UnitedHealthcare Insurance Company

Home Office: 185 Asylum Street, Hartford, Connecticut 06103-3408
Administrative Office: 9900 Bren Road East, Minnetonka, MN 55343
www.uhc.com

POLICY

Policyholder:	Golden Rain Foundation of Walnut Creek
Policy Number:	371484
Policy Effective Date:	January 1, 2024
Premium Due Dates:	January 1 and the first day of each month thereafter
Policy Anniversary Date:	January 1 of each year

UnitedHealthcare Insurance Company (We, Our, Us or the Company), agrees to provide benefits according to the terms, provisions, conditions and limitations of the Policy.

The Policy becomes effective on the Policy Effective Date.

Read the Policy Carefully

This is a legal contract between the Policyholder and Us. If the Policyholder has questions about the Policy, contact Our Home Office by calling 1-888-299-2070.

The Policy is issued in and governed by the laws of California.

NOTICE TO POLICYHOLDER

This is an Accident only Policy and it does not pay benefits for loss from Sickness. Review the Policy carefully. This Policy provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT CONTRACT

If a Covered Person is eligible for Medicare, he should review the Guide to Health Insurance for People with Medicare available from the Company.

Signed for the Company by:

Tracy A. Arney, Secretary Jessica Paik, President

Group Accident Insurance Policy
Non-Participating (no dividends)

Noninsurance Benefits: Noninsurance benefits are not part of a Covered Person's Certificate and do not modify their insurance benefits. We may offer or arrange for various entities or vendors to offer benefits or other considerations to the Covered Person for the purpose of promoting their general health and well-being. Noninsurance benefits may be modified or terminated at any time. Such modification or termination may be made based on availability of services or other reasons at Our discretion or at the discretion of the insurer or entity providing such services.

POLICY GENERAL PROVISIONS

Certificates: We will furnish Certificates to the Policyholder to distribute or make available to each Covered Person. The Certificate(s) describe the benefits, terms, conditions, limitations and exclusions provided by the Policy. If there is a conflict between the Policy and the Certificate, the Policy will control.

Conformity with State or Federal Statutes: If any provision of the Policy conflicts with any applicable law, the provision will be deemed to conform to the requirements of the applicable law.

Entire Group Contract; Changes: The Entire Group Contract between the Policyholder and Us consists of this Policy, Certificate and the application of the Employer, if any, constitute(s), and any statement made by the Employer or by any Employee shall, in the absence of fraud, be deemed a representation and not a warranty. No such statement shall be used in defense to a claim hereunder unless it is contained in a written application, nor shall any such statement of the Employer, except a fraudulent misstatement, be used at all to void this policy after it has been in force for three years from the date of its issue, nor shall any such statement of any Employee eligible for coverage under the policy, except a fraudulent misstatement, be used at all in defense to a claim for loss incurred or disability (as defined in the Policy) commencing after the insurance coverage with respect to which claim is made has been in effect for three years from the date it became effective.

No change in this Policy shall be valid unless approved by an executive officer of Us and unless such approval be endorsed herein or attached hereto. No agent has authority to change this Policy or waive any of its provisions.

Information to be Furnished: The Policyholder may be required to furnish the following information needed to administer the Policy:

1. data relative to Employee population, industry, and corporate changes of the Policyholder; and
2. Employee benefit elections and contribution levels.

The Policyholder must furnish information reasonably required by Us to:

1. compute premiums; and
2. maintain necessary records.

Records of the Policyholder, which have a bearing on insurance, must be made available for inspection by Us upon reasonable request.

Clerical Error: Clerical error by the Policyholder will not:

1. affect the amount of insurance which would otherwise be in effect;
2. continue insurance which otherwise would be terminated; or
3. result in the payment of benefits not otherwise payable.

Once an error is discovered, an adjustment in premium will be made. If the premium adjustment involves the return of unearned premium, the amount of the return may be limited to the 12 month period, which precedes the date We receive proof such an adjustment should be made or when applicable, may be calculated on a pro-rata basis for any actual coverage period.

Payment of Premiums: Insurance provided by the Policy will be in effect when the first premium for such insurance is paid. For insurance to remain in effect, each subsequent premium must be paid on or before its due date. The Policyholder is responsible for paying all premiums as they become due. The premiums may be paid to Us by another party, however We may require a mutual binding agreement among the other party, the Policyholder and Us. Premiums are payable on or before their due dates at Our Home Office. Payment of Premium for a period before it is due will not guarantee that the insurance will remain in effect for that period.

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

Premium Rate Change: On or after the first Policy Anniversary Date, We have the right to change premium rates as of any Premium Due Date but not more than once in any 12 month period. We will notify the Policyholder in writing at least 31 days prior to the change in rates.

The premium rate may change prior to this time for reasons that affect the insurance risk, which include:

1. a change occurs in benefits;
2. a division, subsidiary, or affiliated company is added or deleted;
3. the number of Employees insured changes by 10% or more; or
4. a new Law or a change in any existing Law is enacted which applies to the Policy. A change may take effect on an earlier date if both the Policyholder and We agree to it. Except in the case of fraud, any premium adjustments, refunds or charges will be made for only the current Policy year.

Premium Rates: The premium rates for the Policy are on file at the office of the Policyholder.

INCORPORATION PROVISION

All of the provisions in the Certificate(s), which may include riders, endorsements and amendments issued for the Policyholder and shown below are incorporated in and made part of the Policy.

DOCUMENTS	DESCRIPTION	EFFECTIVE DATE
Accident Insurance Certificate	All active full-time Employees	January 1, 2024
Certificate Modifications Rider	Amends the Certificate as outlined	January 1, 2024

NOTICE OF PROTECTION PROVIDED BY CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

- **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance
  80% of death benefits but not to exceed $300,000
  80% of cash surrender or withdrawal values but not to exceed $100,000

- Annuities and Structured Settlement Annuities
  80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C)

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance Guarantee Association
P.O Box 16860,
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927- 4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

UnitedHealthcare®

GROUP ACCIDENT INSURANCE CERTIFICATE OF COVERAGE

FOR GOLDEN RAIN FOUNDATION OF WALNUT CREEK

POLICY NUMBER: 371484

EFFECTIVE DATE: January 1, 2024

CA – UHIC/2018R
(3-24)

California Consumer Complaint Notice

If the Covered Person has any questions or problems with their coverage, We will be ready to help. Our contact information is:

UnitedHealthcare Insurance Company

A Stock Company

Administrative Offices: 9900 Bren Road East, Minnetonka, MN 55343

1-888-299-2070

The Covered Person may also call the California Department of Insurance for assistance. However, We ask that the Covered Person gives Us the opportunity to try to resolve the problem. Please, call us first. If, We fail to help, the Covered Person may still ask the California Department of Insurance for assistance. Their contact information is:

California Department of Insurance

Consumer Services Division

300 South Spring Street

Los Angeles, California 90013

1-800-927-HELP

(1-800-927-4357)

http://www.insurance.ca.gov/01-consumers/

UnitedHealthcare Insurance Company

Home Office: 185 Asylum Street, Hartford, Connecticut 06103-3408
Administrative Office: 9900 Bren Road East, Minnetonka, MN 55343
www.uhc.com

CERTIFICATE OF COVERAGE

Policyholder: Golden Rain Foundation of Walnut Creek

Effective Date: January 1, 2024

Policy Number: 371484

Policy Anniversary Date: January 1st

Beneficiary: As on file with the Administrator

UnitedHealthcare Insurance Company (We, Our, Us or the Company), has issued the Policy to the Policyholder shown above.

This Certificate replaces any other Certificate previously issued and is incorporated in and made part of the Policy on the Effective Date shown in the Policy's Incorporation Provision.

Read Your Certificate Carefully. If You have questions or need information about Your insurance, call 1-888-299-2070.

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

Time Periods: All periods begin and end at 12:01 A.M., standard time, at the Policyholder's address.

NOTICE TO CERTIFICATE HOLDER
This is an Accident only Certificate and it does not pay benefits for loss from Sickness. Review this Certificate carefully. This Certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CONTRACT
If a Covered Person is eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

Signed for the Company by:

Tracy A. Arney, Secretary Jessica Paik, President

GROUP ACCIDENT INSURANCE

Noninsurance Benefits: Noninsurance benefits are not part of Your Certificate and do not modify Your insurance benefits. We may offer or arrange for various entities or vendors to offer benefits or other considerations to You for the purpose of promoting Your general health and well-being. Noninsurance benefits may be modified or terminated at any time. Such modification or termination may be made based on availability of services or other reasons at Our discretion or at the discretion of the insurer or entity providing such services.

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SCHEDULE

Policyholder: Golden Rain Foundation of Walnut Creek

Description of Eligible Class(es): Employees of the Policyholder who are Actively at Work and who are in an Eligible Class:

Full-time Employees working at least 20 hours per week

Employee Waiting Period: The first day of the month following the date the Employee begins continuous employment with the Policyholder, subject to the requirements shown in the Eligibility provision

Dependent Child Maximum Age: 26 years

Insurance Funding Information:
Contributory Insurance – You pay the entire premium

Premium Rate Change: Your premium may change on any premium due date if rates for Your Class are changed under the Policy.

Plan Coverage Type:	24 Hour Coverage for On Job and Off Job Injuries
Portability Portability Policy Age Limit	Included Age 75
Waiver of Premium	Included

Your Benefits and Benefit Amounts are those which You elect at the time You Enroll

INITIAL CARE BENEFIT	**MAXIMUM BENEFIT AMOUNT**
Ground Ambulance	$400
Air Ambulance	$2,400
Emergency Care Treatment	$200
Physician Office / Urgent Care Center Visit	$200
HOSPITAL CARE BENEFIT	**MAXIMUM BENEFIT AMOUNT**
Hospital Admission	$1,000
Hospital Confinement	$200
Hospital ICU Admission	$2,000
Hospital ICU Confinement	$400

SCHEDULE (continued)

FOLLOW UP CARE BENEFIT	MAXIMUM BENEFIT AMOUNT
Appliances:	
• Wheelchair	$300
• Knee Scooter	$300
• Knee Immobilizer	$300
• Lumbar Spine Brace	$300
• Walking Boot	$200
• Walker	$200
• Crutches	$200
• Leg Brace	$200
• Cervical Collar	$200
• Cane	$100
• Ankle Brace	$100
• Ankle Boot	$100
• Air Cast	$100
Follow Up Physician Visit	$100
Major Diagnostic Exam	$325
Minor Diagnostic Exam	$100
Prosthetic Device	
• One Device	$1,000
• Two Devices	$2,000
Rehabilitation Facility	$200
Rehabilitation Therapy	$50

COMMON INJURIES BENEFIT	MAXIMUM BENEFIT AMOUNT
Surgical Procedures:	
Abdominal/Thoracic Surgery	
• Surgery to repair	$2,000
• Exploratory surgery without repair	$200
Arthroscopic Surgery	$400
Cranial Surgery	$400
Eye Surgery:	
• Removal of foreign body	$200
• Surgical Repair	$400
Hernia Surgery	$400
Non-Specific Surgery:	
• General Anesthesia	$400
• Conscious Sedation	$200
Tendon/Ligament/Shoulder Cartilage/Rotator Cuff/Knee Cartilage Surgery	
• Surgery to repair	$800
• Surgery to repair more than one	$1,600
• Exploratory surgery without repair	$300
Blood/Plasma/Platelets	$500

COMMON INJURIES BENEFIT (continued)	**MAXIMUM BENEFIT AMOUNT**	
Burns:		
• 2nd degree burns (at least 36% of body surface)	$1,000	
• 3rd degree burns (9 to 34 sq inches)	$2,000	
• 3rd degree burns (35 or more sq inches)	$16,000	
Coma	$20,000	
Concussion	$300	
Dislocation (Separated Joint)		
Type of Dislocation:	**Open Reduction (Surgically Corrected)**	**Closed Reduction (Non- Surgically Corrected)**
• Ankle	$3,000	$1,500
• Collar Bone (Sternoclavicular)	$1,800	$900
• Collar Bone (Acromioclavicular separation)	$1,000	$500
• Elbow	$1,800	$900
• Finger	$1,000	$500
• Foot (except toes)	$3,000	$1,500
• Hand	$1,800	$900
• Hip	$9,000	$4,500
• Knee Cap (Patella)	$4,500	$2,250
• Lower Jaw	$1,800	$900
• Shoulder blade	$1,800	$900
• Toe	$1,000	$500
• Wrist	$1,800	$900
Emergency Dental Work		
• Crown	$400	
• Extraction	$200	
Family Child Daycare	$60	

COMMON INJURIES BENEFIT (continued)	**MAXIMUM BENEFIT AMOUNT**	
Fractures	**Open Reduction (Surgically Corrected)**	**Closed Reduction (Non- Surgically Corrected)**
Type of Fracture:		
• Skull (except bones of face or nose)		
◦ Depressed	$9,000	$4,500
◦ Simple	$5,000	$2,500
• Sternum	$9,000	$4,500
• Hip and Thigh (Femur)	$9,000	$4,500
• Vertebrae (body of)	$5,000	$2,500
• Pelvis (excluding coccyx)	$5,000	$2,500
• Leg (from top of tibia to ankle joint)	$5,000	$2,500
• Face or nose (except teeth)	$1,800	$900
• Upper Jaw (except Alveolar process)	$1,800	$900
• Upper Arm (Elbow to Shoulder)	$1,800	$900
• Lower Jaw (except Alveolar process)	$1,800	$900
• Shoulder Blade or Collarbone	$1,800	$900
• Forearm, hand, wrist (except fingers)	$1,800	$900
• Kneecap	$1,800	$900
• Foot (excluding toes)	$1,800	$900
• Ankle	$1,800	$900
• Coccyx	$1,400	$700
• Finger or toe	$600	$300
• Sacral/Sacrum	$1,800	$900
• Vertebral Process	$1,800	$900
Fractures (Chip/Avulsion)	25% of the Closed Reduction (Non-Surgically Corrected) Benefit Amount	
Laceration:		
• Laceration not requiring stitches, staple, or glue	$60	
• Less than 5 cm	$100	
• 5 cm -15 cm	$400	
• Greater than 15 cm	$800	
Lodging	$300	
Medical Supplies	$30	
Organized Sporting Activity	25%	
Paralysis		
• Hemiplegia	$10,000	
• Paraplegia	$10,000	
• Quadriplegia	$20,000	
Ruptured/Herniated Disc	$800	
Skin Graft		
• Percentage of Amount Payable under the Burn Benefit	25%	
Transportation	$400	
ADDITIONAL BENEFITS	**MAXIMUM BENEFIT AMOUNT**	
Wellness	$50	

GENERAL DEFINITIONS

Accident/Accidental means an unforeseen event that:

1. occurs suddenly as a result of an external circumstance or trauma;
2. has specific and identifiable components, including date and time; and
3. results in Injury to the physical structure of the body or death or dismemberment.

Active Work or Actively at Work means You are performing all of the regular duties of Your occupation:

1. at Your usual place of employment or any other business location where You are required to travel;
2. for the entire normal workday; and
3. for at least the minimum number of hours per week, as shown in the Description of Eligible Class(es) in the Schedule.

You or Your Employer must provide Us satisfactory documentation that You are Actively at Work in accordance with the Proof of Claim provision.

Unless You are disabled or terminate Your employment on the prior workday or on a day of absence, We will consider You to be 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 approved or emergency leave of absence (except medical leave).

Age means Your age on Your last birthday.

Beneficiary means the person(s) You name in writing to receive any amount of insurance payable due to Your death. You may name or change a Beneficiary by giving written notice to the Administrator. The Beneficiary notice will be effective on the date made, subject to any payment We may have made before the notice was received. For Beneficiary notices, Administrator means the Employer.

If You name more than one Beneficiary, those who survive will share equally unless You specify otherwise. If there is no named Beneficiary living at the time of Your death, We will pay any amount due in the following order:

1. to Your legal spouse or domestic partner; or
2. to Your natural or legally adopted children in equal shares; or
3. to Your estate.

If Your named primary beneficiaries die before You, their share will be payable in equal shares to any other named primary beneficiaries who survive You. If You have named a contingent beneficiary, the contingent beneficiary will only be paid if all primary beneficiaries die before You. If You have not named a primary or contingent beneficiary, or if all the person(s) You have named as primary or contingent beneficiaries die before You, payment will be made as follows:

1. to Your legal spouse or domestic partner, if any.
2. if there is no spouse or domestic partner, in equal shares to Your children.
3. if there is no spouse, domestic partner or children, to Your parents, equally or to the survivor.
4. if there is no spouse, domestic partner, children, or parents, in equal shares to Your brothers and sisters.
5. if none of the above survives, to Your executors or administrators.

Certificate or Certificate of Coverage means this document, which describes the benefits, terms, conditions, limitations and exclusions provided by the Policy. If there is a conflict between the Policy and the Certificate, the Policy will control.

Change in Status means any of the following changes:

1. a change in marital status (marriage, divorce, legal separation, annulment);
2. a change in the number of Your dependents for tax purposes (birth, legal adoption of a child, placement of a child for adoption, or death of a dependent);
3. certain changes in employment status that affect Your or your dependent's benefits eligibility 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 insurance or a significant reduction of insurance under Your other insurance or Your spouse's insurance; or
5. the addition, elimination, or significant reduction of an insurance option.

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

1. a natural Child;
2. a stepchild, legally adopted Child or Child placed for adoption;
3. a Domestic Partner's Child
4. a Child for whom legal guardianship has been awarded to You or Your spouse; or
5. a foster Child, or any other Child who lives with You in a regular parent-child relationship, provided You claim such Child as a Dependent on Your most recent federal income tax return.

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

Coma means a state of prolonged unconsciousness. The Coma must be continuous for a period of at least 7 days and be:

1. characterized by the absence of eye opening, motor response, and verbal response; and
2. require intubation for respiratory assistance.

Confined or Confinement means being an inpatient in a Hospital or Rehabilitation Facility due to an Injury that resulted from a Covered Accident. There must be a charge for at least one full day of room and board for any day to be considered a day of Confinement. Successive periods of Confinement which are:

1. separated by less than 90 days; and
2. due to the same Covered Accident;

will be considered the same period of Confinement.

Contributory Insurance means insurance which You have elected and for which You have agreed to make the required premium contributions.

Covered Accident means an Accident that occurs while Your or Your Dependent's insurance is in force for an Off Job or On Job Injury (24 hour Coverage) subject to all the terms, limits, and exclusions of the Policy.

Covered Person means the Employee insured under the Policy and to whom this Certificate is issued.
Dependent means Your Spouse and Your Child. A Dependent must be a citizen or legal resident of the United States, Puerto Rico, Guam or any other locations where We may legally provide such insurance. No one can be insured as a Dependent of more than one Covered Person. **Domestic Partner:** a person with whom You have established a domestic partnership and filed a valid Declaration of Domestic Partnership with the California Secretary of State or an equivalent document for registration of a domestic partnership with an authorized state or municipal agency. We must be notified if the domestic partnership terminates.

Emergency Room means a special, designated area in a Hospital that is supervised by Physicians and equipped and staffed to render immediate medical attention on an Outpatient basis, 24 hours a day, seven days a week for the sudden onset of symptoms related to an Injury or Sickness. An Emergency Room is not a clinic, an Urgent Care Center or Physician's office.

Employee means a person who works for the Employer on a regular basis:

1. in the normal business of the Employer;
2. is paid for services by the Employer;
3. who resides in the United States, its territories and protectorates; and
4. is Actively at Work for the Employer.

Employee does not include temporary, leased or seasonal Employees.

No director or officer of an Employer will be considered an Employee unless they work directly for and receive a salary from the Employer.

Employer means the Policyholder and:

1. may also include any division, subsidiary, or affiliated company named in the Schedule; and
2. does not include any employer who is not the Policyholder.

Enroll or Enrollment means a completed written request for enrollment or a change in insurance, for which You or Your Dependent are eligible and which is:

1. given to the Employer during an Enrollment Period, or within 31 days of a Change in Status; and
2. on a form furnished by Us for making such request.

Enrollment Period means a period of time, determined by the Employer and Us, as described below:

1. **Initial Enrollment Period**: the period during which You may first enroll for insurance;
2. **Re-Enrollment Period:** the period during which You may enroll after You have let Your insurance end;
3. **Annual Enrollment Period:** the period of time before each Policy Anniversary Date, during which You may enroll for insurance or change Your insurance;
4. **Open Enrollment Period:** the period during which You may enroll for insurance or change Your insurance; or
5. **Modified Open Enrollment Period:** the period during which You may increase Your amount of insurance by one unit/increment.

Hospital means an institution which:

1. operates pursuant to law;
2. primarily and continuously provides medical care and Treatment of sick and injured persons on an inpatient basis;
3. operates facilities for medical and surgical diagnosis and Treatment by or under the supervision of a staff of legally qualified Physicians;
4. provides 24 hour a day nursing service by or under the supervision of registered graduate nurses (R.N.);and
5. is located within the United States and is approved by the Joint Commission on the Accreditation of Hospitals (JCAH).

Hospital does not mean any institution or part thereof which is used primarily as:

1. a nursing home, or convalescent home, or skilled nursing facility;
2. a place for rest, custodial care, or for the aged;
3. a clinic; or
4. a place for the Treatment of mental illness, alcoholism, or drug addiction.

Immediate Family means Your spouse or domestic partner, child, parent or sibling; or Your spouse's or domestic partner's child, parent or sibling.

Incapacitated Child means a Child who is:

1. insured under the Policy on the date that they reach the Dependent Child Maximum Age;
2. physically or mentally disabled;
3. unmarried;
4. financially dependent upon You; and
5. meets the conditions stated in the Continuation of an Incapacitated Child provision.

Injury means bodily harm.

Intoxicated or Intoxication means being under the influence as defined by applicable state law as determined by:

1. the blood alcohol content; or
2. the results of other means of testing blood alcohol content or the content of other substances.

Non-Contributory Insurance means insurance which You do not have to elect or make any premium contributions.

On Job Injury means an Injury that is due to an Accident that occurs while You or Your Dependent are:

1. working for pay or profit, or while on an assignment for Your Employer; or
2. on the premises of the Employer during working hours.

Off Job Injury means an Injury that is not due to an Accident that occurs while You or Your Dependent are:

1. working for pay or profit, or while on an assignment for Your Employer; or
2. on the premises of the Employer during working hours.

Outpatient means Treatment for which a Confinement is not required and no charge is made for room and board.

Paralysis means the permanent impairment and loss of the ability to voluntarily move or to have sensation in any entire extremity. Paralysis must be:

1. the result of an Injury to the brain or spinal cord; and
2. without the severance of a limb.

Physician means a person who is:

1. a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that We recognize or are required by law to recognize;
2. licensed to practice in the jurisdiction where care is being given; and
3. practicing within the scope of that license.

The term Physician does not include You or members of Your Immediate Family.

Policy means the legal contract between the Policyholder and Us. It may be changed or discontinued without Your or Your Beneficiary's consent. The Policy may be inspected at the office of the Policyholder.

Rehabilitation Facility: a facility providing therapy and training for rehabilitation. The facility may offer occupational therapy, physical therapy, vocational training, and special training such as speech therapy. A Rehabilitation Facility is not:

1. a nursing home;
2. an extended care facility;
3. a skilled nursing facility;
4. a rest home or home for the aged;
5. a hospice care facility;
6. a place for the care of drug addicts or alcoholics; or
7. an assisted living facility.

Sickness means any illness, infection, or disease which is not an Injury and not caused by an Accident. The term Sickness includes pregnancy, infection (except for pyogenic infection through an Accidental wound) which is not caused by an Accident. No benefits are provided for a loss resulting from Sickness.

Spouse means Your Spouse who:

1. is lawfully married to You; and
2. is not legally separated or divorced from You.

Spouse will also mean Your Domestic Partner. We may require proof of marriage, or proof of valid domestic partnership.

Treatment means any tests, attendance or observation, Confinement, supplies or equipment including prescriptions or use of prescription drugs or medications.

Urgent Care Center means a medical clinic with expanded hours that is specially equipped to diagnose and treat a broad spectrum of non-life and limb threatening illnesses and injuries.

We, Our, Us or the Company means UnitedHealthcare Insurance Company, and its administrators and representatives.

You or Your means the Employee insured under the Policy and to whom this Certificate is issued.

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

Covered Person Eligibility: You will become eligible for insurance on the latest of:

1. the Effective Date of the Policy;
2. the date You complete the required Employee Waiting Period shown in the Schedule;
3. the date the Policy is changed to include Your Class; or
4. the date You enter a Class eligible for insurance, as shown in the Schedule.

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

1. the date a person becomes a Dependent;
2. the date You become eligible for Dependent insurance; or
3. the date Your Class becomes eligible for Dependent insurance under the Policy.

Your Dependents will not be eligible for Dependent insurance if they:

1. are eligible for insurance under the Policy as a Covered Person; or
2. are 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.

Dependents will not be insured until You are insured.

Enrolling for Your Insurance and Your Dependent's Insurance Under the Policy:

For Non-Contributory Insurance: Your Employer will automatically enroll You and Your Dependents.

For Contributory Insurance: You must complete Your Employer's enrollment process for You and Your Dependents. If You do not enroll for Your insurance and/or Your Dependent's insurance within 31 days after becoming eligible under the Policy, You may enroll only:

1. during an Annual Enrollment Period; or
2. within 31 days of the date You have a Change in Status.

During an Annual Enrollment Period, if You do not request changes or re-enroll for insurance, You will continue to be insured for the same insurance amount.

Covered Person Effective Date of Insurance or Change in Insurance:
If Your insurance is Non-Contributory, Your insurance will start on the date You become eligible for insurance, regardless of when You apply.

If Your insurance is Contributory, Your insurance will start on the latest of:

1. the date You become eligible, if You enroll on or before that date;
2. the first day of the month on or next following the last day of the Annual Enrollment Period, if You enroll during an Annual Enrollment Period; or
3. the date You enroll, if You do so within 31 days from the date You are eligible or have a Change in Status.

All Effective Dates of insurance are subject to the Deferred Effective Date provision.

Dependent Effective Date of Insurance or Change in Insurance:
If Dependent insurance is Non-Contributory, insurance will start on the date Your Dependent becomes eligible, regardless of when You apply for Dependent insurance.

If Dependent insurance is Contributory, insurance will start on the latest of:

1. the date Your Dependent became eligible, if You enroll Your Dependent on or before that date; or
2. the date You enroll Your Dependent, if You do so within 31 days from the date Your Dependent is eligible or You have a Change in Status.

All Effective Dates of insurance are subject to the Deferred Effective Date provision.

Newborn Child Provision: Your Newborn Child will become covered by the Policy from the moment of live birth. The Newborn Child will be covered for Injury only, and have the same Benefit Amount that applies to Your other Children covered under the Policy. If You have no other Children covered, then the lowest amount available to Children under the Policy applies. The Newborn Child's insurance will cease on the 31st day next following their effective date unless:

1. We receive written request and any required premium to continue insurance for the Child before that date; or
2. Your 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 Newborn Child is not enrolled.

Deferred Effective Date: If You are not Actively at Work on the date Your insurance is scheduled to take effect, it will take effect on the date You return to Active Work. If Your insurance is scheduled to take effect on a non-working day, Your Actively at Work status will be based on the last working day before the scheduled Effective Date of Your insurance.

Your Dependent's insurance, (other than for a Newborn Child) will not take effect on any day they are Hospital Confined. Insurance will take effect on the day following Your Dependent's discharge from the Hospital.

Covered Person Termination of Insurance: Your insurance will terminate on the earliest of the following dates:

1. the last day of the period the required premium is due but not paid, subject to the Grace Period provision;
2. the last day of the month during which You cease to be a member of a class eligible for insurance;
3. the date the Policy terminates, or a specific benefit terminates;
4. the date You are no longer Actively at Work due to a labor dispute, including but not limited to strike, work slowdown or lock out; or
5. the last day of the month during which You are no longer Actively at Work for any other reason, unless insurance is continued in accordance with the Continuation of Insurance Provisions.

Dependent Termination of Insurance: Your Dependent's insurance will terminate on the earliest of the following dates:

1. the date Your insurance ends;
2. the last day of the month during which Your Dependent no longer meets the definition of Dependent;
3. the last day of the month during which You are no longer eligible for Dependent insurance;
4. the last day of the month during which Your Dependent becomes 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;
5. the last day of the period the required premium is due but not paid, subject to the Grace Period; or
6. the date the Policy terminates, or a specific benefit terminates.

Continuation of an Incapacitated Child: If, on the date a Child reaches the Dependent Child Maximum Age, they are:

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

insurance will not terminate solely due to age.

The Child's insurance will continue as long as:

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

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

You must give Us notice of the incapacity within 31 days of the termination date.

CONTINUATION AND REINSTATEMENT PROVISIONS

Continuation of Insurance:
Insurance under the Policy may be continued beyond a date stated in the Covered Person Termination of Insurance provision, according to the Continuation Provisions. The amount of continued insurance applicable to You and Your Dependents will be the amount of insurance in effect on the date immediately before insurance would otherwise have ended. Insurance that is continued:

1. is subject to payment of premium;
2. may be continued up to the maximum time shown in the applicable provision(s); and
3. terminates if the Policy terminates.

The amount of insurance will not increase while insurance is continued under one or more of the following provisions.
Continuation Provisions:

1. leaves of absence must be approved in writing by Your Employer; and
2. when combined, will not extend longer than 3 months from the date You were last Actively at Work.

All other terms of Your and Your Dependents insurance under the Policy remain unchanged.

Continuation Provisions
Family and Medical Leave: If You are granted a leave of absence, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your insurance (including Dependent insurance) may be continued for up to 12 weeks following the date Your leave commenced. Continuation may be a longer period if required by any other applicable state or local law. If the leave ends prior to the agreed upon date, this continuation will cease immediately.

Layoff: If You are laid off by Your Employer Your insurance may be continued for up to 3 months from the date You stopped being Actively at Work or a longer period if required by law.

Leave of Absence: If You are on a medical or non-medical leave of absence, other than Family and Medical Leave or Military Leave of Absence, all of Your insurance (including Dependent insurance) may be continued for up to:

1. 3 months from the date You stopped being Actively at Work, with respect to a medical leave of absence; or
2. 3 months from the date You stopped being Actively at Work, with respect to a non-medical leave of absence.

Continuation may be a longer period if required by law.

Military Leave of Absence: If You or Your Dependent enter active military service and are granted a military leave of absence, Your insurance (including Dependent insurance) may be continued for up to 12 weeks from the date You stopped being Actively at Work or a longer period if required by law.

Status Change: If You are an Employee, but no longer in an Eligible Class due to a reduction in the number of scheduled hours You work, Your insurance may be continued for up to 90 consecutive days after the date Your scheduled hours were reduced.

Reinstatement: If Your insurance ends because You are no longer employed by the Employer or no longer in Your Eligible Class; then insurance for You and Your previously insured Dependents may be reinstated, provided You request such reinstatement within 30 days of the date You return to work or to an Eligible Class.

The reinstated insurance will be the lesser of:

1. the insurance amounts in force on the date insurance ended; or
2. the amount of insurance in Your new Eligible Class.

The reinstated insurance will:

1. be subject to all the other terms and provisions of the Policy.

We will not reinstate any amount of insurance which You or Your Dependents continued under the Portability provision unless You cancel such insurance.

PORTABILITY

Portability: You may elect to Port Your or Your Dependent's insurance prior to the date Your insurance under the Policy ends.

You may not Port Your insurance if:

1. You fail to pay any required premium;
2. You are on an approved leave of absence;
3. the Policy terminates;
4. You are or become insured under another group accident policy;
5. You reside outside of the United States or its territories;
6. You reside in a state where the insurance is not available; or
7. You are actively in military service or entering active military service.

Electing Portability: To elect to continue Your and Your Dependent's insurance, You must:

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

within 31 days of the date Your insurance ends.

The following combinations may be Ported:

1. You only;
2. You and Your Spouse only;
3. You and Your Children only; or
4. You and all Your Dependents.

No other combinations of Ported insurance amounts will be allowed. You must continue to pay the cost of Your and Your Dependent's Ported insurance.

Your surviving Dependents may Port their insurance if You die. However, Your surviving Spouse must Port in order for Your surviving Children to Port. If there is no surviving Spouse, no Children will be allowed to Port.

The Portability insurance will end on the earliest of:

1. the date You fail to pay the required premium;
2. the date You become insured under any other accident insurance policy; or
3. the date You attain any Portability Policy Age Limit shown in the Schedule.

If You are rehired after You Port Your insurance, You must cancel the Ported insurance to re-enroll as a Covered Person under the Policy.

Portability, Ported or Port means You and Your Dependents may continue insurance under the Policy that would otherwise terminate due to certain conditions.

Portability Premium Contribution: For the first 12 months of Portability, the rate will be the group's current rate for Your or Your Dependent's class. However, the required premium including any part previously paid by Your Employer must be paid.

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

WAIVER OF PREMIUM BENEFIT

Waiver of Premium: If You become Totally Disabled, We will continue Your and Your Dependent's insurance in force without premium payment while You remain Totally Disabled if:

1. You become Totally Disabled as the result of a Covered Accident;
2. You remain Totally Disabled for 30 consecutive days; and
3. You give Us proof of Total Disability, as required.

We will:

1. waive Your and Your Dependent's insurance premium payments on a monthly basis, beginning the first day of the month after the month You have been Totally Disabled for 30 consecutive days; and
2. refund any premium paid for insurance on and after that day.

Total Disability or Totally Disabled: For purposes of this benefit, You will be considered Totally Disabled if, due to a Covered Accident, You are unable to perform each and every duty of:

1. Your occupation at Your usual place of employment; and
2. any job suited to Your education, training or experience.

Successive and Concurrent Total Disability: After You have remained Totally Disabled for 30 consecutive days, concurrent periods of Total Disability, whether due to the same or a different Covered Accident, are considered part of the same period of Total Disability. Successive periods of Total Disability that start while Your insurance is in force, but before You have returned to Active Work for 90 consecutive days:

1. are considered part of the same period of Total Disability;
2. are not subject to a new 30 consecutive day period but will count toward the 6 month maximum waiver period.

If You have a new Covered Accident after the 90th consecutive day of Active Work, You may begin a new Waiver, subject to satisfaction of a new 30 consecutive day period, and all other terms and provisions of the Policy.

Benefits During Waiver of Premium: Benefits continued during the Waiver of Premium are based on the Schedule in force on the date Your Total Disability started. The Waiver will not apply to increases in insurance after the date Your Total Disability started.

Proof of Total Disability: You must give Us proof of Total Disability:

1. on forms We provide;
2. no later than 90 days after the date You became Totally Disabled; and
3. within 60 days of Our request.

We may require You to be examined, initially and periodically, at Our expense, by a Physician, other medical practitioner or vocational expert of Our choice.

Termination of Waiver of Premium Benefit: The Waiver of Premium terminates on the earliest of the following**:**

1. the date premium has been waived for 6 months;
2. the date You cease to be Totally Disabled and do not return to Active Work;
3. the date the Policy terminates;
4. the date You cease to be eligible for insurance (except that this will not apply if You are ineligible solely because You are not Actively at Work due to Total Disability covered by this Waiver;)
5. the last day of the 60 day period following Our request for proof of Total Disability, if You do not give Us proof or refuse to take a medical exam.

If You are still eligible for insurance when the Waiver ends, Your insurance may be continued in force if premium payments are resumed.

INITIAL CARE BENEFIT

Ground Ambulance Benefit: We will pay the Maximum Benefit Amount shown for this benefit in the Schedule if You or Your Dependent sustain an Injury which results in a ground transport by a licensed professional ambulance company or a Hospital owned ambulance service:

1. to or from a Hospital; or
2. between medical facilities;

for Treatment of Injuries received as the result of a Covered Accident.

Ground transport must occur within 90 days of the date of the Covered Accident.

This benefit is payable up to 1 time per Covered Accident for You or Your Dependent.

Air Ambulance Benefit: We will pay the Maximum Benefit Amount shown for this benefit in the Schedule if You or Your Dependent sustain an Injury which results in an air transport by a licensed professional ambulance company or a Hospital owned ambulance service:

1. to or from a Hospital; or
2. between medical facilities;

for Treatment of Injuries received as the result of a Covered Accident.

Air transport must occur within 72 hours of the Covered Accident.

This benefit is payable up to 1 time per Covered Accident for You or Your Dependent.

Emergency Care Treatment Benefit: We will pay the Maximum Benefit Amount shown for this benefit in the Schedule if You or Your Dependent receive Treatment in an Emergency Room for an Injury as the result of a Covered Accident.

Treatment must be:

1. rendered by a Physician or a licensed health care professional under the supervision of a Physician; and
2. received within 72 hours of the Covered Accident causing Injury which requires Treatment on an emergency basis.

This benefit is payable up to 1 time per Covered Accident for You or Your Dependent.

Physician Office / Urgent Care Center Visit Benefit: We will pay the Maximum Benefit Amount shown for this benefit in the Schedule if You or Your Dependent visit a Physician's office or an Urgent Care Center for the Treatment of an Injury as the result of a Covered Accident.

The visit must occur within 60 days of the date of the Covered Accident.

This benefit is payable up to 1 time per Covered Accident for You or Your Dependent.

This benefit does not apply to care provided by a Physician in an Emergency Room or to care provided by a Physician in any other health care facility that does not include the Physician's office or that is not an Urgent Care Center. A Physician's visit does not include services or Treatment at, or by, a dental office, chiropractor, or occupational, physical, speech or mental health therapist.

HOSPITAL CARE BENEFIT

Hospital Admission Benefit: We will pay the Maximum Benefit Amount shown for this benefit in the Schedule for the first day You or Your Dependent are admitted and Confined to a Hospital as the result of an Injury due to a Covered Accident.

The admission must begin within 30 days of the date of the Covered Accident.

This benefit is payable up to 1 time per Covered Accident for You or Your Dependent.

If a benefit is payable under both this benefit and the Hospital Intensive Care Unit Admission Benefit, only the higher benefit will be paid.

Hospital Confinement Benefit: We will pay the Maximum Benefit Amount shown for this benefit in the Schedule for each day that You or Your Dependent are Confined in a Hospital as the result of an Injury due to a Covered Accident.

The Confinement must begin within 30 days of the date of the Covered Accident.

This benefit is payable for each day during Confinement in a Hospital up to a maximum of 365 days per plan year for You or Your Dependent.

If the Hospital Admission Benefit is also payable, this benefit pays for each day after the first day during a Confinement in a Hospital up to a maximum of 364 days.

This benefit is not payable for any day for which the Hospital Intensive Care Unit Confinement Benefit is payable.

Hospital Intensive Care Unit Admission Benefit: We will pay the Maximum Benefit Amount shown for this benefit in the Schedule for the first day You or Your Dependent are admitted and Confined in an Intensive Care Unit of a Hospital as the result of an Injury due to a Covered Accident.

The admission must begin within 30 days of the date of the Covered Accident.

This benefit is payable up to 1 time per Covered Accident for You or Your Dependent.

If a benefit is payable under both this benefit and the Hospital Admission Benefit for the same day, only the higher benefit will be paid.

Hospital Intensive Care Unit Confinement Benefit: We will pay the Maximum Benefit Amount shown for this benefit in the Schedule for each day that You or Your Dependent are Confined in an Intensive Care Unit of a Hospital as the result of an Injury due to a Covered Accident.

The Confinement must begin within 30 days of the date of the Covered Accident.

This benefit is payable for each day during a Confinement in an Intensive Care Unit up to a maximum of 30 days per plan year for You or Your Dependent.

If the Hospital Intensive Care Unit Admission Benefit is also payable, this benefit pays for each day after the first day during a Confinement in a Hospital up to a maximum of 29 days.

If a benefit is payable under both this benefit and the Hospital Confinement Benefit for the same day, only this benefit will be paid.

FOLLOW UP CARE BENEFIT

Appliance Benefit: We will pay the Maximum Benefit Amount shown for this benefit in the Schedule if You or Your Dependent sustain an Injury due to a Covered Accident for which a Physician prescribes a medical Appliance that aids in personal mobility.

The expense for the Appliance must be incurred within 90 days of the date of the Covered Accident that caused the Injury.

This benefit is payable up to 1 time per Covered Accident for You or Your Dependent.

For the purpose of this benefit, **Appliance means**: wheelchair, knee scooter, knee immobilizer, lumbar spine brace, walking boot, walker, crutches, leg brace, cervical collar, cane, ankle brace, ankle boot, or air cast.

Follow Up Physician Visit Benefit: We will pay the Maximum Benefit Amount shown for this benefit in the Schedule if You or Your Dependent sustain an Injury due to a Covered Accident for which:

1. benefits were payable under either the Emergency Care Treatment Benefit or the Physician Office/Urgent Care Visit Benefit;
2. follow up Treatment was recommended by a Physician;
3. the recommendation results in Your or Your Dependent's follow up Treatment visit to a Physician; and
4. You or Your Dependent are insured under the Policy at the time of the follow up Treatment visit.

The follow up visit(s) must occur within 90 days of the date of the Covered Accident.

This benefit is payable up to 3 visits per Covered Accident for You or Your Dependent.

Major Diagnostic Exam Benefit: For the purpose of diagnosis of an Injury due to a Covered Accident, We will pay the Maximum Benefit Amount shown for this benefit in the Schedule if You or Your Dependent receive, on an Outpatient basis:

1. a Magnetic Resonance Imaging (MRI) scan;
2. a Computerized Tomography (CT) scan;
3. a Positron Emission Tomography (PET) scan;
4. an Electroencephalogram (EEG);
5. ImPACT or other similar cognitive studies; or
6. a Single-photon emission computed tomography (SPECT) scan**.**

The exam must be performed within 60 days of the date of the Covered Accident in which symptoms suggest an Injury has occurred.

This benefit is payable up to 1 exam per plan year for You or Your Dependent.

Minor Diagnostic Exam Benefit: For the purpose of diagnosis of an Injury due to a Covered Accident, We will pay the Maximum Benefit Amount shown for this benefit in the Schedule if You or Your Dependent receive, on an Outpatient basis:

1. an X-ray; or
2. a laboratory test.

The exam must be performed within 60 days of the date of the Covered Accident, in which symptoms suggest an Injury has occurred.

This benefit is payable up to 1 exam per plan year for You or Your Dependent.

Prosthetic Device Benefit: We will pay the Maximum Benefit Amount shown for this benefit in the Schedule if You or Your Dependent sustain an Injury due to a Covered Accident which results in an incurred expense for a Prosthesis.

The Prosthesis must be prescribed by a Physician for functional use due to loss of a hand, foot or sight of an eye.

The expense for the Prosthesis must be incurred within 365 days of the date of the Covered Accident.

This benefit is payable up to 1 time per Covered Accident for You or Your Dependent.

Prosthetic Device means an artificial limb or eye. It does not include:

1. hearing aids;
2. dental aids including false teeth;
3. eye-glasses;
4. artificial joints; or
5. cosmetic prostheses such as hair wigs.

Rehabilitation Facility Benefit: We will pay the Maximum Benefit Amount shown for this benefit in the Schedule for each day that You or Your Dependent are Confined in a Rehabilitation Facility and receive Treatment for an Injury due to a Covered Accident.

Rehabilitation therapy services are limited to:

1. physical therapy;
2. occupational therapy; and
3. speech therapy.

Rehabilitation therapy services must be performed by a:

1. Physician;
2. certified athletic trainer or physical therapy assistant;
3. licensed physical therapist;
4. licensed occupational therapist; or
5. licensed speech therapist.

The Rehabilitation Facility Confinement must occur within 30 days after a Hospital Confinement that is covered under the Hospital Care Benefit and within 90 days of the date of the Covered Accident.

This benefit is payable up to 30 days per Covered Accident for You or Your Dependent.

This benefit will not be paid on a day the Hospital Intensive Care Unit Confinement Benefit, the Hospital Confinement Benefit or the Rehabilitation Therapy Benefit is paid.

Rehabilitation Therapy Benefit: We will pay the Maximum Benefit Amount shown for this benefit in the Schedule if You or Your Dependent receive Treatment, on an Outpatient basis, for rehabilitation therapy services for Injuries due to a Covered Accident.

Rehabilitation therapy services are limited to:
1. physical therapy;
2. occupational therapy; and
3. speech therapy.

Therapy services must occur within 365 days of the date of the Covered Accident.

This benefit is payable 10 days per Covered Accident for You or Your Dependent.

Rehabilitation therapy services must be performed by a:
1. Physician;
2. certified athletic trainer or physical therapy assistant;
3. licensed physical therapist;
4. licensed occupational therapist; or
5. licensed speech therapist.

Benefits include rehabilitation therapy services provided:
1. in a Physician's office; or
2. on an Outpatient basis at a Hospital or Rehabilitation Facility.

This benefit will not be payable for the same visit as the Follow Up Physician Visit Benefit or the Rehabilitation Facility Benefit.

COMMON INJURIES BENEFIT

Abdominal / Thoracic Surgery Benefit: We will pay the Maximum Benefit Amount shown for this benefit in the Schedule if You or Your Dependent sustain an Injury due to a Covered Accident which results in open abdominal or thoracic surgery and:

1. the surgery is performed to repair internal injuries received as the result of a Covered Accident; and
2. the surgery occurs within 90 days of the date of the Covered Accident.

This benefit is payable up to 1 time per Covered Accident for You or Your Dependent. This benefit does not cover surgery related to a hernia. Two or more surgical procedures through the same incision or entry point are considered one surgery.

Arthroscopic Surgery Benefit: We will pay the Maximum Benefit Amount shown for this benefit in the Schedule if You or Your Dependent require non-repair Arthroscopic Surgery as a result of Injuries due to a Covered Accident.

The Arthroscopic Surgery must be performed within 90 days of the date of the Covered Accident.

This benefit is payable up to 1 time per Covered Accident for You or Your Dependent.

Cranial Surgery Benefit: We will pay the Maximum Benefit Amount shown for this benefit in the Schedule if You or Your Dependent require Cranial Surgery as a result of Injuries due to a Covered Accident.

The Cranial Surgery must be performed within 90 days of the date of the Covered Accident.

This benefit is payable up to 1 time per Covered Accident for You or Your Dependent.

Eye Surgery Benefit: We will pay the Maximum Benefit Amount that applies as shown for this benefit in the Schedule if You or Your Dependent sustain an Injury due to a Covered Accident that requires a Physician to:

1. perform surgery; or
2. remove a foreign object from the eye.

The surgery or removal is received from the Physician within 90 days of the date of the Covered Accident.

This benefit is not paid for examination with anesthesia which:

1. does not involve surgery for removal of a foreign object; or
2. involves only the moveable fold of skin and muscle that covers the eye (the eyelid).

This benefit is payable up to 1 time per Covered Accident for You or Your Dependent.

Hernia Surgery Benefit: We will pay the Maximum Benefit Amount shown for this benefit in the Schedule if You or Your Dependent require Hernia Surgery as a result of Injuries due to a Covered Accident.

The Hernia Surgery must be performed within 90 days of the date of the Covered Accident.

This benefit is payable up to 1 time per Covered Accident for You or Your Dependent.

Non-Specific Surgery Benefit: We will pay the Maximum Benefit Amount shown for this benefit in the Schedule if You or Your Dependent require a surgery as a result of Injuries due to a Covered Accident and the surgery required is not covered by any other surgical benefit provided in this Policy.

The surgery must be performed within 180 days of the date of the Covered Accident.

This benefit is payable up to 1 time per Covered Accident for You or Your Dependent.

Tendon/Ligament/Shoulder Cartilage/Rotator Cuff/Knee Cartilage Surgery Benefit: We will pay the Maximum Benefit Amount shown for this benefit in the Schedule if Your or Your Dependent's Injury, due to a Covered Accident, results in surgery to repair:

1. a tendon;
2. ligament;
3. shoulder cartilage;
4. rotator cuff; or
5. knee cartilage.

The applicable repair surgery must be performed within 180 days of the date of the Covered Accident.

If You or Your Dependent sustain more than one Injury that is payable under this benefit, the total amount that We will pay as the result of any one Covered Accident will be the lesser of:

1. the total amount payable for all; or
2. an amount that will not exceed two times the amount determined to be payable for the one Injury payable under this benefit that would pay the largest benefit.

We will pay the reduced amount shown for this benefit if such surgery is exploratory and without repair.

This benefit will not be paid concurrently with the Fracture Benefit or Dislocation Benefit. Of the three benefits, only the one benefit that pays the highest amount will be paid, and not more than once for all Injuries as the result of any one Covered Accident.

Blood/Plasma/Platelets Benefit: We will pay the Maximum Benefit Amount shown for this benefit in the Schedule if You or Your Dependent sustain an Injury due to a Covered Accident which results in:

1. a transfusion; or
2. the administration, cross matching, typing and processing of blood plasma or blood platelets.

The transfusion must occur within 90 days of the date of the Covered Accident.

This benefit is payable up to 1 time per Covered Accident for You or Your Dependent.

Burn Benefit: We will pay the Maximum Benefit Amount that applies as shown for this benefit in the Schedule if You or Your Dependent sustain an Injury due to a Covered Accident which results in a burn to a percentage/size of body surface area.

Treatment must be received from a Physician within 72 hours of the Covered Accident.

This benefit is payable up to 1 time per Covered Accident for You or Your Dependent. The Maximum Benefit Amount that applies is based on percentage of burn of the body surface area. If more than one level of burn is sustained as the result of any one Covered Accident, only the one level that pays the highest amount will be paid. First degree burns are not covered.

Coma Benefit: We will pay the Maximum Benefit Amount shown for this benefit in the Schedule if:

1. You or Your Dependent sustain an Injury due to a Covered Accident which results in a Coma; and
2. the Coma:
   a. begins while You or Your Dependent's insurance is in force; and
   b. is diagnosed by a Physician as having commenced within 90 days of the date of the Covered Accident.

This benefit is payable up to 1 time per Covered Accident for You or Your Dependent.

The Coma diagnosis must be supported by:

1. a Glasgow Coma Scale Score of eight or below throughout the time period stated in the definition of Coma; and
2. an Electroencephalogram (EEG).

The term Coma will not include any medically induced Coma.

Concussion Benefit: We will pay the Maximum Benefit Amount shown for this benefit in the Schedule if You or Your Dependent sustain an Injury due to a Covered Accident which results in a concussion. A Physician must diagnose the concussion within 72 hours of the Covered Accident.

This benefit is payable up to 1 time per Covered Accident for You or Your Dependent.

Dislocation/Separated Joint Benefit: We will pay the Maximum Benefit Amount that applies as shown for this benefit in the Schedule if You or Your Dependent sustain an Injury due to a Covered Accident:

1. which results in Your or Your Dependent's dislocation of a complete separated joint; and
2. for which a Physician treats the dislocation/separated joint either:
   a. surgically; or
   b. non surgically;
   within 90 days of the date of the Covered Accident

This benefit is payable up to 1 time per Covered Accident for You or Your Dependent.

The total amount that We will pay under this benefit and under the Fracture Benefit for all Dislocations and Fractures sustained as the result of any one Covered Accident will be the lesser of:

1. the total amount payable for all; or
2. an amount that will not exceed two times the amount determined to be payable for the one Dislocation or Fracture that pays the largest benefit.

Emergency Dental Work Benefit: We will pay the Maximum Benefit Amount that applies as shown for this benefit in the Schedule if You or Your Dependent sustain an Injury due to a Covered Accident which causes damage to a Sound Natural Tooth(or Teeth) and a Physician:

1. extracts; or
2. repairs the tooth by placement of a crown.

The extraction or placement of a crown must be performed within 90 days of the date of the Covered Accident.

The total amount that We will pay for:

1. all teeth extracted due to any one Covered Accident will not exceed the Maximum Benefit stated in the Schedule per extraction for up to 1 extraction; and
2. all teeth repaired by a crown as the result of any one Covered Accident will not exceed the Maximum Benefit stated in the Schedule per crown for up to 1 crown.

This benefit will not be paid for Injury caused by biting or chewing.

For this benefit, **Sound Natural Tooth (or Teeth)** means a tooth that has no active decay, has at least 50% bony support, has no filling on more than two surfaces, has no root canal treatment, is not an implant, is not in need of treatment except as a result of the Injury, and functions normally in chewing and speech. Crowns, bridges, and dentures are not considered sound natural teeth.

Family Child Daycare Benefit: We will pay the Maximum Benefit Amount shown for this benefit in the Schedule for each day that Your Dependent receives child care if:

1. You sustain an Injury due to a Covered Accident which results in Your Confinement to a Hospital; and
2. the Confinement begins:
    a. within 30 days of a Covered Accident which caused the Injury; and
    b. while Your insurance is in force;
3. an expense is charged for a day of care by a child care provider who is licensed to provide such services in the jurisdiction in which the services are provided; and
4. the day of child care coincides with a day of Hospital Confinement which is covered under the Policy.

We will not pay this benefit for any day of child care that extends beyond a maximum payment period of 30 days. The Child receiving child care does not need to be a Dependent, but must:

1. qualify as a Child, as defined, except that such Child must be under age 14; or
2. qualify as an Incapacitated Child.

Fracture Benefit: We will pay the Maximum Benefit Amount that applies as shown for this benefit in the Schedule if You or Your Dependent sustain an Injury due to a Covered Accident:

1. which results in a Fracture; and
2. for which a Physician treats the Fracture either:
    a. surgically; or
    b. non surgically;

    within 90 days of the date of the Covered Accident.

Fracture means a broken bone which can be seen by x-ray or other similar diagnostic imaging and is a result of a serious Injury. Fracture does not include stress fractures, which are tiny cracks in a bone that can arise by the repetitive application of force, or from normal use of a weakened bone. Benefits are not payable for stress fractures.

Chip/Avulsion Fracture means a piece of the bone is broken off near a joint at a place where a ligament is usually attached.

This benefit is payable up to 1 time per Covered Accident for You or Your Dependent.

The total amount that We will pay under this benefit for multiple Fractures sustained as the result of any one Covered Accident will be the lesser of:

1. the total amount payable for all; or
2. an amount that will not exceed two times the amount determined to be payable for the Fracture that pays the largest benefit.

Laceration Benefit: We will pay the Maximum Benefit Amount that applies as shown for this benefit in the Schedule if You or Your Dependent sustain an Injury due to a Covered Accident which results in a Laceration that is treated by a Physician within 72 hours of a Covered Accident.

This benefit is payable up to 1 time per Covered Accident for You or Your Dependent.

Laceration means a cut.

Lodging Benefit: We will pay the Maximum Benefit Amount shown for this benefit in the Schedule for each day of a companion's Lodging if You or Your Dependent sustain an Injury due to a Covered Accident and:

1. due to an Injury, requires a Confinement that is more than 100 miles one-way from Your or Your Dependent's principal residence;
2. the Confinement occurs within 90 days from the date of the Covered Accident;
3. a person who is a companion accompanies You or Your Dependent and such companion incurs Lodging expense for the day;
4. the day coincides with a day the Confinement is covered under the Policy; and
5. Treatment is prescribed by a Physician.

This benefit is payable up to 30 days per Covered Accident for Your or Your Dependent's companion. The Lodging cannot be owned by the companion, You, or Your Immediate Family.

Lodging when used for this benefit means an overnight accommodation:

1. for which a room charge is made; and
2. in a hotel, motel, lodge, inn, or similar facility.

Medical Supplies Benefit: We will pay the Maximum Benefit Amount shown for this benefit in the Schedule for Your or Your Dependent's purchase of over-the-counter medical supplies for an Injury due to a Covered Accident.

The purchase of the over-the-counter medical supplies must be within 90 days of the date of the Covered Accident.

This benefit is payable up to 1 time per plan year for You or Your Dependent.

Medical Supplies mean supplies used to alleviate or treat the Injury due to a Covered Accident. These supplies cannot be cosmetic in nature or only beneficial to Your general health.

Organized Sporting Activity Benefit: If You or Your Dependent sustain an Injury due to a Covered Accident that occurs while participating in an Organized Sporting Activity, We will increase the amounts payable under:

1. the other benefits which are stated in the Common Injury Benefit; and
2. the benefits which are stated in the Follow Up Care Benefit;

by the percentage shown in the Schedule for this benefit.

This benefit will not increase the amounts payable under:

1. the Initial Care Benefit; or
2. any other benefits not specifically stated under the Common Injuries or Follow Up Care Benefits.

This benefit is payable up to 1 time per Covered Accident for You or Your Dependent.

The **Organized Sporting Activity** must be:

1. a competition; or
2. practice for a competition;

for amateurs only.

The competition must be:

1. governed by a set of written rules;
2. supervised by an adult that has completed all training required by the organization, and
3. overseen by a legal entity such as a public school system or sports association that is governed by a board of directors.

Paralysis Benefit: We will pay the Maximum Benefit Amount shown for the applicable benefit in the Schedule if You or Your Dependent sustain an Injury due to a Covered Accident which results in:

1. **Hemiplegia**: total and permanent Paralysis of one upper and one lower limb on opposite sides of the body;
2. **Paraplegia**: total and permanent Paralysis of both lower limbs**;** or
3. **Quadriplegia**: total and permanent Paralysis of both upper and lower limbs.

The Paralysis must:

1. be confirmed by a Physician;
2. be based on documented evidence that the Paralysis was caused by an Injury due to a Covered Accident; and
3. commence within 90 days of the date of the Covered Accident.

This benefit is payable for 1 Paralysis up to 1 time per Covered Accident for You or Your Dependent.

Ruptured/Herniated Disc Benefit: We will pay the Maximum Benefit Amount shown for this benefit in the Schedule if You or Your Dependent sustain an Injury due to a Covered Accident:

1. which results in a Ruptured or Herniated Disc of the spine that is a direct result of the Covered Accident; and
2. for which Treatment is received from a Physician within 90 days of the date of the Covered Accident.

This benefit is payable up to 3 times per Covered Accident for You or Your Dependent.

Ruptured or Herniated Disc means the center of the spinal disc (nucleus pulposus) has ruptured, pushed or protruded outside its normal space and through the surrounding outer ring of cartilage (annulus fibrosus). The center nucleus has to go through the outer edge of the disc.

Skin Grafts Benefit: We will pay the Maximum Benefit Amount shown for this benefit in the Schedule if You or Your Dependent sustain an Injury due to a Covered Accident:

1. which results in a skin graft; and
2. the skin graft is for a burn that is payable under the Burn Benefit.

This benefit is payable up to 3 times per Covered Accident for You or Your Dependent.

Transportation Benefit: We will pay the Maximum Benefit Amount shown for this benefit in the Schedule if:

1. You or Your Dependent sustain an Injury due to a Covered Accident;
2. the Injury requires Special Treatment; and
3. the first trip to the Special Treatment occurs within 90 days of the date of the Covered Accident.

This benefit is not payable for:

1. transport by ambulance if the Ground or Air Ambulance Benefit is also payable; or
2. any later transport if the initial transport to the Special Treatment occurred more than 90 days from the date of the Covered Accident.

This benefit is payable up to 3 times per Covered Accident for You or Your Dependent.

Special Treatment means Treatment that is prescribed by a Physician and that is not available within 100 miles of Your or Your Dependent's residence.

ADDITIONAL BENEFITS

Wellness Benefit: We will pay the Maximum Benefit Amount shown for this Benefit in the Schedule for up to 1 Health Screening Test performed for each person insured under this benefit. per calendar year.

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
- Hemoccult 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 You or Your Spouse remain 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 You and/or Your Spouse receive under the Policy.

Interaction with Wellness Benefit: If You have 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 calendar year for each person insured under this benefit, 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.

GENERAL LIMITATIONS AND EXCLUSIONS

General Limitations and Exclusions: We will not pay a benefit for a loss contributed to or caused by:

1. Sickness, disease, bodily or mental infirmity, or medical or surgical Treatment of these (except pyogenic infections through an Accidental wound);
2. suicide or any loss which is intentionally self-inflicted;
3. active participation in a riot;
4. commission of or attempt to commission a felony;
5. an act or accident of war, declared or undeclared, whether civil or international, or any substantial armed conflict between organized forces of a military nature;
6. loss sustained or contracted in consequence of being intoxicated or under the influence of any controlled substance unless administered on the advice of a Physician;
7. driving or in physical control of a Motor Vehicle while Intoxicated;
8. engaging in the following hazardous activities, including skydiving, hang gliding, auto racing, dirt bike riding, mountain climbing, Russian Roulette, autoerotic asphyxiation, bungee jumping, base jumping or using off-road vehicles that are not registered for use on-road based on applicable state law;
9. riding in or driving any motor-driven vehicle in a race, stunt show or speed test;
10. travel or flight in, or descent from any aircraft, unless as a fare-paying passenger on a commercial airline flying between established airports on: a) a scheduled route; or b) a charter flight seating 15 or more people;
11. travel or flight in, or descent from any aircraft, except if employment duties require You to be a pilot and/or passenger in a privately owned aircraft, or as a fare-paying passenger on a commercial airline flying between established airports on: a) a scheduled route; or b) a charter flight seating 15 or more people;
12. practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received;
13. Injury arising out of or in the course of any occupation or employment for pay or profit, or any Injury or Sickness for which You or Your Dependent are entitled to benefits under any Workers' Compensation Law, Employers' Liability Law or similar law, unless this insurance is issued on an 24 hour basis as shown in the Schedule; or
14. an Accident that occurs outside of the United States.

In addition to the exclusions shown above, no payment will be made for Treatment received outside of the United States.

GENERAL PROVISIONS

Time Limit on Certain Defenses:

1. After two years from the date of issue of the policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for the policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of the two-year period.
2. No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of the policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage under the policy.

Grace Period: A grace period of 60 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force (subject to Our right to cancel in accordance with the cancellation provision hereof).

Unpaid Premium: Upon the payment of a claim under the policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

Notice of Claim: Written notice of claim must be given to Us within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to Us at the administrative address shown on the face page of this certificate, or to any authorized agent of Ours, with information sufficient to identify the insured, shall be deemed notice to Us.

Claim Forms: Upon receipt of a notice of claim, We will furnish to the claimant such forms as are usually furnished by Us for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proofs of Loss: Written proof of loss must be furnished to Us at Our said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which We are liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Time of Payment of Claim: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof

Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at Our option, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, We may pay such indemnity, up to an amount not exceeding $1,000.00, to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by Us in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

Physical Examinations and Autopsy: We, at Our own expense shall have the right and opportunity to examine the person of the insured when and as often as We may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Change of Beneficiary: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

Misstatement of age: If the age of the insured has been misstated, all amounts payable under the policy shall be such as the premium paid would have purchased at the correct age.

Cancellation: We may cancel the policy at any time by written notice delivered to the Policyholder, or mailed to his last address as shown by Our records, stating when, not less than five days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term the Policyholder may cancel the policy at any time by written notice delivered or mailed to Us, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation by either the Policyholder or Us, We will return promptly the unearned portion of any premium paid. The Policyholder shall pay, on a pro rata basis, the earned premium which has not been paid. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

Upon providing the Policyholder with notice of Our intent to cancel, We will cease accepting applications under the Policy. However, the Policy will not terminate with respect to inforce certificates until the last certificate cancels in accordance with its termination provisions and no person remains insured under the Policy. The Policy will only terminate earlier with respect to inforce certificates if We and the Policyholder:

1. agree to such termination;
2. arrange separately or jointly for coverage under any inforce certificate to transition to a new policy; and
3. the new policy continues such coverage for the same or similar benefits.

Conformity With State Statutes: Any provision of the policy which, on its effective date, is in conflict with the statutes of California, is hereby amended to conform to the minimum requirements of such statutes.

Fraud: The falsity of any statement in the application for coverage shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by Us.

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

• hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

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.

NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

- **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance
  80% of death benefits but not to exceed $300,000
  80% of cash surrender or withdrawal values but not to exceed $100,000

- Annuities and Structured Settlement Annuities
  80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C)

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance Guarantee Association
P.O Box 16860,
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927- 4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

CERTIFICATE MODIFICATIONS RIDER

Modification(s) to the Certificate

Policyholder: Golden Rain Foundation of Walnut Creek

Policy Number: 371484

It is agreed that the Certificate is amended as follows:

Effective January 1, 2024, 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, and all other conditions apply.

Signed for UnitedHealthcare Insurance Company by:

Tracy A. Arney, Secretary Jessica Paik, President

UnitedHealthcare Insurance Company
Hartford, Connecticut 06103-3408

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:

General Definitions
If Dependent coverage is included and **Domestic Partner** is defined, it is amended so that any references to gender (i.e., "of the opposite or same sex" or "of the same sex") are removed.

Initial Care Benefit
If the **Physician Office / Urgent Care Center Visit Benefit** is included, a Physician's visit includes services or Treatment at, or by, a dental office, chiropractor, or occupational, physical, speech or mental health therapist.

General Limitations and Exclusions
The hazardous activities exclusion is amended to remove any reference to off-road vehicles.

The travel/flight exclusion is amended with regard to charter flights by deleting the phrase "seating 15 or more people."

The Accident that occurs outside of the United States exclusion is amended to add "unless the Accident occurs in Canada while enroute to another Alaska location."

The Treatment received outside of the United States exclusion is amended to add "or Canada."

Claim Provisions
Overpayment of Claim is amended to advise that we have the right to recover any overpayments within 180 days of payment of a benefit.

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
9700 Health Care Lane – 8th Floor
Minnetonka, MN 55343
1-866-615-8727

Policyholders have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:

Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, Arkansas 77202

Eligibility, Effective Date, and Termination
If Dependent coverage is included, **Continuation of an Incapacitated Child** is amended to remove the 31 day notice requirement of the incapacity.

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:

General Definitions
If Dependent coverage is included, the definition of **Child** is amended to include foster Child(ren).

If Dependent coverage is included and **Domestic Partnership** is defined, it is amended to remove any specific living arrangements and affiliated time period requirements.

If Dependent coverage is included, the definition of **Incapacitated Child** is amended to remove any requirement that the Child be unmarried.

Eligibility, Effective Date and Termination Provisions
If Dependent coverage is included, **Newborn Child Provision** is amended to include an adopted Child. The adopted Child will become insured on the date the Child was placed with You for adoption at the same Benefit Amount that applies to Your other Children. If no other Children are insured, then the lowest amount available to Children under the Policy applies until We are notified of another amount that is available for Children. The timeframe for notification of, and premium payment for, a newborn or adopted Child is extended to 60 days; and insurance for the newborn/adopted Child may end on the date You request.

Claim Provisions
Time of Claim Payment is amended to advise that if an extension is required, We must provide within 45 days of receipt of initial proof, a description of any further proof needed and an explanation of why such material is needed.

Legal Actions is amended to extend the timeframe in which no suit may be brought from three years after the date of loss to five years.

IDAHO

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

NOTICE TO CERTIFICATE HOLDER
This is an Accident only Certificate and it does not pay benefits for loss from Sickness. Review this Certificate carefully. This Certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.

10 Day Free Look: You have the right to return this certificate within 10 days of its delivery and to have any premium paid, refunded if after examination, You are not satisfied for any reason.

Insurer Information Notice

Any questions regarding the Policy may be directed to:

UnitedHealthcare Insurance Company
Administrative Offices
9900 Bren Road East
Minnetonka, MN 55343
1-888-299-2070

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:

ACCIDENT ONLY COVERAGE

THIS CERTIFICATE PROVIDES LIMITED BENEFITS

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

OUTLINE OF COVERAGE for UHI-ACC-POL-ID-1 (2018) and UHI-ACC-CERT-ID-1 (2018)

This IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare, review the Guide to Health Insurance for People With Medicare available from the company

1. *Read your Certificate Carefully* - This outline of coverage provides a very brief description of some important features of your 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**!

2. Accident-only coverage is designed to provide coverage for certain losses resulting from a covered accident ONLY, subject to any limitations contained in the policy. Coverage is not provided for medical expenses.

3. *Amount and Duration of Benefits* – The coverage pays you or your Dependent (if applicable) the Maximum Benefit Amount for each Benefit shown on the Certificate Schedule, subject to all the terms, limits, and exclusions of the policy.

   Refer to the Certificate Schedule for:
   a. Maximum Benefit Amount; and
   b. Any Additional Benefits that apply

4. *Exceptions, Reductions and Limitations* - We will not pay a benefit for a loss contributed to or caused by:

   1. Sickness, disease, bodily or mental infirmity, or medical or surgical Treatment of these (except pyogenic infections through an Accidental wound);
   2. suicide or any loss which is intentionally self-inflicted;
   3. active participation in a riot;
   4. commission of or attempt to commission a felony;
   5. an act or accident of war, declared or undeclared, whether civil or international, or any substantial armed conflict between organized forces of a military nature;
   6. loss sustained or contracted in consequence of being intoxicated or under the influence of any controlled substance unless administered on the advice of a Physician;
   7. driving or in physical control of a Motor Vehicle while Intoxicated;
   8. engaging in the following hazardous activities, including skydiving, hang gliding, auto racing, dirt bike riding, mountain climbing, Russian Roulette, autoerotic asphyxiation, bungee jumping, base jumping or using off-road vehicles that are not registered for use on-road based on applicable state law;
   9. riding in or driving any motor-driven vehicle in a race, stunt show or speed test;
   10. travel or flight in, or descent from any aircraft, unless as a fare-paying passenger on a commercial airline flying between established airports on: a) a scheduled route; or b) a charter flight seating 15 or more people;
   11. travel or flight in, or descent from any aircraft, except if employment duties require You to be a pilot and/or passenger in a privately owned aircraft, or as a fare-paying passenger on a commercial airline flying between established airports on: a) a scheduled route; or b) a charter flight seating 15 or more people;

12. practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received;
13. Injury arising out of or in the course of any occupation or employment for pay or profit, or any Injury or Sickness for which You or Your Dependent are entitled to benefits under any Workers' Compensation Law, Employers' Liability Law or similar law, unless this insurance is issued on an 24 hour basis as shown in the Schedule; or
14. an Accident that occurs outside of the United States.

In addition to the exclusions shown above, no payment will be made for Treatment received outside of the United States.

Renewability - Your insurance will terminate on the earliest of the following dates:

1. the last day of the period the required premium is due but not paid, subject to the Grace Period provision;
2. the last day of the month during which You cease to be a member of a class eligible for insurance;
3. the date the Policy terminates, or a specific benefit terminates;
4. the date You are no longer Actively at Work due to a labor dispute, including but not limited to strike, work slowdown or lock out; or
5. the last day of the month during which You are no longer Actively at Work for any other reason, unless insurance is continued in accordance with the Continuation of Insurance Provisions.

UHI-ACC-OOC-ID-1

General Definitions

If Dependent and **Domestic Partner** and/or **Civil Union** coverage is included, the definition of **Child** is amended to include a Child for whom legal guardianship has been awarded to you or your spouse, Domestic Partner, or partner in a Civil Union. If Dependent coverage is included and **Domestic Partner** and/or **Civil Union** is defined, it is amended to always include both opposite or same sex.

The **Hospital** definition is amended to include an institute which operates either on its premises or in facilities available to the hospital on a prearranged basis.

Eligibility, Effective Date and Termination Provisions

Enrolling for Your Insurance and Your Dependent's Insurance Under the Policy is amended to allow for 60 days to enroll in coverage for a newborn or newly adopted child.

If Dependent coverage is included, the **Newborn Child Provision** is amended to include adopted newborn Children that are Placed with You within 60 days of the adopted Child's date of birth, and will become covered by the Policy from the moment of live birth. An adopted newborn Child Placed with You more than 60 days after their birth is covered by the Policy from and after the date the Child is so Placed. 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.

We must receive notification the Child within 60 days next following the date of birth, adoption or placement for adoption. The appropriate premium, if any, must be received within 31 days of the date the monthly premium invoice is received by the Policyholder and a notice of premium, if any, is provided to You by the Policyholder.

Coverage will cease unless We receive written request and any required premium as stated above.

The coverage amount offered is the lowest amount available to Children under the Policy if no other Children are insured, until We are notified of another amount that is available for Children.

A Congenital Anomaly refers to a condition existing at or from birth that is a Significant Deviation from the common form or function of the body. Congenital Anomaly is often caused by a hereditary or developmental defect or disease.

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.

General Limitations and Exclusions

The following exclusions are not applicable (if included in your Certificate):

- taking part in the commission of an assault or being engaged in an illegal activity;
- driving or in physical control of a Motor Vehicle while Intoxicated;
- travel or flight in, or descent from any aircraft, unless as a fare-paying passenger on a commercial airline flying between established airports on: a) a scheduled route; or b) a charter flight seating 15 or more people;
- travel or flight in, or descent from any aircraft, except if employment duties require You to be a pilot and/or passenger in a privately owned aircraft, or as a fare-paying passenger on a commercial airline flying between established airports on: a) a scheduled route; or b) a charter flight seating 15 or more people;

The crime exclusion is replaced with “actively committing a felony, or actively participating in a felony.”

The act of war exclusion is replaced with “an act of war, declared or undeclared, whether civil or international.”

The use of alcohol exclusion is replaced with “alcoholism or drug addiction.”

The engaging in hazardous activities exclusion is replaced with “engaging as a professional in the following hazardous activities, including sky diving, hang gliding, mountain climbing, bungee jumping, or base jumping.”

The riding in or driving in a race, stunt show, or speed test exclusion is replace with “riding in or driving as a professional any motorized dirt bike, off-road vehicle, or motor driven vehicle in a race, stunt show or speed test.”

The competitive athletic contest exclusion is amended to remove “semi professional”.

MINNESOTA

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

General Definitions

If Dependent coverage is included, the definition of **Child** Is amended to 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 Limitations and Exclusions

The use of alcohol exclusion is replaced with “use of narcotics, unless administered on the advice of a Physician.”

The riding in or driving any motor-driven vehicle exclusion is replaced with “riding in or driving any motor-driven vehicle in an organized race, stunt show or speed test.”

NORTH CAROLINA

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

The following disclosure is added:

Important Cancellation Information — Please Read the Provision Entitled, **Covered Person Termination of Insurance.**

General Definitions

The “change in the number of dependents” item in the **Change in Status** definition is amended to remove the requirement that it be for tax purposes. This item is also amended to include placement of a Child in a foster home.

If Dependent coverage is included, the definition of **Child** is amended to include the following: a non-custodial Child; a foster Child from the date they are placed in a foster home; or a Child for whom You are required to provide insurance due to a court or administrative order. An adopted Child’s insurance 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

The definition of **Hospital** is amended to include: In North Carolina, Hospital 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. State tax-supported institutions includes community mental health centers and other health clinics which are certified as Medicaid providers.

Eligibility, Effective Date and Termination Provisions
If Dependent coverage is included, the **Newborn Child Provision** includes Adopted and Foster Children.

Continuation of an Incapacitated Child is amended to require proof of continued incapacity not more than once per year.

Initial Care Benefit
If the **Physician Office / Urgent Care Center Visit Benefit** is included, a Physician's visit includes services or Treatment at, or by, a chiropractor.

Waiver of Premium Benefit
If the **Waiver of Premium Benefit** is included, the timeframe to provide proof of Total Disability is amended to extend to no later than 180 days after the date of Total Disability. The extension of 180 days also applies to providing proof after requested.

General Limitations and Exclusions
The On Job Injury exclusion is replaced with the following:

On Job Injury or any Injury arising out of or in the course of any occupation or employment for pay or profit, services or supplies for the treatment of an occupational injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act. This exclusion does not apply if this insurance is issued on a 24 hour basis as shown in the Schedule.

Claim Provisions
Notice of Claim is amended to allow that written notice of a claim may also be given to Our authorized agent.

Proof of Claim is amended to extend the timeframe in which written proof of claim must be filed, to 180 days.

NORTH DAKOTA

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

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

General Definitions
If Dependent coverage is included, the definition of **Child** includes a child of a Dependent.

If Dependent coverage is included and **Eligible Student** is defined, the restriction of not being in the armed forces is removed.

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 are 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.

FRAUD WARNING

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

CERTIFICATE MODIFICATIONS RIDER

Eligibility, Effective Date, Termination

If Dependent coverage is included, the **Newborn Child Provision** is replaced with the following:

Newborn Child: Your newborn child will become covered under the Policy from the moment of birth. The child will be covered for Injury only, and have the same benefits as applies to Your other Children covered under the Policy. If the Primary Covered Person has no children covered under the Policy, the newborn will have the same benefits as You, except that any benefit payable under the Policy at a reduced percentage for Dependent Children, will also be at the reduced percentage for the newborn. You must notify Us that he has a newborn child within 31 days of the child's birth. The newborn's coverage will cease on the later of:

1. the Premium Due Date; or
2. the 31st day;

next following the child's birth unless the child is Enrolled and required Premium paid on or before that date.

General Limitations and Exclusions

The act of war exclusion is amended to include "when serving in the military or an auxiliary unit."

Claim Provisions

Overpayment of Claim is amended to limit the recovery period to 24 months unless it is a case of claimant fraud.

TEXAS

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

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

UnitedHealthcare Insurance Company

To get information or file a complaint with your insurance company or HMO:

Call: UnitedHealthcare Insurance Company
Toll-free: 1-866-615-8727
Mail: United HealthCare Insurance Company Administrative Offices
9900 Bren Road East, Minnetonka. MN 55343

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance,
P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de sucompañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

UnitedHealthcare Insurance Company
Para obtener información o para presentar una queja ante su compañía de seguros o HMO:
Llame a: UnitedHealthcare Insurance Company
Teléfono gratuito: 1-866-615-8727
Dirección postal: United HealthCare Insurance Company Administrative Offices,
9900 Bren Road East, Minnetonka. MN 55343

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:
Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: Consumer Protection, MC: CO-CP,
Texas Department of Insurance,
P.O. Box 12030, Austin, TX 78711-2030

07/2023

The following disclosure is included:
THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

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.

UHCAC-CIVUNION-VT

WASHINGTON

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

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

IMPORTANT INFORMATION ABOUT THE COVERAGE YOU ARE BEING OFFERED

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

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

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

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

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

The benefits under this policy are summarized below:

Type of Coverage: Group Accident Insurance Coverage. This is an Accident only Certificate and it does not pay benefits for loss from Sickness. This certificate does NOT provide general health insurance.

Your Benefits and Benefit Amounts are those which You elect at the time You Enroll	
INITIAL CARE BENEFIT	**MAXIMUM BENEFIT AMOUNT**
Ground Ambulance	$400
Air Ambulance	$2,400
Emergency Care Treatment	$200
Physician Office / Urgent Care Center Visit	$200
HOSPITAL CARE BENEFIT	**MAXIMUM BENEFIT AMOUNT**
Hospital Admission	$1,000
Hospital Confinement	$200
Hospital ICU Admission	$2,000
Hospital ICU Confinement	$400

FOLLOW UP CARE BENEFIT	MAXIMUM BENEFIT AMOUNT
Appliances:	
• Wheelchair	$300
• Knee Scooter	$300
• Knee Immobilizer	$300
• Lumbar Spine Brace	$300
• Walking Boot	$200
• Walker	$200
• Crutches	$200
• Leg Brace	$200
• Cervical Collar	$200
• Cane	$100
• Ankle Brace	$100
• Ankle Boot	$100
• Air Cast	$100
Follow Up Physician Visit	$100
Major Diagnostic Exam	$325
Minor Diagnostic Exam	$100
Prosthetic Device	
• One Device	$1,000
• Two Devices	$2,000
Rehabilitation Facility	$200
Rehabilitation Therapy	$50

COMMON INJURIES BENEFIT	MAXIMUM BENEFIT AMOUNT
Surgical Procedures:	
Abdominal/Thoracic Surgery	
• Surgery to repair	$2,000
• Exploratory surgery without repair	$200
Arthroscopic Surgery	$400
Cranial Surgery	$400
Eye Surgery:	
• Removal of foreign body	$200
• Surgical Repair	$400
Hernia Surgery	$400
Non-Specific Surgery:	
• General Anesthesia	$400
• Conscious Sedation	$200
Tendon/Ligament/Shoulder Cartilage/Rotator Cuff/Knee Cartilage Surgery	
• Surgery to repair	$800
• Surgery to repair more than one	$1,600
• Exploratory surgery without repair	$300
Blood/Plasma/Platelets	$500

COMMON INJURIES BENEFIT (continued)	**MAXIMUM BENEFIT AMOUNT**	
Burns:		
• 2nd degree burns (at least 36% of body surface)	$1,000	
• 3rd degree burns (9 to 34 sq inches)	$2,000	
• 3rd degree burns (35 or more sq inches)	$16,000	
Coma	$20,000	
Concussion	$300	
Dislocation (Separated Joint)	**Open Reduction (Surgically Corrected)**	**Closed Reduction (Non- Surgically Corrected)**
Type of Dislocation:		
• Ankle	$3,000	$1,500
• Collar Bone (Sternoclavicular)	$1,800	$900
• Collar Bone (Acromioclavicular separation)	$1,000	$500
• Elbow	$1,800	$900
• Finger	$1,000	$500
• Foot (except toes)	$3,000	$1,500
• Hand	$1,800	$900
• Hip	$9,000	$4,500
• Knee Cap (Patella)	$4,500	$2,250
• Lower Jaw	$1,800	$900
• Shoulder blade	$1,800	$900
• Toe	$1,000	$500
• Wrist	$1,800	$900
Emergency Dental Work		
• Crown	$400	
• Extraction	$200	
Family Child Daycare	$60	

COMMON INJURIES BENEFIT (continued)	**MAXIMUM BENEFIT AMOUNT**	
Fractures	**Open Reduction (Surgically Corrected)**	**Closed Reduction (Non- Surgically Corrected)**
Type of Fracture:		
• Skull (except bones of face or nose)		
◦ Depressed	$9,000	$4,500
◦ Simple	$5,000	$2,500
• Sternum	$9,000	$4,500
• Hip and Thigh (Femur)	$9,000	$4,500
• Vertebrae (body of)	$5,000	$2,500
• Pelvis (excluding coccyx)	$5,000	$2,500
• Leg (from top of tibia to ankle joint)	$5,000	$2,500
• Face or nose (except teeth)	$1,800	$900
• Upper Jaw (except Alveolar process)	$1,800	$900
• Upper Arm (Elbow to Shoulder)	$1,800	$900
• Lower Jaw (except Alveolar process)	$1,800	$900
• Shoulder Blade or Collarbone	$1,800	$900
• Forearm, hand, wrist (except fingers)	$1,800	$900
• Kneecap	$1,800	$900
• Foot (excluding toes)	$1,800	$900
• Ankle	$1,800	$900
• Coccyx	$1,400	$700
• Finger or toe	$600	$300
• Sacral/Sacrum	$1,800	$900
• Vertebral Process	$1,800	$900
Fractures (Chip/Avulsion)	25% of the Closed Reduction (Non-Surgically Corrected) Benefit Amount	
Laceration:		
• Laceration not requiring stitches, staple, or glue	$60	
• Less than 5 cm	$100	
• 5 cm -15 cm	$400	
• Greater than 15 cm	$800	
Lodging	$300	
Medical Supplies	$30	
Organized Sporting Activity	25%	
Paralysis		
• Hemiplegia	$10,000	
• Paraplegia	$10,000	
• Quadriplegia	$20,000	
Ruptured/Herniated Disc	$800	
Skin Graft		
• Percentage of Amount Payable under the Burn Benefit	25%	
Transportation	$400	

CERTIFICATE MODIFICATIONS RIDER

ADDITIONAL BENEFITS	MAXIMUM BENEFIT AMOUNT
Wellness	$50

Benefit Trigger: The coverage pays You or Your Dependent (if applicable) the Maximum Benefit Amount for each Benefit shown on the Certificate Schedule, subject to all the terms, limits, and exclusions of the policy. No Benefit Waiting Period is required.

Duration of Coverage: Your insurance will terminate on the earliest of the following dates:

1. the last day of the period the required premium is due but not paid, subject to the Grace Period provision;
2. the last day of the month during which You cease to be a member of a class eligible for insurance;
3. the date the Policy terminates, or a specific benefit terminates;
4. the date You are no longer Actively at Work due to a labor dispute, including but not limited to strike, work slowdown or lock out; or
5. the last day of the month during which You are no longer Actively at Work for any other reason, unless insurance is continued in accordance with the Continuation of Insurance Provisions.

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

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 pay a benefit for a loss contributed to or caused by:

1. Sickness, disease, bodily or mental infirmity, or medical or surgical Treatment of these (except pyogenic infections through an Accidental wound);
2. suicide or any loss which is intentionally self-inflicted;
3. active participation in a riot;
4. commission of or attempt to commission a felony;
5. an act or accident of war, declared or undeclared, whether civil or international, or any substantial armed conflict between organized forces of a military nature;
6. loss sustained or contracted in consequence of being intoxicated or under the influence of any controlled substance unless administered on the advice of a Physician;
7. driving or in physical control of a Motor Vehicle while Intoxicated;
8. engaging in the following hazardous activities, including skydiving, hang gliding, auto racing, dirt bike riding, mountain climbing, Russian Roulette, autoerotic asphyxiation, bungee jumping, base jumping or using off-road vehicles that are not registered for use on-road based on applicable state law;
9. riding in or driving any motor-driven vehicle in a race, stunt show or speed test;
10. travel or flight in, or descent from any aircraft, unless as a fare-paying passenger on a commercial airline flying between established airports on: a) a scheduled route; or b) a charter flight seating 15 or more people;

11. travel or flight in, or descent from any aircraft, except if employment duties require You to be a pilot and/or passenger in a privately owned aircraft, or as a fare-paying passenger on a commercial airline flying between established airports on: a) a scheduled route; or b) a charter flight seating 15 or more people;
12. practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received;
13. Injury arising out of or in the course of any occupation or employment for pay or profit, or any Injury or Sickness for which You or Your Dependent are entitled to benefits under any Workers' Compensation Law, Employers' Liability Law or similar law, unless this insurance is issued on an 24 hour basis as shown in the Schedule; or
14. an Accident that occurs outside of the United States.

In addition to the exclusions shown above, no payment will be made for Treatment received outside of the United States.

UHI-ACC-OOC-WA

General Definitions
If Dependent coverage is included and **Eligible Student** is defined, the restriction of not being married is removed.

If Dependent coverage is included and **Domestic Partner** is defined, it is amended to always include both opposite or same sex.

General Limitations and Exclusions
The following exclusions are not applicable (if included in your Certificate):

- use of alcohol or the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance, unless prescribed for You by a Physician and taken as prescribed;
- driving or in physical control of a Motor Vehicle while Intoxicated;

If any of the following benefits are included, the applicable amendments apply:
Accidental Death and Dismemberment Benefit

- Accidental Death and Dismemberment Benefit – the Loss occurs within 365 days of the date of the Covered Accident.
- The Accidental Death Common Carrier Benefit – the Loss of life occurs within 365 days of the Covered Accident that caused the Injury.

Initial Care Benefit

- Ground Ambulance Benefit - Ground transport must occur within 365 days of the date of the Covered Accident.
- Air Ambulance Benefit - Air transport must occur within 365 days of the Covered Accident.
- Emergency Care Treatment Benefit – Treatment must be received within 365 days of the Covered Accident causing Injury which requires Treatment on an emergency basis.
- Physician Office/Urgent Care Center Visit Benefit - The visit must occur within 365 days of the date of the Covered Accident.

Hospital Care Benefit

- Hospital Admission Benefit - The admission must begin within 365 days of the date of the Covered Accident.
- Hospital Confinement Benefit - The Confinement must begin within 365 days of the date of the Covered Accident.
- Hospital Intensive Care Unit Admission Benefit - The admission must begin within 365 days of the date of the Covered Accident.
- Hospital Intensive Care Unit Confinement Benefit - The Confinement must begin within 365 days of the date of the Covered Accident.

Follow Up Care Benefit

- Appliance Benefit - The expense for the Appliance must be incurred within 365 days of the date of the Covered Accident that caused the Injury.

- Follow Up Physician Visit Benefit - The follow up visit(s) must occur within 365 days of the date of the Covered Accident.
- Major Diagnostic Exam Benefit - The exam must be performed within 365 days of the date of the Covered Accident in which symptoms suggest an Injury has occurred.
- Minor Diagnostic Exam Benefit - The exam must be performed within 365 days of the date of the Covered Accident, in which symptoms suggest an Injury has occurred.
- Prosthetic Device Benefit - The expense for the Prosthesis must be incurred within 365 days of the date of the Covered Accident.
- Rehabilitation Facility Benefit - is covered under the Hospital Care Benefit and within 365 days of the date of the Covered Accident.
- Rehabilitation Therapy Benefit - Therapy services must occur within 365 days of the date of the Covered Accident.

Common Injuries Benefit

- Abdominal/Thoracic Surgery Benefit – the surgery occurs within 365 days of the date of the Covered Accident.
- Arthroscopic Surgery Benefit - The Arthroscopic Surgery must be performed within 365 days of the date of the Covered Accident.
- Cranial Surgery Benefit - The Cranial Surgery must be performed within 365 days of the date of the Covered Accident.
- Eye Surgery Benefit - The surgery or removal is received from the Physician within 365 days of the date of the Covered Accident.
- Hernia Surgery Benefit - The Hernia surgery must be performed within 365 days of the date of the Covered Accident.
- Non-Specific Surgery Benefit - The surgery must be performed within 365 days of the date of the Covered Accident.
- Tendon/Ligament/Shoulder Cartilage/Rotator Cuff/Knee Cartilage Surgery Benefit - The applicable repair surgery must be performed within 365 days of the date of the Covered Accident.
- Blood/Plasma/Platelets Benefit - The transfusion must occur within 365 days of the date of the Covered Accident.
- Burn Benefit - Treatment must be received from a Physician within 365 days of the Covered Accident.
- Coma Benefit – is diagnosed by a Physician as having commenced within 365 days of the date of the Covered Accident.
- Concussion Benefit - A Physician must diagnose the concussion within 365 days of the Covered Accident.
- Dislocation/Separated Joint Benefit – a Physician treats the dislocation/separated joint either surgically or non surgically within 365 days of the date of the Covered Accident.
- Emergency Dental Work Benefit - The extraction or placement of a crown must be performed within 365 days of the date of the Covered Accident.
- Family Child Daycare Benefit – the Confinement begins within 365 days of a Covered Accident which caused the Injury.
- Fracture Benefit – a Physician treats the Fracture either surgically or non surgically within 365 days of the date of the Covered Accident.
- Laceration Benefit - a Laceration that is treated by a Physician within 365 days of a Covered Accident.
- Lodging Benefit – a Confinement occurs within 365 days from the date of the Covered Accident.
- Medical Supplies Benefit - The purchase of the over-the-counter medical supplies must be within 365 days of the date of the Covered Accident.
- Pain Management/Epidural Benefit - The epidural anesthesia must be administered within 365 days of the date of the Covered Accident.
- Paralysis Benefit – The Paralysis must commence within 365 days of the date of a Covered Accident.
- Prescription Drugs Benefit - dispensed by a licensed pharmacy within 365 days for the Treatment of a Covered Accident.
- Raptured/Herniated Disc Benefit – for which Treatment is received from a Physician within 365 days of the date of the Covered Accident.
- Transportation Benefit - the first trip to the Special Treatment occurs within 365 days of the date of the Covered Accident. The benefit is not payable for any later transport if the initial transport to the Special Treatment occurred more than 365 days from the date of the Covered Accident.

CERTIFICATE MODIFICATIONS RIDER

Additional Benefits

- Automobile Modification Benefit - The expense for the automobile modification must occur within 365 days of the date of the Covered Accident.
- Catastrophic Accident Benefit - the Loss occurs within 365 days of the date of a Covered Accident; and must be treated for the Injury by a Physician within 365 days of the Covered Accident.
- Medical Expense Benefit - the expenses are incurred for Treatment received within 365 days of the Covered Accident.
- Occupational Human Immunodeficiency Virus (HIV) Benefit - a follow-up confirmatory antibody HIV test is taken within 365 days after the Injury and the result is positive.

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut

(Home Office)

Policyholder:	Golden Rain Foundation of Walnut Creek
Policy Number:	371484
Effective Date:	January 1, 2024
Premium Due Date:	January 1 and the first day of each month thereafter
Policy Anniversaries:	January 1 of each year

We, UnitedHealthcare Insurance Company, agree to provide, for eligible persons becoming insured under the Policy, the benefits according to the terms, provisions and limitations of it. The following pages, including any application(s), riders, endorsements or amendments, are part of the Policy. The Policy is issued in consideration of payment of the required premium.

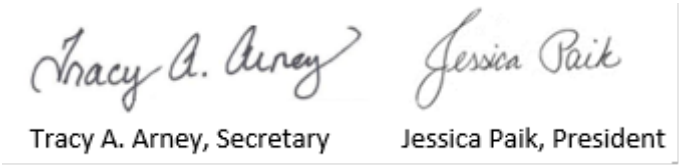
The Policy becomes effective at 12:01 A.M. Eastern Standard time on the Effective Date shown above. The Policy will continue in force by the payment of premiums when due. The Policy is subject to termination according to its terms.

Read the Policy Carefully

This is a legal contract between the Policyholder and Us. 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.

The Policy is issued in and governed by the laws of the State of California.

We have, by Our President and Secretary, executed the Policy at Our Home Office. If the Policyholder or the Covered Person have questions, needs information about their insurance, or needs assistance in resolving complaints, call 1-888-299-2070.



Tracy A. Arney, Secretary Jessica Paik, President

Group Critical Illness Insurance Policy

Administrative Office:
9900 Bren Road East
Minnetonka, MN 55343

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

Form UHICI-POL-1-CA
Printed in U.S.A.

POLICY GENERAL PROVISIONS

Certificates: The Policyholder will be furnished with a Certificate for delivery to each Covered Person. The Certificate(s) describe the benefits, terms, conditions, limitations and exclusions provided by the Policy. If there is a conflict between the Policy and the Certificate, the Policy will control.

Entire Group Contract: The entire Group Contract between the Policyholder and Us consists of the Policy, Certificate(s), riders, endorsements, or amendments(s), the Policyholder's application and the individual applications, if any, of the individual insured. All Certificate(s),riders, endorsements and any amendments are listed on the Policy Contents page.

All statements made by the Policyholder and by any person covered by the Policy are in the absence of fraud, representations and not warranties. No statement made by the Covered Person will be used to contest the insurance provided by the Policy, unless:

1. it is contained in a written application signed by the Covered Person; and
2. a copy of the application is furnished to the Covered Person or beneficiary.

Nonparticipation: The Policy is non-participating. It does not pay dividends.

Information To Be Furnished: The Policyholder may be required to furnish information needed to administer claims, compute premiums, and manage eligibility under the terms of the Policy. Information will include data relative to employee population, industry, corporate changes of the Policyholder, employee benefit elections and contribution levels.

Clerical error by the Policyholder, Us, will not:

1. affect the amount of insurance which would otherwise be in effect; or
2. continue insurance which otherwise would be terminated; or
3. result in the payment of benefits not otherwise payable.

Once an error is discovered, an equitable adjustment in premium will be made. If the premium adjustment involves the return of unearned premium, the amount of the return will be limited to the 12-month period, which precedes the date We receive proof such an adjustment should be made. We may inspect any of the Policyholder's records which relate to the Policy.

Records of the Policyholder, which have a bearing on insurance, will be available for inspection by Us at any reasonable time.

Payment of Premiums: No insurance provided by the Policy will be in effect until the first premium for such insurance is paid. For insurance to remain in effect, each subsequent premium must be paid on or before its due date. The Policyholder is responsible for paying all premiums as they become due. However, the premiums may be paid to Us by any other person according to a mutual agreement among the other person, the Policyholder and Us. Premiums are payable on or before their due dates at Our Home Office.

Premium Rate Change: On or after the first Policy Anniversary Date, We have the right to change premium rates as of any Premium Due Date but not more than once in any 12 month period. We will notify the Policyholder in writing at least 31 days prior to the change in rates.

The premium rate may change prior to this time however, for reasons that affect the insured risk, which include:

1. a change occurs in benefits;
2. a division, subsidiary, or affiliated company is added or deleted;
3. the number of Employees insured changes by 10% or more; or
4. a new Law or a change in any existing Law is enacted which applies to the Policy.

A change may take effect on an earlier date if both the Policyholder and We agree to it. Except in the case of fraud, premium adjustments, refunds or charges will be made for only the current Policy year.

Premium Rates: The Premium Rates for the Policy may be provided by Rider, or be as on file at the office of the Policyholder.

TABLE OF CONTENTS

All of the provisions in the Certificate(s) of Coverage, riders, endorsements and any amendments issued for the Policyholder shown below are included and made part of this Policy.

DOCUMENTS	DESCRIPTION	EFFECTIVE DATE
Critical Illness Certificate Of Coverage	All active full-time Employees	January 1, 2024
Certificate Modifications Rider	Amends the contract as outlined	January 1, 2024

NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

- **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance
  80% of death benefits but not to exceed $300,000
  80% of cash surrender or withdrawal values but not to exceed $100,000

- Annuities and Structured Settlement Annuities
  80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $543,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C)

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance Guarantee Association
P.O Box 16860,
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927- 4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

UnitedHealthcare®

GROUP CRITICAL ILLNESS INSURANCE CERTIFICATE OF COVERAGE

FOR GOLDEN RAIN FOUNDATION OF WALNUT CREEK

POLICY NUMBER: 371484

EFFECTIVE DATE: January 1, 2024

CA – UHIC/2015
(3-24)

California Consumer Complaint Notice

If the Covered Person has any questions or problems with their coverage, We will be ready to help. Our contact information is:

UnitedHealthcare Insurance Company

A Stock Company

Administrative Offices: 9900 Bren Road East, Minnetonka, MN 55343

1-888-299-2070

The Covered Person may also call the California Department of Insurance for assistance. However, We ask that the Covered Person gives Us the opportunity to try to resolve the problem. Please, call us first. If, We fail to help, the Covered Person may still ask the California Department of Insurance for assistance. Their contact information is:

California Department of Insurance

Consumer Services Division

300 South Spring Street

Los Angeles, California 90013

1-800-927-HELP

(1-800-927-4357)

http://www.insurance.ca.gov/01-consumers/

UNITEDHEALTHCARE INSURANCE COMPANY
CRITICAL ILLNESS COVERAGE OUTLINE OF COVERAGE

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

Read Your Certificate Carefully -This outline of coverage provides a very brief description of the important features of your certificate. This is not the insurance contract and only the actual policy and certificate provisions shall control. The certificate sets forth in detail the rights and obligations of both you and UnitedHealthcare Insurance Company. It is, therefore, important that you READ YOUR CERTIFICATE CAREFULLY!

Critical Illness Coverage - The certificate is designed to provide to certificate holders, restricted coverage paying benefits ONLY when certain losses occur as a result of diagnosis of a Critical Illness. Benefits are not provided for basic hospital, basic medical-surgical, or major medical expenses.
Benefits - A fixed percentage of the maximum benefit is payable for a Critical Illness. The Maximum Benefit for an employee is $30,000; a Spouse is $30,000 and each Child is $15,000.

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 listed in your certificate, the fixed percentage is 100%.

The following are some examples of Level 2 Cancer:
1. a lump in the breast that shows no evidence of metastases.
2. Papillary Carcinoma of the Thyroid that measures less than 1 cm in diameter;
3. Prostate Cancer if it has been Gleason method staged at less than 7;
4. Papillary Cancer of the Bladder if it has been TNM method staged into a class less than TaN0M0.
5. Chronic lymphocytic leukemia that has not progressed to at least Rai stage II or Binet Stage B.

Exceptions, Reductions and Limitations – There may be an eligibility waiting period before you are eligible for coverage. Once eligible, coverage may be subject to evidence of good health if you enroll late or if you enroll for an amount of coverage in excess of the guaranteed issue limits that are outlined in your certificate.

If the plan you are covered under includes cancer benefits, please be aware that no benefit will be payable for Melanomas under the Policy, except for Level 1 Skin Cancer. While the most common Melanomas are a type of Skin Cancer, some affect other parts of the body. This exclusion applies all to Melanomas.

Some conditions are not Cancer, but may be confused with Cancer because they have some potential to become Cancer in the future. For example, a polyp or small growth in the colon may be removed during a medical procedure to ensure that it does not develop into Cancer later. These kinds of conditions are not covered because they have not yet, and might not ever, become Cancer. These conditions are not covered even when a medical procedure is advisable or performed to prevent the possibility of future Cancer.

If the plan you are covered under includes benefits for Heart Attack, please be aware that Heart Attack does not include any other disease or injury involving the cardiovascular system. In addition, the following are not covered:
1. Heart Attacks that occur during a medical procedure; or
2. Cardiac Arrest not caused by a blockage of one or more coronary arteries leading to the death of a portion of the Heart (myocardial infarction) is not a Heart Attack. Cardiac Arrest alone, when not immediately preceded by such coronary blockage, is not a covered event.

For all coverage, no benefit is payable for a critical illness that:
- a) is due to war or an act of war;
- b) is due to loss sustained while on active duty as a member of the armed forces;
- c) is intentionally self-inflicted;
- d) is due to active participation in a riot, commission of or attempt to commit a felony, engagement in an illegal occupation;
- e) is sustained or contracted in consequence of being intoxicated or under the influence of any controlled substance unless administered on the advice of a Physician;
- f) is due to attempted suicide;
- g) is diagnosed outside of the US or Canada (unless the diagnosis was confirmed by a physician practicing in the US or Canada); and
- h) with respect to children, if it is caused or contributed by a congenital defect.

Cosmetic or Elective Surgery Exclusion: We will not cover a Critical Illness under the Policy if it is due to Cosmetic Surgery or Elective Surgery.

Cosmetic Surgery means surgery performed to modify or improve the appearance of a physical feature or defect. For purposes of excluding benefits, Cosmetic Surgery does not mean Reconstructive Surgery performed to correct or repair abnormal structures of the body caused by:

1. congenital defects;
2. developmental abnormalities;
3. trauma;
4. infection;
5. tumors; or
6. disease;

when intended to either improve function or create a normal appearance to the extent possible.

Reconstructive Surgery includes:

1. dental or orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures; and
2. surgery and prosthetic devices to restore and achieve symmetry incident to a mastectomy.

Elective Surgery means:

1. Cosmetic Surgery; and
2. any other surgery that is:
    a. not for the purpose of correcting or repairing abnormal structures of the body;
    b. not for the purpose of improving function; or
    c. if intended to improve appearance or create a normal appearance, is not caused by a condition listed in 1-6 above.

For purposes of excluding benefits, Elective Surgery does not include:

1. Caesarean section;
2. any surgery related to Complications of Pregnancy; or
3. bariatric surgery performed in conjunction with a diagnosis of morbid obesity.

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 last day of the month you cease to be in a class eligible for coverage; the date the master policy terminates; or the last day of the month 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.

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut

(Home Office)

Policyholder: Golden Rain Foundation of Walnut Creek

Effective Date: January 1, 2024

Policy Number: 371484

Policy Anniversary Date: January 1st

Beneficiary: As on file with the Administrator

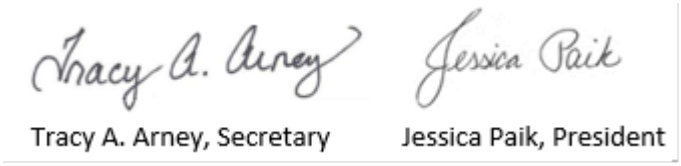
We, UnitedHealthcare Insurance Company, issue this Certificate to the Covered Person as evidence of insurance under the Policy We issued to the Policyholder shown above. This Certificate describes the benefits and other important provisions of the Policy.

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:



Administrative Office:
9900 Bren Road East
Minnetonka, MN 55343

THE POLICY PAYS NO BENEFITS FOR CERTAIN SKIN CANCERS. PLEASE REFER TO THE EXCLUSIONS UNDER THE CANCER BENEFIT SECTION.

Group Critical Illness Insurance Certificate

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

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

Eligible Class:	Employees of **Golden Rain Foundation of Walnut Creek** 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 20 hours per week
Employee Waiting Period:	An Employee is eligible for insurance on the first day of the month following the date the Employee begins continuous employment with the Policyholder
Maximum Benefit Amount:	Option 1 Employee: $15,000 Spouse: $15,000 Child: $7,500 Option 2* Employee: $30,000 Spouse: $30,000 Child: $15,000 *Employee may choose from lower coverage options for Spouse and Child(ren)

SCHEDULE OF BENEFITS

NOTE: As indicated in this Schedule, a reduced benefit is payable for **Cancer - Level 2** and **Coronary Artery Disease**. Cancer - Non-Invasive Level 2 includes a cancerous lump in the breast with no evidence of metastases. For example, if a Maximum Benefit Amount of $30,000 is payable for Cancer – Level 1, the amount payable for the Cancer - Level 2 is $7,500.

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

SCHEDULE OF BENEFITS

Portability • Portability Policy Age Limit	Included Coverage continued under Portability terminates at Age 75
Reoccurrence Benefit:	Included For each Critical Illness Condition, not to exceed: • 100% of Employee's Maximum Benefit Amount • 100% of Spouse's Maximum Benefit Amount • 100% of Child's Maximum Benefit Amount whichever applies
Additional Critical Illnesses Rider:	Included
Wellness Benefit:	$50 per calendar year
Waiver of Premium:	Included

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).

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. We may require proof of marriage or proof of valid domestic partnership.

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

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

Existing children of newly formed domestic partnerships will be covered the same as step children.

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

A Child is an Incapacitated Child if he is:

1. unmarried;
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 with whom the Covered Person has established a domestic partnership and filed a valid Declaration of Domestic Partnership with the California Secretary of State or an equivalent document for registration of a domestic partnership with an authorized state or municipal agency. The Covered Person must notify Us if the domestic partnership terminates.

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.

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: Unless specifically excluded in the following Benefit Descriptions, We will pay the stated percentage of the Maximum Benefit Amount for each Critical Illness Condition 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.

A reduced benefit is payable for:

1. a lump in the breast that shows no evidence of metastases or any other Level 2 Cancer; and
2. a Coronary Artery Disease.

For example, if a Maximum Benefit Amount of $30,000 is payable for Cancer – Invasive Level 1, the amount payable for the Cancer - Non-Invasive Level 2 is $7,500.

The Schedule of Benefits outlines reductions in the Maximum Benefit Amount that occur due to age, the percentage of the Maximum Benefit Payable and the Maximum Benefit Amount for each Critical Illness.

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: means the Diagnosis of Benign Brain Tumor, Level 1 Cancer, Level 2 Cancer, Chronic Renal Failure, Coma, Coronary Artery Disease, Heart Attack, Heart Failure, Major Organ Failure, Paralysis, Ruptured Aneurysm and Stroke as those conditions are defined in each Benefit Description.

Diagnosis: means a 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, means:

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;

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

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, atherectomy 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.

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. germinomas.

Cancer: means a Physician's Diagnosis of Cancer that is confirmed through the use of a medical test on a Covered Person's or Dependent's blood or tissue. A Diagnosis of Cancer that is based only on symptoms will also be recognized if:

1. there is medical evidence to support the diagnosis; and
2. a Physician is treating the Covered Person or Dependent for Cancer.

Level 1 Cancer means:

1. Cancer cells have entered a phase of uncontrolled and aggressive growth beyond the primary site and have invaded other lymph nodes or organs and tissues, except that the following types are Level 1 only at these stages:
    a. Skin Cancer, only if Breslow method staged at 1.0 mm maximum thickness or greater;
    b. Papillary Carcinoma of the Thyroid, only if measured more than 1 cm in diameter;
    c. Prostate Cancer only if having a Gleason method stage at 7 or higher;
    d. Papillary Cancer of the Bladder only if TNM method staged into a class greater than TaN0M0; or
2. abnormal growth of white blood cells in the blood, bone marrow and lymphatic system, which includes lymph nodes, lymphatic vessels, tonsils, thymus, spleen, and digestive tract lymphoid tissue. Chronic lymphocytic leukemia that has progressed to at least Rai stage II or Binet Stage B is considered Level 1 Cancer.

Examples of Level 1 Cancer: The following are some examples of Level 1 Cancer:

1. Cancer that has spread from one organ to another such as from the liver to the lung;
2. Cancer that has spread from an organ where it started to another system such as the lymphatic system or blood stream when it is not a blood Cancer that started in one of those systems;
3. Cancer that started in one organ and remains only in that organ, but it has grown into a layer of tissue beyond the place where it started such as:
   a. Colon Cancer that started on the inside colon wall and advanced into adjacent tissue next to or at the outer wall;
   b. Breast Cancer where a tumor started in one place in the breast but has grown to the point where it has invaded deeper layers of tissues within the breast;
   c. Cancer that has spread from one lobe of an organ to the other lobe of the same organ such as from one lobe of the liver to its other lobe, or from one lung to the other lung.

Level 2 Cancer means:

1. Cancer cells are found only in their primary site which is the layer of cells in which they started; or
2. Cancer cells are limited to the same organ in which they started, and there is no medical evidence that the Cancer has grown into a layer of tissue beyond the place where it started.

Examples of Level 2 Cancer: The following are some examples of Level 2 Cancer:

6. Breast Cancer where a tumor is still contained and has not grown to the point where it has invaded deeper layers of tissues within the breast.
7. Papillary Carcinoma of the Thyroid that measures less than 1 cm in diameter;
3. Prostate Cancer if it has been Gleason method staged at less than 7;
4. Papillary Cancer of the Bladder if it has been TNM method staged into a class less than TaN0M0.

Chronic lymphocytic leukemia that has not progressed to at least Rai stage II or Binet Stage B

Methods of Measuring the Severity of Cancer: To determine how severe the Cancer has become and how far it has spread, Physicians use methods which include, but are not limited to, the methods and stages in the chart below. These methods are used to confirm each specific type of Cancer. In order to be objective and consistent in how We pay claims, We will consider codes in the Covered Person's medical records to determine the Severity of Cancer.

Method	Cancer Measured	Stages (Severity Scale)
Rai	Leukemia (CLL)	0, I, II, III & IV (Least 0 to most severe Stage IV)
Binet	Leukemia (CLL).	A, B & C (Least A to most severe Stage C)
CIN	Cervical Cancer	CIN-1, CIN-2 & CIN-3 (Least CIN-1 to most severe CIN-3)
Breslow	Skin Cancer	Depth from less than or equal to .75 mm to greater than 3.0
Gleason	Prostate Cancer	Adds two scores from 1 to 5, and sum is least 1 to most severe 10
TNM	Multiple Cancers	T = the size and extent of a tumor; N = whether the abnormal cells have spread to Lymph nodes; M = whether it has metastasized (spread.)

Exclusions:
No benefit will be payable for:

1. melanomas except for melanomas that rise to the definition of Level 1 Cancer. Melanoma may begin in a tissue other than the skin, such as the eye or the intestines. Only skin cancer that is a Level 1 Cancer as defined above, is covered. No benefit is payable for any other skin cancer.
2. pre-cancerous conditions. Some conditions are not Cancer, but may be confused with Cancer because they have some potential to become Cancer in the future. For example, a polyp or small growth in the colon may be removed during a medical procedure to ensure that it does not develop into Cancer. These kinds of conditions are not covered because they have not yet, and might not ever, become Cancer. These conditions are not covered even when a medical procedure is advisable or performed to prevent the possibility of future 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. a bodily injury resulting directly from an accident and independently of all other causes;
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.

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 a bodily injury resulting directly from an accident and independently of all other causes.

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:

1. Transient Ischemic Attacks (TIA). A transient ischemic attack (**TIA**), also called a “mini stroke,” occurs when a blood clot blocks blood flow in the brain. The block is temporary (transient), and unlike an actual stroke, Transient Ischemic Attacks do not generally kill brain tissue; or
2. attacks of Vertebrobasilar Ischemia.

Benefits Payable for the Child Critical Illness: We will pay a benefit 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 the Child Critical Illnesses is the percentage of the Covered Person’s Maximum Benefit Amount shown 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 under this benefit , We will only pay for one of the Child Critical illnesses. No further benefits are paid for the Child Critical Illness benefit.

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 legally qualified in the applicable field of medicine 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 who is legally qualified in the applicable field of medicine and is 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 who is legally qualified in the applicable field of medicine and is familiar with the Diagnosis and/or Treatment makes a Diagnosis of Muscular Dystrophy.

Child Critical Illness: means one of the conditions 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 legally qualified in the applicable field of medicine.

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.

Child Critical Illnesses defined below:

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 Physician who is legally qualified in the applicable field of medicine 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 Physician who is legally qualified in the applicable field of medicine and is 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 legally qualified in the applicable field of medicine 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 who is legally qualified in the applicable field of medicine and is familiar with Spina Bifida. This policy does not cover spina bifida occulta.

Reoccurrence Benefit: We will pay a Reoccurrence Benefit equal to 100% 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 6 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 6 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.

New Employees will be added to the group as they become eligible.

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.

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 last day of the month during which he becomes a member of the armed forces on active duty, except:
   a. for duty of 30 days or less for training in the Reserves or National Guard; or
   b. to the extent coverage is continued under the Leave of Absence Continuation provision;
3. the last day of the month during which he ceases to be a member of a class eligible for insurance;
4. the date the Policy terminates, or with respect to a specific benefit, the date that such benefit terminates;
5. the last day of the month during which he ceases to be Actively at Work, unless Active Work ceases during an approved 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 last day of the month during which he ceases to be a Dependent as defined in the Policy;
2. the last day of the month during which he ceases to be a member of a class eligible for Dependent insurance;
3. the date the Covered Person's insurance under the Policy terminates;
4. the last day of the month during which 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 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; 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 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. 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.

Reinstatement: If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by Us or Our agent duly authorized by Us to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if We or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon Our approval of such application or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless We have previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only Dates of Diagnosis sustained after the date of reinstatement. In all other respects the insured and We shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

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 100% of the Maximum Benefit for each of the Schedules 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 loss which is intentionally self-inflicted;
4. active participation in a riot;
5. the Covered Person's or Dependent's commission of or attempt to commit a felony, or to which a contributing cause was the Covered Person's or Dependent's engagement in an illegal occupation;
6. loss sustained or contracted in consequence of the Covered Person or Dependent being intoxicated or under the influence of any controlled substance unless administered on the advice of a Physician;
7. attempted suicide, while sane or insane.

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

8. 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
9. 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.

Cosmetic or Elective Surgery Exclusion: We will not cover a Critical Illness under the Policy if it is due to Cosmetic Surgery or Elective Surgery.

Cosmetic Surgery means surgery performed to modify or improve the appearance of a physical feature or defect. For purposes of excluding benefits, Cosmetic Surgery does not mean Reconstructive Surgery performed to correct or repair abnormal structures of the body caused by:

1. congenital defects;
2. developmental abnormalities;
3. trauma;
4. infection;
5. tumors; or
6. disease;

when intended to either improve function or create a normal appearance to the extent possible.

Reconstructive Surgery includes:

1. dental or orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures; and
2. surgery and prosthetic devices to restore and achieve symmetry incident to a mastectomy.

Elective Surgery means:

1. Cosmetic Surgery; and
2. any other surgery that is:
   a. not for the purpose of correcting or repairing abnormal structures of the body;
   b. not for the purpose of improving function; or
   c. if intended to improve appearance or create a normal appearance, is not caused by a condition listed in 1-6 above.

For purposes of excluding benefits, Elective Surgery does not include:

1. Caesarean section;
2. any surgery related to Complications of Pregnancy; or

3. bariatric surgery performed in conjunction with a diagnosis of morbid obesity.

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.

GENERAL PROVISIONS

Entire Contract; Changes: The policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of Ours and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

Time Limit on Certain Defenses:

1. After two years from the date of issue of the policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for the policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of the two-year period.
2. No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of the policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage under the policy.

Grace Period: A grace period of 60 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force (subject to Our right to cancel in accordance with the cancellation provision hereof).

Unpaid Premium: Upon the payment of a claim under the policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

Notice of Claim: Written notice of claim must be given to Us within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to Us at the administrative address shown on the face page of this certificate, or to any authorized agent of Ours, with information sufficient to identify the insured, shall be deemed notice to Us.

Claim Forms: Upon receipt of a notice of claim, We will furnish to the claimant such forms as are usually furnished by Us for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proofs of Loss: Written proof of loss must be furnished to Us at Our said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which We are liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Time of Payment of Claim: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at Our option, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, We may pay such indemnity, up to an amount not exceeding $1,000.00, to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

Physical Examinations and Autopsy: We, at Our own expense shall have the right and opportunity to examine the person of the insured when and as often as We may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Change of Beneficiary: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

Misstatement of age: If the age of the insured has been misstated, all amounts payable under the policy shall be such as the premium paid would have purchased at the correct age.

Cancellation: We may cancel the policy at any time by written notice delivered to the Policyholder, or mailed to his last address as shown by Our records, stating when, not less than five days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term the Policyholder may cancel the policy at any time by written notice delivered or mailed to Us, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation by either the Policyholder or Us, We will return promptly the unearned portion of any premium paid. The Policyholder shall pay, on a pro rata basis, the earned premium which has not been paid. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

Upon providing the Policyholder with notice of Our intent to cancel, We will cease accepting applications under the Policy. However, the Policy will not terminate with respect to inforce certificates until the last certificate cancels in accordance with its termination provisions and no person remains insured under the Policy. The Policy will only terminate earlier with respect to inforce certificates if We and the Policyholder:

1. agree to such termination;
2. arrange separately or jointly for coverage under any inforce certificate to transition to a new policy; and
3. the new policy continues such coverage for the same or similar benefits.

Conformity With State Statutes: Any provision of the policy which, on its effective date, is in conflict with the statutes of California, is hereby amended to conform to the minimum requirements of such statutes.

Fraud: The falsity of any statement in the application for coverage shall not bar the right to recovery under the policy unless such **false** statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by Us.

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, 2024. 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 legally qualified in the applicable field of medicine 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 legally qualified in the applicable field of medicine makes an accurate certification of the Covered Person's or Dependent's Complete Blindness, as defined;
3. for Complete Loss of Hearing, the date a Physician who is legally qualified in the applicable field of medicine 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 the Covered Person's or Dependent's insurance under the Policy is in force and is subject to all provisions of the in force Policy. However, Policy Benefits will be payable only if coverage remains in force to the Date of Advanced Diagnosis.

4. 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;
5. 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;
6. 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.

Other motor neuron diseases are not considered to be ALS. ALS must be Diagnosed by a Physician who is legally qualified in the applicable field of medicine and 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 Physician who is legally qualified in the applicable field of medicine 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 who is legally qualified 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 legally qualified in the applicable field of medicine 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, a Karnofsky Performance Status Scale assessment of 50 or less (or equivalent)). This impairment must result in a significant reduction in mental and social functioning.

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

As used above to define Advanced Alzheimer's:

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 legally qualified in the applicable field of medicine. 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.

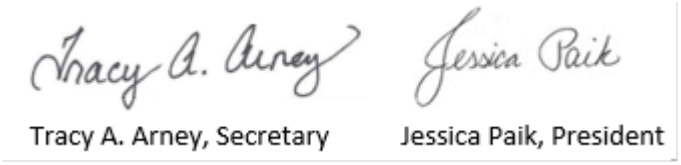
Other diseases are not considered to be MS.

Advanced Parkinson's Disease means Parkinson's Disease that is diagnosed by a Physician who is legally qualified in the applicable field of medicine. 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:



Tracy A. Arney, Secretary Jessica Paik, President

UnitedHealthcare Insurance Company
Hartford, Connecticut

WAIVER OF PREMIUM

Waiver of Premium Benefit: We will continue the Covered Person's insurance without further payment of the Contributory portion of the premium while the Covered Person is Totally Disabled if he:

1. becomes Totally Disabled while a Covered Person and as the result of a Covered Critical Illness for which he:
    a. is insured under the Policy; and
    b. was Diagnosed while insured under the Policy;
2. remains Totally Disabled for a 90 consecutive day period immediately prior to the date this Waiver will commence;
3. gives Us proof of Total Disability, as required;

not to exceed a maximum Waiver period of 24 months for any one period of Total Disability.

We will waive the premium on a monthly basis, starting the first day of the month after the month during which he finished the 30 day Waiting Period. If this Waiver applies to a partial month, it will be pro-rated. This Waiver of Premium only applies to the Primary Covered Person's insurance and it does not waive premium for the cost of Dependent insurance, if any.

Total Disability or Totally Disabled: For purposes of this section, the Covered Person will be considered Totally Disabled if, due to a Covered Critical Illness:

1. he is unable to perform the material and substantial duties of his occupation at his usual place of employment; and
2. he is not in fact working at his regular place of employment**.**

Successive and Concurrent Total Disability: After the 90 day Waiting Period for this Waiver has been met, concurrent periods of Total Disability, whether due to the same or a different Critical Illness, are considered part of the same period of Total Disability. Successive periods of Total Disability that start while the Covered Person's insurance is in force, but before he has returned to Active Work for 90 consecutive days:

1. are considered part of the same period of Total Disability**;**
2. are not subject to a new 90 day Waiting Period but will count toward the 24 month maximum.

If he has a new Critical Illness after the 90th day, he may begin a new Waiver, subject to satisfaction of a new 90 day Waiting Period, and again meeting all of the Policy conditions.

Benefits During Waiver Period: Benefits continued during the Waiver period are based on the Schedule in force on the date the Totally Disability started including any scheduled reductions. The Waiver will not apply to increases in coverage after the date the Total Disability started. The Portability provision does not apply during the Waiver period.

Proof of Total Disability: We will provide forms which the Covered Person must use when giving Us proof of Total Disability.

The Covered Person must give Us proof as soon as possible, but no later than 90 days after the date his Total Disability started. If he is not able to provide the proof within that time:

1. it must be sent as soon as reasonably possible; but,
2. no later than one year unless he is legally incapacitated.

We may at any time, after the Waiver starts, require proof that Total Disability continues. The Covered Person must give Us proof within 60 days after Our request. We may require the Covered Person to be examined, at Our expense, by a Physician of Our choice.

WAIVER OF PREMIUM

Termination of the Waiver Benefit: The Waiver ends on the first to occur of :

1. the date premium has been waived for 24 months;
2. the date the Covered Person:
    a. ceases to be Totally Disabled; or
    b. returns to Active Work;
3. the date the Policy terminates;
4. the date the Primary Covered Person ceases to be eligible for insurance (except that this will not apply if he is ineligible solely because he is not Actively at Work due to Total Disability covered by this Waiver;)
5. the last day of the 60-day period following Our request for proof of continued Total Disability, if he does not give Us proof or refuses to take a medical exam.

If the Covered Person is still eligible for Insurance when the Waiver ends, his Insurance may be continued in force if premium payments are resumed.

Signed for the Company by:

Tracy A. Arney, Secretary Jessica Paik, President

UnitedHealthcare Insurance Company
Hartford, Connecticut

WELLNESS BENEFIT

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

Health screening test is defined as:

- Generally medically accepted cancer screening tests including, but not limited to:
  - Mammography;
  - CA 15-3 (blood test for breast cancer)
  - CA 125 (blood test for ovarian cancer)
  - CEA (blood test for colon cancer)
  - an annual cervical cancer screening test which includes a conventional Pap test, a human papillomavirus screening test that is approved by the federal Food and Drug Administration, or the option of any cervical cancer screening test approved by the federal Food and Drug Administration
  - PSA (blood test for prostate cancer)
  - Serum Protein Electrophoresis (blood test for myeloma)
- 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
- Chest X-ray
- Colonoscopy
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- 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 calendar 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

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.

NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

- **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance

80% of death benefits but not to exceed $300,000
80% of cash surrender or withdrawal values but not to exceed $100,000

- Annuities and Structured Settlement Annuities

80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C)

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance Guarantee Association
P.O Box 16860,
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927- 4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

CERTIFICATE MODIFICATIONS RIDER

Modification(s) to the Certificate

Policyholder: Golden Rain Foundation of Walnut Creek

Policy Number: 371484

It is agreed that the Certificate is amended as follows:

Effective January 1, 2024, 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, and all other conditions apply.

Signed for UnitedHealthcare Insurance Company by:

Tracy A. Arney, Secretary

Jessica Paik, President

UnitedHealthcare Insurance Company
Hartford, Connecticut 06103-3408

STATUTORY PROVISIONS

ALASKA

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

Claim Information
Overpayment of Claim is amended to advise that we have the right to recover any overpayments within 180 days of payment of a benefit.

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

Policyholders have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:

Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, Arkansas 77202

Continuation and Reinstatement Provisions
If Dependent coverage is included, **Continuation of an Incapacitated Child** is amended to remove the 31 day notice requirement of the incapacity.

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:

General Definitions
If Dependent coverage is included, the definition of **Child** is amended to include foster Child(ren).

If Dependent coverage is included and **Domestic Partnership** is defined, it is amended to remove any specific living arrangements and affiliated time period requirements.

If Dependent coverage is included, the definition of **Incapacitated Child** is amended to remove any requirement that the Child be unmarried.

Benefits Payable and Benefit Definitions
Diagnosis is amended to clarify that a diagnosis made post mortem is recognized as a diagnosis of a covered condition as long as the individual was insured under the policy on the date of death.

If Coma is a covered benefit, the **Date of Diagnosis** waiting period for Coma condition will never exceed 14 days.

Eligibility, Effective Date and Termination Provisions
If Dependent coverage is included, **Newborn Child Provision** is amended to include an adopted Child. The adopted Child will become insured on the date the Child was placed with You for adoption at the same Benefit Amount that applies to Your other Children. If no other Children are insured, then the lowest amount available to Children under the Policy applies until We are notified of another amount that is available for Children. The timeframe for notification of, and premium payment for, a newborn or adopted Child is extended to 60 days; and insurance for the newborn/adopted Child may end on the date You request.

General Exclusions and Limitations
If **Pre-Existing Condition** is included, it is amended to remove routine follow up care to determine whether a breast cancer has recurred in a person who has been previously determined to be free of breast cancer, unless evidence of breast cancer is found during or as a result of the follow up care.

Claim Information
The following **Time Payment of Claim** provision is added.

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.

The timeframe in which no suit may be brought in the **Legal Action** provision is amended from three years after the date
of loss to the expiration of the statute of limitations from the time Proof of Claim is required.

CERTIFICATE MODIFICATIONS RIDER

IDAHO

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

Notice to Buyer: This is a specified disease Certificate. This Certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your Certificate carefully with the outline of coverage.

10 Day Free Look: The Covered Person has the right to return this certificate within 10 days of its delivery and to have any premium paid, refunded if after examination, he is not satisfied for any reason.

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

The following Outline of Coverage is included: CRITICAL ILLNESS COVERAGE
AS PROVIDED BY POLICY FORM UHICI-POL-ID (2020)
THIS CERTIFICATE PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE

This IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare, review the Guide to Health Insurance for People With Medicare available from the company.

(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 $30,000; a spouse is $30,000 and each child is $15,000.

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%.

CERTIFICATE MODIFICATIONS RIDER

No benefit is payable for a critical illness that 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 loss which is intentionally self-inflicted;
4. active participation in a riot;
5. the Covered Person's or Dependent's commission of or attempt to commit a felony, or to which a contributing cause was the Covered Person's or Dependent's engagement in an illegal occupation;
6. loss sustained or contracted in consequence of the Covered Person or Dependent being intoxicated or under the influence of any controlled substance unless administered on the advice of a Physician;
7. attempted suicide, while sane or insane.

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

8. 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
9. 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.

Coverage terminates on the first to occur of: the last day of the period for which premium is paid; the last day of the month during which you or your dependent enter active duty of the armed forces; the last day of the month during which 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 an approved medical or non-medical leave of absence or during a layoff if the certificate includes such continuation provisions. When your coverage terminates because you are no longer eligible, you will have the option to continue your coverage under the portability privilege explained in your certificate.

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

UHICI-OOC-ID (2020)
Printed in U.S.A.

General Definitions

The following definition of **Congenital Anomaly** is added:

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.

If Dependent coverage is included and **Domestic Partner** is defined, the definition of **Child** is amended to include a Child for whom legal guardianship has been awarded to the Covered Person or the Covered Person's Spouse or Domestic Partner.If Dependent coverage is included and **Domestic Partner** is defined, it is amended to always include both opposite or same sex.

The **Hospital** definition is amended to include an institute which operates either on its premises or in facilities available to the hospital on a prearranged basis.

CERTIFICATE MODIFICATIONS RIDER

Eligibility, Effective Date and Termination Provisions

If Dependent coverage is included, **Enrolling in or Changing Dependent Insurance Under the Policy** is amended to allow for 60 days to enroll in coverage for a newborn or newly adopted child.

If Dependent coverage is included, the **Newborn Child Provision** is amended to include adopted newborn Children that are Placed with You within 60 days of the adopted Child's date of birth, and will become covered by the Policy from the moment of live birth. An adopted newborn Child Placed with You more than 60 days after their birth is covered by the Policy from and after the date the Child is so Placed. 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.
We must receive notification the Child within 60 days next following the date of birth, adoption or placement for adoption. The appropriate premium, if any, must be received within 31 days of the date the monthly premium invoice is received by the Policyholder and a notice of premium, if any, is provided to You by the Policyholder.

Coverage will cease unless We receive written request and any required premium as stated above.

The coverage amount offered is the lowest amount available to Children under the Policy if no other Children are insured, until We are notified of another amount that is available for Children.

A Congenital Anomaly refers to a condition existing at or from birth that is a Significant Deviation from the common form or function of the body. Congenital Anomaly is often caused by a hereditary or developmental defect or disease.

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.

General Exclusions and Limitations

The following exclusion is not applicable (if included in your Certificate):

- We will also not pay a benefit for a Critical Illness for which the Covered Person's or Dependent's (if applicable) Date of Diagnosis for any type of Critical Illness, as defined in the Policy, was prior to his Effective Date of insurance;

The act of war exclusion is replaced with "an act of war, declared or undeclared, whether civil or international."

The felony exclusion is replaced with "participation in a felony."

The use of alcohol exclusion is replaced with "alcoholism or drug addiction."

The cosmetic or elective surgery exclusion is replaced with "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."

If the **Pre-Existing Conditions Exclusion** is included, the definition of **Pre-existing Condition** is amended to exclude any congenital anomaly of a Dependent Child and to remove any condition for which the Covered person or Dependent had symptoms for which a reasonably prudent person would have sought Treatment.

CERTIFICATE MODIFICATIONS RIDER

Claim Information
Time of Claim Payment is added.

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

MINNESOTA

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

General Definitions
If Dependent coverage is included, the definition of **Child** is amended to 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 Limitations and Exclusions
The use of alcohol exclusion is replaced with "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.

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 your Dependent (if applicable), 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: $15,000 Spouse: $15,000 Child: $7,500 Option 2* Employee: $30,000 Spouse: $30,000 Child: $15,000 *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 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%

CERTIFICATE MODIFICATIONS RIDER

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:	Included For each Critical Illness Condition, not to exceed: • 100% of Employee's Maximum Benefit Amount • 100% of Spouse's Maximum Benefit Amount • 100% of Child's Maximum Benefit Amount whichever applies
Additional Critical Illnesses Rider:	Included
Wellness Benefit:	$50 per calendar year
Waiver of Premium:	Included

UHICI-OOC-NH
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General Definitions
If Dependent coverage is included, the **Child**, **Incapacitated Child**, and **Eligible Student** (if applicable) definitions are amended to remove the restriction of not being married.

Benefits Payable and Benefit Definitions
If **Severe Brain Damage** coverage is included, the Activities of Daily Living requirements are removed.

General Exclusions and Limitations
The use of alcohol or non medical use of narcotics exclusion is amended to remove "use of alcohol."

The cosmetic surgery exclusion is amended to clarify 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.

Claim Information
Proof of Claim is amended to advise that if an extension is required, We must provide within 45 days of receipt of initial proof, a description of any further proof needed and an explanation of why such material is needed.

Additional Critical Illnesses Rider
If this rider is included, the following **Sickness** definition is added with respect to the **Complete Blindness** and **Complete Loss of Hearing** definitions:

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

The **Advanced Alzheimer's** definition is amended to remove that the impairment require the insured to need Substantial Assistance to perform at least two of six Activities of Daily Living (ADLs).

The **Substantial Assistance** definition is amended 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 Dependent, if applicable, while he is performing daily activities, including activities of self-care.

Waiver of Premium
If this rider is included, **Proof of Claim** is amended to state that proof must be given as soon as reasonably possible.

NORTH CAROLINA

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

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

Important Cancellation Information — Please Read the Provision Entitled, **Termination of Covered Person's Insurance.**

General Definitions
The "change in the number of dependents" item in the **Change in Status** definition is amended to remove the requirement that it be for tax purposes. This item is also amended to include placement of a Child in a foster home.

If Dependent coverage is included, the definition of **Child** is amended to include the following: a non-custodial Child; a foster Child from the date they are placed in a foster home; or a Child for whom You are required to provide insurance due to a court or administrative order. 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.

The definition of **Hospital or Medical Facility** is amended to include: "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."

Benefits Payable and Benefit Definitions
If **Cancer** coverage is included, it is amended to clarify that if the requisite pathological/clinical diagnosis can only be made postmortem, liability will be assumed retroactively.

Continuation and Reinstatement Provisions
If Dependent coverage is included, **Continuation of an Incapacitated Child** is amended to clarify that proof of dependency may be required within 31 days of attainment of limiting age, but not more frequently than annually.

CERTIFICATE MODIFICATIONS RIDER

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

Claim Provisions
Proof of Claim is amended to extend the timeframe in which written proof of claim must be filed, to 180 days.

NORTH DAKOTA

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

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

General Definitions
If Dependent coverage is included, the definition of **Child** includes a child of a Dependent.

General Exclusions and Limitations
If **Pre-Existing Conditions Exclusion** is included, the definition of **Pre-existing Condition** is amended to remove that it includes any condition for which the Covered person or Dependent had symptoms for which a reasonably prudent person would have sought Treatment.

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 are 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.

Newborn Child Provision
Any reference in the Certificate to *live birth* is replaced with *birth*.

General Exclusions and Limitations
The act of war exclusion is amended to include “when serving in the military or an auxiliary unit.”

Claim Information
Overpayment of Claim is amended to limit the recovery period to 24 months unless it is a case of claimant fraud.

The following **Time of Claim Payment** provision is added:

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:

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

UnitedHealthcare Insurance Company
To get information or file a complaint with your insurance company or HMO:

Call: UnitedHealthcare Insurance Company
Toll-free: 1-866-615-8727
Mail: United HealthCare Insurance Company Administrative Offices
9900 Bren Road East, Minnetonka. MN 55343

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance,
P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de sucompañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

UnitedHealthcare Insurance Company
Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: UnitedHealthcare Insurance Company
Teléfono gratuito: 1-866-615-8727
Dirección postal: United HealthCare Insurance Company Administrative Offices,
9900 Bren Road East, Minnetonka. MN 55343

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una
queja ante el estado:

CERTIFICATE MODIFICATIONS RIDER

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: Consumer Protection, MC: CO-CP,
Texas Department of Insurance,
P.O. Box 12030, Austin, TX 78711-2030

07/2023

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

CERTIFICATE MODIFICATIONS RIDER

WASHINGTON

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

The following Outline of Coverage is included:

UnitedHealthcare Insurance Company
185 Asylum Street
Hartford, Connecticut
(Home Office)

IMPORTANT INFORMATION ABOUT THE COVERAGE YOU ARE BEING OFFERED

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

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

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

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

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

The benefits under this policy are summarized below:

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

2. **Benefit Amount:**

Maximum Benefit Amount	Option 1 Employee: $15,000 Spouse: $15,000 Child: $7,500 Option 2* Employee: $30,000 Spouse: $30,000 Child: $15,000 *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	Included
• Portability Policy Age Limit	Coverage continued under Portability terminates at Age 75
Reoccurrence Benefit:	Included For each Critical Illness Condition, not to exceed: • 100% of Employee's Maximum Benefit Amount • 100% of Spouse's Maximum Benefit Amount • 100% of Child's Maximum Benefit Amount whichever applies
Additional Critical Illnesses Rider:	Included
Wellness Benefit:	$50 per calendar year
Waiver of Premium:	Included

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 (if applicable):
   1. receives a Diagnosis of a Critical Illness; and
   2. for which you are insured on the Date of Diagnosis (as defined in the Certificate).
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 last day of the month during which you enter active duty of the armed forces; the last day of the month during which 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:

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

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

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 loss which is intentionally self-inflicted;
4. active participation in a riot;
5. the Covered Person's or Dependent's commission of or attempt to commit a felony, or to which a contributing cause was the Covered Person's or Dependent's engagement in an illegal occupation;
6. loss sustained or contracted in consequence of the Covered Person or Dependent being intoxicated or under the influence of any controlled substance unless administered on the advice of a Physician;
7. attempted suicide, while sane or insane.

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

8. 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
9. 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.

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.

UHICI-OOC-WA-1
Printed in U.S.A.

CERTIFICATE MODIFICATIONS RIDER

General Definitions

If Dependent coverage is included and **Eligible Student** is defined, the restriction of not being married is removed.

General Exclusions and Limitations

The following exclusion is not applicable (if included in your Certificate):

- use of alcohol or the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance, whether or not prescribed by a Physician; this exclusion does not apply to the Drug and Alcohol Treatment Benefit (Inpatient) if covered under this Policy.

The act of war exclusion is replaced with “due to war or act of war, whether declared or undeclared.”

Benefits Payable and Benefit Definitions

If Coma is a covered benefit, the **Date of Diagnosis** waiting period for Coma condition will never exceed 14 days.

Eligibility, Effective Date and Termination Provisions

If Dependent coverage is included, the **Newborn Child Provision** is amended to extend the timeframe for notification of, and premium payment for, a newborn to 60 days.

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-3408

Policyholder:	Golden Rain Foundation of Walnut Creek
Policy Number:	371484
Effective Date:	January 1, 2024
Premium Due Date:	January 1 and the first day of each month thereafter
Policy Anniversaries:	January 1 of each year

We, UnitedHealthcare Insurance Company, agree to provide, for eligible persons becoming insured under the Policy, the benefits according to the terms, provisions and limitations of it. The following pages, including any riders, endorsements or amendments, are part of the Policy. The Policy is issued in consideration of payment of the required premium.

The Policy becomes effective at 12:01 A.M. Eastern Standard time on the Effective Date shown above. The Policy will continue in force by the payment of premiums when due. The Policy is subject to termination according to its terms.

Read the Policy Carefully

This is a legal contract between the Policyholder and Us. If the Policyholder has any questions or problems with the Policy, We will be ready to help the Policyholder. The Policyholder may call upon Our Home Office for assistance at any time.

The Policy is issued in and governed by the laws of the State of California.

We have, by Our President and Secretary, executed the Policy at Our Home Office. If the Policyholder or the Covered Person have questions, needs information about their insurance, or needs assistance in resolving complaints, call 1-888-299-2070.

NOTICE TO POLICYHOLDER

Review the Policy carefully. This Policy provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.

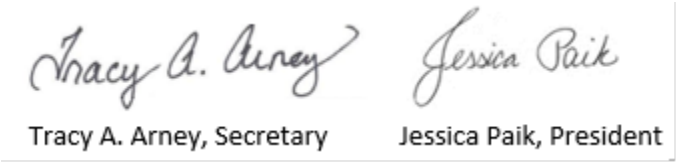
THIS POLICY IS NOT A MEDICARE SUPPLEMENT CONTRACT

If a Covered Person is eligible for Medicare, he should review the Guide to Health Insurance for People with Medicare available from the company.

Hospital Indemnity Plan
Insurance Policy

Administrative Office:
9900 Bren Road East
Minnetonka, MN 55343

This Policy is signed for UnitedHealthcare Insurance Company by:



Tracy A. Arney, Secretary Jessica Paik, President

THIS IS A SUPPLEMENT TO HEALTH INSURANCE. IT IS NOT A SUBSTITUTE FOR HOSPITAL OR MEDICAL EXPENSE INSURANCE, A HEALTH MAINTENANCE ORGANIZATION (HMO) CONTRACT OR MAJOR MEDICAL EXPENSE INSURANCE. IT IS NOT A SUBSTITUTE FOR ESSENTIAL HEALTH BENEFITS OR MINIMUM ESSENTIAL COVERAGE AS DEFINED IN FEDERAL HEALTH LAW. FAILURE TO HAVE OTHER HEALTH INSURANCE COVERAGE MAY BE SUBJECT TO A TAX PENALTY. PLEASE CONSULT A TAX ADVISOR.

POLICY GENERAL PROVISIONS

Certificates: The Policyholder will be furnished with a Certificate for delivery to each Covered Person. The Certificate(s) describe the benefits, terms, conditions, limitations and exclusions provided by the Policy. If there is a conflict between the Policy and the Certificate, the Policy will control.

Conformity with State or Federal Statutes: If any provision of the Policy conflicts with any applicable law, the provision will be deemed to conform to the minimum requirements of the law.

Entire Group Contract; Changes: The entire Group Contract between the Policyholder and Us consists of the Policy, Certificate(s), and any riders, endorsements, or amendments(s), and the Policyholder's application. All Certificate(s), and any riders, endorsements and any amendments are listed on the Policy Contents page.

All statements made by the Policyholder and by any person covered by the Policy are representations and not warranties. No statement made by the Covered Person will be used to contest the insurance provided by the Policy, unless:

1. it is contained in a written statement signed by the Covered Person; and
2. a copy of the statement is furnished to the Covered Person or beneficiary.

Only We may change the Policy or extend the time for payment of any premium. No change will be valid unless made in writing and signed by Us. Any change so made will be binding on all persons referred to in the Policy. No agent has the authority to change the Policy or waive any of the provisions. For purposes of the Policy, the Policyholder acts on its own behalf, or as the Covered Person's agent. The Policyholder is not an agent of Ours.

Nonparticipation: The Policy is non-participating. It does not pay dividends.

Information To Be Furnished: The Policyholder may be required to furnish any information needed to administer the Policy. Information will include data relative to Employee population, industry, corporate changes of the Policyholder, Employee benefit elections and contribution levels.

Clerical error by the Policyholder or Us will not:

1. affect the amount of insurance which would otherwise be in effect; or
2. continue insurance which otherwise would be terminated; or
3. result in the payment of benefits not otherwise payable.

Once an error is discovered, an equitable adjustment in premium will be made. If the premium adjustment involves the return of unearned premium, the amount of the return will be limited to the 12-month period, which precedes the date We receive proof such an adjustment should be made. We may inspect any of the Policyholder's records which relate to the Policy.

Records: The Policyholder must furnish all information required by Us to:

1. compute premiums; and
2. maintain necessary administrative records.

Records of the Policyholder, which have a bearing on insurance, will be available for inspection by Us at any reasonable time.

Payment of Premiums: No insurance provided by the Policy will be in effect until the first premium for such insurance is paid. For insurance to remain in effect, each subsequent premium must be paid on or before its due date. The Policyholder is responsible for paying all premiums as they become due. However, the premiums may be paid to Us by any other person according to a mutual agreement among the other person, the Policyholder and Us. Premiums are payable on or before their due dates at Our Home Office.

Premium Rate Change: On or after the first Policy Anniversary Date, We have the right to change premium rates as of any Premium Due Date but not more than once in any 6-month period. We will notify the Policyholder in writing at least 31 days prior to the change in rates.

The premium rate may change prior to this time however, for reasons that affect the insured risk, which include:

1. a change occurs in benefits;
2. a division, subsidiary, or affiliated company is added or deleted;
3. the number of Employees insured changes by 10% or more; or
4. a new Law or a change in any existing Law is enacted which applies to the Policy.

A change may take effect on an earlier date if both the Policyholder and We agree to it. Except in the case of fraud, premium adjustments, refunds or charges will be made for only the current Policy year.

Premium Rates: The Premium Rates for the Policy may be provided by Rider or be as on file at the office of the Policyholder**.**

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All of the provisions in the Certificate(s) of Coverage, riders, endorsements and any amendments issued for the Policyholder shown below are included and made part of this Policy.

DOCUMENTS	DESCRIPTION	EFFECTIVE DATE
Hospital Indemnity Plan Certificate Of Coverage	All active full-time Employees	January 1, 2024
Certificate Modifications Rider	Amends the contract as outlined	January 1, 2024

NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

- **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance
  80% of death benefits but not to exceed $300,000
  80% of cash surrender or withdrawal values but not to exceed $100,000

- Annuities and Structured Settlement Annuities
  80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $543,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C)

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance Guarantee Association
P.O Box 16860,
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927- 4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

UnitedHealthcare®

GROUP HOSPITAL INDEMNITY INSURANCE CERTIFICATE OF COVERAGE

FOR

GOLDEN RAIN FOUNDATION OF WALNUT CREEK

POLICY NUMBER: 371484

EFFECTIVE DATE: January 1, 2024

CA – UHIC/2017
(3-24)

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut

(Home Office)

Policyholder: Golden Rain Foundation of Walnut Creek

Effective Date: January 1, 2024

Policy Number: 371484

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 this Certificate Carefully. If the Covered Person has questions, needs information about their insurance, or needs assistance in resolving complaints, call 1-888-299-2070. If the Policyholder has any questions or problems with the Policy, the Policyholder may call upon Our Home Office for assistance at any time.

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

Tracy A. Arney, Secretary Jessica Paik, President

Administrative Office:

9900 Bren Road East
Minnetonka, MN 55343

Group Hospital Indemnity Plan Only Certificate

THIS IS A SUPPLEMENT TO HEALTH INSURANCE. IT IS NOT A SUBSTITUTE FOR HOSPITAL OR MEDICAL EXPENSE INSURANCE, A HEALTH MAINTENANCE ORGANIZATION (HMO) CONTRACT OR MAJOR MEDICAL EXPENSE INSURANCE. IT IS NOT A SUBSTITUTE FOR ESSENTIAL HEALTH BENEFITS OR MINIMUM ESSENTIAL COVERAGE AS DEFINED IN FEDERAL HEALTH LAW. FAILURE TO HAVE OTHER HEALTH INSURANCE COVERAGE MAY BE SUBJECT TO A TAX PENALTY. PLEASE CONSULT A TAX ADVISOR.

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SCHEDULE

Policyholder	Golden Rain Foundation of Walnut Creek
Eligible Class	Employees of Golden Rain Foundation of Walnut Creek 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 20 hours per week

The following Covered Benefits and Daily Benefit Amounts are applicable to the Covered Person, only if elected at the time of enrollment

Covered Benefits	**Daily Benefit Amount**
Hospital Admission Benefit	$1,000
Daily Hospital Confinement Benefit	$200
Daily Intensive Care Unit Confinement Benefit	$200
Intensive Care Unit Admission Benefit	$1,000
Drug and Alcohol Treatment Benefit (Inpatient)	$200
Mental and Nervous Disorder Treatment Benefit (Inpatient)	$200
Rehabilitation Therapy Benefit (Inpatient)	$200

SCHEDULE (continued)

Portability	Included
• Portability Policy Age Limit	Coverage continued under Portability terminates at Age 75

Maximum Age for Dependent Child: 26 years

Premium Rate Change: The premium 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 Certificate, includes the female.

Accident: an unforeseen occurrence which results in bodily Injury to a Covered Person or Dependent while coverage is in force.

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 shown in the Description of Class in the Schedule.

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).

Certificate: this document which provides a description of the insurance provided by the Policy issued to the Policyholder. It describes the essential features of the coverage and to whom benefits are payable.

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.

Complications of Pregnancy: a condition whose diagnosis is distinct from pregnancy, but adversely affected or caused by pregnancy, such as:

1. acute nephritis or nephrosis;
2. cardiac decompensation;
3. missed abortion;
4. similar medical and surgical conditions of comparable severity;
5. non-elective cesarean section;
6. termination of ectopic pregnancy; or
7. spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

However, the term Complications of Pregnancy will not include:

1. false labor, occasional spotting, hyperemesis gravidarum, pre-eclampsia or morning sickness; or
2. physician prescribed rest; or
3. any similar condition associated with the management of a difficult pregnancy not consisting of a nosologically distinct Complications of Pregnancy.

Confined or Confinement: being an Inpatient in a Hospital due to a covered Injury or Sickness.

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.

Custodial Care: the provision of services and supplies for activities of daily living that can be provided safely and reasonably by individuals who are neither skilled nor licensed medical personnel.

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

Spouse: a legal spouse includes a Domestic Partner ,as defined in the Policy. We may require proof of marriage, or proof of valid domestic partnership .

A Child is an unmarried Child under the Maximum Age for Dependent Child shown in the Schedule and who is:

1. a natural Child;
2. a stepchild;
4. a legally adopted Child;
5. a Child placed for adoption;
6. a Child for whom legal guardianship has been awarded to the Covered Person or the Covered Person's Spouse: or
7. a foster child, or any child who lives with the Covered Person in a regular parent-child relationship, provided the Covered Person claims such Child as a Dependent on the Covered Person's most recent federal income tax return.

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

A Child is an Incapacitated Child if he is:

1. covered under the Policy on the date that he reaches the Maximum Age for Dependent Child;
2. unmarried;
3. physically or mentally disabled;
4. financially dependent upon the Covered Person; and
5. meets the conditions stated in the Continuation of an Incapacitated Child provision.

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

Domestic Partner: a person with whom the Employee has established a domestic partnership and filed a valid Declaration of Domestic Partnership with the California Secretary of State or an equivalent document for registration of a domestic partnership with an authorized state or municipal agency. We must be notified if the domestic partnership terminates.

Emergency Room: a special, designated area in a Hospital that is supervised by Physicians and equipped and staffed to render immediate medical attention on an Outpatient basis, 24 hours a day, seven days a week for the sudden onset of symptoms related to an Injury or Sickness. An Emergency Room is not a clinic, an Urgent Care Facility or Physician's office.

Employee: a person who is authorized to work for the Employer on a regular basis and is:

1. directly employed in the normal business of the Employer;
2. paid for services by the Employer; and
3. 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: an institution which:

1. operates pursuant to law;
2. primarily and continuously provides medical care and Treatment of sick and injured persons on an Inpatient basis;
3. operates facilities for medical and surgical diagnosis and Treatment by or under the supervision of a staff of legally qualified Physicians;
4. provides 24 hour a day nursing service by or under the supervision of registered graduate Nurses (R.N.s); and
5. is located within the United States or its territories and is approved by the Joint Commission on the Accreditation of Hospitals (JCAH).

Hospital does not mean any institution or part thereof which is used primarily as:

1. a nursing home, convalescent home or Skilled Nursing Facility;
2. a Rehabilitation Center;
3. a place for rest, Custodial Care, or for the aged;
4. a clinic; or
5. unless otherwise specified within this Certificate, a place for the Treatment of Mental and Nervous Disorders, alcoholism or drug addiction.

Immediate Family: a person's spouse or domestic partner, child, parent or sibling; or the spouse's or domestic partner's child, parent or sibling.

Injury: bodily harm.

Inpatient: admission to a Hospital for at least 20 hours
for which a full day's room and board charge is made.

It does not include an Emergency Room admission, any Outpatient Treatment or any stay in an Observation Unit when there is no charge for room and board.

Intensive Care Unit: a Hospital area of special care, including cardiac and coronary care units, surgical intensive care units or cardiovascular intensive care units, which at the time of admission are separate and apart from the surgical recovery room, or other rooms, beds or wards normally used for patient Confinement.

In addition, such a unit must provide the following:

1. 24 hour continuous nursing care and attendance by Nurses assigned to the unit on a full-time basis;
2. direction and/or supervision by a full-time Physician director or a standing intensive care committee of the medical staff; and
3. special medical apparatus used to treat the critically ill.

The following do not qualify as Hospital Intensive Care Units:

1. progressive care units;
2. sub-acute intensive care units;
3. intermediate care units;
4. private rooms with monitoring;
5. step-down units; or
6. any other lesser care treatment units.

Mental and Nervous Disorder: any Sickness, disease or disorder, which is:

1. listed in the current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (or any successor diagnostic manual) published by the American Psychiatric Association; and
2. generally treated by a licensed mental health provider or other qualified provider, using psychotherapy, psychotropic drugs or other similar methods of Treatment.

Mental and Nervous Disorder includes any such conditions whether or not related to an underlying physical, genetic, chemical, organic or biological cause, although it may be associated with physical symptoms, manifestations or expressions. Specific conditions include, but are not limited to: bipolar disorder; depression and depressive disorders; psychoses; mood disorders; manic-depressive illness; anxiety disorders; stress disorders including post-traumatic stress disorders; somatoform disorders; factitious disorders; eating disorders; adjustment disorders; and personality disorders. However, for purposes of the Policy, Mental and Nervous Disorder does not include coma (unless a consequence of Substance Abuse), mental retardation or Alzheimer's disease and other forms of dementia with an objectifiable organic basis.

Nurse: any one of the following who is not a member of the Covered Person's Immediate Family:

1. licensed practical Nurse (L.P.N.);
2. licensed vocational Nurse (L.V.N.); or
3. registered graduate Nurse (R.N.).

Observation Unit: a specialized area within a Hospital, apart from the Emergency Room, where a patient can be monitored following Outpatient Surgery or Treatment in the Emergency Room by a Physician. Such a unit must:

1. be under the direct supervision of a Physician or registered graduate Nurse (R.N.);
2. be staffed by Nurses assigned specifically to that unit; and
3. provide care seven days per week, 24 hours per day.

Outpatient: Treatment for which a Confinement is not required and no charge is made for room and board.

Period of Confinement: an interval of time during which a Covered Person or Dependent is Confined as an Inpatient. A Period of Confinement begins on the date of admission. Successive Confinements commencing while coverage is in force, and:

1. due to the same or related causes; and
2. separated by less than 90 days;

are part of the same Period of Confinement.

A new Period of Confinement begins when the Covered Person is admitted:

1. for a new Injury or Sickness unrelated to the causes of a prior Confinement; or
2. after he has not been Confined for 90 days or more.

Physician: a person:

1. performing tasks that are within the limits of his medical license; and
2. who is licensed to practice medicine and prescribe and administer drugs or to perform Surgery; or
3. who is a legally qualified medical practitioner according to the laws and regulations of the state he practices in.

For the purposes of the Policy, the term Physician does not include the Covered Person, the Covered Person's spouse, domestic partner, or any Immediate Family members.

Policy: the 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.

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 first page of this Certificate.

Rehabilitation Center: a facility providing therapy and training for rehabilitation. The center may offer occupational therapy, physical therapy, vocational training, and special training such as speech therapy. A Rehabilitation Center is not:

1. a nursing home;
2. an extended care facility;
3. a Skilled Nursing Facility;
4. a rest home or home for the aged;

5. a hospice care facility;
6. a place for the care of drug addicts or alcoholics; or
7. an assisted living facility.

Sickness: an illness, disease, pregnancy or Complications of Pregnancy.

Skilled Nursing Facility: an institution which:

1. operates pursuant to law;
2. primarily and continuously provides skilled nursing care and related services to persons recuperating from Injury or Sickness on an Inpatient basis for which a charge is made;
3. maintains a daily medical record of each patient;
4. has established policies developed and executed by a professional group including at least one legally qualified Physician and at least one registered graduate Nurse (R.N.);
5. provides adequate procedures for the administration of drugs;
6. provides each patient with a planned program of medical care by or under the supervision of a Physician; and
7. has a qualified Physician available to furnish medical care in case of emergency.

Skilled Nursing Facility or convalescent Hospital does not mean any institution or part thereof used principally as:

1. a Hospital;
2. a rest home, a home for the aged, or a place for Custodial Care; or
3. a place for the care of drug addicts, alcoholics, or the mentally ill.

If an institution has multiple licenses or purposes, a separate portion, ward, wing or unit thereof can qualify as a Skilled Nursing Facility only if that portion, ward, wing or unit is engaged primarily in providing skilled nursing care and related services in accordance with the authority granted by its license.

Substance Abuse: alcoholism, or the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance, whether or not prescribed by a Physician.

Surgery: manual procedures involving cutting of body tissue, debridement or permanent joining of body tissue for repair of wounds, Treatment of fractured bones or dislocated joints, endoscopic procedures, and other manual procedures, when used in lieu of cutting for purposes of removal, destruction or repair of body tissue.

Treatment: Any consultation, advice, tests, attendance or observation, supplies or equipment, including the prescription or use of prescription drugs or medicines.

Urgent Care Facility: a category of walk-in clinic focused on the delivery of Treatment in a dedicated medical facility outside of a traditional Emergency Room. Urgent Care Facilities primarily treat Injuries or Sicknesses requiring immediate care.

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

HOSPITAL ADMISSION BENEFIT

Hospital Admission Benefit: We will pay the Daily Benefit Amount shown for this benefit in the Schedule for the first day a Covered Person or Dependent is admitted and Confined in a Hospital as an Inpatient as a result of an Injury or Sickness.

This benefit is payable up to 3 day per plan year per Covered Person or Dependent. This benefit is payable once per Period of Confinement in a Hospital per Covered Person or Dependent.
We will pay the Daily Benefit Amount for the Hospital Admission Benefit in addition to the Daily Benefit Amount for the Intensive Care Unit Admission Benefit.

The Hospital Admission Benefit is not payable for:

1. a newborn child's routine nursing or routine well baby care during the initial Confinement in a Hospital;
2. admissions to Skilled Nursing Facilities and Rehabilitation Centers;
3. Treatment for Mental and Nervous Disorders;
4. Treatment for drug and alcohol addictions;
5. Emergency Room Treatment, Outpatient Surgery or Treatment, or a Hospital stay of less than 20 hours in an Observation Unit; or
6. when a charge for a Hospital room and board is not made.

UHIHIP-FDHC

DAILY HOSPITAL CONFINEMENT BENEFIT

Daily Hospital Confinement Benefit: We will pay the Daily Benefit Amount shown for this benefit in the Schedule for each day that a Covered Person or Dependent is Confined in a Hospital as a result of an Injury or Sickness.

This benefit is payable for each day during a Period of Confinement in a Hospital up to a maximum of 365 days per plan year per Covered Person or Dependent.

If the Hospital Admission Benefit is also payable, this benefit pays for each day after the first day during a Period of Confinement in a Hospital up to a maximum of 364 days.
The Daily Hospital Confinement Benefit is not payable for:

1. any day for which the Hospital Admission Benefit is payable;
2. a newborn child's routine nursing or routine well baby care during the initial Confinement in a Hospital;
3. admissions to Skilled Nursing Facilities and Rehabilitation Centers;
4. Treatment for Mental and Nervous Disorders;
5. Treatment for drug and alcohol addictions; or
6. when a charge for a Hospital room and board is not made.

UHIHIP-DHC

DAILY INTENSIVE CARE UNIT CONFINEMENT BENEFIT

Daily Intensive Care Unit Confinement Benefit: We will pay the Daily Benefit Amount shown for this benefit in the Schedule for each day that a Covered Person or Dependent is Confined in an Intensive Care Unit of a Hospital as an Inpatient, as a result of an Injury or Sickness.

We will pay the Daily Benefit Amount for each day during a Period of Confinement in the Intensive Care Unit up to a maximum of 365 days per plan year per Covered Person or Dependent.
If the Hospital Admission Benefit is also payable, this benefit pays for each day after the first day during a Period of Confinement in a Hospital up to a maximum of 364 days.
The Daily Intensive Care Unit Confinement Benefit is not payable for:

1. any day for which the Intensive Care Unit Admission Benefit is payable;
2. Treatment for Mental and Nervous Disorders;
3. Treatment for drug and alcohol addictions; or
4. when a charge for Intensive Care Unit room and board is not made.

UHIHIP-DICU

INTENSIVE CARE UNIT ADMISSION BENEFIT

Intensive Care Unit Admission Benefit: We will pay the Daily Benefit Amount shown for this benefit in the Schedule, for the first day a Covered Person or Dependent is admitted and Confined in an Intensive Care Unit of a Hospital as an Inpatient, as a result of an Injury or Sickness.

This benefit is payable up to 3 day per plan year per Covered Person or Dependent. This benefit is payable once per Period of Confinement in an Intensive Care Unit per Covered Person or Dependent.
We will pay the Daily Benefit Amount for the Intensive Care Unit Admission Benefit in addition to the Daily Benefit Amount for the Hospital Admission Benefit.

The Intensive Care Unit Admission Benefit is not payable for:

1. a newborn child's routine nursing or routine well baby care during the initial Confinement in a Hospital;
2. Treatment for Mental and Nervous Disorders;
3. Treatment for drug and alcohol addictions;
4. Emergency Room Treatment, Hospital admission, Outpatient Surgery or Treatment; or
5. when a charge for Intensive Care Unit room and board is not made.

UHIHIP-FDICU

DRUG AND ALCOHOL TREATMENT BENEFIT (INPATIENT)

Drug and Alcohol Treatment Benefit (Inpatient): We will pay the Daily Benefit Amount shown for this benefit in the Schedule for each day:

1. a Covered Person or Dependent is Confined as an Inpatient in a Hospital; and
2. receives Treatment for drug and/or alcohol addictions. Treatment must be at the direction and under the care of a Physician.

This benefit is payable up to 30 days per Covered Person or Dependent per plan year. No benefit is payable after the Covered Person or Dependent has met their lifetime limit of 300 days.

For the purposes of this benefit, a place for the Treatment of drug and/or alcohol addictions will be regarded as a Hospital if:

1. it is part of an institution that meets the requirements shown in the definition of Hospital in this Certificate; and
2. it is listed in the American Hospital Association Guide as a general hospital.

This benefit is not payable for the same day the Daily Hospital Confinement Benefit or Mental and Nervous Disorder Treatment Benefit (Inpatient) is paid.

UHIHIP-DRUGACL

MENTAL AND NERVOUS DISORDER TREATMENT BENEFIT (INPATIENT)

Mental and Nervous Disorder Treatment Benefit (Inpatient): We will pay the Daily Benefit Amount shown for this benefit in the Schedule for each day:

1. a Covered Person or Dependent is Confined as an Inpatient in a Hospital; and
2. receives Treatment for Mental and Nervous Disorders. Treatment must be at the direction and under the care of a Physician.

This benefit is payable up to 30 days per Covered Person or Dependent per plan year. No benefit is payable after the Covered Person or Dependent has met their lifetime limit of 300 days.

For the purposes of this benefit, a place for the Treatment of Mental and Nervous Disorder will be regarded as a Hospital if:

1. it is part of an institution that meets the requirements shown in the definition of Hospital in this Certificate; and
2. it is listed in the American Hospital Association Guide as a general hospital.

This benefit is not payable for the same day the Daily Hospital Confinement Benefit or Drug and Alcohol Treatment Benefit **(**Inpatient**)** is paid.

UHIHIP-MENTNERV

REHABILITATION THERAPY BENEFIT (INPATIENT)

Rehabilitation Therapy Benefit (Inpatient): We will pay the Daily Benefit Amount shown for this benefit in the Schedule for each day a Covered Person or Dependent receives Treatment, on an Inpatient basis in a Hospital, for Rehabilitation and Therapy Services due to an Injury or Sickness.

Rehabilitation and Therapy Services are limited to:

1. physical therapy;
2. occupational therapy;
3. speech therapy;
4. pulmonary rehabilitation therapy;
5. cardiac rehabilitation therapy; and
6. post-cochlear implant aural therapy.

This benefit is payable up to 30 days per Covered Person or Dependent per plan year.

Rehabilitation and Therapy Services must be performed by a:

1. Physician;
2. licensed therapy provider;
3. licensed cardiac rehabilitation therapist;
4. licensed physical therapist; or
5. licensed speech therapist.

We will pay the benefit for speech therapy for the Treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorders.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Autism Spectrum Disorders - a group of neurobiological disorders, as defined in the Diagnostic and Statistical Manual, that includes Autistic Disorder, Rhett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder and Pervasive Development Disorders Not Otherwise Specified (PDDNOS).

UHIHIP-INREHAB

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

Covered Person's Eligibility: Employees who are Actively at Work are eligible for insurance 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.

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

1. the Effective Date of the Policy;
2. the date the Policy is changed to include the Employee's class; or
3. 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.

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; or
    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; or
    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; or
    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; or
    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 applies within:
    a. 31 days of the date he first became eligible for insurance, on the later of:
        i. the date the Employee became eligible for insurance; or
        ii. the date we approve the Employee's application if evidence of insurability is required;
    b. 31 days of a Change in Family Status, on the latest of:
        i. the date of the Change in Family Status;
        ii. the date the Employee became eligible for the insurance; or
        iii. the date we approve the Employee's application 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 Employee applies for coverage of his Dependent within:
    a. 31 days of the date the Dependent first became eligible for insurance, on the later of:
        i. the date the Dependent became eligible for insurance; or
        ii. the date we approve the application if evidence of insurability is required;
    b. 31 days of a Change in Family Status, on the latest of:
        i. the date of the Change in Family Status;
        ii. the date the Dependent became eligible for the insurance; or
        iii. the date we approve the application if evidence of insurability is required.
3. Evidence of Insurability is not required for Dependent Children.

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 Benefit 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 last day of the month during which he becomes a member of the armed forces on active duty, except:
    a. for duty of 30 days or less for training in the Reserves or National Guard; or
    b. to the extent coverage is continued under the Leave of Absence Continuation provision;
3. the last day of the month during which he ceases to be a member of a class eligible for insurance;
4. the date the Policy terminates, or with respect to a specific benefit, the date that such benefit terminates; or
5. the last day of the month during which 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 last day of the month during which he ceases to be a Dependent as defined in the Policy;
2. the last day of the month during which he ceases to be a member of a class eligible for Dependent insurance;
3. the date the Covered Person's insurance under the Policy terminates;
4. the last day of the month during which 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 Continuation During Leave of Absence 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

Reinstatement: If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by Us or Our agent duly authorized by Us to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if We or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon Our approval of such application or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless We have previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss sustained after the date of reinstatement. In all other respects the insured and We shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

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)
2. the leave period required by the Uniformed Services Employment and Reemployment Rights Act (USERRA); or
3. 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; 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 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. The coverage will become effective on the first day of the month after military service terminates. However, the Policy will not cover loss or other disability resulting from the military service.

PORTABILITY

Portability: If the Covered Person's and his Dependent's insurance under the Policy ends because his employment with the Employer ends, he may choose to continue his and his Dependent's Group Hospital Indemnity's coverage under the 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 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 Hospital Indemnity 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 his and his 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 Hospital Indemnity policy; or
3. the date he attains any Policy Age Limit shown in the Policy.

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

The Portability coverage will be on the form the Insurer is then issuing for Hospital Indemnity 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 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 and Limitations: This Certificate does not cover any loss caused by or resulting from (directly or indirectly):

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 loss which is intentionally self-inflicted;
4. active participation in a riot;
5. committing or attempting to commit a felony, or participating or attempting to participate in a felony;
6. loss sustained or contracted in consequence of being intoxicated or under the influence of any controlled substance unless administered on the advice of a Physician, this exclusion does not apply to the Drug and Alcohol Treatment Benefit (Inpatient) if covered under this Policy;
7. Treatment received outside the United States or its territories;
8. the reversal of a tubal ligation or vasectomy;
9. artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications or Physician services, unless required by law;
10. participation in any form of aeronautics (including parachuting and hang gliding) except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports;
11. a newborn child's routine nursing or routine well baby care during the initial Confinement in a Hospital;
12. driving in any organized or scheduled race or speed test or while testing an automobile or any motorized vehicle on any racetrack or speedway;
13. Mental and Nervous Disorders; this exclusion does not apply to the Mental and Nervous Disorder Treatment Benefit (Inpatient) if covered under this Policy;
14. dental or plastic surgery for cosmetic purposes except when such surgery is required to: (a) treat an Injury; or (b) correct a disorder of normal bodily function; and
15. practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.

Cosmetic or Elective Surgery Exclusion: We will not cover any loss under the Policy if it is due to Cosmetic Surgery or Elective Surgery.

Cosmetic Surgery means surgery performed to modify or improve the appearance of a physical feature or defect. For purposes of excluding benefits, Cosmetic Surgery does not mean Reconstructive Surgery performed to correct or repair abnormal structures of the body caused by:

1. congenital defects;
2. developmental abnormalities;
3. trauma;
4. infection;
5. tumors; or
6. disease;

when intended to either improve function or create a normal appearance to the extent possible.

Reconstructive Surgery includes:

1. dental or orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures; and
2. surgery and prosthetic devices to restore and achieve symmetry incident to a mastectomy.

Elective Surgery means:

1. Cosmetic Surgery; and
2. any other surgery that is:
   a. not for the purpose of correcting or repairing abnormal structures of the body;
   b. not for the purpose of improving function; or
   c. if intended to improve appearance or create a normal appearance, is not caused by a condition listed in 1-6 above.

For purposes of excluding benefits, Elective Surgery does not include:

1. Caesarean section;
2. any surgery related to Complications of Pregnancy; or
3. bariatric surgery performed in conjunction with a diagnosis of morbid obesity.

GENERAL PROVISIONS

Time Limit on Certain Defenses:

1. After two years from the date of issue of the policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for the policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of the two-year period.
2. No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of the policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage under the policy.

Grace Period: A grace period of 60 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force (subject to Our right to cancel in accordance with the cancellation provision hereof).

Unpaid Premium: Upon the payment of a claim under the policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

Notice of Claim: Written notice of claim must be given to Us within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to Us at the administrative address shown on the face page of this certificate, or to any authorized agent of Ours, with information sufficient to identify the insured, shall be deemed notice to Us.

Claim Forms: Upon receipt of a notice of claim, We will provide to the claimant such forms as are usually furnished by Us for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proofs of Loss: Written proof of loss must be furnished to Us within 90 days after the date of loss or after the insurer becomes liable for periodic payments. Failure to furnish proof within 90 days shall not invalidate nor reduce any claim if it was not reasonably possible to give such proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. Proof of Loss must include a completed claim form signed by the Covered Person and Physician(s) including documentation furnished by the Physician and supported hospital billing records.

Time of Payment of Claim: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at Our option, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, We may pay such indemnity, up to an amount not exceeding $1,000.00, to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by Us in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

Physical Examinations and Autopsy: We, at Our own expense shall have the right and opportunity to examine the person of the insured when and as often as We may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been provided. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be provided.

Change of Beneficiary: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

Misstatement of age: If the age of the insured has been misstated, all amounts payable under the policy shall be such as the premium paid would have purchased at the correct age.

Cancellation: We may cancel the policy at any time by written notice delivered to the Policyholder, or mailed to his last address as shown by Our records, stating when, not less than five days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term the Policyholder may cancel the policy at any time by written notice delivered or mailed to Us, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation by either the Policyholder or Us, We will return promptly the unearned portion of any premium paid. The Policyholder shall pay, on a pro rata basis, the earned premium which has not been paid. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

Upon providing the Policyholder with notice of Our intent to cancel, We will cease accepting applications under the Policy. However, the Policy will not terminate with respect to inforce certificates until the last certificate cancels in accordance with its termination provisions and no person remains insured under the Policy. The Policy will only terminate earlier with respect to inforce certificates if We and the Policyholder:

1. agree to such termination;
2. arrange separately or jointly for coverage under any inforce certificate to transition to a new policy; and
3. the new policy continues such coverage for the same or similar benefits.

The Termination of an Insurance Option under the Policy: We may cancel or modify any Insurance Option if the number of Employees insured falls below the greater of:

1. 10 Covered Persons; or
2. 10% of all eligible Employees.

Conformity With State Statutes: Any provision of the policy which, on its effective date, is in conflict with the statutes of California, is hereby amended to conform to the minimum requirements of such statutes.

Fraud: The falsity of any statement in the application for coverage shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by Us.

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

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.

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut

Important notice about your Hospital Indemnity Plan.

What is a Hospital Indemnity Plan?

A hospital indemnity plan is not health insurance that pays medical expenses. This is a plan that pays a set amount of money when you are in the hospital.

What do I need to know?

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

Why is this important to me?

You need to know that your hospital indemnity plan is not a substitute for health insurance that pays medical expenses. This plan doesn't provide essential health benefits. This is why you also need health insurance for medical expenses.

What happens if I don't have health insurance for medical expenses?

The Affordable Care Act requires everyone to have health insurance for medical expenses. This hospital indemnity plan is not enough to meet the requirement. You must also have health insurance for medical expenses.

California Consumer Complaint Notice

If the Covered Person has any questions or problems with their coverage, We will be ready to help. Our contact information is:

UnitedHealthcare Insurance Company

A Stock Company

Administrative Offices: 9900 Bren Road East, Minnetonka, MN 55343

1-888-299-2070

The Covered Person may also call the California Department of Insurance for assistance. However, We ask that the Covered Person gives Us the opportunity to try to resolve the problem. Please, call us first. If, We fail to help, the Covered Person may still ask the California Department of Insurance for assistance. Their contact information is:

California Department of Insurance

Consumer Services Division

300 South Spring Street

Los Angeles, California 90013

1-800-927-HELP

(1-800-927-4357)

http://www.insurance.ca.gov/01-con

NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

- **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance
  80% of death benefits but not to exceed $300,000
  80% of cash surrender or withdrawal values but not to exceed $100,000

- Annuities and Structured Settlement Annuities
  80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C)

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance Guarantee Association
P.O Box 16860,
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927- 4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

CERTIFICATE MODIFICATIONS RIDER

Modification(s) to the Certificate

Policyholder: Golden Rain Foundation of Walnut Creek

Policy Number: 371484

It is agreed that the Certificate is amended as follows:

Effective January 1, 2024, 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, and all other conditions apply.

Signed for UnitedHealthcare Insurance Company by:

Tracy A. Arney, Secretary Jessica Paik, President

UnitedHealthcare Insurance Company
Hartford, Connecticut 06103-3408

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:

General Definitions
If Dependent coverage is included and **Domestic Partner and Civil Union** are defined, they are amended so that any references to gender (i.e., "of the opposite or same sex" or "of the same sex") are removed.

General Exclusions and Limitations
The Treatment received outside of the United States exclusion is amended to add "or Canada."

Claim Provisions
Overpayment of Claim is amended to advise that we have the right to recover any overpayments within 180 days of payment of a benefit.

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

Policyholders have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:

Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, Arkansas 77202

Continuation and Reinstatement Provisions
If Dependent coverage is included, **Continuation of an Incapacitated Child** is amended to remove the 31 day notice requirement of the incapacity.

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:

Dependent Definition

If Dependent coverage is included, the definition of **Child** is amended to include foster Child(ren).If Dependent coverage is included and **Domestic Partnership** is defined, it is amended to remove any specific living arrangements and affiliated time period requirements.

If Dependent coverage is included, the definition of **Incapacitated Child** is amended to remove any requirement that the Child be unmarried.

If **Mental and Nervous Disorder** coverage is included, it is amended to remove "mental retardation or Alzheimer's disease and other forms of dementia with an objectifiable organic basis."

Eligibility, Effective Date and Termination Provisions

If Dependent coverage is included, **Newborn Child Provision** is amended to include an adopted Child. The adopted Child will become insured on the date the Child was placed with You for adoption at the same Benefit Amount that applies to Your other Children. If no other Children are insured, then the lowest amount available to Children under the Policy applies until We are notified of another amount that is available for Children. The timeframe for notification of, and premium payment for, a newborn or adopted Child is extended to 60 days; and insurance for the newborn/adopted Child may end on the date You request.

Claim Provisions

Legal Actions is amended to extend the timeframe in which no suit may be brought from three years after the date of loss to five years.

IDAHO

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

10 Day Free Look: The Covered Person has the right to return this certificate within 10 days of its delivery and to have any premium paid, refunded if after examination, he is not satisfied for any reason.

Notice to Buyer: This is a Hospital Indemnity Certificate. This Certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your Certificate carefully with the outline of coverage.

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:

GROUP HOSPITAL CONFINEMENT INDEMNITY COVERAGE

THIS CERTIFICATE PROVIDES LIMITED BENEFITS

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

OUTLINE OF COVERAGE for UHIHIP-POL-ID-1

This IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare, review the Guide to Health Insurance for People With Medicare available from the company.

10 Day Free Look: You have the right to return this certificate within 10 days of its delivery and to have any premium paid, refunded if after examination, you are not satisfied for any reason.

(1) 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!**

(2) Hospital confinement indemnity coverage is designed to provide coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered injury or sickness, subject to any limitations set forth in the policy. Coverage is not provided for any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.

(3) Amount and Duration of Benefits: The coverage pays you or your Dependent (if applicable) the Maximum Benefit Amount for each Benefit shown on the Certificate Schedule, subject to all the terms, limits, and exclusions of the policy.

Refer to the Certificate Schedule for:

a. Maximum Benefit Amount; and
b. Any Additional Benefits that apply

(4) Exceptions, Reductions and Limitations: We will not cover any loss caused by or resulting from (directly or indirectly):

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 loss which is intentionally self-inflicted;
4. active participation in a riot;
5. committing or attempting to commit a felony, or participating or attempting to participate in a felony;
6. loss sustained or contracted in consequence of being intoxicated or under the influence of any controlled substance unless administered on the advice of a Physician, this exclusion does not apply to the Drug and Alcohol Treatment Benefit (Inpatient) if covered under this Policy;
7. Treatment received outside the United States or its territories;
8. the reversal of a tubal ligation or vasectomy;
9. artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications or Physician services, unless required by law;
10. participation in any form of aeronautics (including parachuting and hang gliding) except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports;
11. a newborn child's routine nursing or routine well baby care during the initial Confinement in a Hospital;
12. driving in any organized or scheduled race or speed test or while testing an automobile or any motorized vehicle on any racetrack or speedway;
13. Mental and Nervous Disorders; this exclusion does not apply to the Mental and Nervous Disorder Treatment Benefit (Inpatient) if covered under this Policy;
14. dental or plastic surgery for cosmetic purposes except when such surgery is required to: (a) treat an Injury; or (b) correct a disorder of normal bodily function; and
15. practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.

Renewability: You will cease to be a Covered Person and your insurance will terminate 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 last day of the month during which he becomes a member of the armed forces on active duty;
3. the last day of the month during which he ceases to be a member of a class eligible for insurance;
4. the date the policy terminates, or with respect to a specific benefit, the date that such benefit terminates;
5. the last day of the month during which he ceases to be actively at work, unless active work ceases during an approved 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.

UHIHIP-OOC-ID-1

General Definitions

If Dependent coverage is included, the definition of **Child** is amended to include: a Child for whom legal guardianship has been awarded to the Covered Person or the Covered Person's, Domestic Partner, partner in a Civil Union.

The **Complications of Pregnancy** definition is amended to remove "non-elective" from the cesarean section condition.

The **Hospital** definition is amended to include an institution which operates either on its premises or in facilities available to the hospital on a prearranged basis.

Benefits

Drug and Alcohol Treatment Benefit (Inpatient) / Mental and Nervous Disorder Treatment Benefit (Inpatient) / Rehabilitation Therapy Benefit (Inpatient) / Skilled Nursing Facility Benefit are amended to be payable up to 31 days.

Eligibility, Effective Date and Termination Provisions

If Dependent coverage is included, **Enrolling in or Changing Dependent Insurance Under the Policy** is amended to allow for 60 days of a Change in Family Status for a newborn or newly adopted child.

If Dependent coverage is included, the **Newborn Child Provision** is amended to include adopted newborn Children that are Placed with You within 60 days of the adopted Child's date of birth, and will become covered by the Policy from the moment of live birth. An adopted newborn Child Placed with You more than 60 days after their birth is covered by the Policy from and after the date the Child is so Placed. 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.

We must receive notification the Child within 60 days next following the date of birth, adoption or placement for adoption. The appropriate premium, if any, must be received within 31 days of the date the monthly premium invoice is received by the Policyholder and a notice of premium, if any, is provided to You by the Policyholder.

Coverage will cease unless We receive written request and any required premium as stated above.

The coverage amount offered is the lowest amount available to Children under the Policy if no other Children are insured, until We are notified of another amount that is available for Children.

A Congenital Anomaly refers to a condition existing at or from birth that is a Significant Deviation from the common form or function of the body. Congenital Anomaly is often caused by a hereditary or developmental defect or disease.

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.

General Limitations and Exclusions

The following exclusions are not applicable (if included in your Certificate):

- taking part in the commission of an assault or being engaged in an illegal activity;
- the reversal of a tubal ligation or vasectomy;
- artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications or Physician services, unless required by law;

CERTIFICATE MODIFICATIONS RIDER

The act of war exclusion is replaced with “an act of war, declared or undeclared, whether civil or international.”

The felony exclusion is replaced with “active participation in a felony.”

The use of alcohol exclusion is replaced with “Alcohol or drug addiction; this exclusion does not apply to the Drug and Alcohol Treatment Benefit (Inpatient) if covered under this Policy.”

The Cosmetic or elective surgery exclusion is amended to include “except that “cosmetic surgery” shall not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child.”

The participation in any form of aeronautics exclusion is replaced with “operating any aircraft as a professional for wage or profit.”

The driving in any organized or scheduled race or speed test exclusion is amended to include the requirement of driving or testing as a professional.

The Dental or plastic surgery exclusion is amended to include “or (c) reconstructive surgery because of congenital disease or anomaly of a Dependent Child.”

The practicing for or participating in any semi-professional or professional competitive athletic contests exclusion is amended to remove “semi-professional”.

If **Pre-existing Conditions Exclusion** is included, it is amended to remove that we will not cover any Injury or Sickness that is “contributed to” by a Pre-Existing Condition.

If **Pre-Existing Conditions Exclusion** is included, the definition of **Pre-existing Condition** is amended to exclude any congenital anomaly of a Dependent Child and to remove any condition for which the Covered person or Dependent had symptoms for which a reasonably prudent person would have sought Treatment.

Claim Information
Time of Claim Payment is added:

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

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

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

MINNESOTA

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

General Definitions
If Dependent coverage is included, the definition of **Child** is amended to 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 Limitations and Exclusions
The use of alcohol exclusion is replaced with “use of narcotics, unless administered on the advice of a Physician.”

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:

The following disclosures are added (reference to Dependent only applies if dependent coverage is included):

Important Cancellation Information — Please Read the Provision Entitled, Termination of Employee Insurance.

General Definitions
The "change in the number of dependents" item in the **Change in Status** definition is amended to remove the requirement that it be for tax purposes. This item is also amended to include placement of a Child in a foster home.

If Dependent coverage is included, the definition of **Child** is amended to include the following: a non-custodial Child; a foster Child from the date they are placed in a foster home; or a Child for whom You are required to provide insurance due to a court or administrative order. An adopted Child's insurance 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.

The definition of **Hospital** is amended to include: In North Carolina, Hospital 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. State tax-supported institutions includes community mental health centers and other health clinics which are certified as Medicaid providers.

Physician's Visit Benefit
If **Physician's Visit Benefit** is included, Chiropractic office visits are covered.

Surgery Benefit (Inpatient)/Surgery Benefit (Outpatient)
If **Surgery Benefit** (Inpatient) and/or **Surgery Benefit** (Outpatient) are included, the anesthesia benefit amount is changed from 25% of the Daily Benefit Amount to $12.50 per $50 of the Daily Benefit Amount Shown on the Schedule.

Eligibility, Effective Date and Termination Provisions
If Dependent coverage is included, the **Newborn Child Provision** includes Adopted and Foster Children.

Continuation of an Incapacitated Child is amended to require proof of continued incapacity not more than once per year.

Waiver of Premium Benefit
If the **Waiver of Premium Benefit** is included, the timeframe to provide proof of Total Disability is amended to extend to no later than 180 days after the date of Total Disability. The extension of 180 days also applies to providing proof after requested.

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

If **Pre-Existing Conditions Exclusion** is included, the definition of **Pre-existing Condition** is amended to exclude any congenital anomaly of a Dependent Child and to remove any condition for which the Covered person or Dependent had symptoms for which a reasonably prudent person would have sought Treatment.

CERTIFICATE MODIFICATIONS RIDER

Claim Provisions
Notice of Claim is amended to allow that written notice of a claim may also be given to Our authorized agent.

Proof of Claim is amended to extend the timeframe in which written proof of claim must be filed, to 180 days.

Time of Claim Payment is added:

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.

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.

General Definitions
If Dependent coverage is included, the definition of **Child** includes a child of a Dependent.

If Dependent coverage is included and **Eligible Student** is defined, the restriction of not being in the armed forces is removed.

Mental and Nervous Disorder Treatment Benefit (Inpatient)/Drug and Alcohol Treatment Benefit (Inpatient)
If the **Mental and Nervous Disorder Treatment Benefit (Inpatient)** and/or **Drug and Alcohol Treatment Benefit (Inpatient)** are included, mental health and substance abuse must be covered as any other illness, therefore any references to, limitations of, or restrictions applied to:

- Mental and Nervous Disorder Treatment Benefit (Inpatient), Drug and Alcohol Treatment Benefit (Inpatient), and
- a Residential Treatment Facility, with respect to the Mental and Nervous Disorder Treatment Benefit (Inpatient) and Drug and Alcohol Treatment Benefit (Inpatient), and
- a place for the Treatment of Mental and Nervous Disorders, alcoholism or drug addiction, and
- a place for the care of drug addicts, alcoholics, or the mentally ill, and
- treatment for drug and alcohol addictions,

are removed.

Surgery Benefit (Inpatient)/Surgery Benefit (Outpatient)
If the **Surgery Benefit** (Inpatient) and/or **Surgery Benefit** (Outpatient) are included, the limitation that the Surgery occur within a specified time period of the Injury or Sickness is removed.

Transportation Benefit
If the **Transportation Benefit** is included, the limitation that the Hospital Confinement occur within a specified time period of the Injury or Sickness is removed.

Continuation and Reinstatement Provisions
Extension of Benefits for Disability is added:

Extension of Benefits for Disability: If the Policy cancels while the Covered Person is disabled and entitled to benefits, the benefits:

1. will continue as long as he remains disabled by the same disability; but
2. will not continue beyond the earlier of:
   a. the date benefits would have ceased had the insurance remained in force; or
   b. the last day of a period of 12 consecutive months following the date the Policy canceled.

General Exclusions and Limitations
The following exclusions are not applicable (if included in your Certificate):

- use of alcohol or the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance, whether or not prescribed by a Physician; this exclusion does not apply to the Drug and Alcohol Treatment Benefit (Inpatient) if covered under this Policy;
- Mental and Nervous Disorders; this exclusion does not apply to the Mental and Nervous Disorder Treatment Benefit (Inpatient) if covered under this Policy;

If **Pre-existing Condition Exclusion** is included, the definition of **Pre-existing Condition** is amended to remove any condition for which the Covered person or Dependent had symptoms for which a reasonably prudent person would have sought Treatment.

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 are included: (reference to Dependent only applies if Dependent coverage is 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. 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.

FRAUD 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.

Eligibility, Effective Date and Termination Provisions
If Dependent coverage is included, the **Newborn Child Provision** is amended to indicate that the Covered Person's Newborn Child will become covered by the Policy from the moment of "birth" rather than "live birth".

General Exclusions and Limitations
The act of war exclusion is amended to include "when serving in the military or an auxiliary unit."

Claim Provisions
Overpayment of Claim is amended to limit the recovery period to 24 months unless it is a case of claimant fraud.

Time of Claim Payment is added:

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:

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

UnitedHealthcare Insurance Company

To get information or file a complaint with your insurance company or HMO:

Call: UnitedHealthcare Insurance Company
Toll-free: 1-866-615-8727
Mail: United HealthCare Insurance Company Administrative Offices
9900 Bren Road East, Minnetonka. MN 55343

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance,
P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de sucompañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

UnitedHealthcare Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: UnitedHealthcare Insurance Company
Teléfono gratuito: 1-866-615-8727
Dirección postal: United HealthCare Insurance Company Administrative Offices,
9900 Bren Road East, Minnetonka. MN 55343

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: Consumer Protection, MC: CO-CP,
Texas Department of Insurance,
P.O. Box 12030, Austin, TX 78711-2030

07/2023

Claim Provisions
Time of Claim Payment is added:

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.

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

CERTIFICATE MODIFICATIONS RIDER

WASHINGTON

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

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

IMPORTANT INFORMATION ABOUT THE COVERAGE YOU ARE BEING OFFERED

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

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

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

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

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

The benefits under this policy are summarized below:

Type of Coverage: Hospital Confinement Indemnity Insurance Coverage. Hospital confinement indemnity coverage pays you a fixed dollar amount during or resulting from periods of hospitalization resulting from a covered injury or sickness, subject to any limitations set forth in the policy. Coverage is not provided for any benefits other than the benefits described below. The certificate does NOT provide general health insurance.

Covered Benefits: **Daily Benefit Amount:**

The following Covered Benefits and Daily Benefit Amounts are applicable to the Covered Person, only if elected at the time of enrollment	
Covered Benefits	**Daily Benefit Amount**
Hospital Admission Benefit	$1,000
Daily Hospital Confinement Benefit	$200
Daily Intensive Care Unit Confinement Benefit	$200
Intensive Care Unit Admission Benefit	$1,000
Drug and Alcohol Treatment Benefit (Inpatient)	$200
Mental and Nervous Disorder Treatment Benefit (Inpatient)	$200
Rehabilitation Therapy Benefit (Inpatient)	$200

Benefit Trigger: The coverage pays you or your Dependent, if applicable, the Daily Benefit Amount for each Benefit shown on the Certificate Schedule, subject to all the terms, limits, and exclusions of the policy.

CERTIFICATE MODIFICATIONS RIDER

Duration of Coverage: Your coverage terminates on the first to occur of: the last day of the period for which premium is paid; the last day of the month during which you enter active duty of the armed forces; the last day of the month during which you cease to be in a class eligible for coverage; the date the Policy terminates; the date a benefit 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***.

CERTIFICATE MODIFICATIONS RIDER

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 any loss caused by or resulting from (directly or indirectly):

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 loss which is intentionally self-inflicted;
4. active participation in a riot;
5. committing or attempting to commit a felony, or participating or attempting to participate in a felony;
6. loss sustained or contracted in consequence of being intoxicated or under the influence of any controlled substance unless administered on the advice of a Physician, this exclusion does not apply to the Drug and Alcohol Treatment Benefit (Inpatient) if covered under this Policy;
7. Treatment received outside the United States or its territories;
8. the reversal of a tubal ligation or vasectomy;
9. artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications or Physician services, unless required by law;
10. participation in any form of aeronautics (including parachuting and hang gliding) except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports;
11. a newborn child's routine nursing or routine well baby care during the initial Confinement in a Hospital;
12. driving in any organized or scheduled race or speed test or while testing an automobile or any motorized vehicle on any racetrack or speedway;
13. Mental and Nervous Disorders; this exclusion does not apply to the Mental and Nervous Disorder Treatment Benefit (Inpatient) if covered under this Policy;
14. dental or plastic surgery for cosmetic purposes except when such surgery is required to: (a) treat an Injury; or (b) correct a disorder of normal bodily function; and
15. practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.

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.

UHIHIP-OCC-WA

CERTIFICATE MODIFICATIONS RIDER

General Definitions

If Dependent coverage is included and **Eligible Student** is defined, the restriction of not being married is removed.

If Dependent coverage is included and **Domestic Partner** is defined, it is amended to always include both opposite or same sex.

Eligibility, Effective Date and Termination Provision

If Dependent coverage is included, the **Newborn Child Provision** is amended to allow 61 days to submit written request of a newborn's enrollment.

General Exclusions and Limitations

The following exclusion is not applicable (if included in your Certificate):

- use of alcohol or the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance, whether or not prescribed by a Physician; this exclusion does not apply to the Drug and Alcohol Treatment Benefit (Inpatient) if covered under this Policy.

The act of war exclusion is replaced with "due to war or act of war, whether declared or undeclared.'