how to appeal a claim denial.

Claims Decisions

Humana will provide notice of a favorable or adverse determination within a reasonable time but no later than 45 days after the plan receives the claim.

This period may be extended an additional 30 days, if Humana determines the extension is necessary due to matters beyond the plan's control. Before the end of the initial 45-day period, Humana will notify the affected Claimant of the extension, the circumstances requiring the extension and the date by which the plan expects to make a decision.

The review period may be extended for another 30 days, if before the end of the first 30-day extension, the plan determines a second extension is necessary due to matters beyond the plan's control. Before the end of the first 30-day extension, Humana will notify the affected Claimant of the additional extension, the circumstances requiring the extension and the date by which the plan expects to make a decision.

If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the Claimant will have at least 45 days from the date the notice is received to provide the specified information. Humana will make a decision on the earlier of the date on which the Claimant responds or the expiration of the time allowed for submission of the requested information.

Initial Denial Notices

Notice of a claim denial (including a partial denial) will be provided to Claimants by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time frames noted above.

A claims denial notice will convey the specific reason for the adverse determination and the specific plan provisions upon which the determination is based. The notice will also include a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary. The notice will disclose if any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to Claimants, free of charge, upon request.

APPEALS OF ADVERSE DETERMINATIONS

A Claimant must appeal an adverse determination within 180 days after receiving written notice of the denial (or partial denial). An appeal may be made by a Claimant by means of written application to Humana, in person, or by mail, postage prepaid.

Determination of appeals of denied claims will be conducted promptly, will not defer to the initial determination and will not be made by the person who made the initial adverse claim determination or a subordinate of that person

On appeal, a Claimant may review pertinent documents and may submit issues and comments in writing. A Claimant on appeal may, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the adverse determination being appealed, as permitted under applicable law.

If the claims denial is based in whole, or in part, upon a medical judgment, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

Time Periods for Decisions on Appeal

Appeals of claims denials will be decided and notice provided within 45 days after Humana receives the appeal request.

This period may be extended an additional 45 days, if Humana determines the extension is necessary due to matters beyond the plan's control. Before the end of the initial 45-day period, Humana will notify the affected Claimant of the extension, the circumstances requiring the extension and the date by which the plan expects to make a decision.

Appeals Denial Notices

Notice of a claim denial (including a partial denial) will be provided to Claimants by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time periods noted above.

A notice that a claim appeal has been denied will include:

- The specific reason or reasons for the adverse determination.
- Reference to the specific plan provision upon which the determination is based.
- If any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to the Claimant, free of charge, upon request.
- A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures, and a statement about the Claimant's right to bring an action under ERISA.

In the event an appealed claim is denied, the Claimant will be entitled to receive, without charge, reasonable access to and copies of any documents, records or other information that:

- Was relied upon in making the determination.
- Was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination.
- Demonstrates compliance with the administrative processes and safeguards required in making the determination.
- Constitutes a statement of plan policy or guidance with respect to the plan concerning the denied benefit, without regard to whether the statement was relied on in making the benefit determination.

EXHAUSTION OF REMEDIES

Upon completion of the appeals process under this section, a Claimant will have exhausted his or her administrative remedies under the plan. If Humana fails to complete a claim determination or appeal within the time limits set forth above, the claim shall be deemed to have been denied and the Claimant may proceed to the next level in the review process.

After exhaustion of remedies, a Claimant may pursue any other legal remedies available, which may include bringing civil action under ERISA section 502(a) for judicial review of the plan's determination. Additional information may be available from the local U.S. Department of Labor Office.

LEGAL ACTIONS AND LIMITATIONS

No lawsuit may be brought with respect to plan benefits until all remedies under the plan have been exhausted.

No lawsuit with respect to plan benefits may be brought after the expiration of the applicable limitations period stated in the benefit plan document. If no limitation is stated in the benefit plan document, then no such suit may be brought after the expiration of the applicable limitations under applicable law.

YOUR RIGHTS UNDER ERISA

Under the Employee Retirement Income Security Act of 1974 (ERISA), all plan participants covered by ERISA are entitled to certain rights and protections, as described below. Notwithstanding anything in the group health plan or group insurance policy, following are a covered person's minimum rights under ERISA. ERISA requirements do not apply to plans maintained by governmental agencies or churches.

Information About the Plan and Benefits

Plan participants may:

1. Examine, free of charge, all documents governing the plan. These documents are available in the plan administrator's office.
2. Obtain, at a reasonable charge, copies of documents governing the plan, including a copy of any updated summary plan description and a copy of the latest annual report for the plan (Form 5500), if any, by writing to the plan administrator.
3. Obtain, at a reasonable charge, a copy of the latest annual report (Form 5500) for the plan, if any, by writing to the plan administrator.

As a plan participant, you will receive a summary of any material changes made in the plan within 210 days after the end of the plan year in which the changes are made unless the change is a material reduction in covered services or benefits, in which case you will receive a summary of the material reduction within 60 days after the date of its adoption.

If the plan is required to file a summary annual financial report, you will receive a copy from the plan administrator.

Responsibilities of Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. These people, called "fiduciaries" of the plan, have a duty to act prudently and in the interest of plan participants and beneficiaries.

No one, including an employer, may discharge or otherwise discriminate against a plan participant in any way to prevent the participant from obtaining a benefit to which the participant is otherwise entitled under the plan or from exercising ERISA rights.

Continue Group Health Plan Coverage

Participants may be eligible to continue health care coverage for themselves, their spouse or dependents if there is a loss of coverage under the group health plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the COBRA notice in this document regarding the rules governing COBRA continuation coverage rights.

Participants should review their group health plan document regarding reduction or elimination of exclusionary periods for preexisting conditions due to creditable coverage from another plan.

The group health plan or health insurance issuer should provide a certificate of creditable coverage when coverage ends under the plan, the participant becomes entitled to elect COBRA continuation coverage, COBRA continuation coverage ceases (if COBRA is requested before losing coverage) or, if requested, up to 24 months after losing coverage. Without evidence of creditable coverage, a participant may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after the coverage enrollment date.

Claims Determinations

If a claim for a plan benefit is denied or disregarded, in whole or in part, participants have the right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial within certain time schedules.

Enforce Your Rights

Under ERISA, there are steps participants may take to enforce the above rights. For instance, if a participant requests a copy of plan documents and does not receive them within 30 days, the participant may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$ 110 a day until the participant receives the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If a claim for benefits is denied or disregarded, in whole or in part, the participant may file suit in a state or Federal court. In addition, if the participant disagrees with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, the participant may file suit in Federal court. If plan fiduciaries misuse the plan's money, or if participants are discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person sued to pay costs and fees. If the participant loses, the court may order the participant to pay the costs and fees.

Assistance with Questions

Contact the group health plan human resources department or the plan administrator with questions about the plan. Contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210 with questions about ERISA rights. Call the publications hotline of the Employee Benefits Security Administration to obtain publications about ERISA rights.

PRIVACY AND CONFIDENTIALITY STATEMENT

We understand the importance of keeping your personal and health information private (PHI). PHI includes both medical information and individually identifiable information, such as your name, address, telephone number or social security number. We are required by applicable federal and state law to maintain the privacy of your PHI.

Under both law and our policies, we have a responsibility to protect the privacy of your PHI. We:

- Protect your privacy by limiting who may see your PHI;
- Limit how we may use or disclose your PHI;
- Inform you of our legal duties with respect to your PHI;
- Explain our privacy policies; and
- Strictly adhere to the policies currently in effect.

We reserve the right to change our privacy practices at any time, as allowed by applicable law, rules and regulations. We reserve the right to make changes in our privacy practices for all PHI that we maintain, including information we created or received before we made the changes. When we make a significant change in our privacy practices, we will send notice to our health plan subscribers. For more information about our privacy practices, please contact us.

As a covered person, we may use and disclose your PHI, without your consent/authorization, in the following ways:

Treatment: we may disclose your PHI to a health care practitioner, a hospital or other entity which asks for it in order for you to receive medical treatment.

Payment: we may use and disclose your PHI to pay claims for covered services provided to you by health care practitioners, hospitals or other entities.

We may use and disclose your PHI to conduct other health care operations activities.

It has always been our goal to ensure the protection and integrity of your personal and health information. Therefore, we will notify you of any potential situations where your identification would be used for reasons other than treatment, payment and health plan operations.