# Group Benefits

NOTICE:
If you are age 65 or older on the effective date of your insurance under this Certificate, you may return this Certificate by mail or other delivery method within 30 days after its receipt if it is not acceptable for any reason. We will cancel your insurance under this Certificate back to your effective date of insurance and issue a full refund for any premiums paid.

**Northern California Conference of Seventh-day Adventists**

**Cancer Only**

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: | Trustees of The Services Industry Trust Fund |
| Participating Employer: | Northern California Conference of Seventh-day Adventists |
| Group Policy Number: | 7999989 |
| Participation Number: | 4998325 |
| Effective Date: | See Statement of Coverage form |
| Type of Insurance: | Group *Cancer Only Insurance*<br>Group *Cancer Only Insurance* for Dependents |

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

Tammy L. Schultz

President and
Chief Executive Officer

## SCHEDULE

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

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

as identified on the *participating employer'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:** None

**Service Requirement:** None

**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.

**Cancer Only Insurance**

At the time of enrollment, you may be eligible to select the level of coverage. If you are eligible to select a level of coverage, the level selected must be the same for both you and your *covered dependents*, if any.

Some of the benefits described in the *policy* may not apply depending on the level of coverage selected.

We will pay the benefits corresponding to the level you selected as shown below.

You may change your Plan Level according to the Plan Changes provision below.

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

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

**Maximum Level Without Proof of Good Health:**

*Proof of good health* is required for all levels of coverage.

**Schedule Amount:**

| | **Level I** | **Level II** |
|---|---|---|
| **Cancer Screening:**<br>Limited to once per *benefit year* | $50 | $75 |
| | **Level I** | **Level II** |
| **Hospital Confinement:**<br>Limited to 90 days per *period of hospital confinement* | $200 per day | $400 per day |
| | **Level I** | **Level II** |
| **Radiation and Chemotherapy:** | | |
| **Injected Cytotoxic Medications** | $300 per *week* not to exceed $4,000 per *benefit year* | $1,000 per *week* not to exceed $12,000 per *benefit year* |
| **First Prescription Pump Dispensed Cytotoxic Medications** | $300 per prescription not to exceed $4,000 per *benefit year* | $1,000 per prescription not to exceed $12,000 per *benefit year* |

**SCHEDULE (continued)**

| | | |
|---|---|---|
| **Refill Pump Dispensed Cytotoxic Medications** | $300 per *week* not to exceed $4,000 per *benefit year* | $1,000 per *week* not to exceed $12,000 per *benefit year* |
| **Oral Cytotoxic Medications** | $150 per prescription not to exceed $450 per month | $500 per prescription not to exceed $1,500 per month |
| **Cytotoxic Medications Administration by Any Other Method** | $300 per *week* not to exceed $4,000 per *benefit year* | $1,000 per *week* not to exceed $12,000 per *benefit year* |
| **External Radiation Therapy** | $400 per *week* not to exceed $4,000 per *benefit year* | $600 per *week* not to exceed $12,000 per *benefit year* |
| **Insertion of Interstitial or Intracavity Administration of Radioisotopes or Radium** | $450 per *week* not to exceed $4,000 per *benefit year* | $750 per *week* not to exceed $12,000 per *benefit year* |
| **Oral or I.V. Radiation** | $400 per *week* not to exceed $4,000 per *benefit year* | $600 per *week* not to exceed $12,000 per *benefit year* |
| | **Level I** | **Level II** |
| **In-hospital Blood and Plasma:** | $50 | $50 |
| | **Level I** | **Level II** |
| **Outpatient Blood and Plasma:** | $50 | $50 |
| | **Level I** | **Level II** |
| **Extended-care Facility:** Limited to a maximum of 90 days per *benefit year* | $200 per day | $200 per day |
| | **Level I** | **Level II** |
| **Hospice:** Limited to a maximum of 100 days per *lifetime* | $100 per day | $100 per day |
| | **Level I** | **Level II** |
| **In-hospital Doctor Visits:** Limited to a maximum of 75 visits | $25 per daily visit | $25 per daily visit |
| | **Level I** | **Level II** |
| **Post-hospital Doctor Visits:** Limited to once every 6 months not to exceed 5 years after the *diagnosis* of *cancer* | Not Covered | $50 per visit |
| | **Level I** | **Level II** |
| **Prosthesis:** | | |
| **Surgically Implanted Devices** | $2,000 per device not to exceed a *lifetime* maximum of $4,000 | $3,000 per device not to exceed a *lifetime* maximum of $6,000 |
| **Other Devices** | $200 per device not to exceed a *lifetime* maximum of $400 | $300 per device not to exceed a *lifetime* maximum of $600 |

| | Level I | Level II |
|---|---|---|
| **Ambulance Benefit:**<br>Limited to 2 one-way trips per *period of hospital confinement* | $250 | $250 Ground<br>$2,000 Air |

| | Level I | Level II |
|---|---|---|
| **Lodging:**<br>Limited to 1 benefit per day not to exceed a maximum of 90 days per *benefit year* | Not Covered | $100 per day |

| | Level I | Level II |
|---|---|---|
| **Second Surgical Opinion:**<br>Limited to once per surgical procedure | $200 | $200 |

| | Level I | Level II |
|---|---|---|
| **Skin Cancer:** | | |
| **Biopsy only** | $100 | $100 |
| **Reconstructive surgery following previous excision of skin *cancer*** | $250 | $250 |
| **Excision of skin *cancer* without flap or graft** | $375 | $375 |
| **Excision of skin *cancer* with flap or graft** | $600 | $600 |

**Surgery and General Anesthesia for Internal Cancer:**

Limited to a combined maximum of $2,000 for Level I for one operation
Limited to a combined maximum of $7,500 for Level II for one operation

| Procedure | Level I & II General Anesthesia Benefit | Level I & II Surgical Benefit |
|---|---|---|
| Mandible - Mandibulectomy | $760 | $2,300 |
| Misc - Pathological hip fracture | $400 | $1,200 |
| Breast - Needle biopsy | $50 | $150 |
| Breast - Excisional biopsy | $50 | $150 |
| Breast - Lumpectomy | $100 | $300 |
| Breast - Mastectomy partial | $100 | $300 |
| Breast - Mastectomy simple | $180 | $550 |
| Breast - Mastectomy radical | $400 | $1,200 |
| Throat - Laryngectomy (without neck dissection) | $365 | $1,100 |
| Throat - Laryngectomy (with neck dissection) | $730 | $2,200 |
| Throat - Laryngoscopy | $50 | $150 |
| Throat - Tracheostomy | $50 | $150 |
| Chest - Bronchoscopy | $70 | $200 |
| Chest - Thoracentesis | $50 | $150 |
| Chest - Thoracostomy | $50 | $150 |
| Chest - Thoracotomy | $165 | $500 |
| Chest - Pneumonectomy | $400 | $1,200 |

**Surgery and General Anesthesia for Internal Cancer:**

Limited to a combined maximum of $2,000 for Level I for one operation
Limited to a combined maximum of $7,500 for Level II for one operation

| Procedure | Level I & II General Anesthesia Benefit | Level I & II Surgical Benefit |
|---|---|---|
| Chest - Lobectomy | $365 | $1,100 |
| Chest - Wedge resection | $250 | $750 |
| Misc - Venous-catheters/venous port (chemo) | $50 | $150 |
| Misc - Bone marrow biopsy or aspiration | $50 | $150 |
| Lymphatic - Splenectomy | $225 | $675 |
| Lymphatic - Excision or biopsy of a single lymph node | $60 | $175 |
| Lymphatic - Lymphadenectomy (bilateral) | $365 | $1,100 |
| Lymphatic - Lymphadenectomy (unilateral) | $255 | $775 |
| Lymphatic - Axillary node dissection | $215 | $650 |
| Chest - Mediastinoscopy | $100 | $300 |
| Mouth - Hemiglossectomy | $115 | $350 |
| Mouth - Glossectomy | $430 | $1,300 |
| Mouth - Resection of palate | $200 | $600 |
| Salivary glands - Biopsy | $50 | $150 |
| Salivary glands - Parotidectomy | $300 | $900 |
| Salivary glands - Radical neck dissection | $730 | $2,200 |
| Mouth - Tonsil/Mucous membranes | $290 | $875 |
| Esophagus - Resection of esophagus | $305 | $925 |
| Esophagus - Esophagoscopy | $50 | $150 |
| Stomach - Gastroscopy | $75 | $225 |
| Intestines - ERCP | $135 | $400 |
| Esophagus - Esophagogastrectomy | $1,155 | $3,500 |
| Stomach - Gastrectomy (complete) | $430 | $1,300 |
| Stomach - Gastrectomy (partial) | $325 | $975 |
| Stomach - Gastrojejunostomy | $265 | $800 |
| Intestines - Resection of small intestine | $305 | $925 |
| Intestines - Colectomy | $265 | $800 |
| Intestines - Ileostomy | $250 | $750 |
| Intestines - Colostomy/or revision of | $200 | $600 |
| Intestines - Excesional on rectum for biopsy | $70 | $200 |
| Intestines - Abdominal-perineal resection | $400 | $1,200 |
| Intestines - Proctosigmoidoscopy | $50 | $150 |
| Intestines - Sigmoidoscopy | $50 | $150 |
| Intestines - Colonoscopy (does not include virtual or CT Colonography) | $85 | $250 |
| Liver - Needle biopsy | $50 | $150 |
| Liver - Wedge biopsy | $175 | $525 |
| Liver - Resection of liver | $1,090 | $3,300 |
| Abdomen - Cholecystectomy | $250 | $750 |
| Pancreas - Pancreatectomy | $400 | $1,200 |
| Pancreas - Whipple procedure | $1,520 | $4,600 |
| Pancreas - Jejunostomy | $530 | $1,600 |
| Abdomen - Exploratory laparotomy | $175 | $525 |
| Abdomen - Paracentesis | $50 | $150 |
| Kidney - Nephrectomy (simple) | $300 | $900 |

**Surgery and General Anesthesia for Internal Cancer:**

Limited to a combined maximum of $2,000 for Level I for one operation
Limited to a combined maximum of $7,500 for Level II for one operation

| Procedure | Level I & II General Anesthesia Benefit | Level I & II Surgical Benefit |
|---|---|---|
| Kidney - Nephrectomy (radical) | $530 | $1,600 |
| Bladder - Cystectomy (partial) | $250 | $750 |
| Bladder - Cystectomy (complete) | $1,485 | $4,500 |
| Bladder - Cystectomy (with ureteroileal conduit) | $1,815 | $5,500 |
| Prostate - Cystoscopy | $50 | $150 |
| Bladder - Cystoscopy | $50 | $150 |
| Bladder - (TUR) transurethral resection bladder tumors | $135 | $400 |
| Prostate - (TUR) transurethral resection prostate | $265 | $800 |
| Penis - amputation, partial | $175 | $525 |
| Penis - amputation, complete | $265 | $800 |
| Penis - amputation, radical | $430 | $1,300 |
| Testis - Orchiectomy (unilateral) | $110 | $325 |
| Testis - Orchiectomy (bilateral) | $165 | $500 |
| Prostate - Needle biopsy | $50 | $150 |
| Prostate - Radical prostatectomy | $565 | $1,700 |
| Vulva - Vulvectomy (partial) | $190 | $575 |
| Vulva - Vulvectomy (radical) | $235 | $700 |
| Female Reproductive - Colposcopy | $50 | $150 |
| Female Reproductive - D & C | $60 | $175 |
| Female Reproductive - Abdominal hysterectomy/uterus only | $400 | $1,200 |
| Female Reproductive - Uterus, tubes & ovaries with total pelvic exenteration | $1,650 | $5,000 |
| Female Reproductive - Vaginal hysterectomy/uterus only | $330 | $1,000 |
| Female Reproductive - Oophorectomy | $190 | $575 |
| Female Reproductive - Uterus, tubes & ovaries | $500 | $1,500 |
| Thyroid - Thyroidectomy (partial: one lobe) | $265 | $800 |
| Thyroid - Thyroidectomy (total: both lobes) | $430 | $1,300 |
| Brain - Burr holes not followed by surgery | $200 | $600 |
| Brain - Exploratory craniotomy | $695 | $2,100 |
| Brain - Excision brain tumor | $1,090 | $3,300 |
| Brain - Ventriculoperitoneal shunt | $530 | $1,600 |
| Spine - Cordotomy | $430 | $1,300 |
| Spine - Laminectomy | $1,090 | $3,300 |
| Eye - Enucleation | $265 | $800 |
| Radium Implants - Insertion | $365 | $1,100 |
| Radium Implants - Removal | $200 | $600 |

| | Level I | Level II |
|---|---|---|
| **First Occurrence:**<br>Limited to once per *lifetime*<br>A 30 day waiting period applies | Not Covered | $5,000 |

| | Level I | Level II |
|---|---|---|
| **Alternative Care:** | | |
| **Integrative Assessment and Education Benefit**<br>Limited to a one time benefit | Not Covered | $150 |
| **Palliative Care Benefit**<br>Limited to 20 visits per *benefit year*<br>*Lifetime* maximum of 2 *benefit years* | Not Covered | $50 per visit |
| **Lifestyle Benefit**<br>Limited to 20 visits per *benefit year*<br>*Lifetime* maximum of 2 *benefit years* | Not Covered | $50 per visit |

| | Level I | Level II |
|---|---|---|
| **Experimental Treatment:** | | |
| **Oral, Injected or Pump Dispensed Medications** | Not Covered | $150 per day<br>$1,050 per month |

| | Level I | Level II |
|---|---|---|
| **Medical Imaging:**<br>Limited to twice per *benefit year* | Not Covered | $100 |

| | Level I | Level II |
|---|---|---|
| **National Cancer Institute Evaluation/Consultation:**<br>Limited to once per *lifetime* | Not Covered | $500 |

| | Level I | Level II |
|---|---|---|
| **Anti-nausea:** | Not Covered | $100 per month |

| | Level I | Level II |
|---|---|---|
| **Bone Marrow Transplant:**<br>Limited to once per *lifetime** | Not Covered | $10,000 for you or your *covered dependent*<br>$1,500 to the bone marrow donor |
| **Stem Cell Transplant:**<br>Limited to once per *lifetime** | Not Covered | $2,500 |

*Benefits will only be paid once per *lifetime* for either a *bone marrow transplant* or *stem cell transplant*, not both.

| | Level I | Level II |
|---|---|---|
| **Immunotherapy:** | Not Covered | $450 per month not to exceed a *lifetime* maximum of $3,500 |

| | Level I | Level II |
|---|---|---|
| **Home Health Care:**<br>Limited to a maximum of 10 visits after any *period of hospital confinement* not to exceed a maximum of 30 visits per *benefit year* | Not Covered | $50 per visit |

| | Level I | Level II |
|---|---|---|
| **Nursing Services:**<br>Limited to 30 days per *benefit year* | Not Covered | $125 per day |

| | Level I | Level II |
|---|---|---|
| **Transportation:**<br>Limited to 3 round trips per *benefit year* | Not Covered | $500 per round trip |

| | Level I | Level II |
|---|---|---|
| **Reconstructive Surgery:** | | |
| **Breast Symmetry (modification of the non-cancerous breast performed within 5 years of reconstructing the cancerous breast)** | Not Covered | $350 |
| **Breast Reconstruction** | Not Covered | $700 |
| **Facial Reconstruction** | Not Covered | $700 |
| **Breast Transverse Rectus Abdominis Myocutaneous (TRAM) Flap** | Not Covered | $2,500 |

In addition, we will pay 30% of the amounts shown above for *general anesthesia* during these procedures.

| | Level I | Level II |
|---|---|---|
| **Outpatient Hospital Surgical**<br>Limited to 3 days per procedure | Not Covered | $250 per day |

**Plan Changes**

**Plan Changes at Annual Enrollment**

You may choose to change your plan of insurance, subject to any required *proof of good health*, from December 1 through December 31 of each year, the annual enrollment period agreed upon by the *participating employer* and us. You must submit *proof of good health* for any plan level increase. The amount of any increase, with or without *proof of good health*, is subject to the Pre-Existing Conditions provision in the Cancer Only 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.

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, or the termination of employment of your spouse, or any other event specified in the *participating employer's* IRC Section 125 plan. If you apply for insurance or increase your plan of insurance following a change in family status, you must submit *proof of good health* for you or your *covered dependent*. Any amount or increase in insurance is subject to the Pre-Existing Conditions provision in the Cancer Only 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 an eligible person is not at *active work* on the day insurance, or a 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 an *eligible dependent* is in a *hospital* or similar facility on the day insurance, or a change in insurance, would otherwise take effect.

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## 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 *participating employer* 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 *participating employer*.

*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 or member of the *participating employer* 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 or membership in a group.

*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 19 hours per week, unless indicated otherwise in the *policy*.

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

*Noncontributory* means the *participating employer* pays the premium.

*Participating employer* means an employer who has met all the eligibility requirements.

*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.

*This trust* means The Services Industry Trust Fund.

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

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

## DEFINITIONS FOR CANCER ONLY INSURANCE

*Accredited practitioner* means a *naturopathic doctor, ayurvedic practitioner, acupuncturist, bio-feedback practitioner, hypnotherapist*, or *massage therapist* who is licensed (if applicable) under the laws of the state where *treatment* is received as qualified to treat the type of condition for which a claim is made. If licensed, the practitioner must be practicing within the scope of his or her license.

*Acupuncture* means a therapy that involves puncture with long thin needles into established body points for symptom relief or for anesthesia.

*Acupuncturist* means an a*ccredited practitioner* who has been trained and certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). He or she may be called "Diplomat in Acupuncture (NCCAOM)" or represented as "National Board Certified in Acupuncture (NCCAOM)" and is currently licensed, if required, in the state that he or she practices.

*Ambulatory surgical center* means a licensed or accredited facility that provides medical or surgical intervention requiring care for immediate (day of procedure), pre-procedure and immediate post-procedure care. The total length of care is less than 24 hours. A *doctor* must be directly involved in the care.

*Ayurvedic medicine* means a practice of health promotion, disease prevention, and personal growth that includes physical, psychological and spiritual aspects. Ayurvedic practices are intended to promote well being and reduce stress and may include yoga, meditation, massage, dietary changes and herbs.

*Ayurvedic practitioner* means an *accredited practitioner* who has been certified through the American Association of Drugless Accredited Practitioners for Ayurvedic Medicine.

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

*Bio-feedback* means a therapy that trains and uses the mind to control body functions that are typically regulated automatically such as muscle tension, heart rate, blood pressure or temperature.

*Bio-feedback practitioner* means an *accredited practitioner* who has a bachelor's degree in a health related profession, such as a degree in medicine, osteopathy or *naturopathic* medicine and who has received certification from the Biofeedback Society of America and is currently licensed in the state that he or she practices.

*Bone marrow transplant* means a procedure in which a patient's bone marrow is replaced with cellular elements to reconstitute the bone marrow. It may be preceded by chemotherapy, radiotherapy or other treatments which cause residual bone marrow to be destroyed. The collection of stem cells or other peripheral blood cells and their later reinfusion is not a *bone marrow transplant*.

*Cancer* means you or your *covered dependent* has been *diagnosed* with a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells in any part of the body. This includes leukemia, Hodgkin's disease, lymphoma, sarcoma, malignant tumors and melanoma. *Cancer* includes carcinomas in situ (in the natural or normal place, confined to the site of origin without having invaded neighboring tissue). Pre-malignant conditions or conditions with malignant potential, such as myelodysplastic and myeloproliferative disorders, leukoplakia, hyperplasia, and nonmalignant skin lesions will not be considered *cancer*.

*Cancer only insurance* means the group *cancer only insurance* under the *policy* issued by us to the *policyholder*.

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

*Cytotoxic* means chemotherapeutic medications prescribed by a *doctor* for *diagnosed cancer* and that cause cell damage primarily by targeting cell growth. These medications do not include *immunotherapy*, hormones, or hormone antagonists.

*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:

- 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.

*Extended-care facility* means an accredited medical institution that provides prolonged skilled nursing or medical care including a skilled nursing facility, a rehabilitation unit or facility, a transition care unit or any bed designated as a swing bed, or to a section of the *hospital* used in that manner as approved by Medicare. It does not include any institution which is primarily for the care and *treatment* of mental disease.

*General anesthesia* means the induction of a state of unconsciousness with the absence of pain sensation over the entire body, through the administration of anesthetic drugs used during a medical or surgical procedure. It must require respiratory support by a *doctor* or certified registered nurse anesthetist (CRNA).

*Hospice* means an organization that provides medical services in an *inpatient*, *outpatient* or home setting to support and care for persons who are terminally ill with a life expectancy of 6 months or less as certified by a *doctor*. A *hospice* must meet all of the following requirements:

- Comply with all state licensing requirements.
- Be Medicare certified and/or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
- Provide a *treatment* plan and services under the direction of a *doctor*.
- An *inpatient hospice* facility must meet all of the following requirements in addition to the requirements above:
    - Be a dedicated unit within an Acute Medical Facility or a Subacute Rehabilitation Facility or a separate facility that provides *hospice* services on an *inpatient* basis.
    - Be licensed by the state in which the services are rendered to provide *inpatient hospice* services.
    - Be staffed by an on call *doctor* 24 hours per day.
    - Provide nursing services supervised by an on duty registered nurse 24 hours per day.
    - Maintain daily clinical records.
    - Admit patients who have a terminal illness.
    - Not provide patients with services that involve active intervention for the terminal illness although ongoing care for comorbid conditions and *palliative care* for the terminal illness may be provided.

*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 a *doctor*;
- provide 24 hour nursing service provided by a 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.

*Hospital confined* or *hospital confinement* means admission to a *hospital* as an *inpatient* for at least 24 consecutive hours by a *doctor* for an *injury* or sickness. A *hospital* stay that does not result in charges to you or your *covered dependent* is not a *hospital confinement* under this *policy* unless there is no charge because the *hospital* is a United States government facility.

*Hypnotherapist* means an *accredited practitioner* who has been certified by the American Board of Hypnotherapy or the American Clinical Board of Hypnotherapy.

*Hypnosis* means a change in a person's conscious awareness, induced by another person, which may alter memory and consciousness, increase susceptibility to suggestion, and bring about responses and ideas that may be considered unusual.

*Immunotherapy* means *treatments* intended to improve the immune system by providing antibodies, colony stimulating factors, or immunoglobulins for the purpose of treating *cancer*.

*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.

*Internal cancer* means a *cancer* contained within the body. *Internal cancers* do not include *cancers* of the skin except for melanomas classified as Clark's Level III and higher or a Breslow level greater than or equal to 0.76mm.

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

*Massage therapist* means an *accredited practitioner* who is a graduate of a program accredited by the American Massage Therapy Association and has completed the National Certification Exam.

*Massage therapy* means the manipulation of the soft tissue of the body with the objective of normalizing the tissue. Forms of *massage therapy* are limited to sports massage, manual lymph drainage, Swedish massage, deep tissue massage, and neuro-muscular massage.

*Mental illness* means a mental disorder as listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders, as published by the American Psychiatric Association. A *mental illness*, as so defined, may be related to or be caused by physical or biological factors, or result in physical symptoms or expressions. For the purposes of the *policy*, *mental illness* does not include any mental disorder listed within any of the following categories found in the Diagnostic and Statistical Manual of Mental Disorders, as published by the American Psychiatric Association:

- Mental Retardation;
- Motor Skills Disorder;
- Pervasive Developmental Disorders;
- Delirium, Dementia, and Amnestic and other Cognitive Disorders;
- Schizophrenia; and
- Narcolepsy, Obstructive Sleep Apnea, and Sleep Disorder due to a general medical condition.

*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.

*Naturopathic doctor* means an *accredited practitioner* who has graduated from a four year naturopathic medical school, which is accredited by the Council on Naturopathic Medical Education.

*Naturopathic treatment* means the services and *treatments* used by a *naturopathic doctor* in the course of *treatment* for a covered illness.

*Naturopathy/naturopathic* means the art, science, philosophy and practice of *diagnosis*, *treatment* and prevention of illness, using the least invasive, most physiologically supportive method possible. The practice of *naturopathy* identifies and treats the cause of an illness or disease rather than the symptoms of an illness and usually includes a plan of prevention that includes education and alteration of mental, emotional, genetic, social, spiritual and other lifestyle factors.

*NCI-designated cancer center* means a facility, having a current National Cancer Institute (NCI) designation, that provides *treatment* for or research concerning *cancer*.

*NCI-listed* means a *cancer treatment* protocol that is listed in the National Cancer Institute's (NCI) Physician Data Query (PDQ). The PDQ is an online database that contains *cancer* information summaries, listings of clinical trials, and directories of *doctors* and organizations involved in *cancer* care.

*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* or sickness.

*Palliative care* means *treatment* or services designed to reduce the severity of a condition or symptoms without curing the underlying disease.

*Period of hospital confinement* means *hospital confinement* for a continuous and uninterrupted period of time while under the regular care and attendance of a *doctor.* A new *period of hospital confinement* will begin if a new *hospital confinement* occurs 30 or more days after the end of the previous *hospital confinement* or if the *hospital confinement* results from a completely independent cause from the previous *hospital confinement*.

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

*Prosthesis* or *prosthetic* means an artificial replacement for a missing or defective body part.

*Stem cell transplant* means the delivery of autologous or allogeneic stem cells to a person who has received chemotherapy or radiation to treat *internal cancer*. This definition does not include allogeneic or autogeneic bone marrow collection and infusion of bone marrow under *general anesthesia.*

*Timely applicant* means a person whose application for insurance is received by us 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.

*Week* means a calendar period of seven consecutive days, beginning on 12:00 a.m. Sunday and ending on 11:59 p.m. Saturday.

## SUMMARY OF GROUP CANCER ONLY INSURANCE

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

**Cancer Only Insurance**

There may be certain benefits and amounts you may be eligible to elect, and the coverage in force for you or a *covered dependent* will depend on any elections made.

This is a *cancer* only *policy*. It does not pay benefits for loss from any other cause. The *policy* pays benefits if you or a *covered dependent* is *diagnosed* with *cancer* and receives services or *treatment* for *cancer* after your or a *covered dependent's* effective date and while the *policy* is in force. The *policy* explains which expenses receive limited or no benefits. In addition, waiting periods and pre-existing condition exclusions may apply.

The *policy* includes a portability provision. If your *cancer only insurance* ends under certain circumstances, it may be possible to *port* your *cancer only insurance* and your dependent's *cancer only 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 *cancer only* certificate. It does not pay benefits for loss from any other cause. This is NOT a medical insurance certificate, Medicare Supplement certificate or a high deductible health plan.**

**Please read your certificate carefully.**

## ELIGIBILITY AND TERMINATION PROVISIONS FOR CANCER ONLY 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 *participating employer*, 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 *participating employer's* application. 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 all levels of coverage. If the proof is acceptable to us, any *noncontributory* insurance will take effect on the Entry Date shown in the Schedule in the *policy,* or if later, 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. *Proof of good health* is required. If the proof is acceptable to us, insurance will take effect on the following:

- If a person applies before becoming eligible, insurance will take effect on the Entry Date shown in the Schedule in the *policy*, or if later, 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, insurance will take effect on the Entry Date occurring on or after the date of the application, or if later, 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, then application must be made during an annual enrollment period. Insurance will take effect on the policy anniversary occurring on or after the date of the application, or if later, 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 *participating employer'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.

### When a Person's Insurance Ends

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

- the *policy* or *participating employer's* application ends;
- the *policy* or *participating employer's* application 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
- a person's employer is no longer a *participating employer*.

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 *participating employer* 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 *cancer only 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 *participating employer* 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 *participating employer* 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 CANCER ONLY INSURANCE

### Eligible Dependents

Your *eligible dependents* are:

- your lawful spouse, and
- 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 all levels of coverage. If the proof is acceptable to us, any *noncontributory* dependent insurance will take effect on the later of the day the dependent becomes an *eligible dependent*, 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 the *eligible dependent's proof of good health*.

For any *contributory* dependent insurance, you must apply for dependent insurance on a form acceptable to us. You must also agree to pay your share of the premium. *Proof of good health* is required. If the proof is acceptable to us, insurance will take effect on the following:

- If you apply before the dependent becomes eligible, dependent insurance will take effect on the Entry Date shown in the Schedule in the *policy*, or if later, the Entry Date occurring on or after the date of our correspondence notifying you of our approval of the *eligible dependent's proof of good health*.
- If you apply on the date the dependent becomes eligible, or within 90 days after that, dependent insurance will take effect on the Entry Date occurring on or after the date of your application, or if later, the Entry Date occurring on or after the date of our correspondence notifying you of our approval of the *eligible dependent's proof of good health*.
- If you apply more than 90 days after the date the dependent becomes eligible or after dependent insurance ended because the premium was not paid, then application must be made during an annual enrollment period. Dependent insurance will take effect on the policy anniversary occurring on or after the date of application, or, if later, the Entry Date occurring on or after the date of our correspondence notifying you of our approval of the *eligible 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.

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.

**DEPENDENT ELIGIBILITY AND TERMINATION PROVISIONS FOR CANCER ONLY INSURANCE (continued)**

**When Dependent Insurance Ends**

A dependent's insurance will end on the date:

- the *policy* or *participating employer's* application ends;
- the *policy* or *participating employer's* application is changed to end dependent insurance;
- that dependent is no longer eligible;
- your insurance for the same coverage under the *policy* or *participating employer's* application ends;
- a required contribution for dependent insurance was not paid; or
- a person's employer is no longer a *participating employer*.

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 *cancer only 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 *cancer only 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 *cancer only 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 *cancer only insurance* coverage beyond the date insurance would otherwise terminate. You should contact the *participating employer* concerning your right to continue coverage.

## CANCER ONLY INSURANCE

### Insurance Provided

We will pay the *cancer only* benefit amounts shown in the Schedule for covered benefits identified in the *policy* if you or your *covered dependent* is *diagnosed* with *cancer* and receives services or *treatment* for *cancer* while covered under the *policy*. Any benefits are subject to the provisions of the *policy*.

Some of the benefits described in the *policy* may not apply depending on the level of coverage selected. A covered condition must occur while you or your *covered dependent* is insured under this *policy*. Benefit payments are subject to the exclusions and limitations described in this *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.

If any of the benefits below require a charge and you or your *covered dependent* is not charged because the facility is a United States government facility, then we will pay the covered benefit amounts shown in the Schedule.

### Cancer Screening

We will pay the Cancer Screening amount shown in the Schedule if you provide proof satisfactory to us that you or your *covered dependent* was tested for *internal cancer* and charged for undergoing a 1) colonoscopy, 2) CA 125 test, 3) chest x-ray, 4) flexible sigmoidoscopy, 5) mammogram, 6) pap smear, 7) biopsy, 8) PSA, 9) CT scans or MRI scans, 10) BRCA testing, or 11) Hemocult stool specimen while covered under the *policy*. We will pay this benefit only once per *benefit year* for you or your *covered dependent* regardless of whether multiple tests are performed. The benefit will be paid even if *internal cancer* is not *diagnosed*. In order to receive this benefit, you must submit proof that the *internal cancer* screening test was performed by providing us with documentation from your *doctor*.

### Hospital Confinement

We will pay the Hospital Confinement amount shown in the Schedule for each day during a *period of hospital confinement* in which you or your *covered dependent* is *hospital confined* as an *inpatient* for the *treatment* of *internal cancer*. This benefit is limited to 90 days per *period of hospital confinement*.

### Radiation and Chemotherapy

If you or your *covered dependent* receives *cytotoxic* medications or radiation administered by medical personnel in a *hospital*, *clinic* or *doctor's* office as *internal cancer treatment* for the purpose of changing or destroying abnormal tissue, then we will pay the Radiation and Chemotherapy benefits described below.

> If you or your *covered dependent* receives and is charged for an injected *cytotoxic* medication (approved by the FDA or *NCI-listed*) as *internal cancer treatment* for the purpose of destroying or changing abnormal tissue, then we will pay the amount shown in the Schedule for each *week* in which you or your *covered dependent* receives such *treatment*, not to exceed the maximum per *benefit year* shown in the Schedule for all medications.
>
> If you or your *covered dependent* receives and is charged for *cytotoxic internal cancer treatment* medications (approved by the FDA or *NCI-listed*) dispersed by a pump or implant for the purpose of destroying or changing abnormal tissue, then we will pay the amount shown in the Schedule for the first prescription and for each *week* in which you or your *covered dependent* receives a pump refill, not to exceed the maximum per *benefit year* shown in the Schedule. This benefit is in addition to surgical/*general anesthesia* benefits that may also be available for installing or removing the device. Benefits are not based on the number of days of continuous infusion of the medications pumped.
>
> If you or your *covered dependent* receives and is charged for *cytotoxic internal cancer treatment* medications (approved by the FDA or *NCI-listed*) administered orally at any location, we will pay the amount shown in the Schedule for each prescription not to exceed the maximum per month shown in the Schedule for all prescriptions.

If you or your *covered dependent* receives and is charged for external radiation *internal cancer treatment* therapy administered for the purpose of destroying or changing abnormal tissue, we will pay the amount shown in the Schedule for each *week* the external radiation is administered not to exceed the maximum per *benefit year* shown in the Schedule. Benefits will not be based on the length of time the radium or radioisotope stays in the body.

If you or your *covered dependent* is charged for the insertion of interstitial or intracavity administration of radioisotopes or radium *internal cancer treatments* for the purpose of destroying or changing abnormal tissue, we will pay the amount shown in the Schedule for each *week* in which an insertion is performed, not to exceed the maximum per *benefit year* shown in the Schedule. This benefit is in addition to surgical/anesthesia benefits which may also be available for insertion or removal of radiation delivery devices.

If you or your *covered dependent* receives and is charged for *cytotoxic internal cancer treatment* medications (approved by the FDA or *NCI-listed*) administered by any other method or radiation (approved by the FDA or *NCI-listed*) administered orally or intravenously (I.V.), we will pay benefits for each *week* in which you or your *covered dependent* receives such *treatment*, not to exceed the maximum per *benefit year* shown in the Schedule.

We will not pay benefits for *treatment* planning, therapeutic devices, *immunotherapy*, laboratory tests, diagnostic x-rays, dosimetry or simulation associated with these procedures.

We will not pay benefits under this provision for *internal cancer treatment* administered on the same day as *treatments* covered by the Experimental Treatment benefit. However, if you or your *covered dependent* is eligible for both the Radiation and Chemotherapy benefit and the Experimental Treatment benefit on the same day, then we will pay the higher benefit.

**In-hospital Blood and Plasma**

For each day you or your *covered dependent*, while confined as an *inpatient* in a *hospital* for *internal cancer treatment*, receives blood and/or plasma, we will pay the In-hospital Blood and Plasma amount shown in the Schedule.

**Outpatient Blood and Plasma**

For each day you or your *covered dependent* receives *outpatient* blood and/or plasma transfusions in a *doctor's* office, *clinic*, *hospital*, or *ambulatory surgical center*, we will pay the Outpatient Blood and Plasma amount shown in the Schedule. These transfusions must be directly related to *internal cancer treatment*.

**Extended-care Facility**

If we make payments under the Hospital Confinement Benefit for you or your *covered dependent* and you or your *covered dependent* is thereafter confined due to *internal cancer* to an *extended-care facility*, then we will pay the Extended-care Facility amount shown in the Schedule. We will pay for each day of confinement in an *extended-care facility* that is within 30 days of *hospital confinement* for *internal cancer.* Benefits are payable for you or your *covered dependent* for a maximum period of 90 days per *benefit year*.

This benefit will not be paid for any day that a benefit is paid under the Hospital Confinement provision of this *policy*. Confinements in an *extended-care facility* must begin no later than 30 days after the end of *hospital confinement*.

**Hospice**

We will pay the Hospice amount shown in the Schedule per day you or your *covered dependent* receives *hospice* care not to exceed a maximum of 100 days during the *covered person's* or *covered dependent's lifetime*.

Benefits will be paid provided your or your *covered dependent's doctor* gives a statement in writing that you or your *covered dependent* is terminally ill as a result of *internal cancer,* that it is no longer appropriate to intervene

with medical therapies to try to cure the *internal cancer*, and your or your *covered dependent's* medical prognosis is a life expectancy of less than 6 months.

This benefit is not payable for the same day the Extended-care Facility Benefit, the Home Health Care Benefit or the Hospital Confinement Benefit is payable. However, if you or your *covered dependent* is eligible for the Hospice benefit, the Extended-care Facility benefit, the Home Health Care Benefit and the Hospital Confinement benefit on the same day, then we will pay the highest benefit.

**In-hospital Doctor Visits**

While you or your *covered dependent* is *hospital confined* for *internal cancer treatment*, we will pay the In-hospital Doctor Visits amount shown in the Schedule for each day you or your *covered dependent* is visited by a *doctor* for *internal cancer treatment* other than the operating surgeon not to exceed a maximum of 75 visits.

**Post-hospital Doctor Visits**

If you or your *covered dependent* visits the *doctor* after being released from a *hospital*, we will pay the Post-hospital Doctor Visits amount shown in the Schedule per *doctor* visit once every 6 months not to exceed 5 years after the *diagnosis* of *internal cancer* for the purpose of ongoing *cancer* evaluation.

**Prosthesis**

We will pay the Prosthesis amount shown in the Schedule for each surgically implanted *prosthetic* device not to exceed a *lifetime* maximum amount shown in the Schedule for you or your *covered dependent*, if, as a direct result or consequence of surgical *treatment* of *internal cancer*, you or your *covered dependent* receives an implantable *prosthetic* device, or other non-implantable *prosthetic* devices as the result of *internal cancer treatment.*

If as a direct result or consequence of *treatment* for *internal cancer,* you or your *covered dependent* receives non-implantable *prosthetic* devices such as voice boxes, hairpieces or removable breast *prosthesis*, we will pay the Prosthesis amount shown in the Schedule for each non-implantable device up to the *lifetime* maximum amount shown in the Schedule for you or your *covered dependent*. The Prosthesis Benefit does not include coverage for a Breast Transverse Rectus Abdominis Myocutaneous (TRAM) Flap procedure as listed under the Reconstructive Surgery Benefit.

**Ambulance**

We will pay the Ambulance amount shown in the Schedule if a licensed professional ambulance is used to transport you or your *covered dependent* to a *hospital* where you or your *covered dependent* is *hospital confined* as an *inpatient* for *internal cancer treatment*. This benefit is limited to two one-way trips per *period of hospital confinement*.

**Lodging**

If you or your *covered dependent* or his/her adult family companion stays in a hotel while you or your *covered dependent* is receiving *internal cancer treatment* at a *hospital* or *clinic* more than 100 miles from your or your *covered dependent's* residence, we will pay the Lodging amount shown in the Schedule per day not to exceed a maximum of 1 benefit per day and 90 days per *benefit year*. We will not pay for any day that a hotel charge is incurred if a stay begins, if either more than 24 hours prior to *treatment* or more than 24 hours after *treatment*.

**Second Surgical Opinion**

If a *doctor* has *diagnosed* you or your *covered dependent* with *internal cancer* requiring surgery and you or your *covered dependent* obtains a second surgical opinion, we will pay the Second Surgical Opinion amount shown in the Schedule when you or your *covered dependent* obtain a second surgical opinion from a different *doctor* regarding the *internal cancer* surgery.

This benefit will be paid only once per surgical procedure and will not be payable for the same day that a National Cancer Institute Evaluation/Consultation Benefit is payable. However, if the Second Surgical Opinion Benefit under this provision is payable the same day that a National Cancer Institute Evaluation/Consultation Benefit is payable, then we will pay the higher benefit.

**Skin Cancer**

We will pay the Skin Cancer amount shown in the Schedule if a biopsy, reconstructive surgery following previous excision of skin *cancer*, excision of skin *cancer* without flap or graft and excision of skin *cancer* with flap or graft for *diagnosed* skin *cancer* is performed. The amount shown in the Schedule includes the amount payable for anesthesia services.

**Surgery and General Anesthesia for Internal Cancer**

If a *doctor* performs one of the procedures shown in the Schedule for the purpose of treating *internal cancer diagnosed* in you or your *covered dependent*, we will pay the Surgery and General Anesthesia for Internal Cancer amounts shown in the Schedule, provided the total combined benefits payable under this provision for one operation is limited to the maximum shown in the Schedule. The Schedule of Operations shall not apply to surgery for skin *cancer*, which will be covered only under the Skin Cancer Benefit. Similarly, the Schedule of Operations shall not apply to reconstructive surgery, which will be covered only under the Reconstructive Surgery Benefit.

If more than one surgical procedure is performed through the same incision, benefits will be paid for only one procedure based upon the highest eligible benefit.

**First Occurrence**

When you or your *covered dependent* is *diagnosed* for the first time as having *internal cancer*, we will pay the First Occurrence amount shown in the Schedule for the First Occurrence Benefit.

If you or your *covered dependent* was *diagnosed* or treated for *internal cancer* before the end of the 30 day waiting period that follows your or your *covered dependent's* effective date, then we will not pay the First Occurrence Benefit even if the *internal cancer* metastasizes, extends or recurs after the end of the 30 day waiting period. The First Occurrence Benefit is not payable for skin *cancer* classified as Clark's Levels I and II, or a Breslow level less than .76 mm. This benefit will be paid for you or your *covered dependent* only once per *lifetime*.

**Alternative Care**

The following benefits will only be payable upon the *diagnosis* of *internal cancer*. We will require that the *cancer diagnosis* be re-confirmed on a regular basis, either by proof of on-going *treatment*, or by a *doctor's* certification.

- **Integrative Assessment and Education Benefit:** A one-time benefit per *diagnosis* of *internal cancer* amount shown in the Schedule is payable for assessment/education services performed by an *accredited practitioner*.

- **Palliative Care Benefit:** We will pay the amount shown in the Schedule for each visit to an *accredited practitioner*, for up to 20 visits per *benefit year* for a *lifetime* maximum of 2 *benefit years* for *acupuncture, massage therapy*, *bio-feedback* and *hypnosis*.

- **Lifestyle Benefit:** We will pay the amount shown in the Schedule for each visit for up to 20 visits per *benefit year* for a *lifetime* maximum of 2 *benefit years* to an *accredited practitioner* for the following types of alternate care: smoking cessation, Yoga, meditation, relaxation techniques, Tai-Chi and nutritional counseling.

**Experimental Treatment**

If a *doctor* prescribes experimental *treatments* for the purpose of destroying or changing abnormal tissue, and the *treatment* is administered by medical personnel in a *doctor's* office, *clinic* or *hospital*, we will pay the Experimental Treatment amount shown in the Schedule for each day the *treatment* is administered by these medical personnel. All *treatments* must be *NCI-listed* as viable experimental *treatment* for *internal cancer*.

We will not pay benefits under this provision for laboratory tests, *immunotherapy*, diagnostic x-rays, and therapeutic devices or other procedures related to these *treatments*. We will not pay benefits under this provision for the same day the Radiation and Chemotherapy Benefit is payable. However, if you or your *covered dependent* is eligible for both the Experimental Treatment benefit and the Radiation and Chemotherapy benefit on the same day, then we will pay the higher benefit.

**Medical Imaging**

If, after an initial *diagnosis* of *internal cancer*, a follow-up evaluation is performed using any imaging test as directed by a *doctor* (except breast mammography and breast ultrasound), we will pay the Medical Imaging amount shown in the Schedule. We will only pay this benefit twice per *benefit year* provided you or your *covered dependent* is charged for and these procedures are performed when you or your dependent is an *outpatient*.

**National Cancer Institute Evaluation/Consultation**

If you or your *covered dependent* is *diagnosed* with *internal cancer* by a *doctor* and an evaluation or consultation is obtained at an *NCI-designated cancer center* strictly to determine the appropriate course of *cancer treatment*, we will pay the National Cancer Institute Evaluation/Consultation amount shown in the Schedule upon such evaluation or consultation. This benefit is payable only once per *lifetime* for you or your *covered dependent* and is not payable for the same day the Second Surgical Opinion Benefit is payable. However, if you or your *covered dependent* is eligible for both the National Cancer Institute Evaluation/Consultation benefit and the Second Surgical Opinion benefit on the same day, then we will pay the higher benefit. The Transportation and Lodging benefits will apply for this evaluation or consultation provided the requirements under those benefits are met.

**Anti-nausea**

If a *doctor* prescribes drugs to control nausea related to chemotherapy or radiation *internal cancer treatments*, we will pay the Anti-nausea amount shown in the Schedule for each month during which you or your *covered dependent* receives and is charged for the drugs. This benefit will be paid as long as you or your *covered dependent* is receiving radiation or chemotherapy *treatments* and prescribed drugs to control nausea.

**Bone Marrow or Stem Cell Transplant**

If you or your *covered dependent* receives and is charged for a *bone marrow transplant* as a result of *internal cancer*, we will pay the Bone Marrow Transplant amount shown in the Schedule for you or your *covered dependent* and the amount shown in the Schedule to the bone marrow donor. If you or your *covered dependent* receives and is charged for a peripheral *stem cell transplant* procedure to treat *internal cancer*, then we will pay the Stem Cell Transplant amount shown in the Schedule. We will pay benefits under this provision only once during your or your *covered dependent's lifetime* for either a *bone marrow transplant* or a *stem cell transplant*, not both.

**Immunotherapy**

If a *doctor* prescribes *immunotherapy* as a *treatment* for *internal cancer* and you or your *covered dependent* is charged for such *treatment*, then we will pay the Immunotherapy amount shown in the Schedule per month that you or your *covered dependent* is charged for such *treatments*, up to the *lifetime* maximum shown in the Schedule. We will not pay benefits under this provision for the same *treatment* under either the Radiation and Chemotherapy benefit or the Experimental Treatment benefit. However, if you or your *covered dependent* is eligible for the Immunotherapy benefit, the Radiation and Chemotherapy benefit and the Experimental Treatment benefit on the same day, then we will pay the highest benefit.

**Home Health Care**

If, after you or your *covered dependent* is released from *hospital confinement* due to *internal cancer*, the attending *doctor* prescribes home health care or health support services and these services begin within 7 days of your or your *covered dependent's* release from *hospital confinement*, we will pay the Home Health Care amount shown in the Schedule for each home health visit up to a maximum of 10 visits after any *period of hospital confinement*, but no more than 30 visits per *benefit year*.

To receive this benefit, the prescribing *doctor* must certify that you or your *covered dependent* would need to be *hospital confined* if home health care visits were not available to give you or your *covered dependent* necessary care and *treatment*.

We will pay benefits under this provision only if the home health care and health supportive services providers are licensed or certified and as qualified as caregivers providing comparable services at a *hospital* or other appropriate medical facility. This benefit will not be paid for any day that a benefit is paid under the Hospice Benefit. If the Home Health Care Benefit under this provision is payable the same day that a Hospice Benefit is payable, then we will pay the higher benefit.

**Nursing Services**

If the attending *doctor* prescribes for you or your *covered dependent* while *hospital confined* for *internal cancer* the services of private nurses, in addition to those ordinarily provided by a *hospital*, then we will pay the Nursing Services amount shown in the Schedule per day for up to 30 days per *benefit year* that you or your *covered dependent* is charged for such additional full time care. Care must be provided by a licensed registered graduate nurse or licensed practical or vocational nurse, but not by a *family member*.

**Transportation**

We will pay the Transportation amount shown in the Schedule upon completion of a round trip to transport you or your *covered dependent* to a *hospital* or *clinic* more than 100 miles away from your or your *covered dependent's* residence if the purpose of the trip is to obtain *internal cancer treatment* prescribed by your or your *covered dependent's* local attending *doctor.* We will pay this benefit only for your or your *covered dependent's* transportation. However, we will pay this benefit for commercial travel by bus, train or airplane for a parent or guardian if the medical care is for a *covered dependent* child and he or she is accompanied by a parent or guardian. You or your *covered dependent* is limited to 3 round trips per *benefit year* for you or your *covered dependent* including trips in which the *covered dependent* child is accompanied by a parent or guardian. This benefit does not apply to transportation by ambulance to or from any *hospital*.

**Reconstructive Surgery**

We will pay the Reconstructive Surgery amount shown in the Schedule for you or your *covered dependent* for *internal cancer* related reconstructive surgery listed below:

- Breast Symmetry (modification of the non-cancerous breast performed within 5 years of reconstructing the cancerous breast)
- Breast Reconstruction
- Facial Reconstruction
- Breast Transverse Rectus Abdominis Myocutaneous (TRAM) Flap

In addition, we will pay 30% of the Reconstructive Surgery amounts shown in the Schedule for *general anesthesia* during these procedures.

**Outpatient Hospital Surgical**

We will pay the Outpatient Hospital Surgical amount shown in the Schedule per day not to exceed 3 days per procedure if you or your *covered dependent* is *diagnosed* with *internal cancer* and a *doctor* performs a surgical procedure on you or your *covered dependent diagnosed* with *internal cancer* and the procedure is performed on an *outpatient* basis in a *hospital* (including an *ambulatory surgical center*, but not a *doctor's* office).

Only surgeries for *internal cancer* qualify for this benefit. We will not pay this benefit if you or your *covered dependent* is *hospital confined* on the same day.

**Pre-Existing Conditions**

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 *diagnosed* with *cancer* after 12 consecutive months during which you or your *covered dependent* is continuously insured under the *cancer only insurance policy.*

A "pre-existing condition" means a sickness, symptom or physical finding, or any related 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 *cancer only insurance policy*.

**General Exclusions**

We will not pay benefits for you or your *covered dependent* related to or resulting, directly or indirectly, from any of the following:

- 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*;
- services or *treatment* rendered or *hospital confinement* outside the United States;
- any *cancer diagnosed* solely outside the United States;
- services or *treatment* provided primarily for cosmetic purposes;
- services or *treatment* for premalignant conditions;
- services or *treatment* for conditions with malignant potential;
- services or *treatment* for non-cancer illnesses;
- 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;
- 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;
- *treatment* of *mental illness;*
- 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);
- intentionally self-inflicted injury, while sane or insane; or
- suicide or attempted suicide, while sane or insane.

**Porting to a Group Portability Policy**

If all of your *cancer only 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 *cancer only insurance* in order to *port* your *covered dependent's cancer only insurance*. A *covered dependent* may not *port* his or her *cancer only 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 *cancer only 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* receives services or *treatment* within 31 days after your *cancer only 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$^{th}$ 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.

## CLAIM PROVISIONS FOR CANCER ONLY INSURANCE

### Payment of Benefits

We will pay benefits when we receive all the required proof of covered loss. We will pay all benefits within 25 days after receipt of due written proof in the form of a clean claim where a claim is submitted electronically and within 35 days where a claim is submitted in paper format, other than loss for which the *policy* provides any periodic payment. Subject to due written proof of loss, all accrued benefits for loss for which the *policy* provides periodic payment will be paid not less frequently than monthly and any balance remaining unpaid upon the termination of liability will be paid within 30 days after receipt of due written proof. If we fail to pay benefits within the required time frame, we will pay interest at the rate of one and one-half percent per month accruing from the day after payment was due until the claim is finally settled or adjudicated.

### 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.

### Authority

The *policyholder* delegates to us and agrees that we have the sole discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the *policy*. All determinations and interpretations made by us are conclusive and binding on all parties.

### 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, and receipts.

You must provide us with a written authorization allowing the sources of relevant 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 will pay third party charges for any independent medical exam 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 you of your 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.

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, the *participating employer* 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 *participating employer'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 *participating employer* 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.

## ENDORSEMENT

Effective on and after its effective date, the Certificate is endorsed as follows:

1. The term “spouse” shall also mean a domestic partner. A “domestic partner” is defined in Section 297 of the California Family Code.

# 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 <u>other</u> 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).

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

Policy 7999989
Participant 4998325
Booklet 2
1/27/2017