

## Critical Illness

### Definitions

Please note that certain words used in this Certificate have specific meanings. Other than references to he, him, his, you, your, yours, we, us or our, the words defined below and capitalized within the text of this Certificate have the meanings set forth below. The definitions listed here are standard for HM Life Insurance Company's Worksite products. State-specific and employer-specific variations may apply.

**Active Service** means that the Covered Employee is either:

- at work on one of the Employee's scheduled workdays and is performing his regular duties on a scheduled basis, either at one of the Employer's usual places of business or at some other location to which the Employer's business requires him to travel;
- on a scheduled holiday or vacation day or period of Employer-approved paid leave of absence, only if the Employee was in Active Service on the preceding scheduled workday.

A Covered Person is considered in Active Service if he is not one of the following:

- an inpatient in a Hospital, skilled nursing facility, rehabilitation hospital or convalescent/personal care facility or receiving outpatient care and/or therapy that affects a Covered Person's ability to perform his regular duties on a scheduled basis;
- confined at home under the care of a Physician or Doctor for a treatment of an Injury or Sickness; or
- totally disabled.

**Affiliate or Affiliated** means a company or organization that is subsidiary to, affiliated with or controlled by the Policyholder.

**Cancer** has the following meanings:

**Invasive Cancer** means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of distant tissue. Cancer includes Leukemia. Excluded are Cancers such as:

- pre-malignant tumors or polyps;
- Carcinoma in Situ (non-invasive);
- Skin Cancer, melanoma diagnosed as Clark's Level I or II or Breslow less than .77mm, basal cell carcinoma and squamous cell carcinoma of the skin; and
- Stage 1 Hodgkin's Disease and Stage A Prostate Cancer.

**Carcinoma in Situ** means Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

**Skin Cancer** means melanoma that is diagnosed as Clark's Level III, IV or V, or Breslow greater than .77 mm. Excluded are melanoma diagnosed as Clark's Level I or II or Breslow less than .77mm, basal cell carcinoma and squamous cell carcinoma of the skin.

Cancer also is defined as Cancer that meets the diagnosis criteria of malignancy established by The American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue or specimen.

Cancer, and/or Carcinoma in Situ and/or Skin Cancer, must be diagnosed in one of two ways:

- Pathological Diagnosis – A Pathological Diagnosis of Cancer or Carcinoma in Situ is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a Certified Pathologist whose diagnosis of malignancy is in keeping with the standards set up by the American Board of Pathology.
- Clinical Diagnosis – A Clinical Diagnosis of Cancer or Carcinoma in Situ is based on the study of symptoms. We will pay benefits for a Clinical Diagnosis only if:
  - a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening; and
  - there is medical evidence to support the diagnosis; and
  - a doctor is treating a Covered Person for Cancer, Carcinoma in Situ and/or Skin Cancer.

**Certificate** means the document issued for delivery to the Covered Person that lists the benefits, conditions and limits of the Policy.

**Coma** means a profound state of unconsciousness that lasts for a period of 30 consecutive days and from which the Covered Person cannot be aroused to consciousness, even by powerful stimulation, as determined by a Physician. The Diagnosis of Coma must indicate that a permanent neurological deficit is present.

**Company or we, us, or our** means HM Life Insurance Company, domiciled in Pennsylvania.

**Coronary Artery Bypass** means undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, but excluding procedures such as, but not limited to, balloon angioplasty, laser relief, stents or other non-surgical procedures. The diagnosis of the condition that necessitates the need for a Coronary Artery Bypass must be made by a cardiologist and based on angiographic evidence of the underlying disease.

**Covered Person** means an Employee, spouse, Domestic Partner or Dependent child for whom an enrollment form has been accepted by us; the required premium has been paid when due; and for whom coverage under this Policy remains in force. If the Employee is shown in the Schedule of Benefits of the Certificate, we insure the Employee. Dependents are insured if either spouse, Domestic Partner or Dependent child(ren) are shown in the Schedule of Benefits.

**Date of Diagnosis.** The date of diagnosis is:

- For Cancer, Carcinoma in Situ and/or Skin Cancer: The day the tissue specimen, blood samples and/or titer(s) are taken on which the first diagnosis of Cancer or Carcinoma in Situ is based.
- For Heart Attack: The date that the death (infarction) of a portion of the heart muscle occurred based on the criteria listed under the Myocardial Infarction (Heart Attack) definition.
- For Stroke: The date a Stroke occurred as determined by a licensed neurologist and based on documented neurological deficits and confirmatory neuroimaging studies.
- For End-stage Renal Disease: The date a physician recommends that a Covered Person qualifies for Medicare coverage for End-stage Renal Disease.
- For Major Organ Transplant surgery: The date the surgery occurs for a transplant.
- For Coronary Artery Bypass open heart surgery: The date the surgery occurs for Coronary Artery Bypass surgery.
- For all other conditions: The date a Physician in the applicable field of medicine determines a Covered Critical Illness.

**Dependent** means the Employee's:

- spouse, unless such spouse is eligible as an Employee; and
- Domestic Partner, unless such person is eligible as an Employee; and
- unmarried natural child or stepchild, unless such child is eligible for medical coverage as an Employee and who:
  - is less than 19 years old; or
  - is unmarried, under 25 years of age and attends an accredited educational institution as a full-time student; or
  - becomes incapable of self-support because of mental retardation or physical handicap before reaching the limiting age for Dependent children. The Company must receive proof of incapacity within 31 days after coverage would otherwise terminate. This insurance will continue for as long as the Employee's insurance stays in force and the child remains incapacitated. Additional proof may be required from time to time but not more often than once a year after the child attains age 19.

This term includes a child who:

- is living with the Employee in a parent-child relationship; or
- is adopted by, placed for adoption with or is party in a suit for adoption by the Employee; or
- is required to be provided coverage by the Covered Person or his spouse or Domestic Partner under the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO also will include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under and having the force and effect of state law and which satisfies the QMCSO requirements of ERISA.

**Domestic Partner** means a person of the same or the opposite sex who:

- is not married or legally separated;
- has not been party to an action or proceeding for divorce or annulment within the last six months or has been a party to such an action or proceeding and at least six months have elapsed since the date of the judgment terminating the marriage;
- is not currently registered in a Domestic Partnership with a different Domestic Partner and has not been in such a relationship for at least six months;
- occupies the same residence as the Employee;
- has not entered into a Domestic Partnership relationship that is temporary, social, political, commercial or economic in nature; and
- has entered into a Domestic Partnership Arrangement with the Employee.

**Domestic Partnership Arrangement** means the Employee and another person of the same or the opposite sex have any three of the following in common (documentation may be requested to the extent allowed by the city, county or state in which you reside):

- joint lease, mortgage or deed;
- joint ownership of a vehicle;
- joint ownership of a checking account or credit account;
- designation of the Domestic Partner as a beneficiary for the Employee's life insurance or retirement benefits;
- designation of the Domestic Partner as a beneficiary of the Employee's will;
- designation of the Domestic Partner as holding power of attorney for health care; or
- shared household expenses.

**Eligibility Waiting Period** means the period of time that must lapse before an Employee is eligible for this insurance. It will be extended by the number of days the Employee is not in Active Service. We will not pay benefits for a Specified Critical Illness that begins during the Eligibility Waiting Period or a Health Screening performed during such period.

**Employee** means an Employee of the Policyholder who works an average of 15 hours per week.

**End-stage Renal Disease** (Kidney Failure) means End-stage Renal Disease presenting as chronic, irreversible failure of one or both kidneys to function. The Kidney Failure must necessitate regular renal dialysis, hemodialysis or peritoneal dialysis (at least weekly) or result in kidney transplantation. End-stage Renal Disease is covered, provided it is not caused by a traumatic event, including surgical traumas. The diagnosis of End-stage Renal Disease must be based on chronic irreversible failure of the function of at least one kidney requiring regular hemodialysis or necessitating a kidney transplant.

Provide **Evidence of Insurability** means a Covered Person must:

- complete and sign our enrollment form;
- provide any additional reasonable information about his insurability that we request

**Guaranteed Issue Benefit Amount** means the maximum Benefit Amount available to a Covered Person without providing Evidence of Insurability.

**He, him or his** means an individual, male or female.

**Hospital** means an institution that meets all of the following:

- it is licensed pursuant to applicable law; it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
- it is managed under the supervision of a staff of legally licensed physicians;
- it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);
- it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises or available on a prearranged basis;
- it charges for its services.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:

- rehabilitation, convalescent or custodial care; or
- the aged.

**Illness** means a bodily disorder or disease that:

- is first manifested while the Covered Person is insured under the Certificate and after any applicable Eligibility Waiting Period;
- is not subject to the Pre-Existing Condition Limitation; and
- is not otherwise excluded under the terms of the Certificate.

**Loss of Sight, Speech or Hearing** means the irreversible loss of sight in both eyes, the irreversible loss of the ability to speak or the irreversible loss of hearing for all sounds in both ears. The diagnosis of:

- Loss of Sight, Speech or Hearing must be made by a licensed professional or specialist in the applicable field of medicine.
- Loss of Sight must indicate that corrective visual acuity is greater than 20/200 in both eyes or the field of vision is less than 200 degrees in both eyes.
- Loss of Speech must include documented evidence of the illness for the continuous 12-month period prior to the diagnosis.
- Loss of Hearing must be established by an audiometric and auditory threshold test. The auditory threshold cannot be more than 90 decibels while utilizing a hearing aid.

**Major Organ Transplant** means undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney or pancreas. This term does not include animal-to-human transplants; transplants of human-to-human organs other than a human heart, lung, liver, kidney or pancreas; tissue transplants (corneas, skin, heart valves, bone, tendons, ligaments, cartilage and bone marrow); or a human-to-human transplant of a uterus, face or hand.

**Myocardial Infarction (Heart Attack)** means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. The diagnosis must include at least three of the following criteria:

- new and serial Electrocardiographic (EKG) findings consistent with Myocardial Infarction;
- elevation of cardiac enzymes above generally accepted laboratory levels of normal in case of creatine phosphokinase (CPK) – a CPK-MB measurement must be used;
- confirmatory imaging studies such as thallium scans, MUGA scans or stress echocardiograms; and
- chest pain.

**Open Enrollment Period** means a period of time agreed upon by the Policyholder and the Company during which an Employee may apply for insurance.

**Paralysis** means complete and permanent loss of function of two or more limbs. Paralysis as a result of Stroke is excluded. The Diagnosis of Paralysis must include documented evidence of the illness or injury that caused the Paralysis. As used herein, “limb” means an arm or leg.

**Pathologist** means a Physician other than a Covered Person or a family member who is licensed to practice medicine and who also is licensed to practice pathologic anatomy by the American Board of Pathology. A Pathologist also means an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

**Physician or Doctor** means a licensed health care provider practicing within the scope of his license and rendering care and treatment to a Covered Person that is appropriate for the condition and locality and who is not:

- employed or retained by the Policyholder; or
- living in the Covered Person’s household; or
- a parent, sibling, spouse, Domestic Partner or child of the Covered Person.

**Plan Year** means a period of 12 consecutive months beginning on the policy effective date and subsequent anniversary dates.

**Policyholder** means the entity shown on the cover page of this Policy.

**Specified Critical Illness** means an illness shown in the Schedule of Benefits of the Certificate and as defined.

**Stroke** means a cerebrovascular incident caused by: infarction of brain tissue, cerebral hemorrhage, thrombosis or embolization from an extra-cranial source lasting more than 24 hours that produces measurable evidence of permanent neurological deficit. The following are not considered Strokes:

- transient ischemic attacks (TIAs)\*;
- vertebro-basilar insufficiency;
- incidental findings on imaging studies;
- head injury;
- chronic cerebrovascular insufficiency; and
- reversible ischemic neurological deficits.

*\*A “transient ischemic attack” (TIA) means a neurological condition or event with the signs and symptoms of a Stroke, but which disappear within a short period of time with no residual signs, symptoms, deficits or abnormalities that are revealed or shown on neuroimaging studies.*