

## Group Benefits

**Goodwill Industries of Western Missouri & Eastern Kansas**

**Critical Illness**



**CERTIFICATE OF  
GROUP INSURANCE**

**Union Security Insurance Company** certifies that the insurance stated in this Certificate became effective on the Effective Date shown in your Statement of Coverage form. This Certificate is subject to the provisions of the below numbered *policy* issued by Union Security Insurance Company to the *policyholder*.

Policyholder: Goodwill Industries of Western Missouri & Eastern Kansas

Group Policy Number: 5469055

Effective Date: See Statement of Coverage form

Type of Insurance: Group *Critical Illness Insurance*  
Group *Critical Illness Insurance* for Dependents

***Critical Illness Insurance* benefits reduce at age 70.**

This Certificate replaces any and all Certificates and Certificate Endorsements, if any, issued to you under the *policy*.



President and  
Chief Executive Officer

**NOTICE**

If you have any questions about your insurance, please contact:

Union Security Insurance Company  
Customer Advocacy  
P.O. Box 419596  
Kansas City, MO 64141-9958

You may also reach Union Security by telephone at 800.733.7879.

When contacting us, please have your policy number available.

## SCHEDULE

**Eligible Class:** For employee insurance - Each *full-time* employee of the *policyholder* or an *associated company*,

- who is at *active work*, and
- who is working in the United States of America,

as identified on the *policyholder's* or our records, except any temporary or seasonal worker.

For dependent insurance - Each *eligible dependent* of a person eligible and insured for employee insurance.

**Associated Companies:** Helping Hand of Goodwill

**Service Requirement:** 60 day(s)

**Entry Date:** An eligible person will become insured on the first of the month occurring on or after the day all eligibility requirements are met.

### Critical Illness Insurance

At the time of enrollment, you may be eligible to select a Schedule Amount.

You may change the Schedule Amount for you or your *covered dependents* according to the Plan Changes provision below.

Any limitation applies separately to you and each *covered dependent*.

Please see the Critical Illness Insurance provisions for a complete description of benefits, limitations and exclusions.

### Schedule Amount

1. A *covered person* who has not reached age 70 may choose an amount of *critical illness insurance* of \$10,000.
2. For each *covered person* who has reached age 70 or more, the amount of insurance will be 50% of the amount chosen in 1 above.\*
3. For each *covered person* who has reached age 70 or more and is electing coverage for the first time, the amount of insurance will be 50% of the amount they could have otherwise elected in 1 above.\*

\*The amount will be rounded to the next higher multiple of \$1,000, if not already an exact multiple. Any reduction will take effect on the policy anniversary occurring on or after the change. Any reduction will be subject to the other provisions of the *policy*.

The amount of *critical illness insurance* may be limited by the Proof of Good Health provision. Any reduction based on age will apply to the amount of insurance in force, taking into account the Proof of Good Health provision.

**Maximum Amount Without Proof of Good Health:** \$10,000

### Schedule Amount for Dependents

1. A *covered person* may choose an amount of dependent *critical illness insurance* for the *covered dependent* spouse in the amount of \$5,000.
2. A *covered person* may choose an amount of dependent *critical illness insurance* for each *covered dependent* child according to age as follows:

**SCHEDULE (continued)**

Age

Amount

Live birth but less than age 26

A *covered person* may choose \$5,000

The amount of insurance for a dependent will not be more than 50% of the *covered person's* amount of insurance. This amount will be reduced if it exceeds 50% of the *covered person's* amount following an age reduction. Any reduction will take effect on the policy anniversary occurring on or after the change.

The amount of dependent *critical illness insurance* may be limited by the Proof of Good Health provision.

**Dependent Maximum Amount Without Proof of Good Health:**

Spouse - \$5,000; Child - \$5,000

**Benefits for Covered Critical Illnesses and Procedures**

Benefits for you or your *covered dependent* are payable under this *policy* for only the *critical illnesses* and *procedures* listed in the categories below.

You or your *covered dependent* will not receive more than 100% of your Schedule Amount in any one category unless you are eligible for the recurrence benefit. In order for benefits to be paid in more than one category, there must be 6 or more consecutive months between the dates the *critical illness* is *diagnosed* or the *procedure* is undergone. Please see the Amount of Benefit provision for a complete description of benefits.

| <b>Category 1<br/>Critical<br/>Illnesses and<br/>Procedures</b> | <b>Heart/Stroke</b>   | <b>Percentage<br/>of Schedule<br/>Amount</b>  |
|---|---|---|
|   | <i>Heart Attack</i>   | 100%  |
|   | <i>Heart Failure</i>  | 100%  |
|   | <i>Stroke</i>   | 100%  |
|   | <i>Coronary Bypass Surgery</i>  | 25%   |
|   | Recurrence Benefit (additional benefit for a subsequent <i>diagnosis</i> of the same <i>critical illness</i> or <i>procedure</i> in this category; recurrence <i>diagnosis</i> must occur more than 18 months after any previous <i>diagnosis</i> for the same <i>critical illness</i> or <i>procedure</i> ; recurrence <i>diagnosis</i> must follow a treatment free period of at least 18 months for the same <i>critical illness</i> or <i>procedure</i> ) | 25% of the previously paid benefit for the same <i>critical illness</i> or <i>procedure</i> |

| <b>Category 2<br/>Critical<br/>Illnesses and<br/>Procedures</b> | <b>Other Major Illnesses</b>  | <b>Percentage<br/>of Schedule<br/>Amount</b>  |
|---|---|---|
|   | <i>Blindness</i>  | 100%  |
|   | <i>Major Organ Failure (excluding heart failure)</i>  | 100%  |
|   | <i>End-stage Kidney Disease</i>   | 100%  |
|   | <i>Paralysis (excluding paralysis from stroke)</i>  | 100%  |
|   | <i>Coma</i>   | 100%  |
|   | Recurrence Benefit (additional benefit for a subsequent <i>diagnosis</i> of the same <i>critical illness</i> or <i>procedure</i> in this category; recurrence <i>diagnosis</i> must occur more than 18 months after any previous <i>diagnosis</i> for the same <i>critical illness</i> or <i>procedure</i> ; recurrence <i>diagnosis</i> must follow a treatment free period of at least 18 months for the same <i>critical illness</i> or <i>procedure</i> ) | 25% of the previously paid benefit for the same <i>critical illness</i> or <i>procedure</i> |

**SCHEDULE (continued)**

| <b>Category 3<br/>Critical<br/>Illnesses and<br/>Procedures</b> | <b>Cancer</b>          | <b>Percentage<br/>of Schedule<br/>Amount</b> |
|---|------------------------|--|
|   | <i>Invasive Cancer</i> | 100%   |
|   | <i>Cancer in situ</i>  | 25%  |

**Wellness Screening Benefit Amount:** \$50

**Plan Changes**

**For Changes at Annual Enrollment**

You may choose to change your Schedule Amount, subject to any required *proof of good health*, from November 1 through November 30 of each year, the annual enrollment period agreed upon by the *policyholder* and us. You must submit *proof of good health* for any increase in excess of \$0 annually. The amount of any increase, with or without *proof of good health*, is subject to the Pre-Existing Conditions provision, as described in the Critical Illness Insurance provisions of the *policy*. A pre-existing condition will be considered to have occurred in relation to the effective date of the change, not the original effective date of your coverage. Any reductions based on age will apply to any increase.

The effective date of any change made during the annual enrollment period will be the later of the policy anniversary or the first of the month occurring on or after the date of our correspondence notifying you of our approval of your or your *covered dependent's proof of good health*, if required. Please see Exception to Effective Date if you are not at *active work* on the day the change in insurance would otherwise take effect, or if that day is not a regular work day. Please see Exception to Dependent Effective Date if your *covered dependent* is in a *hospital* or similar facility on the day the change in insurance would otherwise take effect.

**Change in Family Status**

You may apply for insurance or change your plan of insurance, within 31 days of a change in family status. A "change in family status" means your marriage or divorce, the death of your spouse or child, the birth or adoption of your child, the termination of employment of your spouse, or any other event specified in the *policyholder's* IRC Section 125 plan. If you apply for an amount of insurance in excess of the Maximum Amount Without Proof of Good Health or increase your plan of insurance by more than \$0 following a change in family status, you must submit *proof of good health*. If you apply for an amount of dependent insurance in an amount exceeding the Dependent Maximum Amount Without Proof of Good Health, you must submit *proof of good health* for your dependent. Any amount or increase in insurance is subject to the Pre-Existing Conditions provision in the Critical Illness Insurance provisions section of the *policy*. A pre-existing condition will be considered to have occurred in relation to the effective date of the change, not the original effective date of your coverage.

If you are first applying for insurance for yourself or for your *eligible dependent* within 31 days after a change in family status, insurance will take effect on the first of the month occurring on or after the later of the date of the request or the date of our correspondence notifying you of our approval of your or your *eligible dependent's proof of good health*, if required.

If you are changing your existing plan of insurance, the effective date of any change due to a change in family status will be the first of the month occurring on or after the later of the date of the request or the date of our correspondence notifying you of our approval of your or your *eligible dependent's proof of good health*, if required.

Please see Exception to Effective Date if you are not at *active work* on the day the change in insurance would otherwise take effect, or if that day is not a regular work day. Please see Exception to Dependent Effective Date if your *covered dependent* is in a *hospital* or similar facility on the day the change in insurance would otherwise take effect.

**TABLE OF CONTENTS**

SCHEDULE .....5  
GENERAL DEFINITIONS.....9  
DEFINITIONS FOR CRITICAL ILLNESS INSURANCE..... 10  
SUMMARY OF GROUP CRITICAL ILLNESS INSURANCE ..... 13  
ELIGIBILITY AND TERMINATION PROVISIONS FOR CRITICAL ILLNESS INSURANCE ..... 14  
    Eligible Persons ..... 14  
    Effective Date for an Eligible Person ..... 14  
    Exception to Effective Date ..... 14  
    When a Person’s Insurance Ends ..... 15  
    Continuance of Insurance..... 15  
    Reinstatement..... 15  
DEPENDENT ELIGIBILITY AND TERMINATION PROVISIONS FOR CRITICAL ILLNESS INSURANCE..... 16  
    Eligible Dependents..... 16  
    Dependent Effective Date..... 16  
    Exception to Dependent Effective Date..... 16  
    When Dependent Insurance Ends..... 17  
SPECIAL DEPENDENT INSURANCE CONTINUANCE PROVISIONS ..... 18  
    Physically or Mentally Handicapped Dependent Children ..... 18  
SPECIAL FEDERAL CONTINUANCE PROVISIONS ..... 19  
CRITICAL ILLNESS INSURANCE ..... 20  
    Insurance Provided ..... 20  
    Proof of Good Health ..... 20  
    Amount of Benefit ..... 20  
    Recurrence Benefit ..... 21  
    Wellness Screening Benefit..... 21  
    Pre-Existing Conditions ..... 22  
    General Exclusions..... 22  
    Porting to a Group Portability Policy..... 23  
    Assignment ..... 23  
CLAIM PROVISIONS FOR CRITICAL ILLNESS INSURANCE ..... 24  
    Payment of Benefits..... 24  
    To Whom Payable ..... 24  
    Authority..... 24  
    Filing a Claim ..... 24  
    Proof of Loss..... 24  
    Right to Examine or Interview..... 25  
    Limit on Legal Action ..... 25  
    Review Procedure ..... 25  
    Incontestability ..... 25  
    Overpayment ..... 25  
GENERAL PROVISIONS ..... 27  
    Entire Contract..... 27  
    Errors ..... 27  
    Misstatements..... 27  
    Certificates ..... 27  
    Workers' Compensation ..... 27  
    Agency..... 27  
    Fraud ..... 27



## GENERAL DEFINITIONS

These terms have the meanings shown here when *italicized*. The pronouns “we”, “us”, “our”, “you”, and “your” are not *italicized*.

*Active work* means the expenditure of time and energy for the *policyholder* or an *associated company* at your usual place of business on a *full-time* basis.

*Associated company* means any company shown in the *policy* which is owned by or affiliated with the *policyholder*.

*Contributory* means you pay part or all of the premium.

*Covered dependent* means an *eligible dependent* who is insured under the *policy*.

*Covered person* means an eligible employee of the *policyholder* or *associated company* who has become insured for a coverage.

*Doctor* means a person acting within the scope of his or her license to practice medicine, prescribe drugs or perform surgery. Also, a person whom we are required to recognize as a *doctor* by the laws or regulations of the governing jurisdiction, or a person who is legally licensed to practice psychiatry, psychology or psychotherapy and whose primary work activities involve the care of patients, is a *doctor*. However, neither you nor a *family member* will be considered a *doctor*.

*Eligible class* means a class of persons eligible for insurance under the *policy*. This class is based on employment.

*Family member* means a person who is a parent, spouse, child, sibling, domestic partner, grandparent or grandchild of the *covered person*.

*Full-time* means working at least 20 hours per week, unless indicated otherwise in the *policy*.

*Home office* means our office in Kansas City, Missouri.

*Noncontributory* means the *policyholder* pays the premium.

*Policy* means the group policy issued by us to the *policyholder* that describes the benefits for which you may be eligible.

*Policyholder* means the entity to whom the *policy* is issued.

*Proof of good health* means evidence acceptable to us of the good health of a person.

We, us, and our mean Union Security Insurance Company.

You and your mean an eligible employee of the *policyholder* or *associated company* who has become insured for a coverage.

## DEFINITIONS FOR CRITICAL ILLNESS INSURANCE

*Applicable percentage* means the percentage of the *benefit amount* that is payable for a *critical illness* or *procedure* as listed in the Schedule.

*Benefit amount* means the amount of insurance specified in the Schedule which you elected and that we approved.

*Benefit year* means a calendar year beginning on January 1 of any year and ending on December 31 of that year.

*Blindness* means you or your *covered dependent* has been *diagnosed* with an irreversible reduction in sight, lasting at least 180 days, that results in a corrected visual acuity of 20/400 or less or a visual field less than 20 degrees when testing both eyes together.

*Cancer in situ* means you or your *covered dependent* has been *diagnosed* with a cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue. *Cancer in situ* includes, but is not limited to:

- Early prostate cancer *diagnosed* as T1N0M0 or equivalent staging; and
- Melanoma not invading the dermis.

*Cancer in situ* does not include:

- Other skin malignancies; or
- Pre-malignant lesions (such as intraepithelial neoplasia); or
- Benign tumors or polyps; or
- *Invasive cancer*.

*Cancer in situ* must be supported by a pathological *diagnosis*.

*Clinic* means an institution, building or part of a building where *outpatients* receive *treatment* for *diagnoses*.

*Coma* means you or your *covered dependent* has been *diagnosed* with a condition from which you or your *covered dependent* cannot be aroused and which requires an external life support system, both of which have persisted continuously for at least 168 hours.

*Coronary bypass surgery* means a procedure to bypass one or more diseased, narrowed or blocked coronary arteries with arterial or venous grafts and is performed by a board certified cardiovascular surgeon. Other procedures such as percutaneous transluminal coronary angioplasty (PTCA) or laser procedures are excluded.

*Critical illness* or *critical illnesses* means one of the following illnesses, *diagnosed* after your coverage effective date and while you are covered under the *policy*, and does not include any other illness, disease or health related event: *heart attack, heart failure, major organ failure, stroke, invasive cancer, cancer in situ, coma, end-stage kidney disease, paralysis* (other than stroke), and *blindness*.

*Critical illness insurance* means the group critical illness insurance under the *policy* issued by us to the *policyholder*.

*Diagnosed, diagnosis* or *diagnoses* means an evaluation of your or your *covered dependent's* medical condition that is performed by a *doctor* whose specialty is appropriate for the condition being evaluated, and who is board certified in that specialty in accordance with the American Board of Medical Specialties criteria. The evaluation must include conclusions that are definite and supported by presence of symptoms, clinical signs on physical examination, and test results consistent with the most current medically accepted diagnostic standards according to *nationally recognized authorities*. In addition, the evaluation must meet one or more of the following criteria depending on the condition that is being evaluated:

## DEFINITIONS FOR CRITICAL ILLNESS INSURANCE (continued)

- if cognitive function is being evaluated, the conclusions must be confirmed with neuropsychological testing conducted by a clinical psychologist at the doctorate level certified through the American Board of Professional Psychology in the area of clinical neuropsychology;
- if pulmonary function is being evaluated, the conclusion must be supported by testing performed in accordance with the American Thoracic Society criteria; and
- if the condition is evaluated using the results of exercise testing, that testing must be performed in accordance with the American College of Sports Medicine or American Heart Association standards.

*End-stage kidney disease* means you or your *covered dependent* has been *diagnosed* with a renal disease that has resulted in the chronic and irreversible failure of both kidneys to function and which requires regular dialysis for a minimum of 90 days.

*Heart attack* means you or your *covered dependent* has been *diagnosed* with a current and new acute myocardial infarction due to blockage of one or more coronary arteries resulting in death of a portion of the heart muscle with loss of heart function. *Diagnosis* of the new heart attack must be based on new changes consistent with an evolving infarction on electrocardiogram (EKG) and concurrent with serial measurement of cardiac biomarkers of a pattern and level of enzymes confirming an acute infarction. Old, established or silent myocardial infarctions are excluded.

*Heart failure* means you or your *covered dependent* has been *diagnosed* with heart failure for which the only treatment option requires your or your *covered dependent's* heart to be replaced with a heart from a suitable human donor. In order for *heart failure* to be covered under this *policy*, the *covered person* or *covered dependent* must be registered with the United Network of Organ Sharing (UNOS).

*Hospital* means an institution which is primarily engaged in providing, by and under the supervision of *doctors* to *inpatients*, diagnostic and therapeutic services for medical *diagnosis*, *treatment* and care of injured, disabled, or sick persons; or rehabilitation services of injured, disabled, or sick persons. It must meet all of the following requirements:

- maintain clinical records on all patients;
- have every patient be under the care of one or more on duty *doctors*;
- provide 24 hour nursing service provided by an on duty licensed practical or registered nurse and supervised by a registered professional nurse;
- be licensed or be approved by the state or local licensing agency;
- meet other health and safety requirements found necessary by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and
- is not primarily a clinic, nursing, rest or convalescent home.

*Injury* means unintentional physical damage or harm caused directly by an accident and not due to sickness, disease or any other causes.

*Inpatient* means a patient who is admitted to a *hospital* for an *injury* or sickness.

*Invasive cancer* means you or your *covered dependent* has been *diagnosed* with a malignant neoplasm, which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of neighboring tissue, and which is not specifically hereafter excluded. Leukemias and lymphomas are considered *invasive cancer*.

The following are not considered *invasive cancer*:

## DEFINITIONS FOR CRITICAL ILLNESS INSURANCE (continued)

- pre-malignant lesions (such as intraepithelial neoplasia);
- benign tumors or polyps;
- early prostate cancer *diagnosed* as T1N0M0 or equivalent staging;
- *Cancer in situ*; and
- any skin cancer (other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic).

*Invasive cancer* must be supported by a pathological *diagnosis*.

*Lifetime* means the period of time you or your *covered dependent* is alive.

*Major organ failure* means you or your *covered dependent* has been *diagnosed* with major organ failure for which the only treatment option requires your or your *covered dependent's* malfunctioning organ(s) or tissue to be replaced with an organ(s) or tissue from a suitable human donor. The organs and tissues covered by this definition are limited to: liver, kidney, lung, small intestine, pancreas, pancreas-kidney or allogeneic bone marrow. In order for *major organ failure* to be covered under this *policy*, the *covered person* or *covered dependent* must be registered with the United Network of Organ Sharing (UNOS) or the National Marrow Donor Program (NMDP).

*Nationally recognized authorities* means the American Medical Association (AMA) Council on Scientific Affairs, the AMA Diagnostic and Therapeutic Technology Assessment Project, the AMA Board of Medical Specialties, the American College of Physicians and Surgeons, the Food and Drug Administration, the Centers for Disease Control and Prevention, the Office of Technology Assessment, the National Institutes of Health, the Health Care Finance Administration, the Agency for Health Care Policy and Research, the Department of Health and Human Services, the National Cancer Institute, and any additional organizations we choose which attain similar status.

*Outpatient* means a patient who is not admitted to a *hospital* but instead is cared for elsewhere such as a doctor's office, *clinic* or day surgery center for an *injury*.

*Paralysis* means you or your *covered dependent* has been *diagnosed* with total and irreversible loss of use of two or more limbs due to neurological *injury* or sickness of associated nerves that is continuously present for a period of at least 180 days, but shall not include any paralysis caused by a *stroke*.

*Port* means to convert to a group portability policy.

*Procedure* means the following medical procedure: *coronary bypass surgery*.

*Stroke* means you or your *covered dependent* has been *diagnosed* with a disease, not including transient ischemic attack (TIA), that resulted in loss of motor function in an upper and lower extremity concurrently with resulting sustained disturbance of gross and dexterous movements of those limbs, gait or station with ineffective communication or speech persisting for at least 96 hours and this condition is expected to be permanent.

*Timely applicant* means a person whose application for insurance is made no later than 90 days after becoming eligible for insurance under the *policy*.

*Treatment* means any medical service, procedure, consultation, advice, tests, observation, supplies, equipment, x-rays, or surgery, including the prescription of drugs or use of prescription drugs or insulin.

## SUMMARY OF GROUP CRITICAL ILLNESS INSURANCE

This summary is intended to help understand your group insurance. It does not change any of its provisions.

### Critical Illness Insurance

There may be certain benefits and amounts you may elect and the coverage in force for you will depend on the elections made.

The *policy* pays a fixed benefit when you or a *covered dependent* is *diagnosed* with a covered *critical illness* or undergoes a covered *procedure*.

The *critical illness* must be *diagnosed* or the *procedure* undergone while you or your *covered dependent* is insured under this *policy* and is subject to the limitations and exclusions described in this *policy*. We will not pay benefits for any *critical illness* or *procedure* if you or your *covered dependent* has been *diagnosed* with that *critical illness* or has undergone that *procedure* at any time prior to the effective date of your or your *covered dependent's* coverage under the *policy*.

The *policy* explains the situations in which you or a *covered dependent* will receive limited or no benefits. In addition, pre-existing exclusions may apply to some situations.

The *policy* includes a portability provision. If your *critical illness insurance* ends under certain circumstances, it may be possible to *port* your *critical illness insurance* and your dependent's *critical illness insurance*, if any.

Premiums must continue to be paid, either under the *policy* or under the group portability policy, if eligible, for benefits to be paid.

In the following pages, the provisions that describe a particular coverage were designed to be used in both the *policy* and the certificate. Therefore the terms "you" and "your" are used to refer to the *covered person*.

### **IMPORTANT:**

**The benefits of this certificate are provided under a limited *policy*.**

**This is a *critical illness insurance* certificate.**

**This is NOT a medical insurance certificate, a Medicare Supplement certificate or a high deductible health plan.**

**Please read  
your certificate  
carefully.**

## ELIGIBILITY AND TERMINATION PROVISIONS FOR CRITICAL ILLNESS INSURANCE

### Eligible Persons

To be eligible for insurance, a person must:

- be a member of an *eligible class*; and
- complete any Service Requirement shown in the Schedule by continuous service with the employer, the *policyholder*, or an *associated company*; and
- give us *proof of good health*, if required.

The Present Service Requirement applies to persons in an *eligible class* on the Effective Date of the *policy*. The Future Service Requirement applies to persons who become members of an *eligible class* after that.

### Effective Date for an Eligible Person

*Proof of good health* is required for any amount in excess of the Maximum Amount Without Proof of Good Health. Any *noncontributory* insurance will take effect on the Entry Date shown in the Schedule unless *proof of good health* is required. If *proof of good health* is required, and the proof is acceptable to us, any *noncontributory* insurance will take effect on the later of the Entry Date shown in the Schedule in the *policy* or the Entry Date occurring on or after the date of our correspondence notifying you of our approval of your *proof of good health*.

For any *contributory* insurance, a person must apply for insurance on a form acceptable to us, and agree to pay part or all of the premium. Insurance will take effect on the following:

- If a person applies before becoming eligible, *proof of good health* is required for any amount in excess of the Maximum Amount Without Proof of Good Health. Insurance will take effect on the Entry Date shown in the Schedule in the *policy* unless *proof of good health* is required. If *proof of good health* is required, and the proof is acceptable to us, insurance will take effect on the later of the Entry Date shown in the Schedule in the *policy* or the Entry Date occurring on or after the date of our correspondence notifying you of our approval of your *proof of good health*.
- If the application is made on the date the person becomes eligible, or within 90 days after that, *proof of good health* is required for any amount in excess of the Maximum Amount Without Proof of Good Health. Insurance will take effect on the Entry Date occurring on or after the date of the application unless *proof of good health* is required. If *proof of good health* is required, and the proof is acceptable to us, insurance will take effect on the later of the Entry Date shown in the Schedule in the *policy* or the Entry Date occurring on or after the date of our correspondence notifying you of our approval of your *proof of good health*.
- If application is made more than 90 days after the day the person becomes eligible, or after insurance ended because the premium was not paid, *proof of good health* is required for all amounts of coverage and application must be made during an annual enrollment period. Insurance will take effect on the later of the policy anniversary occurring on or after the date of the application or the Entry Date occurring on or after the date of our correspondence notifying you of our approval of your *proof of good health*.

In no event will a person's insurance take effect before the *policyholder's* effective date.

### Exception to Effective Date

If an eligible person is not at *active work* on the day insurance would otherwise take effect, insurance will not take effect until the person returns to *active work*. If the day insurance would normally take effect is not a regular work day for a person, insurance will take effect on that day if the person is able to do his or her regular job.

## ELIGIBILITY AND TERMINATION PROVISIONS FOR CRITICAL ILLNESS INSURANCE (continued)

### When a Person's Insurance Ends

A *covered person's* insurance will end on the date:

- the *policy* ends;
- the *policy* is changed to end the insurance for a person's *eligible class*;
- a person is no longer in an *eligible class*;
- a person stops *active work*;
- a required contribution was not paid; or
- all benefits paid or payable for you under this *policy* reach the maximum amount payable as described in the Schedule.

If your insurance ends, you may be eligible to *port* your insurance and continue your benefits. Please see the Porting to a Group Portability Policy provision.

### Continuance of Insurance

If a person is unable to perform *active work* for a reason shown below, the *policyholder* may continue the person's insurance and the person's dependent insurance, if any, on a premium-paying basis provided the person remains in other respects a member of the *eligible class*. The continuance cannot be more than the maximum continuance shown below. Continuance must be based on a uniform policy, and not individual selection.

The maximum continuance for *critical illness insurance* is the longest applicable period described below:

- 12 months\* for *injury*, sickness, or pregnancy;
- 3 months\* for lay-off, leave of absence (other than a family or medical leave of absence described below), or change to part-time; or
- the end of the period the *policyholder* is required to allow\* for a family or medical leave of absence under:
  - the federal Family and Medical Leave Act; or
  - any similar state law.

\* after the last day of *active work*.

Any leave of absence, including a family or medical leave of absence described above, must be approved in advance in writing by the *policyholder* if the person's insurance is to be continued.

### Reinstatement

If a person re-enters an Eligible Class within 12 months after insurance ends, the person will not have to complete the Service Requirement again. Any Pre-Existing Conditions provision will be applied as if insurance never ended if a person re-enters an Eligible Class immediately after the end of a family or medical leave of absence under the federal Family and Medical Leave Act or any similar state law. All other provisions of the *policy* will apply as if the person were newly eligible.

## DEPENDENT ELIGIBILITY AND TERMINATION PROVISIONS FOR CRITICAL ILLNESS INSURANCE

### Eligible Dependents

Your *eligible dependents* are:

- your lawful spouse,
- your children from live birth but less than age 26.

“Children” include any adopted children. A child will be considered adopted on the date of placement in your home. Stepchildren and foster children are also included if they depend on you for support and maintenance. “Children” also include any children for whom you are the legal guardian, who reside with you on a permanent basis and depend on you for support and maintenance.

An *eligible dependent* will not include any person who is a member of an *eligible class*. An *eligible dependent* may not be covered by more than 1 *covered person*.

### Dependent Effective Date

*Proof of good health* is required for any amount in excess of the Dependent Maximum Amount Without Proof of Good Health. Any *noncontributory* dependent insurance will take effect on the Entry Date shown in the Schedule unless *proof of good health* is required. If *proof of good health* is required, and the proof is acceptable to us, any *noncontributory* dependent insurance will take effect on the later of the Entry Date shown in the Schedule in the *policy* or the Entry Date occurring on or after the date of our correspondence notifying you of our approval of your dependent's *proof of good health*.

For any *contributory* dependent insurance, a person must apply for insurance on a form acceptable to us, and agree to pay part or all of the premium. Insurance will take effect on the following:

- If a person applies before the dependent becomes eligible, *proof of good health* is required for any amount in excess of the Dependent Maximum Amount Without Proof of Good Health. Insurance will take effect on the Entry Date shown in the Schedule in the *policy* unless *proof of good health* is required. If *proof of good health* is required, and the proof is acceptable to us, insurance will take effect on the later of the Entry Date shown in the Schedule in the *policy* or the Entry Date occurring on or after the date of our correspondence notifying you of our approval of your dependent's *proof of good health*.
- If the application is made on the date the dependent becomes eligible, or within 90 days after that, *proof of good health* is required for any amount in excess of the Dependent Maximum Amount Without Proof of Good Health. Insurance will take effect on the Entry Date occurring on or after the date of the application unless *proof of good health* is required. If *proof of good health* is required, and the proof is acceptable to us, insurance will take effect on the later of the Entry Date shown in the Schedule in the *policy* or the Entry Date occurring on or after the date of our correspondence notifying you of our approval of your dependent's *proof of good health*.
- If application is made more than 90 days after the day the dependent becomes eligible, or after insurance ended because the premium was not paid, *proof of good health* is required for all amounts of coverage and application must be made during an annual enrollment period. Insurance will take effect on the later of the policy anniversary occurring on or after the date of the application or the Entry Date occurring on or after the date of our correspondence notifying you of our approval of your dependent's *proof of good health*.

### Exception to Dependent Effective Date

Dependent insurance will not take effect until your insurance for the same coverage under the *policy* takes effect.



## DEPENDENT ELIGIBILITY AND TERMINATION PROVISIONS FOR CRITICAL ILLNESS INSURANCE (continued)

If an *eligible dependent* is in a *hospital* or similar facility on the day insurance would otherwise take effect, it will not take effect until the day after the *eligible dependent* leaves the *hospital* or similar facility. This exception does not apply to a child born while dependent insurance is in effect. Dependent insurance for a newborn dependent child, including an adopted newborn dependent child, will automatically take effect at birth. Insurance will continue for 31 days. If you want insurance to continue for a newborn beyond 31 days, you must notify us (if you do not already have dependent child insurance) and make the required premium payment within the 31-day period.

### When Dependent Insurance Ends

A dependent's insurance will end on the date:

- the *policy* ends;
- the *policy* is changed to end dependent insurance;
- that dependent is no longer eligible;
- your insurance for the same coverage under the *policy* ends;
- a required contribution for dependent insurance was not paid;
- all benefits paid or payable for you under this *policy* reach the maximum amount payable as described in the Schedule; or
- all benefits paid or payable for a *covered dependent* under this *policy* reach the maximum amount payable as described in the Schedule. *Critical Illness insurance* for *covered dependents* who have not reached the maximum amount payable will continue as long as all other *policy* provisions apply.

If your and your dependent insurance ends, you may be eligible to *port* your insurance and continue your benefits. Please see the Porting to a Group Portability Policy provision.

## SPECIAL DEPENDENT INSURANCE CONTINUANCE PROVISIONS

As specified below, dependent *critical illness insurance* may continue, subject to the provisions that describe when insurance ends, and all other terms and conditions of the *policy*. Premiums are required for any coverage continued.

### Physically or Mentally Handicapped Dependent Children

Dependent *critical illness insurance* for an *eligible dependent* child will continue beyond the date a child attains an age limit, if, on that date, he or she:

- is unable to earn a living because of physical or mental handicap; and
- is chiefly dependent upon you for support and maintenance.

We must receive proof of the above within 120 days after the child attains the age limit and each year after that, beginning 2 years after the child attains the age limit. There will be no increase in premium for this continued coverage.

Dependent *critical illness insurance* will end when the child is able to earn a living or is no longer dependent on you for support and maintenance.

## **SPECIAL FEDERAL CONTINUANCE PROVISIONS**

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your *covered dependents* may have the right to continue *critical illness insurance* coverage beyond the date insurance would otherwise terminate. You should contact the *policyholder* concerning your right to continue coverage.

## CRITICAL ILLNESS INSURANCE

### Insurance Provided

Benefits may be payable under this *policy*. If you or your *covered dependent* is *diagnosed* with a *critical illness* or undergoes a *procedure* while insured under the *policy*, we will pay the benefits shown in the Schedule. Some of the benefits described in the *policy* may not apply depending on the level of benefits selected.

The *critical illness* must be *diagnosed* or the *procedure* undergone while you or your *covered dependent* is insured under this *policy* and is subject to the limitations and exclusions described in this *policy*.

We will not pay benefits for any *critical illness* or *procedure* if you or your *covered dependent* has been *diagnosed* with that *critical illness* or has undergone that *procedure* at any time prior to the effective date of your or your *covered dependent's* coverage under the *policy*.

Any benefits are subject to the provisions of the *policy*.

Any required premiums must continue to be paid, either under the *policy* or under the group portability policy, if eligible, for benefits to be paid.

### Proof of Good Health

If you are eligible for more than the Maximum Amount Without Proof of Good Health or your *eligible dependent* is eligible for more than the Dependent Maximum Amount Without Proof of Good Health shown in the Schedule, you or your *eligible dependent* will be limited to that Maximum until you give us *proof of good health* for yourself or your *eligible dependent*. If the proof is accepted, the additional amount of insurance will take effect on the first of the month occurring on or after the later of the date of the request or the date of our correspondence notifying you of our approval of your or your *eligible dependent's proof of good health*, if required.

### Amount of Benefit

We will pay the *applicable percentage* of the *benefit amount*.

After we pay benefits for a particular *critical illness* or *procedure*, we will not pay any additional benefits if you or your *covered dependent* is ever *diagnosed* with that *critical illness* or undergoes that *procedure* again except as described in the Recurrence Benefit provision.

Each *critical illness* and *procedure* is included in a specific category in the Schedule. We will pay up to 100% of the *benefit amount* in each of the categories shown in the Schedule. We will not pay more than 100% of your or your *covered dependent's benefit amount* in any category. After we pay 100% of the benefit in a specific category, we will not pay any additional benefits for any *critical illness* or *procedure* listed in that category except as described in the Recurrence Benefit provision.

We will pay a *benefit amount* in more than one category, if:

- benefits have been paid under this *policy* because you or your *covered dependent* was *diagnosed* with a *critical illness* or has undergone a *procedure* in a specific category; and
- you or your *covered dependent* is *diagnosed* with a *critical illness* or undergoes a *procedure* from a different category more than 6 consecutive months later.

If the date of the *diagnosis* of a *critical illness* or date of a *procedure* is the same for *critical illnesses* or *procedures* listed in different categories, we will pay only the benefit for the *critical illness* or *procedure* with the largest *applicable percentage*.

## CRITICAL ILLNESS INSURANCE (continued)

### Recurrence Benefit

We will pay a recurrence benefit, if

- benefits have been paid under this *policy* because you or your *covered dependent* was *diagnosed* with a *critical illness* or has undergone a *procedure*,
- you or your *covered dependent* is *diagnosed* with the same *critical illness* or undergoes the same *procedure* more than 18 months later, and
- you or your *covered dependent* has not received *treatment* for the same *critical illness* or condition that led to the *procedure* for 18 consecutive months after the *diagnosis* for the *critical illness* or after the *procedure*. For the purposes of this provision, we will not consider follow-up visits to your *doctor* or prescription medications other than cytotoxic medications (cancer chemotherapy) to be *treatment*.

The amount of the recurrence benefit is 25% of the benefit previously paid because of that *critical illness* or *procedure*.

The recurrence benefit will only be paid once in each category.

### Wellness Screening Benefit

We will pay the Wellness Screening Benefit Amount shown in the Schedule if you provide proof satisfactory to us that you or your *covered dependent* had a wellness screening test performed while covered under the *policy*. This benefit is limited to the wellness screening tests listed below and is limited to one test per *benefit year* for you or your *covered dependent*.

- cardiac exercise stress test
- fasting blood glucose test
- blood test for lipids including total cholesterol, LDL, HDL and triglycerides
- breast ultrasound or mammography
- CA15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- chest x-ray
- colonoscopy
- flexible sigmoidoscopy
- hemocult stool analysis
- pap smear
- PSA (blood test for prostate cancer)
- serum protein electrophoresis
- carotid doppler
- electrocardiogram

## CRITICAL ILLNESS INSURANCE (continued)

- echocardiogram.

This benefit will be paid as long as the *policy* is in force and you or your *covered dependent* remains covered under the *policy*. The benefit will be paid regardless of the results of the test. The wellness screening benefit is paid in addition to any other benefits payable under the *policy*. In order to receive this benefit, you must submit proof that the wellness screening test was performed by providing us with documentation from your *doctor*.

### Pre-Existing Conditions

This provision does not apply on the Effective Date of the *policy* for any amount of critical illness insurance for which you or your *covered dependent* was covered under the *policyholder's* prior plan of insurance on the day before the Effective Date of the *policy*.

We will not pay benefits for claims resulting, directly or indirectly, from a pre-existing condition (defined below) unless you or your *covered dependent* is initially *diagnosed* with a *critical illness* or undergoes a *procedure* after the earlier of:

- 12 consecutive months, ending on or after the day you or your *covered dependent* became insured under the *critical illness insurance policy*, during which you or your *covered dependent* does not consult with or receive advice from a licensed medical or dental practitioner or receive medical or dental care, *treatment* or services, including taking drugs, medicine, insulin, or similar substances, for that condition; or
- 12 consecutive months during which you or your *covered dependent* is continuously insured under the *critical illness insurance policy*.

A "pre-existing condition" means an *injury*, sickness, symptom or physical finding, or any related *injury*, sickness, symptom or physical finding, for which you or your *covered dependent*:

- consulted with or received advice from a licensed medical or dental practitioner; or
- received medical or dental care, *treatment*, or services, including taking drugs, medicine, insulin, or similar substances

during the 12 months that end on the day before you or your *covered dependent* became insured under the *critical illness insurance policy*.

### General Exclusions

We will not pay benefits for you or your *covered dependent* if the *critical illness* or *procedure* is related to or resulting directly or indirectly from:

- services or *treatment* not included in the Schedule;
- services or *treatment* for which you or your *covered dependent* is not charged, unless there is no charge because the facility is a United States government facility;
- services or *treatment* provided by a *family member*;
- any *critical illness* that is *diagnosed* outside of the United States;
- services or *treatment* rendered outside the United States;
- services or *treatment* provided primarily for cosmetic purposes;
- *treatment* or complications of *treatment* not related to a *critical illness* or *procedure*;

## CRITICAL ILLNESS INSURANCE (continued)

- an autologous bone marrow transplant, one in which your own bone marrow is used;
- service in the armed forces or related auxiliaries such as the National Guard or Army Reserve of any country, combination of countries, or international organization at war, whether declared or not (upon receipt of written request, we will refund the pro rata unearned premium upon notice that you or your *covered dependent* has been placed on active duty in the armed forces);
- war or any act of war, whether declared or not;
- taking part in a riot or insurrection, or an act of riot or insurrection;
- committing or attempting to commit an assault or felony;
- incarceration in a penal institution of any kind;
- intoxication (intoxication means your or your *covered dependent's* blood alcohol level exceeds the legal limit for operating a motor vehicle in the jurisdiction in which the *injury* occurs);
- use of any drugs, unless the drugs were used as prescribed or directed by a *doctor*;
- intentionally self-inflicted injury, while sane; or
- suicide or attempted suicide, while sane.

### Porting to a Group Portability Policy

If all of your *critical illness insurance* ends for a reason other than you did not pay your share of the premium, you may be eligible to port your insurance and your dependent insurance currently in force. You must *port* your *critical illness insurance* in order to *port* your *covered dependent's critical illness insurance*. A *covered dependent* may not *port* his or her *critical illness insurance*. Your insurance under the group portability policy will be a continuation of your insurance and your dependent insurance, if any, under this *policy* and all benefits, limitations and exclusions under this *policy* will continue to apply to your insurance and your dependent insurance, if any, under the group portability policy.

You are not eligible to *port* if the *critical illness insurance* ends because you did not pay your share of the premium.

You must apply and pay the premium within 31 days after your coverage ends. No *proof of good health* is required.

If you or your *covered dependent* is *diagnosed* with a covered *critical illness* or undergoes a *procedure* within 31 days after your *critical illness insurance* ends, but before you have applied to *port*, we will pay any benefits as if you had *ported*. However, you must pay any premium due. The insurance can be continued under the group portability policy until the later of the day before your 65<sup>th</sup> birthday or 12 months from the date your coverage under the *policy* ends.

We will notify you of the amount of premium due, the frequency of premium payments and the premium due dates. If any premium is not paid when due, you will have a 31 day grace period. Insurance will end at the end of the grace period if you fail to make the required premium payment within that time. We will not change the premium rate more than once in any period of 6 consecutive months and we will give you 31 days advance written notice of any change in rates.

### Assignment

Neither you nor your *covered dependent* can assign any of the *critical illness insurance* benefits.

## CLAIM PROVISIONS FOR CRITICAL ILLNESS INSURANCE

### Payment of Benefits

We will pay benefits within 30 days from when we receive all the required proof of covered loss.

### To Whom Payable

We will pay all benefits to you. However, if medical evidence indicates that a legal guardian should be appointed, we will hold further benefits due until such time as a guardian of your estate is appointed and we will pay benefits to such guardian at that time. If any amount remains unpaid when you die, we will pay your estate.

Any amount we pay in good faith releases us from further liability for that amount.

### Authority

The *policyholder* delegates to us and agrees that we have the authority to determine eligibility for participation or benefits and to interpret the terms of the *policy*.

In addition, our authority includes, but is not limited to, the following:

- the right to resolve all matters when a review has been requested; and
- the right to establish and enforce rules and procedures for the processing of claims and administration of the *policy*.

However, this provision will not restrict any right you may have to pursue an internal appeal or file a lawsuit if your claim for benefits is denied.

### Filing a Claim

You must send us notice of the claim. We must have written notice of any insured loss within 30 days after it occurs, or as soon as reasonably possible. You can send the notice to our *home office*, to one of our regional group claims offices, or to one of our agents or administrators. We need enough information to identify you as a *covered person*.

Within 15 days after the date of your notice, we will send you certain claim forms. The forms must be completed and sent to our *home office* or to one of our regional group claims offices. If you do not receive the claim forms within 15 days, we will accept a written description of the exact nature and extent of the loss.

The time limit for filing a claim is 90 days after the date of the loss, *treatment* or service.

### Proof of Loss

Written proof of loss must be furnished to our *home office*, to one of our regional group claims offices, or to one of our agents or administrators within 90 days after the occurrence or commencement of any covered loss.

In the case of claims for loss for which this *policy* provides any periodic payment contingent upon continuing loss, proof of loss must be furnished within 90 days after the termination of the period for which we are liable. 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.

You must provide us with all of the information we specify as necessary to determine proof of loss and decide our liability. This may include but is not limited to medical records, *hospital* records, pharmacy records, test results, therapy and office notes, mental health progress notes, medical exams and consultations, tax returns, business records, payroll and attendance records, billing records, invoices, receipts, police reports and investigative reports.



## CLAIM PROVISIONS FOR CRITICAL ILLNESS INSURANCE (continued)

You must provide us with a written authorization allowing the sources of medical, vocational, occupational, financial, and governmental information to release documents to us which enables us to decide our liability. If you do not provide us with the items and authorization necessary to allow us to determine our liability, we will not pay benefits.

### Right to Examine or Interview

We may ask you or your *covered dependent* to be examined as often as we require at any time we choose. We may require you or your *covered dependent* to be interviewed by our authorized representative. We will pay third party charges for any independent medical exam or interview which we require. If you or your *covered dependent* fails to attend or fully participate we will not pay benefits.

### Limit on Legal Action

No action at law or in equity may be brought against the *policy* until at least 60 days after you file proof of loss. No action can be brought after the applicable statute of limitations has expired, but, in any case, not after 3 years from the date of loss.

### Review Procedure

You must request, in writing, a review of a denial of your claim within 180 days after you receive notice of denial.

You have the right to review, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits, and you may submit written comments, documents, records and other information relating to your claim for benefits.

We will review your claim after receiving your request and send you a notice of our decision within 30 days after we receive your request or within 60 days if special circumstances require an extension. We will state the reasons for our decision and refer you to the relevant provisions of the *policy*. We will also advise of further appeal rights, if any.

### Incontestability

The validity of the *policy* cannot be contested after it has been in force for 2 years, except if premiums are not paid.

Any statement made by the *policyholder* or a *covered person* will be considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to the *covered person*.

No statement, except fraudulent misstatement, made by a *covered person* about insurability will be used to deny a claim for a loss incurred after coverage has been in effect for 2 years.

No claim for loss starting 2 or more years after the *covered person's* effective date may be reduced or denied because a disease or physical condition existed before the person's effective date, unless the condition was specifically excluded by a provision in effect on the date of loss.

### Overpayment

We have the right to recover any overpayments due to:

- fraud; or
- any administrative error we make in processing a claim.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

**CLAIM PROVISIONS FOR CRITICAL ILLNESS INSURANCE (continued)**

We will not recover more money than the amount we paid you. However, we reserve the right to recover any prior or current overpayment from a claim under the *policy*.

## GENERAL PROVISIONS

### Entire Contract

The *policy* and the *policyholder's* application attached to it are the entire contract. Any statement made by you or the *policyholder* is considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to you.

### Errors

An error in keeping records will not cancel insurance that should continue; nor will it continue insurance that should end. We will adjust the premium, if necessary, but not beyond 3 years before the date the error was found. If the premium was overpaid, we will refund the difference. If the premium was underpaid, the difference must be paid to us.

### Misstatements

If any information about you or the *policyholder's* plan is misstated or altered after the application is submitted, including information with respect to participation or who pays the premium and under what circumstances, the facts will determine whether insurance is in effect and in what amount. We will retroactively adjust the premium.

### Certificates

We will send certificates to the *policyholder* to give to each *covered person*. The certificate will state the insurance to which the person is entitled. It does not change the provisions of the *policy*.

### Workers' Compensation

The *policy* is not in place of, and does not affect any state's requirements for coverage by Workers' Compensation insurance.

### Agency

Neither the *policyholder*, any employer, any *associated company*, nor any administrator appointed by the foregoing is our agent. We are not liable for any of their acts or omissions.

### Fraud

It is unlawful to knowingly provide false, incomplete or misleading facts or information with the intent of defrauding us. An application for insurance or statement of claim containing any materially false or misleading information may lead to reduction, denial or termination of benefits or coverage under the *policy* and recovery of any amounts we have paid.

## HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL, DENTAL AND VISION INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice applies to our HIPAA covered healthcare plans, including dental, vision, cancer only, hospital indemnity, and critical illness.

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### I. Our Commitment

Union Security Insurance Company, Union Security Life Insurance Company of New York, and the prepaid dental companies\* are committed to protecting the personal information entrusted to us by our customers. The trust you place in us when you share your personal information is a responsibility we take very seriously and is the cornerstone of how we conduct our business.

The Health Insurance Portability and Accountability Act (HIPAA) provides guidelines and standards to follow when we use or disclose your Protected Health Information (PHI). This law also gives you, our customer, numerous rights regarding your ability to see, inspect, and copy your PHI. Because our commitment to privacy means complying with all privacy laws, we are providing you this notice outlining our privacy practices. The following information is intended to help you understand what we can and cannot do with your PHI and what your rights are under HIPAA.

### II. Our Use and Disclosure of Your PHI

HIPAA allows us to use and disclose your PHI for treatment, payment, and healthcare operations without asking your permission. For instance, we may disclose information to a healthcare provider to assist the provider in properly treating you or a dependent (Treatment). We may disclose certain information to the healthcare provider in order to properly pay a claim or to your employer in order to collect the correct premium amount (Payment). We may disclose your information in order to help us make the correct underwriting decision or to determine your eligibility (Operations).

Other examples of possible disclosures for purposes of healthcare operations include:

- Underwriting our risk and determining rates and premiums for your healthcare plan;
- Determining your eligibility for benefits;
- Reviewing the competence and qualifications of healthcare providers;
- Conducting or arranging for review, legal services, and auditing functions, including fraud and abuse detection and compliance;
- Business planning and development;
- Business management and general administrative duties such as cost-management, customer service, and resolution of internal grievances;
- Other administrative purposes.

We can also make disclosures under the following circumstances without your permission:

- As required by law, including response to court and administrative orders, or to report information about suspected criminal activity;
- To report abuse, neglect, or domestic violence;
- To authorities that monitor our compliance with these privacy requirements;
- To coroners, medical examiners, and funeral directors;
- For research and public health activities, such as disease and vital statistic reporting;

- To avert a serious threat to health or safety;
- To the military, certain federal officials for national security activities, and to correctional institutions;
- To the entity sponsoring your group healthcare plan but only for purposes of enrollment, disenrollment, eligibility or for the purpose of giving the plan sponsor summary information when necessary to help make decisions regarding changes to the plan. If the plan sponsor has certified that its plan documents have been amended to include certain privacy provisions, we may also disclose protected health information to the plan sponsor to carry out plan administration functions that the plan sponsor performs on behalf of the plan;
- To a spouse, family member, or other personal representative if they can show they are assisting in your care or payment of your care and then, without an authorization, only basic information about the status or payment of a claim.

**Unless you give us written authorization, we cannot use or disclose your PHI for any reason except as otherwise described in this notice**, including uses and disclosures of psychotherapy notes, uses and disclosures of protected health information for marketing purposes, and disclosures that constitute the sale of protected health information. We are prohibited from using or disclosing your protected health information that is genetic information for underwriting purposes. You may revoke your written authorization at any time by writing us at the address indicated at the end of this notice.

### III. Your Individual Rights

You have the following rights with regard to your Protected Health Information:

- **To Restrict our Use or Disclosure.** You have the right to ask us to limit our use or disclosure of your PHI. While we will consider your request, we are not legally required to agree to the additional restrictions. If we do agree to all or part of your request, we will inform you in writing. We cannot agree to limit any use and disclosure of your PHI if the use or disclosure is required by law.
- **To Access your PHI.** You have the right to view and/or copy your PHI at any time by contacting us. If you want copies of your PHI, or want your PHI in a special format, we may charge you a fee. You have a right to choose what portions of your PHI you want copied and to have prior notice of copying costs. If for some reason we deny your request for access to your PHI, we will provide a written explanation of why your request was denied and explain how you can appeal the denial.
- **To Amend your PHI.** You have the right to amend your PHI, if you believe it is incomplete or inaccurate. Your request must be in writing, with an explanation of why you feel the information should be amended. If we approve your request to amend your PHI, we will make reasonable efforts to inform others, including people you name, about the amendment to your PHI. We may deny your request for various reasons, for example, if we determine that the information is correct and complete, or if we did not create the information. If we deny your request, we will provide you a written explanation of our decision. We also will explain your rights regarding having your request and our response included with all future disclosures of your PHI.
- **To Obtain an Accounting of our Disclosures.** You have the right to receive a listing from us of all instances in the past six years in which we or our business associates have disclosed your PHI for purposes other than treatment, payment, health care operations, or as authorized by you. The accounting will tell you the date we made the disclosure, the name of the person or entity to whom the disclosure was made, a description of the PHI that was disclosed, and the reason for the disclosure. There may be a charge for accounting disclosures if requested more than once a year.
- **To Request Alternative Communications.** You have the right to ask us to communicate with you about your confidential information by a different method or at another location. We will accommodate all reasonable requests.

- **To Be Notified of a Breach:** You will be notified in the event that unsecured protected health information is compromised.
- **To Receive Notice.** You are entitled to receive a copy of this notice that outlines our HIPAA privacy practices. We reserve the right to change these practices and the terms of this notice at any time. We will not make any material changes to our privacy practices without first sending you a revised notice. If you receive this notice on our web site or by electronic mail, you may request a paper copy.

#### IV. Who to Contact for Questions and Complaints

If you want more information about our privacy practices, wish to exercise any of your rights with regard to your PHI, or have any questions about the information in this notice, please use the contact information below. If you believe we may have violated your privacy rights, or if you disagree with a decision that we made in connection with your PHI, you may file a complaint using the contact information below. You may also submit a written complaint to the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights. You may locate the regional office nearest to you by visiting their web site, <http://www.hhs.gov/ocr/>. We fully support your right to the privacy of your PHI, and will not retaliate in any way if you choose to file a complaint.

Mailing Address: **Sun Life Financial**  
 Privacy Officer  
 P.O. Box 419052  
 Kansas City, MO 64141-6052

Telephone: 800.733.7879  
 Email: SLF\_US\_Privacy@sunlife.com  
 Web Site: www.sunlife.com/us

#### For New York business:

Mailing Address: **Union Security Life Insurance  
 Company of New York**  
 Privacy Officer  
 Administered by:  
**Sun Life Financial**  
 P.O. Box 419052  
 Kansas City, MO 64141-6052

Telephone: 888.901.6377  
 Email: SLF\_US\_Privacy@sunlife.com

#### V. Organizations Covered by This Notice

This notice applies to the privacy practices of the organizations referenced below. These organizations may share your PHI with each other as needed for payment activities or health care operations relating to the healthcare plans that we provide.

#### VI. Effective Date of This Notice: April 14, 2003. Revised: October 21, 2016

**\* In this notice, “we,” “us,” and “our” refer to Union Security Insurance Company, Union Security Life Insurance Company of New York and the following prepaid dental companies:** DentiCare of Alabama, Inc., Union Security DentalCare of Georgia, Inc., UDC Dental California, Inc., UDC Ohio, Inc., United Dental Care of Arizona, Inc., United Dental Care of Colorado, Inc., United Dental Care of Michigan, Inc., United Dental Care of Missouri, Inc., United Dental Care of New Mexico, Inc., United Dental Care of Texas, Inc., United Dental Care of Utah, Inc., Union Security DentalCare of New Jersey, Inc.

Insurance products are underwritten by Union Security Insurance Company (USIC) (Kansas City, MO) and administered by Sun Life Assurance Company of Canada (SLOC) (Wellesley Hills, MA) in all states except New York. Prepaid dental products are provided by USIC and are administered by SLOC, and are provided by prepaid dental companies affiliated with SLOC in certain states except New York. Prepaid dental companies are

Denticare of Alabama, Inc., United Dental Care of Arizona, Inc., UDC Dental California, Inc., United Dental Care of Colorado, Inc., Union Security DentalCare of Georgia, Inc., United Dental Care of Missouri, Inc., Union Security DentalCare of New Jersey, Inc., United Dental Care of New Mexico, Inc., UDC Ohio, Inc., United Dental Care of Texas, Inc., and United Dental Care of Utah, Inc. In New York, insurance products and prepaid dental products are underwritten or provided by Union Security Life Insurance Company of New York (Fayetteville, NY) and administered by Sun Life and Health Insurance Company (U.S.) (Lansing, MI).

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## SUMMARY PLAN DESCRIPTION

This Summary Plan Description is issued to you in compliance with the Employee Retirement Income Security Act of 1974 (ERISA). Included within this document is your Certificate of Insurance, issued by Union Security Insurance Company in compliance with state law. Your Summary Plan Description does not replace or modify the Master Policy issued by Union Security Insurance Company in any way. The Master Policy is the contract which sets forth the terms and conditions of the benefits the Plan Sponsor chose to provide in its welfare benefit plan. The Master Policy may be amended at any time by agreement between the Plan Sponsor and Union Security Insurance Company. The Master Policy may be terminated at any time by the Plan Sponsor or may be terminated by Union Security Insurance Company for non-payment of premium or for failure to meet the Master Policy's minimum participation requirements. The Plan Administrator has the obligation to prepare, issue, amend and file the Summary Plan Description (SPD) and is solely responsible for its contents.

### GENERAL ADMINISTRATIVE PROVISIONS

**Name of the Plan:**

Goodwill Industries of Western Missouri & Eastern Kansas

**Plan Sponsor:**

Goodwill Industries of Western Missouri & Eastern Kansas  
1817 Campbell St  
Kansas City, MO 64108  
816.842.7425

**Employer I.D. Number:**

43-1125281

**Type of Plan:**

An employee welfare plan providing benefits for:

Critical Illness Insurance  
Critical Illness Insurance for Dependents

**Plan Number:**

PN501 unless another number is assigned by the employer, the Plan Administrator, or on any Form 5500 filed for the Plan.

**Effective Date:**

The plan, as described in this SPD, became effective on January 1, 2014.

Any italicized terms are defined in the certificate, which is hereby incorporated by reference.

**Who Is Eligible:**

**Eligible Class:** For employee insurance - Each full-time employee of the *policyholder* or an *associated company*,

- who is at *active work*, and
- who is working in the United States of America,

as identified on the *policyholder's* or our records, except any temporary or seasonal worker.

For dependent insurance - Each *eligible dependent* of a person eligible and insured for employee insurance.

**Service Requirement:** 60 day(s)



**Entry Date:** An eligible person will become insured on the first of the month occurring on or after the day all eligibility requirements are met.

Full-time means working at least 20 hours per week.

The plan may also cover other persons not included above. Check with the plan administrator.

**Plan Administrator:**

Goodwill Industries of Western Missouri & Eastern Kansas  
Michelle Bower  
1817 Campbell St  
Kansas City, MO 64108  
816.842.7425

**Type of Administration:**

This plan is insured by a contract with Union Security Insurance Company, 2323 Grand Boulevard, Kansas City, Missouri 64108-2670.

**Amendment or Termination of Plan:**

This plan may be amended or terminated at any time by the Plan Sponsor.

**Agent for Service of Legal Process:**

Goodwill Industries of Western Missouri & Eastern Kansas  
Michelle Bower  
1817 Campbell St  
Kansas City, MO 64108  
816.842.7425

**Plan Records:**

The fiscal records for the plan are kept on a policy year basis ending on the last day of December each year.

**Cost of Benefits:**

The premiums for the Critical Illness Insurance plan for employees are paid for entirely by you.

The premiums for the Critical Illness Insurance for Dependents plan are paid for entirely by you.

**Your plan includes:**

Critical Illness Insurance  
Critical Illness Insurance for Dependents

The benefits, limitations and exclusions are described in the Certificate which is found within this Description.

## STATEMENT OF ERISA RIGHTS

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

- (i) Examine, without charge at the plan administrator's office and at other specified locations such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and, if required, a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- (ii) Obtain, upon written request to the plan administrator, copies of all documents governing the plan, including insurance contracts and collective bargaining agreements, and, if required, copies of the latest annual report (Form 5500 Series) and the updated summary plan description. The administrator may make a reasonable charge for the copies.
- (iii) Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.
- (iv) Obtain, without charge, a copy of the plan's procedures governing qualified medical child support order determinations.
- (v) Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate our plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for welfare benefits is denied in whole or in part you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request certain materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court may decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and legal fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

### Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group Critical Illness coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights.

The Plan Administrator is responsible for administering COBRA continuation coverage.

### COBRA Continuation Coverage

COBRA continuation coverage is a continuation of the Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

Your dependent spouse will become a qualified beneficiary if your dependent spouse loses coverage under the Plan because any of the following qualifying events happens:

1. You die;
2. Your hours of employment are reduced;
3. Your employment ends for any reason other than gross misconduct; or
4. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1. You die;
2. Your hours of employment are reduced;
3. Your employment ends for any reason other than gross misconduct;
4. You become divorced or legally separated; or
5. The child stops being eligible for coverage under the Plan as a "dependent child".

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, or death of the employee, the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to the Plan Administrator.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of your employment or reduction of your hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

### **Disability Extension of 18-month Period of Continuation Coverage**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the Plan Administrator.

### **Second Qualifying Event Extension of 18-month Period of Continuation Coverage**

If your family experiences another qualifying event while receiving COBRA continuation coverage, your spouse and dependent children can receive additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to your spouse and dependent children if you die or you get divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator.

### **If You Have Questions**

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

### **Keep Your Plan Informed of Address Changes**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## **CLAIMS PROCEDURE**

The following procedures apply to the extent benefits under your employee benefit plan are insured under a contract issued by Union Security Insurance Company.

### **PRESENTING A CLAIM**

Contact your plan administrator, who will advise you of any forms which are required. These forms should be returned to the Plan Administrator after completion. This Administrator will review them, complete any information concerning eligibility and forward them to Union Security Insurance Company. Time limits for filing the claim and other requirements for notice and proof of loss may be found under the heading, "Filing A Claim".

### **NOTIFICATION OF DECISION— CRITICAL ILLNESS**

A decision will be made within 30 days after receipt by Union Security Insurance Company of a properly executed, complete proof of loss, unless special circumstances beyond the control of the Plan require an extension of time for processing the claim. Such an extension of time may not exceed 15 additional days. If the claim is denied in whole or in part, Union Security Insurance Company will provide written notice either directly to you or to the Plan Administrator for delivery to you. The written notice will contain:

1. The specific reason or reasons for the denial;
2. Specific reference to pertinent provisions of the policy upon which the decision is based;
3. A description of any additional material or information needed to perfect the claim and an explanation of why it is necessary; and
4. An explanation of the plan's claim review procedure.

### **AUTHORITY**

The Plan Sponsor delegates to Union Security Insurance Company and agrees that Union Security Insurance Company has the authority to determine eligibility for participation or benefits and to interpret the terms of the Policy.

In addition, Union Security Insurance Company's authority includes, but is not limited to, the following:

- the right to resolve all matters when a review has been requested; and
- the right to establish and enforce rules and procedures for the processing of claims and administration of the Policy.

However, this provision will not restrict any right you may have to pursue an internal appeal or file a lawsuit if your claim for benefits is denied.

### **REVIEW PROCEDURE—CRITICAL ILLNESS**

You are entitled to a full and fair review of denial of claim. You may make a request to the Plan Administrator or appropriate named fiduciary, if other than the Plan Administrator. The procedure is as follows:

1. The request for review must be in writing and made within 180 days of receipt of written notice of denial;
2. You may review, upon request and free of charge, copies of all documents, records, and other information relevant to the claim for benefits. You have the right to review copies of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making our decision to deny your claim. You have the right to request that we identify all medical experts whose advice was obtained on behalf of the plan;

3. You have the right to submit issues and comments in writing, along with additional documents, records, and other information relating to the claim;
4. If our decision is based on medical necessity or experimental treatment or similar exclusion or limit, you have the right to an explanation of the scientific or clinical judgement for the determination, which will be provided upon request and free of charge;
5. The Plan Administrator will forward the request to Union Security Insurance Company;
6. Union Security Insurance Company will make a decision upon review within 60 days after receipt of the request. The decision on review will be in writing, include the specific reasons for the decision and specific references to the pertinent plan provisions on which the decision is based and be furnished either directly to you or to the Plan Administrator for delivery to you.



**Union Security Insurance Company**  
2323 Grand Boulevard  
Kansas City, MO 64108

Policy 5469055  
Participant 0  
Booklet 2  
2/28/2018