UnitedHealthcare®

GROUP CRITICAL ILLNESS INSURANCE CERTIFICATE OF COVERAGE

FOR

GRANDE CHEESE COMPANY

POLICY NUMBER: 304000

EFFECTIVE DATE: January 1, 2020

WI – UHIC/2015
(12-19)

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut

(Home Office)

Policyholder: Grande Cheese Company

Effective Date: January 1, 2020

Policy Number: 304000

Policy Anniversary Date: January 1st

Beneficiary: As on file with the Administrator

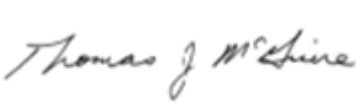
We, UnitedHealthcare Insurance Company, issue this Certificate to the Covered Person as evidence of insurance under the Policy We issued to the Policyholder shown above. This Certificate describes the benefits and other important provisions of the Policy.

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

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

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

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



Secretary

President

Administrative Office:
9900 Bren Road East
Minnetonka, MN 55343

Group Critical Illness Insurance Certificate

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

UHICI-CERT-1
Printed in U.S.A.

IMPORTANT NOTICE
CONCERNING STATEMENTS IN THE ENROLLMENT FORM FOR YOUR INSURANCE

Please read the copy of the enrollment form attached to this notice or to your certificate of which has been otherwise previously delivered to you by the insurer or group policyholder. Omissions or misstatements in the enrollment form could cause an otherwise valid claim to be denied. Carefully check the enrollment form and write to the insurer within 10 days if any information shown on the form is not correct and complete or if any requested medical history has not been included. The insurance coverage was issued on the basis that the answers to all questions and any other material information shown on the enrollment form are correct and complete.

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

UnitedHealthcare Insurance Company
450 Columbus Boulevard
Hartford, Connecticut
(Home Office)
Phone: 1-866-615-8727

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by writing to:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873

or you can call 1-800-236-8517 outside of Madison or 266-0103 in Madison, and request a complaint form.

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SCHEDULE OF BENEFITS

Eligible Class:	Employees of Grande Cheese Company who meet the eligibility requirements and who are Actively at Work**,** and their eligible Dependents
Description of Class:	All Eligible Employees working a minimum of 30 hours per week
Employee Waiting Period:	An Employee is eligible for insurance on the first day of the month following the date he completes 2 months of continuous employment with the Policyholder.
Maximum Benefit Amount:	**Option 1** Employee: $5,000 Spouse: $2,500 Child: $1,250 **Option 2:*** Employee: $10,000 Spouse: $5,000 Child: $2,500 **Option 3:*** Employee: $20,000 Spouse: $10,000 Child: $5,000 *Employee may choose from lower coverage options for Spouse and Child(ren).

SCHEDULE OF BENEFITS (continued)

Critical Illness Conditions	Percentage of Maximum Benefit Amount payable per Covered Person or Dependent
Benign Brain Tumor	100%
Cancer Level 1	100%
Cancer Level 2	25%
Chronic Renal Failure	100%
Coma	100%
Coronary Artery Disease	25%
Heart Attack	100%
Heart Failure	100%
Major Organ Failure	100%
Permanent Paralysis	100%
Ruptured Aneurysm	100%
Stroke	100%

Child Critical Illness Category	Percentage of Maximum Benefit Amount payable per Covered Child
•	
• Cerebral Palsy	25% of Employee's Amount
• Cleft Lip / Palate	25% of Employee's Amount
• Cystic Fibrosis	25% of Employee's Amount
• Down Syndrome	25% of Employee's Amount
• Muscular Dystrophy	25% of Employee's Amount
• Spina Bifida	25% of Employee's Amount

Portability	Included
• Portability Policy Age Limit	Coverage continued under Portability terminates at Age 75
Reoccurrence Benefit:	Included For each Critical Illness Conditions, not to exceed: • 50% of Employee's Maximum Benefit Amount • 50% of Spouse's Maximum Benefit Amount • 50% of Child's Maximum Benefit Amount whichever applies
Additional Critical Illness Rider:	Included
Wellness Benefit:	$50 per plan year

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

Maximum Age for Dependent Child: 26 years

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

GENERAL DEFINITIONS

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

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

Unless disabled on the prior workday or on the day of absence, a Covered Person will be considered Actively at Work on the following days:

1. a Saturday, Sunday or holiday which is not a scheduled workday;
2. a paid vacation day, or other scheduled or unscheduled non-workday; or
3. an excused or emergency leave of absence (except medical leave).

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

Change in Family Status:

1. a change in marital status (marriage, divorce, legal separation, annulment);
2. a change in the number of dependents for tax purposes (birth, legal adoption of a child, placement of a child with the Covered Person for adoption, or death of a dependent);
3. certain changes in employment status that affect benefits eligibility for the Covered Person, spouse or child, such as termination of employment, a strike or lockout, the start of or return from an unpaid leave of absence, a change in worksite, a change in work schedule (between full-time and part-time work, decrease or increase in hours);
4. a significant increase in the cost of coverage or a significant reduction in the benefit coverage under the Covered Person's insurance or his spouse's insurance; or
5. the addition, elimination, or significant curtailment of, a coverage option.

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

Covered Person: the Employee insured under the Policy. References to "Covered Person," "Covered Persons" and "Covered Person's" throughout this Certificate are references to a Covered Person.

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

Spouse means a legal Spouse including a Domestic Partner.

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

1. a natural Child;
2. a stepchild;
3. a grandchild;
4. a legally adopted Child;
5. a Child placed for adoption; or
6. a Child for whom legal guardianship has been awarded to the Covered Person or the Covered Person's Spouse.

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

A Child is an Incapacitated Child if he is:

1. unmarried;
2. physically or mentally disabled; and
3. financially dependent upon the Covered Person.

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

Domestic Partner: a person of the opposite or same sex with whom the Covered Person has established a Domestic Partnership.

Domestic Partnership: a relationship between a Covered Person and one other person of the opposite or same sex. All of the following requirements apply to both persons:

1. they must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside;
2. they must not be currently married to, or a Domestic Partner of another person under either statutory or common law;
3. they must share the same permanent residence and the common necessities of life;
4. they must be at least 18 years of age;
5. they must be mentally competent to consent to contract;
6. they must be financially interdependent and have furnished documents to support the following conditions of such financial interdependence:
   a. they have a single dedicated relationship of at least six months duration;
   b. they have at least two of the following;
      - a joint ownership of an automobile;
      - a joint checking, bank or investment account;
      - a joint credit account;
      - a joint ownership or a lease for a residence identifying both partners as tenants; or
      - a will and/or life insurance policies which designates the other as primary beneficiary;
7. the Covered Person and the Domestic Partner must jointly sign the required Affidavit of Domestic Partnership prior to coverage being issued.

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

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

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

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

Enrollment:

Enrollment Period - the Initial Enrollment Period or Re-Enrollment Period.

Initial Enrollment Period - the period during which the Employee may first apply in writing for insurance.

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

Hospital or Medical Facility: a legally operated, accredited facility licensed to provide full-time care and Treatment for the condition for which benefits are payable under the Policy. It is operated by a full-time staff of licensed physicians and registered nurses. It does not include facilities that primarily provide custodial, education or rehabilitative care, or long-term institutional care on a residential basis.

Injury: a bodily Injury resulting directly from an accident and independently of all other causes and the accident occurs while covered under the Policy.

Physician: a medical doctor or doctor of osteopathy who is:

1. duly licensed in the state or Province in which the Treatment is received; and
2. practicing within the scope of that license.

For the purposes of the Policy, the term Physician does not include the Covered Person, the Covered Person's Spouse, or any family members.

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

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

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

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

We, Our and Us: UnitedHealthcare Insurance Company or its Administrator.

BENEFITS PAYABLE AND BENEFIT DEFINITIONS

Benefit Payable: We will pay the stated percentage of the Benefit Amount for each of the Critical Illness Conditions shown on the Schedule of Benefits for which the Covered Person or Dependent:

1. receives a Diagnosis of a Critical Illness; and
2. for which he is insured on the Date of Diagnosis.

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

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

Diagnosis: The diagnosis by a Physician that is all of the following:

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

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

1. for Benign Brain Tumor, the date the Physician determines a benign brain tumor is present in the Covered Person or Dependent based on:
    a. examination of tissue (biopsy or surgical excision); or
    b. specific neuroradiological examination;
2. for Cancer, the date that the tissue specimen, blood sample(s) and/or titer(s) are taken on which the diagnosis of Cancer is based;
3. for Chronic Renal Failure, the date the Physician recommends that the Covered Person or Dependent undergo hemodialysis or peritoneal dialysis at least weekly, or results in the Covered Person or Dependent being placed on the United Network of Organ Sharing (UNOS) transplant list, whichever occurs first;
4. for Coma, the date the Physician confirms that the Covered Person or Dependent has been in a Coma for a continuous period of at least 14 days;
5. for Coronary Artery Disease, the date the Physician :
    a. recommends that the Covered Person or Dependent undergo heart surgery to correct:
        i. narrowing; or
        ii. blockage of;

    one or more coronary arteries with bypass grafts; or
    b. recommends that the Covered Person or Dependent undergo balloon angioplasty, laser angioplasty, atherectomy or placement of a stent to correct narrowing or blockage of one or more coronary arteries; or
    c. determines in writing at the time that the care is being given that bypass surgery, balloon angioplasty, laser angioplasty, artherectomy or placement of a stent is necessary; and, would be recommended if the Covered Person or Dependent were well enough to undergo such surgery or procedure.
6. for Heart Attack, the date the Physician confirms that a Heart Attack (myocardial infarction) has occurred;
7. for Heart Failure, the date :
    a. the Physician recommends that the Covered Person or Dependent undergo transplant surgery;
    b. the Physician determines in writing at the time that the care is being given that transplant surgery would be necessary if the Covered Person or Dependent were well enough to undergo such surgery; or

   c. the Covered Person or Dependent is placed on the United Network of Organ Sharing (UNOS) transplant list for the organ that has failed;

   whichever occurs first;

8. for Major Organ Failure, the date:
   a. the Physician recommends that the Covered Person or Dependent undergo transplant surgery;
   b. the Physician determines in writing at the time that the care is being given that transplant surgery would be necessary if the Covered Person or Dependent were well enough to undergo such surgery; or
   c. the Covered Person or Dependent is placed on the United Network of Organ Sharing (UNOS) transplant list for the organ that has failed;

   whichever occurs first.
9. for Paralysis, the date the Physician confirms the complete loss of functional use of two or more limbs for a continuous period of at least 30 days;
10. for Ruptured Aneurysm, the date the Physician confirms that a Ruptured Aneurysm occurred;
11. for Stroke, the date the Physician confirms that a Stroke occurred.

Critical Illness Conditions:

Benign Brain Tumor: a Diagnosis of a non-malignant tumor in the brain, cranial nerves, or meninges:
1. within the skull; and
2. with a minimum size of 1 cm.

The tumor must require:
1. surgical or radiation Treatment; or
2. cause permanent irreversible neurological defects.

Diagnosis of Benign Brain Tumor must be:
1. made by a Physician who is a neurologist; and
2. documented on an MRI of the brain or by pathological diagnosis.

If the Covered Person or Dependent is unable to undergo an MRI of the brain, the tumor must be documented by a CT scan of the head, with and without contrast.

Benign Brain Tumor does not include any of the following:
1. tumors of the skull;
2. pituitary adenomas;
3. germanomas.

Cancer: a pathological diagnosis of cancer. However, a clinical diagnosis of Level 1 Cancer that is based on symptoms will be recognized if:

1. a pathological diagnosis cannot be made because it is medically inappropriate or life threatening;
2. there is medical evidence to support the diagnosis; and
3. a Physician is treating the Covered Person or Dependent for Cancer.

Level 1 Cancer means a malignant tumor which has:

1. uncontrolled growth of malignant cells; and
2. invaded normal tissue.

It must be positively diagnosed with histopathological confirmation.

The term does not include the tumors listed below:

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

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

The term does include:

1. carcinoma in-situ;
2. prostate cancer; or
3. papillary carcinoma of the thyroid, and noninvasive papillary cancer of the bladder;

that is not covered under **Level 1 Cancer**.

Level 2 Cancer does not include the tumors listed below:

1. pre-malignant conditions or conditions with malignant potential;
2. Basal cell carcinoma and squamous cell carcinoma of the skin; or
3. Melanoma or melanoma in situ.

Level 2 Cancer also does not include tumors that are borderline malignant.

Level 2 Cancer does include chronic lymphocytic leukemia that:

1. has not progressed to Rai stage II or Binet Stage B; and

fails to meet the criteria to be covered as an invasive **Level 1** Cancer.

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

Coma: a condition Diagnosed as:

1. a continuous state of profound unconsciousness due to Sickness; and
2. with no reaction to external stimuli.

Coma must:

1. last for a period of 14 or more consecutive days; and
2. require:
   a. significant medical intervention; and
   b. life support measures.

Coma does not include:

1. coma caused by:
   a. Stroke; or
   b. Injury;
2. medically induced coma; or
3. a coma which results directly from drug or alcohol use.

Coronary Artery Disease: Heart disease that:

1. has been clinically diagnosed; and
2. requires the Covered Person or Dependent to undergo a surgical procedure.

The procedure must be to open a blockage of one or more coronary arteries using :

1. venous or arterial grafts (Coronary artery bypass does not include placement of intravascular stent, laser relief or other like procedures) ; or
2. balloon angioplasty, laser angioplasty, atherectomy or the placement of a stent to correct narrowing or blockage of one or more coronary arteries.

Such Treatment must be recommended by a Physician who is a cardiologist.

If a Physician who is a cardiologist has determined, in writing at the time the care is being given, that:

1. the Covered Person or Dependent requires one of the above procedures; but
2. is too ill to undergo the procedure;

the requirement that the procedure be recommended will be waived.

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

The diagnosis must include all of the following criteria concurrently:

1. typical clinical symptoms such as central chest pain;
2. acute diagnostic increase of specific cardiac markers; and
3. new electrocardiographic changes of infarction.

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

Heart Failure: a Physician's Diagnosis of failure of the heart requiring the complete replacement of the Covered Person's or Dependent's heart with the heart from a human donor. This must be evidenced by placement on a national transplant list such as UNOS, unless a suitable donor is found otherwise.

Heart Failure also includes any combination heart and lung transplant.

If the Physician has determined, in writing at the time the care is being given, that:
1. the Covered Person or Dependent is too ill to undergo the replacement; but
2. would otherwise meets the criteria for the need for the replacement;

the replacement requirement is waived.

Major Organ Failure: a Diagnosis of failure of the lung, pancreas or liver requiring the complete replacement of the organ with an organ from a human donor. This must be evidenced by placement on a national transplant list such as UNOS, unless a suitable donor is found otherwise. Major Organ Failure also includes disease of the bone marrow and which requires the replacement of the Covered Person's or Dependent's bone marrow by allogeneic and/or umbilical cord blood transplant.

If the Physician has determined, in writing at the time the care is being given, that:
1. the Covered Person or Dependent is too ill to undergo the replacement; but
2. would otherwise meet the criteria for the need for the replacement;

the replacement requirement is waived.

Major Organ Failure does not include any of the following:
1. organs transplanted simultaneously with the heart; however, these may be covered under the definition of Heart Failure instead;
2. Bone marrow transplant that results from the Treatment process for cancer;
3. autologous bone marrow transplant (transplant in which the Covered Person's or Dependent's own bone marrow is used).

Permanent Paralysis: total and permanent loss of the use of two or more limbs (arms or legs or combination) due to Sickness for a continuous period of at least 30 days.

Permanent Paralysis does not include paralysis that:
1. is due to or caused by Stroke; or
2. is due to or caused by Injury.

Ruptured Aneurysm (Ruptured Cerebral, Carotid or Aortic Aneurysm): a Diagnosis by a Physician of a ruptured cerebral, carotid or aortic aneurysm. The Diagnosis must be supported by medical records. These records must include radiographically specific diagnostics such as, but not limited to:
1. angiography;
2. CT scan;
3. MRI; or
4. ultrasound.

Aorta refers to the thoracic and abdominal aorta, but not its branches.

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

Stroke does not include Transient Ischemic Attacks (TIA) or attacks of Vertebrobasilar Ischemia.

Benefits Payable for the Child Critical Illness Category: We will pay a benefit for this Category if the Covered Person's Child is diagnosed with a Child Critical Illness provided:

1. the Covered Person is insured under the Policy on the Child's Date of Diagnosis; and
2. if the Child's Date of Diagnosis is on or before the date of birth, the Child survives to live birth and becomes insured under the Policy as a Newborn Child.

This benefit is provided:

1. as part of the Covered Person's benefits;
2. without regard to whether the Covered Person has Dependent Child coverage.

The only amount paid for this Category is the percentage of the Covered Person's Maximum Benefit Amount shown for this Category in the Schedule. The Dependent Child amount is not also paid.

Any benefit payable will be made as a single per diem amount in one lump sum payment following receipt of a Proof of Claim for:

1. the Date of Diagnosis if that occurs after live birth; or
2. the date of live birth, if the Date of Diagnosis occurred on or before the birth.

If a Child is diagnosed with more than one Child Critical Illness in this Category, We will only pay for one of the Child Critical illnesses. No further benefits are paid for the Child Critical Illness Category.

Child Critical Illness Date of Diagnosis, based on objective clinical or pathological findings, means the initial date that:

1. for Cerebral Palsy, a Physician who is a pediatrician or neurologist diagnoses Cerebral Palsy;
2. for Cleft Lip/Palate, a Physician diagnoses of Cleft Lip or Palate (unilateral or bilateral clefting);
3. for Cystic Fibrosis, a Physician confirms a Diagnosis of Cystic Fibrosis via a sweat test with sweat chloride concentrations greater than 60 mmol/L;
4. for Down Syndrome, a Physician makes a Diagnosis of Down Syndrome through the study of the 21st chromosome revealing Trisomy 21, Translocation or Mosaicism;
5. for Spina Bifida, a Physician familiar with the Diagnosis and/or Treatment of Spina Bifida makes a Diagnosis of Meningocele or Myelomeningocele Spina Bifida;
6. for Muscular Dystrophy, a Physician familiar with the Diagnosis and/or Treatment makes a Diagnosis of Muscular Dystrophy.

Child Critical Illnesses defined below:

Cerebral Palsy: a non-progressive neurological defect affecting muscle control. It is characterized by spasticity and lack of coordination of movements. The Diagnosis of Cerebral Palsy must be made by a licensed Physician who is:

1. board certified in neurology; or
2. a pediatrician who specializes in neurodevelopmental disorders.

Cerebral Palsy does not mean any other similar conditions such as:

1. degenerative nervous disorders;
2. genetic diseases,
3. muscle diseases;
4. metabolic disorders;
5. nervous system tumors;
6. coagulation disorders; or
7. other injuries or disorders which delay early development, but can be outgrown.

Cleft Lip or Palate: a clinical Diagnosis of cleft lip or cleft palate. Cleft lip is a narrow opening or gap in the skin of the upper lip. It extends all the way to the base of the nose. A Cleft Palate is an opening between the roof of the mouth and the nasal cavity.

Under the policy, coverage is only provided for clefts occurring:

1. on one side of the mouth (unilateral clefting); or
2. on both sides of the mouth (bilateral clefting).

Cystic Fibrosis: a Diagnosis of Cystic Fibrosis by a licensed pediatrician or pulmonologist where the Child has:

1. chronic lung disease; and
2. pancreatic insufficiency.

A Diagnosis of Cystic Fibrosis made via a sweat test should be based upon sweat chloride concentrations greater than 60 mmol/L.

Down Syndrome: a Diagnosis of Down Syndrome through study of the 21st chromosome. Diagnosis must be confirmed by a licensed pediatrician or another Physician familiar with Down Syndrome Diagnosis.

Down Syndrome includes:

1. Trisomy 21, where the Child has three instead of two number 21 chromosomes;
2. Translocation, where the Child has an extra part of the 21st chromosome attached to another chromosome; or
3. Mosaicism, where the Child has an extra 21st chromosome in only some of the cells but not all of them. (The other cells have the usual pair of 21st chromosomes.)

Muscular Dystrophy: the Diagnosis of a Covered Person's Child , under age 26, as having muscular dystrophy with well-defined neurological abnormalities. The Diagnosis must be confirmed by a Physician who is a neurologist and by:

1. electromyography; and
2. muscle biopsy.

Spina Bifida means a Diagnosis of either of the following types of Spina Bifida:

1. Meningocele, where the protective coatings (meninges) come through the open part of the spine like a sac that is pushed out. Cerebrospinal fluid is in the sac and there is usually no nerve damage. The Child may suffer minor disabilities, but new problems can develop later in life; or
2. Myelomeningocele, where the meninges (protective covering of the spinal cord) and spinal nerves come through the open part of the spine. This is the most serious type of Spina Bifida, which causes nerve damage and more severe disabilities.

Diagnosis must be made by a licensed Physician familiar with Spina Bifida. This policy does not cover spina bifida occulta.

Reoccurrence Benefit: We will pay a Reoccurrence Benefit equal to 50% of the Maximum Benefit Amount if the Covered Person or Dependent is:

1. Diagnosed with a second occurrence of a Critical Illness for which a benefit was previously paid;
2. Diagnosis is made 12 months or more following the initial diagnosis of the Critical Illness; and
3. the Covered Person or Dependent has not received Treatment for the Critical Illness during this 12 month period. Maintenance medication or therapy is not considered to be Treatment.

Only one Reoccurrence Benefit is payable for each Critical Illness per Covered Person or Dependent.

The Reoccurrence Benefit:

1. does not apply to; and
2. will not be payable for;

an illness under the Child Critical Illness Category.

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

Covered Person's Eligibility: Employees who are Actively at Work are eligible for insurance after completion of the required Employee Waiting Period provided :

1. they are in a class of Employees who are included; and
2. customarily working at least the number of hours per week shown in the Schedule of Benefits.

An Employee will become eligible for insurance on the latest of the following dates:

1. the Effective Date of the Policy;
2. the end of the Employee Waiting Period shown in the Schedule of Benefits;
3. the date the Policy is changed to include the Employee's class; or
4. the date the Employee enters a class eligible for insurance.

Dependent Eligibility: Dependents are eligible for insurance on the latest of the following dates:

1. the date the Covered Person becomes eligible for Dependent Insurance;
2. the date a person becomes a Dependent; or
3. the date the Policy is amended to include the Covered Person's class as being eligible for Dependent Insurance.

The Dependent will not be eligible for Dependent Insurance if he:

1. is eligible for insurance under the Policy as a Covered Person; or
2. is a member of the armed forces on active duty, except for duty of 30 days or less for training in the Reserves or National Guard; or
3. has been diagnosed as having a life expectancy of less than 12 months.

Enrolling in or Changing Insurance for Covered Person Insurance Under the Policy: The Employee may enroll in or change his insurance only under the following situations:

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

During a Re-enrollment Period, if the Covered Person does not re-enroll for insurance, he will continue to be insured for the same insurance.

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

1. during the Initial Enrollment Period:
    a. if the Dependents are eligible for insurance on the Effective Date of the Policy, the Employee may enroll for Dependent insurance during the Initial Enrollment Period. If an Employee fails to enroll his Dependents, then the Dependents will not be insured under the Policy.
    b. if the Dependents become eligible for insurance after the Effective Date of the Policy, the Employee may enroll for Dependent Insurance during his Initial Enrollment Period.
2. during a Re-enrollment Period: The Employee may choose:
    a. to keep the same Dependent Insurance;
    b. no Dependent insurance under the Policy;
    c. to apply for Dependent Insurance under the Policy;
    d. to change any benefit or amount of Dependent Insurance that is optional;
3. within 31 days of a Change in Family Status, as defined, the Employee may choose to enroll or change his Dependent Insurance provided the Dependent is eligible.

The Employee may enroll for:

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

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

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

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

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

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

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

Effective Date of Dependent Initial Insurance: No insurance will take effect on any day the Dependent is confined in a Hospital or Medical Facility. Insurance will take effect on the day following discharge from the Hospital or Medical Facility.

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

The Dependent Insurance will be effective at 12:01 A.M. Eastern Standard time:

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

Dependents will not be insured until the Employee is insured.

Effective Date of Change in Covered Person or Dependent Insurance: A change in insurance that is made during a Re-enrollment Period will be effective at 12:01 a.m. Eastern Standard time on the later of:

1. the date of application;
2. the first day of the pay period for which contributions for his insurance are deducted; or
3. the date the Covered Person or Dependent becomes eligible for the change in insurance, regardless of when application is made.

If the Covered Person is not Actively at Work due to Injury or Sickness, or is on a layoff or leave of absence, any increase in or addition to the Covered Person or Dependent insurance will be effective on the date the Covered Person returns to Active Work.

Newborn Child Provision: The Covered Person's Newborn Child will become covered by the Policy from the moment of live birth. The Newborn Child will be covered for the Critical Illness amount that applies to the Covered Person's other Children covered under the Policy. If the Covered Person has no other Children covered, then the lowest amount available to Children under the Policy applies. The Child's coverage will cease on the 31st day next following the Child's effective date unless:

1. We receive written request and any required premium to continue coverage for the Child before that date; or
2. the Covered Person's other children are covered, and we received written request and any required premium for the Child within 31 days of the day We first deny a claim on the basis that the child is not enrolled.

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

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

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

1. the date he ceases to be a Dependent as defined in the Policy;
2. the date he ceases to be a member of a class eligible for Dependent insurance;
3. the date the Covered Person's insurance under the Policy terminates;
4. the date the Dependent becomes a member of the armed forces on active duty, except:
   a. for duty of 30 days or less for training in the Reserves or National Guard; or
   b. to the extent coverage is continued under the Leave of Absence Continuation provision;
5. the last day of the period for which a Dependent's required premium payment is made, if the next payment is not made; or
6. the date the Policy terminates, or with respect to a specific benefit, the date that such benefit terminates.

CONTINUATION AND REINSTATEMENT PROVISIONS

Continuation during Grace Period: A Grace Period of 31 days will be allowed for the payment of each premium after the first premium payment. During the Grace Period, the insurance will continue in effect provided the premium is paid by the Policyholder before the end of the Grace Period. If the premium is not paid by the end of the Grace Period, coverage will terminate at the end of the Grace Period. The Grace Period will not continue the insurance beyond a date stated in a Termination Provision.

Continuation during Leave of Absence: If the Covered Person is on Family or Medical Leave of Absence, or other leave of absence required by an applicable state or federal law, continuation of his insurance will be governed by his Employer's policy on such leave not to exceed the greater of:

1. the leave period required by the Family and Medical Leave Act of 1993 (FMLA); or
2. the minimum leave period required by applicable state law.

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

If the Covered Person's insurance does not continue during such Leave of Absence, then when he returns to Active Work:

1. he will not have to meet a new Employee Waiting Period; if applicable; and
2. he will not have to give Us evidence of insurability to reinstate the insurance he had in effect before his Leave of Absence began.

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

Continuation of an Incapacitated Child: If, on the date a Child reaches the Maximum Age for Dependent Child as shown in the Schedule, he is:

1. covered under the Policy; and
2. an Incapacitated Child, as defined;

his coverage will not terminate solely due to age. The Covered Person must give Us notice of the incapacity within 31 days of the termination date.

The Child's coverage will continue as long as:

1. the Child qualifies as an Incapacitated Child; and
2. the required premium is paid.

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

Reinstatement of Rehired Employees: If a Covered Person ends employment and is rehired within 6 months, he may be insured on his eligibility date for the insurance that he had under the Policy on the date his employment ended.

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

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

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

PORTABILITY

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

The Covered Person must be insured under the Policy prior to the date his employment ends.

The Covered Person may port his insurance or his insured Dependent's insurance if coverage ends for any reason other than:

1. he failed to pay premium for the cost of his insurance;
2. he is on an approved leave of absence;
3. the group policy is terminating;
4. he is or becomes insured under another group critical illness policy;
5. he resides outside of the United States or in a state where the coverage is not available; or
6. he is actively in military service or entering active military service.

To apply for Portability insurance, within 31 days of the date the Covered Person's insurance ends he must:

1. submit a written application to Us; and
2. pay the first month's premium.

If the above conditions are met, such insurance will:

1 be issued without evidence of insurability; and

2 continue in effect provided the Covered Person continues to pay the cost of hisand his insured Dependent's insurance.

The Portability insurance will end on the earliest of:

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

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

The Portability coverage will be on the form the Insurer is then issuing for Critical Illness Portability purposes.

Insurer as used in this provision means Us or another insurance company which has agreed with Us to issue Portability coverage according to this Portability provision. The Portability coverage may differ from Your coverage under the Policy. The premium for the Portability coverage will be based on the coverage and form of the Portability policy, as well as Your age and risk class.

Portability Premium Contribution: For the first 12 months of Portability, the Covered Person's rate will be the group's current rate for the Covered Person's class. However, the Covered Person must pay the full premium including any part previously paid by his Employer.

After the first 12 months, the rate changes to a Portability rate which may be higher.

Eligibility Age Limit: The Covered Person must be under Age 70 to apply for Portability. To include Dependent coverage, the Covered Dependent must also be under Age 70.

Portability Termination Age: A Covered Person's and Dependent's Portability coverage will terminate on the first day of the month following the date he attains Age 75. If the Covered Person's Portability coverage terminates, his Dependent's coverage also terminates.

GENERAL EXCLUSIONS AND LIMITATIONS

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

1. an act or accident of war, declared or undeclared, whether civil or international, and any substantial armed conflict between organized forces of a military nature;
2. loss sustained while on active duty as a member of the armed forces of any nation except during any time period coverage is extended under the Continuation during Leave of Absence provision;
3. any intentionally self-inflicted Injury;
4. active participation in a riot;
5. committing or attempting to commit a felony, or participating or attempting to participate in a felony;
6. voluntary use of alcohol or the voluntary non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance, whether or not prescribed by a Physician;
7. cosmetic or elective surgery; or
8. attempted suicide, while sane or insane.

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

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

Multiple Critical Illness Limitation: The Covered Person and Dependent can receive a benefit for each Critical Illness only once, unless the Reoccurrence Benefit for that Critical Illness is included in the coverage.

A Covered Person or Dependent can receive benefits for different Critical Illnesses described in the Policy if the Dates of Diagnosis for each of his Critical Illness is separated by at least 90 days.

Coverage for the Covered Person or the Dependent will cease when he is not eligible for any further benefits.

CLAIM INFORMATION

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

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

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

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

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

1 the Date of Diagnosis;

2 a completed claim form signed by the Covered Person and Physician(s) including documentation furnished by the Physician and supported by clinical, radiological, histological, pathological and/or laboratory evidence of the Critical Illness. If the claim is for the Covered Person's Spouse, then the Spouse must also sign the claim form; and

3 the name and address of any Hospital or Medical Facility where Treatment was received and any Physician who provided Treatment prior to the Diagnosis.

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

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

where allowed by law.

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

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

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

Payment of Claim: All benefits are payable to the Covered Person. If he dies before a benefit is paid, We will pay any amount due to his beneficiary if he designated a beneficiary, otherwise in the following order:

1. to his legal Spouse;
2. to his natural or legally adopted children in equal shares; or
3. to his estate.

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

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

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

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

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

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

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

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

Smoker Statement: If a Covered Person or Dependent misstates his status as a non-smoker, premiums will be subject to an equitable adjustment. If the amount of the benefit depends upon such status, then the benefit will be that which would have been payable, based upon the person's correct status.

A **Smoker** is a Covered Person or Dependent who has:

1. smoked a cigarette or cigar;
2. chewed tobacco; or
3. used tobacco or nicotine;

during the 24 month period prior to the date he enrolled for coverage.

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

ADDITIONAL CRITICAL ILLNESSES RIDER

This rider is effective January 1, 2020. It is agreed that the Policy and Certificate are amended to add the following Categories of Critical Illness:

Additional Categories of Critical Illness	Percentage of Maximum Benefit Amount payable per Covered Person or Dependent
Amyotrophic lateral sclerosis (ALS)	100%
Complete Blindness	100%
Complete Loss of Hearing	100%
Advanced Alzheimer's	100%
Advanced Multiple Sclerosis	100%
Advanced Parkinson's	100%

Definitions under this Rider: The following definitions are added to the Definitions section:

Date of Diagnosis: The Date of Diagnosis, based on objective clinical or pathological findings, also means:

1. for ALS (Amyotrophic Lateral Sclerosis), often referred to as Lou Gehrig's Disease, the date a Physician who is a neurologist diagnoses that the Covered Person or Dependent has ALS based on a neurological examination and findings in one or more diagnostic tests stated in the definition of ALS; but, for benefits to be payable, coverage must remain in force to the Date a Physician confirms, in writing at the time the care is being given, that the Covered Person or Dependent is incapacitated to the extent stated in the definition of ALS;
2. for Complete Blindness, the date a Physician who is an ophthalmologist makes an accurate certification of the Covered Person's or Dependent's Complete Blindness, as defined;
3. for Complete Loss of Hearing, an audiologist makes an accurate certification of the Covered Person's or Dependent's total and permanent hearing loss.

The initial **Date of Diagnosis** for the following Critical Illnesses must be made while a Covered Person or Dependent. However, Policy Benefits will be payable only if coverage remains in force to the Date of Advanced Diagnosis.

1. for Advanced Alzheimer's, the date the Physician initially diagnoses the Covered Person or Dependent has Alzheimer's disease; but for benefits to be payable, coverage must remain in force to the Date a Physician confirms, in writing at the time the care is being given, that the Covered Person or Dependent is incapacitated to the extent stated in the definition of Advanced Alzheimer's;
2. for Advanced Multiple Sclerosis, the date the Physician initially diagnosed the Covered Person or Dependent has Multiple Sclerosis; but for benefits to be payable, coverage must remain in force to the Date a Physician who is a neurologist confirms, in writing at the time the care is being given, that the Covered Person or Dependent is incapacitated to the extent stated in the definition of Advanced Multiple Sclerosis;
3. for Advanced Parkinson's Disease, the date the Physician initially diagnoses the Covered Person or Dependent has Parkinson's disease; but for benefits to be payable, coverage must remain in force to the Date a Physician who is a neurologist confirms, in writing at the time the care is being given, that the Covered Person or Dependent is incapacitated to the extent stated in the definition of Advanced Parkinson's.

Amyotrophic Lateral Sclerosis ("ALS") or **Lou Gehrig's Disease**: a progressive degenerative motor neuron disease marked by:

1. muscular weakness and atrophy; and
2. with spasticity and hyperreflexia;

due to a degeneration of anterior horn cells of the spinal cord and cranial nerves.

It must be diagnosed as ALS of the Middle Stage according to the Muscular Dystrophy Association. Other motor neuron diseases are not considered to be ALS. ALS must be Diagnosed by a Physician who is a board certified neurologist based on generally acceptable principles of medicine.

ADDITIONAL CRITICAL ILLNESSES RIDER

Complete Blindness: a condition diagnosed as the irreversible loss of vision in both eyes due to Sickness. Complete Blindness must be diagnosed by a licensed ophthalmologist and must indicate that the best corrected visual acuity is equal to or worse than 20/200 in both eyes or the field of vision is less than 20 degrees in both eyes.

Complete Loss of Hearing: a condition diagnosed as the irreversible loss of hearing in both ears due to Sickness. Complete Loss of Hearing must be diagnosed by a licensed Physician or specialist in the applicable field of medicine and must indicate a total and permanent loss of hearing in both ears with an auditory threshold of more than ninety (90) decibels in each ear at a frequency of 500-4000 cycles, as determined by audiometric testing.

Advanced Alzheimer's: the Diagnosis of Alzheimer's Disease, a progressive degenerative disease of the brain. Diagnosis must be made by a Physician who is a board certified neurologist and must be supported by medical evidence that the insured exhibits loss of intellectual capacity involving impairment of memory and judgment as documented and demonstrated by neuroradiological tests (e.g. CT Scan, MRI, PET of the brain). This impairment must result in a significant reduction in mental and social functioning and require the insured to need Substantial Assistance to perform at least two of six Activities of Daily Living (ADLs).

No other dementing organic brain disorders or psychiatric illnesses are included in this definition.

As used above to define Advanced Alzheimer's:

Activities of Daily Living means:

1. Bathing: wash in a tub or shower; or take a sponge bath; and towel dry.
2. Continence: control bowel and bladder function; or, in the event of incontinence, maintain personal hygiene.
3. Dressing: put on and take off all clothes; and those medically necessary braces or prosthetic limbs usually worn; and fasten or unfasten them.
4. Eating: get food into the body by any means once it has been prepared and made available.
5. Toileting: get to and from and on and off the toilet; to maintain personal hygiene; and care for clothes.
6. Transferring: move in and out of a chair or bed.

Substantial Assistance means the need to have another person present and within arm's reach so as to prevent, by physical intervention, injury to the Covered Person or Dependent while he is performing the ADL.

The need for such assistance must be confirmed in writing by a Physician at the time care is being given. It must be supported by:

1. a Karnofsky Performance Status Scale assessment of 50 or less (or equivalent), indicating that the Covered Person or Dependent:
    a. is only capable of limited self-care; and
    b. is confined to a bed or chair for 50 percent or more of waking hours; or
2. receipt of care which provides the ADL assistance through the services of:
    a. a registered graduate nurse (R.N.) or a license practical nurse (L.P.N.); or
    b. if under the supervision of an RN, a nurse's aide or a home health aide;

    on a regular, ongoing basis for a period of 30 days or longer; or
3. abnormal findings from Cognitive Testing.

Cognitive Testing means a standardized battery of neuropsychological testing with validity measures. It does not mean a clinical screening instrument meant to select patients who might benefit from additional neuropsychological testing.

Advanced Multiple Sclerosis (MS): multiple sclerosis that is diagnosed by a Physician who is a board certified or board eligible neurologist. Diagnosis must be supported by neurological examination. It must demonstrate functional impairments have been met as stated in the most recent McDonald Diagnostic Criteria for MS. The Criteria must include studies of the brain or spine, or analysis of cerebrospinal fluid. If these:

1. demonstrate lesions consistent with MS, the MS must have persisted at least six months;
2. do not demonstrate such lesions, the MS must have persisted and progressed for at least 12 months.

The length of time of the progression must be supported by the presence of the lesions; or by the neurologist in writing and will be based upon notes from the time that care was being given.

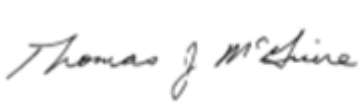
Other diseases are not considered to be MS.

Advanced Parkinson's Disease means Parkinson's Disease that is diagnosed by a Physician who is a board-certified or board-eligible neurologist. To be Advanced Parkinson's, the neurologist must confirm that it has progressed to Stage 4, based on abnormal findings from:

1. neurological examination;
2. cognitive testing; and
3. results of imaging studies.

Parkinson's disease secondary to illegal drug use and other Parkinsonism Syndromes, such as: Progressive Supranuclear Palsy, Corticobasal Degeneration, Multiple System Atrophy, Vascular Parkinsonism, and Dementia with Lewy bodies are not included.

Signed for the Company by:



Secretary

President

UnitedHealthcare Insurance Company
Hartford, Connecticut

WELLNESS BENEFIT

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

Health screening test is defined as:

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

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

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

Interaction with Wellness Benefit: If the Covered Person has purchased this Wellness Benefit under more than one policy issued by UnitedHealthcare Insurance Company, the Wellness Benefit for any health screening test is payable only once per plan year, regardless of any other such benefit. Another Wellness Benefit is only payable if it is for a different health screening test issued under a separate policy.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

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

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

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

• hospitalization

• physician services

• hospice

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

• other approved items and services

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

Before You Buy This Insurance

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

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

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

Questions, Complaints, Grievances

This notice provides you with the information to help you if:

- You have a question or concern about your Benefits;
- You have a complaint or grievance;
- We notify you that we will not be paying a claim because we have determined that your diagnosed condition is not covered under the Policy.

As used in this notice:

a. "complaint" means your expression of dissatisfaction with us.
b. "grievance" any dissatisfaction with the provision of services or claims practices of an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing to the insurer by, or on behalf of, a Covered Person.

To resolve a question, complaint, or grievance, just follow these steps:

What to Do First
Contact Our Customer Service Department
The UnitedHealthcare Insurance Company Customer Service Department telephone number is shown on your Certificate of Coverage. Customer Service representatives are available to take your call during regular business hours, Monday through Friday.

Please note: If you're calling with a question or complaint that relates to a claim payment, please supply:

- The claimant's name and the claim number, if available
- The date(s) of diagnosis.
- The Critical Illness for which you have claimed benefits.
- The reason you believe the claim should be paid.
- Any information to support your request for claim payment.

A Customer Service representative will attempt to address your question or complaint through informal discussion. If you would rather send your concern to us in writing at this point, the Customer Service representative can provide you with the appropriate address to file a grievance.

Grievance Process

Each time we deny a claim or Benefit, or initiate disenrollment proceedings; we will state the specific reason for the denial, determination or initiation of disenrollment and will notify you of your right to file a grievance.

We will acknowledge a grievance, in writing, within 5 days of its receipt and resolve the grievance within 30 calendar days of its receipt. We will investigate each grievance. If we are unable to resolve the grievance within that time, we will extend the time period by an additional 30 calendar days, if you receive notification that the grievance has not been resolved, the reason additional time is needed and the expected date the grievance will be resolved.

Grievance Process (continued)

You or an authorized representative have the right to appear in person before a grievance committee to present written or oral information. We will notify you, in writing, of the time and place of the meeting at least 7 calendar days before the meeting. If you have special needs, reasonable accommodations will be made to allow you or an authorized representative to participate in the meeting. Following a review of your grievance, you will receive a written notification of the committee's decision, along with the titles of the people on the grievance committee.

What to Do if Your Grievance Requires Immediate Action
In situations where the normal duration of the grievance process could have adverse effects on you, a grievance will not need to be submitted in writing. Instead, you or your Physician should contact us as soon as possible. We will resolve the grievance within 72 hours of its receipt, unless more information is needed. If more information is needed, we will notify you of our decision by the end of the next business day following receipt of the required information.

What to Do if You Disagree with Our Decision
You have the right to take your grievance to The Office of the Commissioner of Insurance, if you are not satisfied with our decision or at any time you are dissatisfied with our administration of your Benefits. The address and telephone number are as follows:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873

You may also call to request a complaint form at (800) 236-8517 (outside of Madison) or 608-266-0103 in Madison or email them at http://badger.state.wi/agencies/oci/emailoci.htm.

Please note that our decision is based only on whether or not Benefits are available under the Policy. A Critical Illness must meet specific criteria listed in the definition of Critical Illness contained in your Certificate of Coverage in order for you to be eligible for benefits under this policy. We do not make any judgment concerning the appropriateness of the diagnosis made by your physician.

CERTIFICATE MODIFICATIONS RIDER

Certificate Modification(s) to the Certificate

Policyholder: Grande Cheese Company

Policy Number: 304000

It is agreed that the Certificate is amended as follows:

Effective January 1, 2020, with respect to residents of the states as shown on the subsequent pages, the following provisions amend, replace or are added, when applicable, to the Certificate:

Signed for the Company by:

Secretary

President

UnitedHealthcare Insurance Company
Hartford, Connecticut

CERTIFICATE MODIFICATIONS RIDER

STATUTORY PROVISIONS

ALASKA

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

Dependent Definition

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

Overpayment of Claim

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

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

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

ARKANSAS

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

Insurer Information Notice

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

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

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

CERTIFICATE MODIFICATIONS RIDER

FLORIDA

Residents of the state of Florida:

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

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

Time Payment of Claim

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

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

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

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

Legal Action:

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

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

IDAHO

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

Insurer Information Notice

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

If the question is not resolved, you may contact the Idaho Department of Insurance:

Idaho Department of Insurance
Consumer Affairs
700 W State Street, 3rd Floor
PO Box 83720
Boise ID 83720-0043

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

CERTIFICATE MODIFICATIONS RIDER

The following Outline of Coverage is included:

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

OUTLINE OF COVERAGE

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

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

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

(4) A fixed percentage of the maximum benefit is payable for a critical illness. The critical illnesses are listed in the certificate schedule. The maximum benefit for an employee is $20,000; a spouse is $10,000 and each child is $5,000. When you or your spouse attains age 70, the maximum benefit reduces by 50%.

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

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

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

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

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

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CERTIFICATE MODIFICATIONS RIDER

IDAHO (continued)

The section entitled General Definitions is hereby changed to include the following definition:

Definition of Congenital Anomaly

A condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. For the purposes of this definition the term significant deviation means a deviation which impairs the function of the body and includes but is not limited to the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be congenital anomalies.

Dependent Eligibility

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

Dependent Eligibility: Dependents are eligible for insurance on the latest of the following dates:

1. the date the Covered Person becomes eligible for Dependent Insurance;
2. the date a person becomes a Dependent; or
3. the date the Policy is amended to include the Covered Person's class as being eligible for Dependent Insurance.

The Dependent will not be eligible for Dependent Insurance if he:

1. is eligible for insurance under the Policy as a Covered Person; or
2. is a member of the armed forces on active duty, except for duty of 30 days or less for training in the Reserves or National Guard.

Enrolling in or Changing Dependent Insurance Under the Policy

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

Enrolling in or Changing Dependent Insurance Under the Policy:

The Employee may elect or change Dependent Insurance only under the following situations:

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

IDAHO (continued)

The Employee may enroll for:

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

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

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

The section entitled Eligibility, Effective Date and Termination Provisions, the Newborn and Newly Adopted Child Provision is hereby changed to include Newly Adopted Child:
Newborn and Newly Adopted Child Provision: The Covered Person's newborn Child including adopted newborn Children that are Placed with the Covered Person within 60 days of the adopted Child's date of birth, will become covered by the Policy from the moment of live birth.

The Covered Person's adopted newborn Child Placed with the Covered Person more than 60 days after the birth of the adopted Child shall be covered by the Policy from and after the date the Child is so Placed.

For the purposes of this provision, Placed means physical placement in the care of the adopting Covered Person. If physical placement is prevented due to the medical needs of the child, "placed" means the date the adopting Covered Person signs an agreement for adoption of the child and assumes financial responsibility for the child.

IDAHO (continued)

In order for coverage to continue, We must receive notification of and premium, if required, for newborn and newly adopted Children and Children Placed for adoption within 60 days next following the date of birth, adoption or placement for adoption. Any additional premium, if required, for newborn or newly adopted Children, shall be due 31 days following the date the Covered Person receives a billing for the additional required premium.

The Child's coverage will cease unless We receive written request and any required premium to continue coverage for the Child as stated above.

The newborn or newly adopted Child and children Placed for adoption will be covered for the Critical Illness amount that applies to the Covered Person's other Children covered under the Policy. If the Covered Person has no other Children covered, then the lowest amount available to Children under the Policy applies.

General Exclusions and Limitations

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

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

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

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

Time of Claim Payment

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

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

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

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

Additional Conditions Rider

If this rider is included as an optional rider, all reference to Activities of Daily Living (ADLs) as a condition of Advanced Alzheimer's are removed.

CERTIFICATE MODIFICATIONS RIDER

MINNESOTA

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

Definition of Dependent
When dependent coverage is included in the Certificate of Coverage, the definition of Dependent will include a grandchild of either the Covered Person or the Covered Person's Spouse who is financially dependent upon and who resides with the Covered Person or the Covered Person's Spouse.

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

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

NEW HAMPSHIRE

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

The following disclosures are included:

This is a Limited Policy - Read the Certificate Carefully.

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

NEW HAMPSHIRE (continued)

The following Outline of Coverage is included: GROUP CRITICAL ILLNESS POLICY
SPECIFIED DISEASE COVERAGE
THIS CERTIFICATE PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES
OUTLINE OF COVERAGE

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

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

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

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

   The following Critical Illness Benefits are available under your coverage:

   Maximum Benefit Amount

   Option 1

   Employee: $5,000
   Spouse: $2,500
   Child: $1,250

   Option 2:*

   Employee: $10,000
   Spouse: $5,000
   Child: $2,500

   Option 3:*

   Employee: $20,000
   Spouse: $10,000
   Child: $5,000
   *Employee may choose from lower coverage options for Spouse and Child(ren).

CERTIFICATE MODIFICATIONS RIDER

Critical Illness Conditions	Percentage of Maximum Benefit Amount payable per Covered Person or Dependent
Benign Brain Tumor	100%
Cancer Level 1	100%
Cancer Level 2	25%
Chronic Renal Failure	100%
Coma	100%
Coronary Artery Disease	25%
Heart Attack	100%
Heart Failure	100%
Major Organ Failure	100%
Permanent Paralysis	100%
Ruptured Aneurysm	100%
Stroke	100%

Child Critical Illness Category	Percentage of Maximum Benefit Amount payable per Covered Child
• Cerebral Palsy	25% of Employee's Amount
• Cleft Lip / Palate	25% of Employee's Amount
• Cystic Fibrosis	25% of Employee's Amount
• Down Syndrome	25% of Employee's Amount
• Muscular Dystrophy	25% of Employee's Amount
• Spina Bifida	25% of Employee's Amount

Benefit Riders

Portability • Portability Policy Age Limit	Included Coverage continued under Portability terminates at Age 75
Reoccurrence Benefit:	For each Critical Illness Condition, not to exceed: 50% of Employee's Maximum Benefit Amount 50% of Spouse's Maximum Benefit Amount 50% of Child's Maximum Benefit Amount whichever applies
Wellness Benefit:	$50 per plan year
Additional Critical Illnesses Rider	Included

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CERTIFICATE MODIFICATIONS RIDER

Definition of Dependent
When dependent coverage is included in the Certificate of Coverage the definition Incapacitated Child is modified to delete the term “unmarried”.

Benefits Payable and Benefit Definitions
All references to stroke are referred to as severe stroke in New Hampshire.

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

NEW HAMPSHIRE (continued)

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

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

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

1. for which the Covered Person's or Dependent's Date of Diagnosis for any type of Critical Illness, as defined in the Policy, was prior to his Effective Date of insurance; or
2. that was diagnosed outside of the United States or Canada, unless the diagnosis was confirmed by a Physician practicing within the United States or Canada.

Proof of Claim

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

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

NEW HAMPSHIRE (continued)

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

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

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

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

where allowed by law.

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

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

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

Additional Conditions Rider

If this rider is included as an optional rider, all reference to Activities of Daily Living (ADLs) as a condition of Advanced Alzheimer's is removed.

Sickness is defined to mean an illness or disease (and if included) pregnancy or complication of pregnancy.

Substantial assistance is defined as the need to have another person present and within arm's reach so as to prevent, by physical intervention, injury to the Covered Person or (if included) Dependent while he is performing daily activities, including activities of self-care

Wellness Benefit

If this rider is included as an optional rider, all references to Wellness Benefit are changed to Health Screening Benefit.

Waiver of Premium

If this rider is included as an optional rider, the Proof of Claim provision is revised to state it must be given as soon as reasonably possible.

CERTIFICATE MODIFICATIONS RIDER

NORTH CAROLINA

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

General Definitions

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

Change in Family Status:

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

Dependent

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

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

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

CERTIFICATE MODIFICATIONS RIDER

NORTH CAROLINA (continued)

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

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

Benefits Payable and Benefit Definitions
The definition of Cancer is hereby amended to include the following sentence:

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

The positive Diagnosis of an illness or condition as defined in this section must be communicated to the Covered Person or Dependent (reference to Dependent only applies if Dependent coverage is included).

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

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

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

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

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

CERTIFICATE MODIFICATIONS RIDER

NORTH DAKOTA

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

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

OKLAHOMA

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

The following disclosures have been included:
Certificates delivered in the state of Oklahoma are subject to the terms and conditions of the Certificate and not the Policy. This Certificate is issued in and governed by the laws of the state of Oklahoma.

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

OKLAHOMA (continued)

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

1. they must not be related;

Newborn Child Provision
References to *live birth* in Benefits Payable and Benefit Definitions is replaced with *birth*.

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

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

Overpayment of Claim
The section entitled Overpayment of Claim is changed to add the following:

We will not request reimbursement more than 24 months after the date the claim was paid, unless the overpayment was due to fraud.

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

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

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

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

CERTIFICATE MODIFICATIONS RIDER

TEXAS

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

IMPORTANT NOTICE To obtain information or make a complaint: You may call UnitedHealthcare Insurance Company's toll-free telephone number for information or to make a complaint at 1-866-615-8727 You may also write to UnitedHealthcare Insurance Company at: UnitedHealthcare Insurance Company Administrative Offices 9900 Bren Road East Minnetonka, MN 55343 You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at: **1-800-252-3439** You may write the Texas Department of Insurance at: P.O. Box 149104 Austin, TX 78714-9104 FAX #(512) 490-1007 Web: http://www.tdi.texas.gov E-Mail: ConsumerProtection@tdi.texas.gov **PREMIUM OR CLAIM DISPUTES:** Should you have a dispute concerning your premium or about a claim you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance. **ATTACH THIS NOTICE TO YOUR POLICY:** This notice is for information only and does not become a part or condition of the attached document. Form No. AA-2068 (Rev. 6/15)	**AVISO IMPORTANTE** Para obtener información o para presentar una queja: Usted puede llamar al número de teléfono gratuito de UnitedHealthcare Insurance Company's para obtener información o para presentar una queja al: 1-866-615-8727 Usted también puede escribir a UnitedHealthcare Insurance Company: UnitedHealthcare Insurance Company Administrative Offices 9900 Bren Road East Minnetonka, MN 55343 Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al: **1-800-252-3439** Usted puede escribir al Departamento de Seguros de Texas a: P.O. Box 149104 Austin, TX 78714-9104 Fax: (512) 490-1007 Sitio web: http://www.tdi.texas.gov E-mail: ConsumerProtection@tdi.texas.gov **DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:** Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con (el agente) (la compañía) (el agente o la compañía) primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas. **ADJUNTE ESTE AVISO A SU PÓLIZA:** Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

ACN-TX-MP(8/95)

CERTIFICATE MODIFICATIONS RIDER

VERMONT

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

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

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

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

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

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

WASHINGTON

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

General Exclusions and Limitations

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

    1. due to war or act of war, whether declared or undeclared;
- The alcohol and drug exclusion as contained on the page General Exclusions and Limitations has been removed.

WASHINGTON (continued)

Eligibility, Effective Date and Termination Provisions

In the Newborn Child Provision, the Child's coverage will cease on the 60th day next following the Child's effective date unless:

1. We receive written request and any required premium to continue coverage for the Child before that date; or
2. the Covered Person's other children are covered, and we received written request and any required premium for the Child within 60 days of the day We first deny a claim on the basis that the child is not enrolled.

IMPORTANT INFORMATION ABOUT THE COVERAGE YOU ARE BEING OFFERED

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

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

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

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

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

The benefits under this policy are summarized below:

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

CERTIFICATE MODIFICATIONS RIDER

2. **Benefit Amount:**

Maximum Benefit Amount

Option 1

Employee: $5,000
Spouse: $2,500
Child: $1,250

Option 2:*

Employee: $10,000
Spouse: $5,000
Child: $2,500

Option 3:*

Employee: $20,000
Spouse: $10,000
Child: $5,000
*Employee may choose from lower coverage options for Spouse and Child(ren).

Critical Illness Conditions	**Percentage of Maximum Benefit Amount payable per Covered Person or Dependent**
Benign Brain Tumor	100%
Cancer – Invasive Level 1	100%
Cancer - Non-Invasive Level 2	25%
Chronic Renal Failure	100%
Coma	100%
Coronary Artery Disease	25%
Heart Attack	100%
Heart Failure	100%
Major Organ Failure	100%
Permanent Paralysis	100%
Ruptured Aneurysm	100%
Stroke	100%

Child Critical Illness Category	**Percentage of Maximum Benefit Amount payable per Covered Child**
• Cerebral Palsy	25% of Employee's Amount
• Cleft Lip / Palate	25% of Employee's Amount
• Cystic Fibrosis	25% of Employee's Amount
• Down Syndrome	25% of Employee's Amount
• Muscular Dystrophy	25% of Employee's Amount
• Spina Bifida	25% of Employee's Amount

CERTIFICATE MODIFICATIONS RIDER

Benefit Riders	
Portability	Included
• Portability Policy Age Limit	Coverage continued under Portability terminates at Age 75
Reoccurrence Benefit:	Included For each Critical Illness Condition, not to exceed: • 50% of Employee's Maximum Benefit Amount • 50% of Spouse's Maximum Benefit Amount • 50% of Child's Maximum Benefit Amount whichever applies
Additional Critical Illnesses Rider:	Included
Wellness Benefit:	$50 per plan year

3. **Benefit Trigger:** We will pay the stated percentage of the Maximum Benefit Amount for each of the Critical Illness Conditions shown on the Schedule of Benefits for which you or your Dependent:
   3. receives a Diagnosis of a Critical Illness; and
   4. for which you are insured on the Date of Diagnosis (as defined in the Certificate).
4. **Duration of Coverage:** Your coverage terminates on the first to occur of: the last day of the period for which premium is paid; the date you enter active duty of the armed forces; the date you cease to be in a class eligible for coverage; the date the Policy terminates; the date a benefit for a Critical Illness shown on the Schedule of Benefits is paid to you; or the date you cease to be actively at work.

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

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

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

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

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

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

CERTIFICATE MODIFICATIONS RIDER

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

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

UHICI-OOC-WA-1
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SUMMARY PLAN DESCRIPTION

Name of Plan: Grande Cheese Company

Name, Address and Telephone Number of Plan Sponsor:
Grande Cheese Company
Dairy Road, PO Box 67
Brownsville, WI 53006-0067
(920) 269-7200

Employer Identification Number (EIN): 39-0867071

IRS Plan Number: 503

Effective Date of Plan: January 1, 2020

Type of Plan: Welfare benefit plan

Name, Business Address, and Business Telephone Number of Plan Administrator:
Grande Cheese Company
Dairy Road, PO Box 67
Brownsville, WI 53006-0067
(920) 269-7200

Insurance Carrier:
UnitedHealthcare Insurance Company
Minnetonka, MN

Type of Administration of the Plan:
The Plan is administered on behalf of the Plan Administrator by the Insurance Carrier pursuant to the terms of the group insurance policy issued by the Insurance Carrier.

Person designated as agent for service of legal process:
Grande Cheese Company
Dairy Road, PO Box 67
Brownsville, WI 53006-0067
(920) 269-7200

Source of contributions and funding under the Plan:
The Plan is funded by the payment of premium required by the insurance policy.

Method of calculating the amount of contribution: Employee required contributions to the Plan Sponsor are the employee's share of costs as determined by the Plan Sponsor. From time to time the Plan Sponsor will determine the required employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to employees.

Date of the end of the year for purposes of maintaining Plan's fiscal records: Plan year shall be a twelve-month period ending December 31st.

Plan Details: The Plan's provisions relating to eligibility to participate and termination of eligibility as well as a description of the benefits provided by this Plan are described in detail in the Covered Person's Certificate of Coverage which precedes this ERISA information.

Plan Amendment and Termination: The Plan Sponsor reserves the right to modify, suspend or terminate this Plan at any time. The Employer does not promise the continuation of any benefits nor does it promise any specific level of benefits at or during retirement. Any benefits, rights or obligations of participants and beneficiaries under this Plan following termination are described in detail in the Covered Person's Certificate of Coverage which precedes this ERISA information.

The Plan Sponsor adopts all provisions of the insurance policy issued by the Insurance Carrier, as amended from time to time, as part of this Plan when it arranges for and maintains the insurance provided for in the policy.

This provision applies only where the interpretation of the Policy is governed by the Employee Retirement Income Security Act (ERISA).

STATEMENT OF EMPLOYEE ERISA RIGHTS

The Employee Retirement Income Security Act of 1974 (ERISA) guarantees certain rights and protections to participants of welfare plans. Federal law and regulations require that a "Statement of ERISA Rights" be included in this description of the Plan.

You may examine, without charge, all Plan documents, including any insurance contracts, collective bargaining agreements, annual reports, summary plan descriptions and other documents filed with the Department of Labor. You can examine copies of these documents in the Plan Administrator's office or at other specified locations, or you can ask your supervisor where copies of the documents are available.

If you want a personal copy of Plan documents or related material, you should send a written request to the Plan Administrator. You will be charged only the actual cost of these copies.

You are entitled to receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. These individuals, called "fiduciaries," have an obligation to administer the Plan prudently and to act in the interest of Plan participants and beneficiaries. The named fiduciary for this Plan is the Plan Sponsor. No one, including the Employer or any other person, may fire a Covered Person or otherwise discriminate against a Covered Person in any way to prevent that person from obtaining a benefit or exercising their rights under ERISA.

When you become eligible for payments from the Plan, you should follow the appropriate steps for filing a claim. In case of claim denial, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide you the materials and pay you up to $110 per day until you receive your materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in a state or federal court provided you have exhausted the procedures and complied with the timeframes for review of the adverse claim decision provided below. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay costs and legal fees. For example, if you are successful, the court may order the person you sued to pay those costs and fees. If you lose or if the court finds your suit to be frivolous, you may be ordered to pay these costs and fees.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, contact the nearest Area Office of the Employee Benefits Security Administration, United States 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.

CLAIMS DENIAL FOR CRITICAL ILLNESS INSURANCE

Notice of a decision to deny a claim (in whole or in part) shall be furnished to the claimant within 45 days following the receipt of the claim. Up to two extensions of 30 days each will be allowed for processing the claim for matters beyond the Plan's control or if additional information is needed from the claimant. If special circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the expiration of the initial 45 day period.

The notice of extension shall indicate the special circumstances requiring the extension and the date by which the notice of decision with respect to the claim is expected to be furnished. If a claim is denied (in whole or in part) notice shall be provided to the claimant in writing and shall set forth: 1) the reason(s) for the denial; 2) reference to the provision(s) of the Plan on which the denial is based; 3) a description of any additional material or information necessary for the claimant to perfect the claim, if the claim was denied because the claimant failed to provide all necessary information, and an explanation of why such material or information is necessary; and 4) an explanation of the claim review procedure. If written notice of the denial is not furnished to the claimant within 45 days (or if an extension was required, 105 days) from the date the claim was received, the claim shall be deemed denied and the claimant shall then be permitted to proceed with the procedure set forth below.

REVIEW OF DENIED CLAIMS AND COMPLAINT PROCEDURE FOR CRITICAL ILLNESS INSURANCE

If a covered person or any person claiming through a covered person wishes to have a denied claim reviewed, a written request must be sent to the address identified in the claim denial letter.

Any complaint or dispute related to review of denied claims shall be resolved in accordance with the procedure set forth by the Plan Sponsor and outlined below.

1. The complainant may contact the Insurance Carrier's service representative in an attempt to resolve the complaint in an informal manner.
2. If the complainant is not satisfied with any attempts at informal resolution, the complainant must submit a written request for review of a denied claim or a written notice of the complaint or dispute to the address identified on the claim denial letter within 180 days of receipt of the claim denial notice. The complainant may submit supporting documentation or information to be considered. The complainant must submit any requested additional information or documents.
3. A written notice of the final decision will usually be sent to the complainant within 45 days of receipt of the written request for review of a denied claim or notice of a complaint or dispute. However, if special circumstances require an extension of time to reach a final decision, written notice of the final decision will be sent as soon as possible following the expiration of the initial 45 day period, but no later than 90 days following receipt of the request for review of a denied claim or notice of a complaint or dispute. If special circumstances require such an extension of time, written notice of the extension shall be furnished to the complainant prior to the expiration of the initial 45 day period. The written notice of the final decision will give specific reason(s) for the decision and references to the provision(s) of the Plan on which the decision is based. If the final written decision is not furnished to the complainant within 45 days (or if an extension was required, 90 days) from the date of receipt of the request for review of a denied claim or notice of a complaint or dispute, the request for review or the complaint or dispute shall be deemed to be rejected and denied on review.