Old National Bancorp

Your Critical Illness Plan

Policy No. 943878 011

Underwritten by Unum Insurance Company

12/13/2023

Unum Insurance Company
2211 Congress Street
Portland, ME 04122
(877) 225-2712
services.unum.com

Group Critical Illness Insurance Certificate of Coverage

We welcome you as a customer and are committed to providing quality service. This is your Critical Illness Certificate of Coverage. Critical Illness coverage can ease the potential financial impact of certain critical illnesses by providing benefits. This certificate describes your Critical Illness benefits in detail.

Policyholder: Old National Bancorp

Policy Number: 943878 011

Policy Effective Date: January 1, 2024

Policy Anniversary: January 1

Governing Jurisdiction: Indiana

This certificate is issued to you under the Policy which is a contract between us and the Policyholder. If the terms and provisions of this certificate are different from the Policy, the Policy will govern. A copy of the Policy may be made available to you upon request. The Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable, the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

Glossary defined terms found within this certificate have been capitalized. If you have any questions about the terms and provisions of this certificate, please contact your Employer or us at (877) 225-2712 Monday through Friday 8 a.m. to 8 p.m. Eastern Standard Time.

This Certificate of Coverage provides limited benefits under the non-participating Policy. The limited benefits provided under this Certificate of Coverage are a supplement to major medical coverage and are not a substitute for major medical coverage or other minimal essential coverage as required by federal law. Lack of minimal essential coverage may result in an additional tax payment being due.

This certificate contains certain proof of loss requirements, limitations, exclusions, and other provisions that may reduce benefits or prevent an Insured from receiving benefits under this certificate. Please read your certificate carefully and keep it in a safe place.

Your certificate includes notices as required by your state of residence that may impact your benefits. If you have any questions or concerns regarding your state regulations, you may contact the Indiana Department of Insurance at (800) 622-4461.

Consumer Complaint Notice

If you are a resident of New Mexico, your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If you have concerns regarding a claim, premium, or other matters relating to this coverage, you may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at: https://www.osi.state.nm.us/ConsumerAssistance/index.aspx.

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Critical Illness Insurance provides financial protection for an Insured by paying a lump-sum benefit if the Insured is diagnosed with a Covered Condition payable under this certificate.

This section includes highlights of an Insured's coverage. Please refer to the **Critical Illness Details** for further information on the benefits available.

Eligible Group(s)

All Full-Time Employees in Active Employment in the United States working a minimum of 30 hours per week.

Paying for Coverage

For You
Contributory Coverage
You must make premium contributions for your coverage.

For your Spouse
Contributory Coverage
You must make premium contributions for your Spouse's coverage.

For your Children
Coverage for your Children is automatically included in the cost of your coverage.

Coverage Amount

The following Coverage Amounts are available to you. If you choose to apply and become insured for coverage, your Children will automatically be enrolled for coverage. You will also have the opportunity to apply for coverage for your Spouse.

For You	For your Spouse	For your Children
A minimum of $5,000 to a maximum of $50,000, in $5,000 increments	100% of your Coverage Amount	100% of your Coverage Amount

Benefit Amount

The Benefit Amount is the amount an Insured may receive for a Payable Claim. The Benefit Amount is calculated using the Insured's Coverage Amount multiplied by the Percentage of Coverage Amount for the Covered Condition, subject to all other terms and provisions of this certificate.

The Percentage of Coverage Amount payable for each Covered Condition is listed in the Critical Illness Details section.

Any dollar amount listed under the Percentage of Coverage Amount will be the Benefit Amount payable for that Covered Condition.

Covered Conditions

Covered Conditions for you, your Spouse, and Children:

Critical Illnesses

Coronary Artery Disease (major)	Heart Attack (Myocardial Infarction)
Coronary Artery Disease (minor)	Major Organ Failure Requiring Transplant
End Stage Renal (Kidney) Failure	Stroke

Cancer

Invasive Cancer (including all Breast Cancer)	Skin Cancer
Non-Invasive Cancer	

Supplemental Critical Illnesses

Benign Brain Tumor	Loss of Sight
Coma	Loss of Speech
Infectious Disease	Occupational Human Immunodeficiency Virus (HIV) or Hepatitis
Loss of Hearing	Permanent Paralysis

Progressive Diseases	Amyotrophic Lateral Sclerosis (ALS)	Multiple Sclerosis (MS)
	Dementia (including Alzheimer's Disease)	Parkinson's Disease
	Functional Loss	

Covered Conditions for your Children:

Additional Critical Illnesses for your Children	Cerebral Palsy	Down Syndrome
	Cleft Lip or Palate	Spina Bifida
	Cystic Fibrosis	

The information in this section provides details about the benefits that may be payable to you, any applicable Exclusions and Other Features included in your coverage.

Benefits will only be payable for Covered Conditions that have a Date of Diagnosis on or after the Insured's Coverage Effective Date.

Covered Condition Benefit

The Covered Condition Benefit is payable once per Covered Condition per Insured.

We will pay a Covered Condition Benefit for a different Covered Condition if:
- the new Covered Condition is medically unrelated to the first Covered Condition; or
- the Date of Diagnoses are separated by more than 180 days.

If an Insured's diagnosis satisfies the Condition Definition and Date of Diagnosis requirements for more than one Covered Condition, we will pay the Covered Condition with the highest Percentage of Coverage Amount.

Reoccurring Condition Benefit

We will pay the Reoccurring Condition Benefit for the diagnosis of the same Covered Condition if the Covered Condition Benefit was previously paid and the new Date of Diagnosis is more than 180 days after the prior Date of Diagnosis.

The Benefit Amount for any Reoccurring Condition Benefit is 100% of the Percentage of Coverage Amount for that Covered Condition.

The following Covered Conditions are eligible for a Reoccurring Condition Benefit:

Benign Brain Tumor	Infectious Disease
Coma	Invasive Cancer (including all Breast Cancer)
Coronary Artery Disease (Major)	Major Organ Failure Requiring Transplant
Coronary Artery Disease (Minor)	Non-Invasive Cancer
End Stage Renal (Kidney) Failure	Stroke
Heart Attack (Myocardial Infarction)	

Covered Conditions

Critical Illnesses		Percentage of Coverage Amount
Coronary Artery Disease (Major)	*Condition Definition* A narrowing or blockage of one or more coronary arteries resulting from plaque buildup. *Date of Diagnosis* The date a Physician recommends the Insured undergo a Surgical Procedure of either a coronary artery bypass graft or valve replacement.	**50%**
Coronary Artery Disease (Minor)	*Condition Definition* A narrowing or blockage of one or more coronary arteries resulting from plaque buildup. *Date of Diagnosis* The date a Physician recommends the Insured undergo a catheterization procedure of balloon angioplasty or stent placement.	**10%**
End Stage Renal (Kidney) Failure	*Condition Definition* A chronic irreversible failure of the function of both kidneys.	**100%**

Date of Diagnosis
The earliest date:
- a Physician recommends regular hemodialysis or peritoneal dialysis to sustain life;
- the Insured has a kidney transplant performed; or
- the Insured is placed on the UNOS (United Network for Organ Sharing) list for a kidney transplant.

Heart Attack (Myocardial Infarction) — **100%**

Condition Definition
The death of a portion of heart muscle (myocardium) as a result of obstruction of one or more of the coronary arteries. A positive diagnosis of a heart attack must occur and must be supported by two or more of the following:
- chest pain;
- electrocardiographic (EKG) changes indicative of a heart attack;
- in the case of a heart attack associated with percutaneous coronary intervention (balloon angioplasty, stent implantation, and related procedures to increase the flow of blood through the coronary arteries), evolving ST elevations or new Q wave changes must be documented and included as one of the criteria on establishing a diagnosis;
- elevation of biochemical markers of myocardial necrosis; or
- confirmatory imaging studies.

For purposes of this benefit, the following do not meet the Condition Definition of Heart Attack:
- an established (old) heart attack;
- angina;
- atherosclerotic heart disease;
- cardiac arrest (including arrhythmias);
- congestive heart failure;
- coronary artery disease; and
- any other disease, Injury, or dysfunction of the cardiovascular system.

If a heart attack results in death, an autopsy confirmation or death certificate verifying the heart attack as the cause of death will be accepted.

Date of Diagnosis
The date the death of a portion of the heart muscle occurred based on the criteria listed under the Heart Attack Condition Definition.

Major Organ Failure Requiring Transplant — **100%**

Condition Definition
Failure of the heart, liver, both lungs, or pancreas resulting in the Insured being placed on the UNOS (United Network for Organ Sharing) list for a transplant.

If an Insured is on the UNOS list for a combined transplant (example: heart and lung), a single benefit will be paid.

Date of Diagnosis
The date the Insured is placed on the UNOS list for organ transplant(s).

Stroke — **100%**

Condition Definition
The sudden death of brain cells due to lack of oxygen, caused by blockage of blood flow or rupture of an artery to the brain.

For purposes of this benefit, the following do not meet the Condition Definition of Stroke:
- transient ischemic attack;

- brain injury associated with hypoxia, anoxia, or hypotension;
- brain injury related to trauma or infection;
- ischemic disorders of the vestibular system; and
- vascular disease affecting the eye or optic nerve.

If a stroke results in death, an autopsy confirmation or death certificate verifying the stroke as the cause of death will be accepted.

Date of Diagnosis

The date a Stroke occurs and the diagnosis must be supported by:

- neurological deficits persisting for at least 30 days after the Stroke including but not limited to impaired motor function, altered sensation, vision loss, difficulty swallowing, or Cognitive Impairment confirmed by a Physician; and
- confirmatory neuroimaging studies consistent with the diagnosis of a new Stroke.

Cancer		**Percentage of Coverage Amount**

Invasive Cancer (Including all Breast Cancer)	*Condition Definition*
	A disease which is identified by the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells.
	
	Any cancer of the breast is considered Invasive Cancer including breast cancer which is classified as Stage 0 or In Situ.
	
	For purposes of this benefit, the following do not meet the Condition Definition of Invasive Cancer:
	- pre-malignant conditions or conditions with malignant potential;
	- cancer that has not yet become invasive, typically classified as Stage 0 or In Situ; and
	- cancer on the surface of the body (skin) that may be:
	  - melanomas that are in situ or Stage 1, which require only local treatment and affect only the melanoma and area close to it;
	  - basal cell carcinoma; or
	  - squamous cell carcinoma of the skin.
	
	Date of Diagnosis
	The date the tissue specimen, blood samples or titer(s) are taken on which the Pathological Diagnosis of Invasive Cancer is based. We will accept a Clinical Diagnosis if a Pathological Diagnosis cannot be made.
	
	Any Date of Diagnosis for Invasive Cancer must follow a period of at least 180 days where the Insured has had no evidence of disease or treatment for cancer. Evidence of disease or treatment does not include preventive medications or routine scheduled follow-up visits to a Physician.
		100%

Non-Invasive Cancer	*Condition Definition* A malignant tumor which is typically classified as Stage 0 or In Situ, that has not yet become invasive but is confined to the site of origin without having invaded neighboring tissue. For purposes of this benefit, the following do not meet the Condition Definition of Non-Invasive Cancer: - pre-malignant conditions or conditions with malignant potential;	**25%**

- any Stage 0 or In situ cancer of the breast; and
- cancer on the surface of the body (skin) that may be:
  - melanomas that are in situ or Stage 1, which require only local treatment and affect only the melanoma and area close to it;
  - basal cell carcinoma; or
  - squamous cell carcinoma of the skin.

Date of Diagnosis
The date the tissue specimen, blood samples or titer(s) are taken on which the Pathological Diagnosis of Non-Invasive Cancer is based. We will accept a Clinical Diagnosis if a Pathological Diagnosis cannot be made.

Any Date of Diagnosis for Non-Invasive Cancer must follow a period of at least 180 days where the Insured has had no evidence of disease or treatment for cancer. Evidence of disease or treatment does not include preventive medications or routine scheduled follow-up visits to a Physician.

Skin Cancer — **$500**

Condition Definition
Cancer on the surface of the body (skin) that may be:
- melanomas that are in situ or Stage 1, which require only local treatment and affect only the melanoma and area close to it;
- basal cell carcinoma; or
- squamous cell carcinoma of the skin.

Date of Diagnosis
The date the tissue specimen is taken on which the Pathological Diagnosis of Skin Cancer is based. We will accept a Clinical Diagnosis if a Pathological Diagnosis cannot be made.

Supplemental Critical Illnesses		**Percentage of Coverage Amount**
Benign Brain Tumor	*Condition Definition* A non-cancerous brain tumor resulting in neurological deficits including but not limited to loss of sight, loss of hearing, or balance disruption. For purposes of this benefit, the following do not meet the Condition Definition of Benign Brain Tumor: - tumors of the skull; - pituitary adenomas; and - germinomas. We will not pay this benefit if an Insured is diagnosed with any of the following conditions prior to their Coverage Effective Date: - Neurofibromatosis I; - Neurofibromatosis II; - Von Hippel Lindau; - Tuberous Sclerosis; - Li-Fraumeni Syndrome; - Cowden Disease; and - Turcot Syndrome. *Date of Diagnosis* The date of the examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.	**100%**
Coma	*Condition Definition*	**100%**

	A continuous state of profound unconsciousness requiring intubation for respiratory assistance lasting for a period of 7 or more consecutive days, characterized by the absence of: - eye opening; - verbal response; and - motor response. For purposes of this benefit, the following do not meet the Condition Definition of Coma: - Coma due to Stroke; and - any medically induced Coma. *Date of Diagnosis* The date a Physician confirms a Coma.	
Infectious Disease	*Condition Definition* A severe infectious or contagious disease diagnosed by a Physician that results in the Insured being confined to a Hospital for 7 or more consecutive days. Infectious or contagious diseases may include, but are not limited to: - Rabies - Meningitis - Lyme Disease - Antibiotic resistant bacteria (including MRSA) - Sepsis - Tuberculosis - Diphtheria - Encephalitis - Legionnaire's disease - Malaria - Necrotizing fasciitis (flesh eating bacteria) - Osteomyelitis - Tetanus *Date of Diagnosis* The date a Physician confirms a diagnosis of an Infectious Disease.	**25%**
Loss of Hearing	*Condition Definition* Total and irrecoverable Loss of Hearing in both ears that follows a period where the Insured had the ability to hear. For purposes of this benefit, the following do not meet the Condition Definition of Loss of Hearing: - congenital birth defects; - developmental delays; and - any Loss of Hearing that can be corrected by any procedure, aid, or device. *Date of Diagnosis* The date a Physician confirms Loss of Hearing in both ears.	**100%**
Loss of Sight	*Condition Definition* Permanent reduction in sight certified by a Physician that follows a period where the Insured was not legally blind such that: - sight in the better eye reduced to a best corrected visual acuity of 20/200 or less (Snellen or E-Chart Acuity); or - visual field remaining is less than 20° in the better eye. For purposes of this benefit, the following do not meet the Condition Definition of Loss of Sight: - congenital birth defects; - developmental delays; and	**100%**

- any loss of sight that can be corrected by any procedure, aid, or device.

Date of Diagnosis
The date a Physician confirms Loss of Sight.

Loss of Speech

Condition Definition **100%**
Total and irrecoverable Loss of Speech that follows a period where the Insured had the ability to speak.

For purposes of this benefit, the following do not meet the Condition Definition of Loss of Speech:
- congenital birth defects;
- developmental delays; and
- any loss of speech that can be corrected by any procedure, aid, or device.

Date of Diagnosis
The date a Physician confirms Loss of Speech.

Occupational Human Immunodeficiency Virus (HIV) or Hepatitis

Condition Definition **100%**
An infection resulting from exposure to HIV or Hepatitis B, C, or D contaminated fluids as the result of a Covered Accident during the normal course of duties for an occupation in which the Insured is regularly engaged and for which compensation is earned.

For purposes of this benefit, the following do not meet the Condition Definition of Occupational HIV or Hepatitis:
- exposure or infection as the result of IV drug use;
- exposure or infection as the result of sexual transmission; and
- exposure or infection determined that is not the result of an occupational Covered Accident.

Date of Diagnosis
The date a state certified and licensed laboratory receives a positive confirmatory antibody test for HIV or Hepatitis B, C, or D provided the following actions have been taken:
- within five days of the Covered Accident, it is reported and recorded by the appropriate person according to the legislation, regulations, standards, or guidelines that apply to the Insured's occupation or profession;
- the Covered Accident is investigated by the employer and we receive a copy of the Written investigation report;
- an initial confirmatory antibody test is taken within five days of the Covered Accident and is negative for the presence of HIV or Hepatitis B, C, or D; and
- a follow-up confirmatory antibody test is taken between 90 and 180 days from the date of the initial confirmatory antibody test and is positive for HIV or Hepatitis B, C, or D.

Permanent Paralysis

Condition Definition **100%**
The complete and permanent loss of the use of two or more limbs due to a new paralysis, for a continuous period of at least 90 days.

For a severed spinal cord with supporting clinical and radiological evidence and no expectation of return of function, the continuous 90 day requirement will be waived.

For purposes of this benefit, losing the use of two or more limbs as the result of a Stroke does not meet the Condition Definition of Permanent Paralysis.

Date of Diagnosis
The date a Physician diagnoses the paralysis or severed spinal cord.

Progressive Diseases		**Percentage of Coverage Amount**
Amyotrophic Lateral Sclerosis (ALS)	*Condition Definition* A nervous system disease that causes muscle weakness and impacts physical function. ALS, also known as Lou Gehrig's disease, causes nerve cells to gradually break down and die. *Date of Diagnosis* The date the Insured is unable to perform two or more Activities of Daily Living due to Amyotrophic Lateral Sclerosis (ALS) as diagnosed by a Physician.	**100%**
Dementia (Including Alzheimer's Disease)	*Condition Definition* A progressive, degenerative disorder that attacks the brain's nerve cells or neurons, and may result in loss of memory, thinking, language skills, or behavioral changes. *Date of Diagnosis* The date the Insured is unable to perform two or more Activities of Daily Living or is Cognitively Impaired due to Dementia (including Alzheimer's Disease) as diagnosed by a Physician.	**100%**
Functional Loss	*Condition Definition* An Injury, Sickness, or other infirmity that prevents an Insured from independently performing daily tasks for a period of at least 90 days. For purposes of this benefit, functional loss due to paralysis does not meet the Condition Definition of Functional Loss. *Date of Diagnosis* The date the Insured is unable to perform two or more Activities of Daily Living due to a Functional Loss as diagnosed by a Physician.	**100%**
Multiple Sclerosis (MS)	*Condition Definition* A chronic disease involving damage to the protective sheaths of nerve cells in the brain and spinal cord. Symptoms may include numbness, impairment of speech and of muscular coordination, blurred vision, and severe fatigue. Eventually, the disease can cause the nerves themselves to deteriorate or become permanently damaged. *Date of Diagnosis* The date the Insured is unable to perform two or more Activities of Daily Living due to Multiple Sclerosis (MS) as diagnosed by a Physician.	**100%**
Parkinson's Disease	*Condition Definition* A disease of the nervous system marked by tremor, muscular stiffness, and slow, imprecise movement. It is associated with degeneration of the basal ganglia of the brain and a deficiency of the neurotransmitter dopamine. *Date of Diagnosis* The date the Insured is unable to perform two or more Activities of Daily Living due to Parkinson's Disease as diagnosed by a	**100%**

Physician.

Additional Critical Illnesses for your Children		**Percentage of Coverage Amount**
Cerebral Palsy	*Condition Definition* A group of non-progressive disorders of movement and posture attributed to abnormal development of, or damage to motor control centers of the brain while a child's brain is still developing before, during, and immediately after birth. The motor disorders of Cerebral Palsy are often accompanied by disturbances of sensation, cognition, communication, perception, and behavior, as well as seizures and secondary musculoskeletal problems. *Date of Diagnosis* The date a Physician makes or confirms an initial diagnosis of Cerebral Palsy after the moment of birth.	**100%**
Cleft Lip or Cleft Palate	*Condition Definition*	**100%**

Cleft Lip	A narrow opening or gap in the skin of the upper lip that extends all the way to the base of the nose, including unilateral clefting and bilateral clefting.
Cleft Palate	An opening between the roof of the mouth and the nasal cavity.

Date of Diagnosis
The date a Physician makes or confirms an initial diagnosis of a Cleft Lip or Cleft Palate after the moment of birth.

Cystic Fibrosis — **100%**

Condition Definition
A hereditary disorder affecting the exocrine glands. It causes the production of abnormally thick mucus, leading to the blockage of the pancreatic ducts, intestines, and bronchi and often resulting in respiratory infection.

Date of Diagnosis
The date the condition is first diagnosed by a Physician and supported by a sweat test with sweat chloride concentrations greater than 60 mmol/L.

Down Syndrome — **100%**

Condition Definition
A congenital disorder arising from a chromosome defect involving chromosome 21, causing intellectual impairment, physical abnormalities and developmental delays. Down Syndrome includes:

Trisomy 21	An individual has three instead of two chromosome 21's.
Translocation	An extra part of chromosome 21 is attached to another chromosome.
Mosaicism	The individual has an extra chromosome 21 in only some of the cells but not all of them. The other cells have the usual pair of chromosome 21's.

Date of Diagnosis
The date a Physician makes or confirms an initial diagnosis of Down Syndrome through the study of chromosome 21 after the moment of birth.

Spina Bifida **100%**

Condition Definition

A congenital defect of the spine in which part of the spinal cord and its meninges are exposed through a gap in the backbone. Spina Bifida includes Meningocele or Myelomeningocele.

For purposes of this benefit, a diagnosis of spina bifida occulta does not meet the Condition Definition for Spina Bifida.

Date of Diagnosis

The date a Physician makes or confirms an initial diagnosis of Spina Bifida, Meningocele, or Myelomeningocele after the moment of birth.

Exclusions

We will not pay benefits for a claim that is caused by, contributed to by, or occurs as a result of any of the following:

- committing or attempting to commit a felony;
- being engaged in an illegal occupation or activity;
- injuring oneself intentionally or attempting or committing suicide, whether sane or not;
- active participation in a riot, insurrection, or terrorist activity. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
- participating in war or any act of war, whether declared or undeclared;
- combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations;
- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician;
- being intoxicated; and
- a Date of Diagnosis that occurs while an Insured is legally incarcerated in a penal or correctional institution.

Additionally, no benefits will be paid for a Date of Diagnosis that occurs prior to the Coverage Effective Date.

Continuity of Coverage

We will provide coverage for an Insured if the Insured was covered by a similar prior policy on the day before the Policy Effective Date of this certificate.

Coverage is subject to payment of premium and all other terms of this certificate. If you are on a temporary Layoff or Leave of Absence on the Policy Effective Date of this certificate, we will consider your temporary Layoff or Leave of Absence to have started on that date and coverage will continue for the period provided for temporary Layoff or Leave of Absence under Continuation of your Coverage During Extended Absences in this certificate.

If you have not returned to Active Employment before any Insured's Date of Diagnosis any benefits payable will be limited to what would have been paid by the prior carrier.

Waiting Period

The continuous period of time you must be in an Eligible Group before you are eligible for coverage:

If you are in an Eligible Group on or before January 1, 2024: None
If you enter an Eligible Group after January 1, 2024: None

Coverage Eligibility Date

For you

If you are in an Eligible Group, you are eligible for coverage on the later of:
- the Policy Effective Date; or
- the day after any applicable Waiting Period has been satisfied.

For your Spouse

If you elect coverage for yourself, your Spouse is eligible for coverage on the later of:
- the date you are eligible for coverage; or
- the date you first acquire a Spouse.

For your Children

If you elect coverage for yourself, your Children are eligible for coverage on the later of:
- the date you are eligible for coverage; or
- the date you first acquire the Child.

Enrolling for Coverage

Initial Enrollment

Contributory Coverage

You may apply for any coverage available for you, your Spouse, and Children within 31 days of an Insured's Coverage Eligibility Date.

Late Enrollment

Contributory Coverage

If you did not apply for coverage during an Insured's Initial Enrollment or you voluntarily cancelled coverage for an Insured and are re-applying, you may apply for coverage during any scheduled Enrollment Period.

Applying for Changes in Coverage

Contributory Coverage

You may increase coverage for an Insured subject to the Coverage Amounts available during any scheduled Enrollment Period or within 31 days of a Qualifying Life Event.

Any change in Coverage Amounts applied for as the result of a Qualifying Life Event, must be consistent with the Qualifying Life Event.

You may also decrease coverage for an Insured subject to the Coverage Amounts available or cancel coverage for an Insured at any time during the Policy Year, during any scheduled Enrollment Period, or within 31 days of a Qualifying Life Event.

Coverage Effective Date

Initial Enrollment

Contributory Coverage

Coverage for an Insured will begin on the first day of the month coincident with or next following the later of:
- the Insured's Coverage Eligibility Date if you apply on or before that date;
- the date you apply for the Insured's coverage, if coverage is applied for within 31 days of the Insured's Coverage Eligibility Date.

Late Enrollment

Contributory Coverage

Coverage for an Insured will begin on the first day of the next Policy Year.

Coverage Effective Date for Changes in Coverage

Contributory Coverage

Increases in coverage for an Insured will begin on the latest of:
- the first day of the next Policy Year;
- the first day of the month coincident with or next following the date of a Qualifying Life Event; or
- the first day of the month coincident with or next following the date you apply for the increase in coverage due to a Qualifying Life Event, if it's within 31 days of the

Qualifying Life Event.

Any decrease in coverage for an Insured will take effect on the first day of the month coincident with or next following the date the decrease in coverage is made.

Any decrease in coverage will not affect a Payable Claim that occurs prior to the decrease.

Coverage Effective Date if you are not in Active Employment

You must be in Active Employment in order for coverage to become effective for any Insured in accordance with the Coverage Effective Date provision.

If you are not in Active Employment due to an Injury, Sickness, temporary Layoff, or Leave of Absence on the date coverage would become effective, the Insured's Coverage Effective Date will be the date you return to Active Employment.

Coverage Effective Date for Initial Enrollment, Late Enrollment, and Changes in Coverage is subject to this provision.

A delay of Coverage Effective Date for an increase in coverage will not affect coverage that is currently in force.

Continuation of your Coverage During Extended Absences

Temporary Layoff
You will be covered through the end of the month that immediately follows the month in which your temporary Layoff begins, provided premium is paid.

Family and Medical Leave of Absence
We will continue coverage in accordance with your Employer's Human Resource policy on family and medical leaves of absence if premium payments continue and your Employer approved your leave in Writing. You will be covered up to the end of the latest of:
- the leave period required by the Federal Family and Medical Leave Act of 1993, and any amendments; or
- the leave period required by applicable state law; or
- the leave period provided to you for an Injury or Sickness, provided premium is paid and your Employer has approved your leave in Writing.

If your Employer's Human Resource policy doesn't provide for continuation of your coverage during a family and medical leave of absence, coverage will be reinstated when you return to Active Employment.

We will not apply a new Waiting Period.

Leave of Absence, other than a Family and Medical Leave of Absence
You will be covered through the end of the month that immediately follows the month in which your Leave of Absence begins, provided premium is paid.

Injury or Sickness
You will be covered for up to 3 months from the date your absence due to an Injury or Sickness begins, provided premium is paid.

End of Coverage

For You
If you choose to cancel your coverage under this certificate, your coverage will end on the first of the month coincident with or next following the date you provide notification to your Employer.

Otherwise, your coverage under this certificate ends on the earliest of:
- the date the Policy is cancelled by us or your Employer;
- the date you are no longer in an Eligible Group;
- the date your Eligible Group is no longer covered;
- the date of your death;
- the last day of the period any required premium contributions are made; or
- the last day you are in Active Employment.

However, as long as premium is paid as required, coverage will continue:
- in accordance with the Continuation of your Coverage During Extended Absences provision; or
- if you elect to continue coverage for you, your Spouse, and Children under Portability of Critical Illness Insurance.

We will provide coverage for a Payable Claim that occurs while you are covered under this certificate.

For your Spouse
If, while your coverage is in force, you choose to cancel your Spouse's coverage under this certificate, your Spouse's coverage will end on the first of the month coincident with or next following the date you provide notification to your Employer.

Otherwise, your Spouse's coverage will end on the earliest of:
- the date your coverage under this certificate ends;
- the date your Spouse is no longer eligible for coverage;
- the date your Spouse no longer meets the definition of a Spouse;
- the date of your Spouse's death; or

- the date of divorce or annulment.

If your Spouse's coverage ends as a result of your death, divorce or annulment, your Spouse may elect to continue Spouse and Children coverage, as long as premium is paid as required under Portability of Critical Illness Insurance.

We will provide coverage for a Payable Claim that occurs while your Spouse is covered under this certificate.

For your Children

Your children's coverage will end on the earliest of:

- the date your coverage under this certificate ends;
- the date your Children are no longer eligible for coverage; or
- the date your Children no longer meet the definition of Children.

We will provide coverage for a Payable Claim that occurs while your Children are covered under this certificate.

Filing a Claim

We encourage early notification of a claim for benefits under this certificate so that a claim decision can be made in a timely manner. If there are any questions on how to file a claim, please contact us or your Employer.

Step 1 - Starting a Claim

Notice of a claim may be provided in Writing, online at: **services.unum.com**, or by contacting us directly at 1-800-858-6843. Notice of a claim should be provided within 30 days from the date of the Covered Loss, or as soon as reasonably possible.

Step 2 - Claim Forms

After receiving notice of a claim, we will send a claim form to you or your authorized representative within 15 days from the date we receive the notice of a claim. Claim forms may also be available from your Employer or from us online at: **services.unum.com**.

When you or your authorized representative receive the claim form, you or your authorized representative must fill out your own section of the claim form and provide the Insured's Physician with the applicable section of the claim form. The Insured's Physician should complete their section of the form and send it directly to us.

If you or your authorized representative do not receive a claim form from us within 15 days after we receive notice of a claim, a Written statement from you or your authorized representative as to the nature and extent of the Covered Loss will be deemed Proof of Loss, if sent to us within the time limit stated in the Proof of Loss section below.

Completed claim forms may be sent to us by mail or fax:

Mailing Address: The Benefits Center
P.O. Box 100158
Columbia, South Carolina 29202-3158
Fax: 1-800-447-2498

Step 3 - Proof of Loss

Proof of Loss must be sent to us no later than 90 days after the date of Covered Loss. If it is not reasonably possible to provide Proof of Loss within this time period, it will not affect a Payable Claim if it is provided within one year, unless the Insured lacks the legal capacity to do so.

In no event can Proof of Loss be submitted after the expiration of the time limit for commencing Legal Action as stated in this certificate, even if the failure to provide Proof of Loss is due to a lack of legal capacity or if state law provides an exception to the one year time period.

Proof of Loss, provided at your or your authorized representative's expense, must establish the nature and extent of the Covered Loss and should include but not be limited to the following:

- documentation of diagnosis or treatment provided by a Physician or medical facility and supported by clinical, radiological, histological, pathological, or laboratory evidence;
- it may also include one or more of the following:
  - a Physician's bill;
  - a Hospital bill; or
  - other proof of charges or services; and
- in the case of death, a certified copy of the death certificate, or other lawful evidence providing equivalent information.

If the Proof of Loss is not complete, we will request additional information.

Authorization for Release of Information

We may request Written authorization from an Insured. This authorization may be required in order for us to obtain the necessary medical and non-medical information needed for Proof of Loss. This information may include any appropriate financial records such as income tax returns. Failure to provide us with Written authorization may result in

the denial of a claim if the Insured does not send proof to us and we are not able to obtain the proof that is required to make a claim decision.

Right to Exam, Test, or Interview

We may ask the Insured to be examined or tested by one or more Physicians, other medical practitioners, or vocational experts of our choice. We may also require the Insured to be interviewed by an authorized representative of ours.

We have the right to request exams or tests as often as it is reasonably necessary. Any exam, test, or interview that we require will be paid at our expense. If the Insured fails to attend or fully participate, we will not pay the benefits or we will stop sending benefits under this certificate.

Autopsy

We will have the right, at our expense, to request an Autopsy where it is allowed by law.

Claim Procedures

After the Insured has satisfied the requirements under Filing a Claim, we will process and evaluate the information to determine if a claim is payable. We will notify the Insured of a claim decision and issue payment for a Payable Claim in accordance with the Payment of Benefits provision.

If we determine additional time is needed to review a claim, we may extend this time period by 30 days. We will notify the Insured of the circumstances requiring a review extension and when we anticipate making a claim decision.

If a claim for benefits under this certificate is wholly or partially denied, we will provide notice of our decision in Writing. The notice will contain the following information:

- the specific reason(s) for the determination with reference to those provisions on which the decision is based;
- a description of any additional material or information necessary to complete the claim and why that material or information is necessary;
- procedures and time limits for appealing our decision, and the Insured's right to obtain information about those procedures;
- a statement describing the right to bring a lawsuit under Section 502(a) of ERISA following a claim determination; and
- a statement disclosing any internal rule, guidelines, protocol, or similar criteria used in making the decision (or a statement that such information will be provided free of charge upon request).

Payment of Benefits

Benefits for which we are liable will be paid within 45 days after we complete the Claim Procedures. All benefits will be paid to you, unless we receive Written authorization to pay them elsewhere. This is an assignment of benefits.

In the event of your death, any unpaid benefits will be paid to your beneficiary in accordance with the Beneficiary Designation and Change provision.

In the event of your Spouse's death, should your Spouse have survived you and continued coverage, any unpaid benefits for your Spouse, will be paid to your surviving Spouse's beneficiary in accordance with the Beneficiary Designation and Change provision.

Beneficiary Designation and Change

When a person becomes insured under this certificate, the Insured is responsible for designating a beneficiary in Writing for any benefits due in the event of the Insured's death. It is important to list the full name of each beneficiary and that all beneficiary designations are kept current and provided to us or the Employer. A beneficiary designation form may be available from the Employer or from us online at: **services.unum.com**.

You are the Beneficiary for any Insured under this certificate while you are still living unless there is a valid change in beneficiary designation by an Insured. If an Insured wishes to change their beneficiary designation, they may do so by sending us or the Employer a completed, dated, and signed beneficiary designation change form. Changes in beneficiary designations will take effect on the date notice of the beneficiary designation is signed by the Insured.

Payment of Benefits will be administered based upon the currently available beneficiary designation on file with us or the Employer. If we have taken any action or made any payment before receiving notice of a beneficiary designation, that beneficiary designation will not go into effect for those actions taken or payments made.

If more than one beneficiary is named and the order or share of payments is not designated, the beneficiaries will share equally. The share of a beneficiary who dies before an Insured, the share of a beneficiary who is legally unable to receive benefits, or the share of benefits that are unallocated will pass to any surviving beneficiaries in proportion to their current allocations. The aggregated shares of benefits in excess of 100% will be deducted from surviving beneficiaries in proportion to their current allocations.

If a beneficiary is not named, or if all named beneficiaries do not survive the Insured, or the named beneficiary is legally unable to receive benefits, any benefits due will be paid to the first surviving family member in the order that follows:
- you;
- the Insured's Spouse;
- the Insured's natural offspring and legally adopted children in equal shares;
- the Insured's mother or father in equal shares, if paying both; or
- the Insured's sisters and brothers in equal shares.

Instead of making a payment to a surviving family member, we have the right to pay any benefits due to the Insured's estate. If there are no surviving family members, any benefits due will be paid to the Insured's estate.

In the event of your death, should your Spouse survive you and elect to continue coverage under Portability of Critical Illness Insurance, your surviving Spouse should name a beneficiary according to the requirements specified within this provision.

Payments to a Minor or Incompetent Insured or Insured's Beneficiary

If an Insured or an Insured's beneficiary is a minor or is incompetent, we can pay up to $5,000 to the person or institution that appears to have assumed the custody and main support of the Insured, the minor, or the Insured's beneficiary unless or until that Insured, the minor, or the Insured's beneficiary's appointed legal representative makes a formal claim. If we pay benefits to such person or institution, we will not have to pay those benefits again.

Overpayment of Claims

We have the right to recover any overpayments due to:
- fraud;
- Misstatement of Information; or
- any error we make in processing a claim.

You must reimburse us in full. We will work with you to develop a reasonable method of repayment if you are financially unable to repay us in a lump sum. This may include reducing or withholding future payments.

We will not recover more money than the amount we paid you.

Unpaid Premium

Any Unpaid Premium due for an Insured's coverage at the time of payment for a claim may be deducted from the Insured's claim payment.

Appeal Procedures

Any request to file an appeal of a wholly or partially denied claim must be sent to us in Writing within 180 days from the date of Written notice of our claim decision. You have the right to:
- upon request and free of charge, reasonable access to and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations; and
- submit written comments, documents, records, and other information relating to the claim to us.

Once we receive an Insured's appeal request, it will be assigned to an appeals specialist. The appeals specialist is a person different from the person who made the initial

determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, we will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained in connection with the denial of an Insured's claim, we will provide the Insured with the names of each such expert, regardless of whether the advice was relied upon.

We will make a full and fair review of the claim and all new information submitted, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination. We will notify the Insured of the appeal decision within 45 days from receipt of the Written request for review. If we determine additional time is needed to review the appeal request, we may extend this time period by an additional 45 days. We will notify the Insured if an extension is needed.

If any review extension is necessary due to the Insured's failure to provide the information necessary to make a decision, we will notify the Insured of the review extension and specifically describe what information is required. This information must be sent to us within the time specified from the date of our request. The 45 day review extension will begin on the date we receive the requested information.

If the Insured fails to provide us with the requested information within the specified time period, we will make a decision based on the information available to us at that time.

If an appeal is wholly or partially denied, we will provide notice in Writing. Notice of a denied appeal will contain the following information:

- the specific reason(s) for the denial with reference to those provisions on which the denial is based;
- a statement disclosing any internal rule, guidelines, protocol, or similar criteria used in making the decision (or a statement that such information will be provided free of charge upon request);
- a statement describing the right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the appeal decision;
- a statement that entitles the Insured, at their request, reasonable access to or copies of all documents, records, or other information relevant to the appeal decision free of charge; and
- the statement that "You or your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Unless there are special circumstances, this administrative appeal process must be completed before an Insured begins any Legal Action regarding a claim.

Legal Actions

The time limit on Legal Actions for a Covered Loss is subject to applicable law in the state where the Policy was issued.

If you or your authorized representative disagree with our decision, you or your authorized representative can start Legal Action regarding your claim 60 days after Proof of Loss has been given to us and up to three years from the latest of when:

- original Proof of Loss was first required to have been given to us;
- your claim was denied; or
- your benefits were terminated,

unless otherwise provided under federal law.

When Days Begin and End

For the purpose of all dates under this Certificate of Coverage, all days begin at 12:01 a.m. and end at 12:00 midnight.

Certificate of Coverage Contents

Coverage for an Insured is provided under this Certificate of Coverage which is a part of the Policy issued to the Policyholder. The Policy consists of:

- all Policy provisions, any amendments, riders, and endorsements issued;
- Policyholder's application for group insurance;
- Employee's signed applications, if applicable; and
- this Certificate of Coverage.

Your Certificate of Coverage

We will provide the Employer with a Certificate of Coverage for distribution to each Insured Employee. Your certificate describes:

- the coverage to which an Insured may be entitled;
- to whom we will make a payment; and
- the limitations, exclusions, and requirements that apply to an Insured's coverage.

If any of the terms and provisions of this certificate are different than in the Policy, the Policy will govern.

Cancellation or Modification to the Policy and this Certificate of Coverage

The Policy and this Certificate of Coverage may be cancelled or modified by the Employer at any time without the Insured's consent. Any cancellation or modification to the Policy or certificate requested by the Employer will take effect on the date agreed upon by us and the Employer.

Any Policy and certificate modifications resulting in an increase to an Insured's coverage may be subject to Evidence of Insurability Requirements. All Policy and certificate modifications will take effect according to the Coverage Effective Date provision.

Representation in Applications

Any statements made by you will be considered a representation and not a warranty. We will not use such statements to avoid insurance, reduce benefits, or deny a claim unless it is included in an application signed by you, and a copy of the signed application has been provided to you or your beneficiary.

Assignment

An Assignment transfers all or part of your legal title and rights under the Policy and this certificate to someone else, known as an "assignee." We will recognize your assignee(s) as owners of the rights you transferred under the Policy and this certificate if:

- the Written form has been signed by you and the assignee and the form is acceptable to us; and
- a signed or certified copy of the Written Assignment has been filed with us.

An Assignment will take effect on the date notice of the Assignment is signed by you. If we have taken any action or made any payment before we receive notice of the Assignment, that Assignment will not go into effect for those actions taken or payments made. An Assignment does not change an Insured's coverage or beneficiary designation.

We are not responsible for the validity of any Assignment. We advise you to verify your Assignment is legal in your state and that it accomplishes the goals you intend.

Contestability

We can take legal or other action using statements made in signed applications for coverage only when a Covered Loss occurs during the first two years after an Insured's Coverage Effective Date. However, in the event of Fraud, we can take Legal Action at any time as permitted by applicable law.

Misstatement of Information

If you or your Employer provides us information about an Insured that is incorrect, we will:

- use the facts to decide whether the Insured has coverage under this certificate and the Policy and in what amounts; and
- if necessary, make the applicable premium adjustments.

Fraud

We want to make sure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. We promise to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if anyone knowingly, and with intent to injure, defrauds, or deceives us. This includes filing a claim or providing information that contains any false, incomplete, or misleading information.

These actions will result in denial of a claim, and are subject to prosecution and punishment to the full extent under state and federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

Agency

For purposes of the Policy, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed our agent.

Workers' Compensation or State Disability Insurance

This certificate does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

Communicating With you or your Employer

We may provide notices, information and other communications to you or your Employer in Written form.

To protect our customers, we will abide by all applicable privacy laws and regulations.

Additional Services

This certificate may include enrollment, risk management, financial protection, and other support services related to your Employer's benefit program.

Active Employment

You are working for your Employer for earnings that are paid regularly and you are performing the Material and Substantial Duties of your Regular Occupation. You must be regularly scheduled to work at least the minimum number of hours as determined by your Employer.

Your work site must be:
- your Employer's usual place of business in the United States;
- an alternative work site in the United States at the direction of your Employer; or
- a location in the United States to which your job requires you to travel.

Normal vacation, holidays, or temporary business closures are considered Active Employment provided you are in Active Employment on the last scheduled work day preceding such time off.

For purposes of this certificate, temporary business closures that meet the Glossary definition of Active Employment include, but are not limited to:
- inclement weather;
- power outage; and
- public health agency orders.

Temporary and seasonal workers are excluded from coverage.

Activities of Daily Living (ADLs)

A person is considered unable to perform an Activity of Daily Living if the activity cannot be performed safely without the stand-by assistance or verbal cueing of another person. Activities of Daily Living include the following:

Bathing	The ability to wash oneself either in the tub, shower, or by sponge bath, with or without equipment or adaptive devices.
Dressing	The ability to put on and take off all garments, and medically necessary braces or artificial limbs usually worn including fastening or unfastening them.
Toileting	The ability to get to and from and on and off the toilet and to maintain a reasonable level of personal hygiene.
Transferring	The ability to move in and out of a chair or bed with or without equipment such as canes, quad canes, walkers, crutches, grab bars, or other support devices including mechanical or motorized devices.
Continence	The ability to either voluntarily control bowel and bladder function; or if incontinent, be able to maintain a reasonable level of personal hygiene.
Eating	The ability to get nourishment into your body by any means once it has been prepared and made available to you.

Certificate of Coverage

The document issued to the Employee, also referred to as the "certificate", describing an Insured's benefits and rights under the Policy, including any amendments, riders, endorsements, and other attachments to this certificate and the Policy.

Children

Any child from the moment of birth to age 26 who is:
- your own natural offspring;
- your stepchild;
- your lawfully adopted child as of the earliest of the date:
  - the child is placed in your home or in a medical facility;
  - a petition is filed for you to adopt the child; or
  - an adoption agreement, signed by you that includes your binding obligation to assume financial responsibility for the child;
- a foster child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction;
- any child subject to your legal guardianship; or
- any other child residing with you through legal mandate that is dependent on you for financial support.

Coverage for your Child may be continued past age 26 if your Child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to

reaching age 26 and is dependent upon you for support and maintenance.

You must submit proof of the Child's incapacity and dependency to us within 120 days of the Child's 26th birthday or we will accept proof within 120 days of the Child's Coverage Eligibility Date that the Child was continuously covered under this or another similar group policy since age 26. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year.

Your Children may not be Insured as both a Child and an Employee.

Your Children may not be Insured by more than one Employee.

Clinical Diagnosis

A diagnosis based on the study of symptoms that meets the following criteria:
- a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening;
- there is medical evidence to support the diagnosis; and
- a Physician is treating the Insured for Invasive Cancer, Non-Invasive Cancer, or Skin Cancer.

Cognitively Impaired or Cognitive Impairment

A deterioration or loss in intellectual capacity that requires another person's stand-by assistance or verbal cueing for an Insured's protection or for the protection of others. It is measured by clinical evidence and standardized tests which reliably measure impairment in:
- short or long term memory;
- orientation to people, places, or time; or
- deductive or abstract reasoning.

Contributory Coverage

Any amount of coverage for which you pay all or part of the premium. The maximum amount that you may be required to contribute to the cost of your coverage shall not exceed the premium charged for the amounts of your coverage.

Covered Accident

An accident that is not specifically excluded by name or specific description in this certificate. The loss for which a claim is made must occur on or after the Insured's Coverage Effective Date.

Covered Condition

Any Sickness, diagnosis, or loss listed in the Critical Illness Details section.

Covered Loss

A Covered Condition or Covered Accident for which benefits are payable under this certificate.

Date of Diagnosis

The date a Physician confirms or a test proves that a Covered Condition exists. Date of Diagnosis requirements vary by Covered Condition.

Employee

A person, also referred to as "you," who is in Active Employment in the United States with the Employer.

Employer

The Policyholder, including all United States divisions, subsidiaries, and affiliated companies of the named Policyholder for whose Employees premium is being paid.

Enrollment Period

A period of time determined by your Employer and us during which you are eligible to enroll for or change your coverage. This period of time may be limited.

Hospital

A licensed institution supervised by Physicians and operated pursuant to law on a full-time basis. The Hospital must:
- provide overnight care to people with Injuries or Sicknesses;
- have full-time Nurses on duty or on call who are supervised by a registered Nurse; and
- have X-ray equipment, a laboratory, and a surgical operating room at its locations or available to use on a pre-arranged basis.

For purposes of this certificate, the following hospital units meet the Glossary definition of Hospital:

- Hospital Subacute ICU;
- Progressive Care Unit;
- Intermediate Care Unit; and
- Step-Down Unit.

For purposes of this certificate, the following do not meet the Glossary definition of Hospital:

- a nursing home, a rest home, home for the aged, or an assisted living facility;
- a hospice care facility;
- a Subacute Rehabilitation Unit or Rehabilitation Unit;
- a psychiatric unit or facility for the treatment of Mental or Nervous Disorders; and
- a facility for the treatment of Substance Abuse.

Injury Any damage or harm to the body that is the direct result of an accident and not related to any other cause. Injuries that occur prior to an Insured's Coverage Effective Date will be treated as any other Sickness.

Insured Any person who has coverage under this certificate.

Layoff Temporary absence from Active Employment for a period of time that has been agreed to in advance by your Employer.

Normal vacation time is not considered a temporary Layoff.

Leave of Absence Temporary absence from Active Employment for a period of time under a leave granted in Writing by your Employer that is in accordance with your Employer's formal leave policies.

Normal vacation time is not considered a Leave of Absence.

Material and Substantial Duties Duties that:

- are routinely required for the performance of your Regular Occupation; and
- cannot be reasonably omitted or modified.

Mental or Nervous Disorders A psychiatric or psychological condition classified in the most recent *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM) published by the American Psychiatric Association, as of the date of Covered Loss. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the date of Covered Loss.

Nurse A healthcare professional trained to care for people with Injuries or Sicknesses. A Nurse may include a graduate Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as a Nurse for a claim that you send to us.

Pathological Diagnosis A diagnosis made by a Pathologist based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of malignancy diagnosis must be in accordance with the standards set up by the American Board of Pathology.

Pathologist A Physician licensed by the American Board of Pathology to practice pathological anatomy or a Physician certified by the Osteopathic Board of Pathology as an osteopathic pathologist.

We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as a Pathologist for a claim that you send to us.

Payable Claim A claim for which we are liable for under the terms of this certificate.

Physician A person performing tasks that are within the limits of his or her medical license and is

also:
- a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction;
- licensed to practice medicine, prescribe and administer drugs, or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients.

We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as a Physician for a claim that you send to us.

Plan

Your Employer's Critical Illness Welfare Benefit Plan under ERISA, which includes this certificate, your Employer's Group Critical Illness Insurance Policy, and other benefit plan documents consistent with the Plan.

Policy

The Group Critical Illness Insurance Policy issued to the Policyholder, including this Certificate of Coverage and any amendments, riders, endorsements, and other attachments to this certificate and the Policy.

Policyholder

The entity to which the Policy is issued.

Qualifying Life Event

An event including, but not limited to:
- birth, adoption, or addition of a Child;
- a change in legal marital status;
- a change in employment status; or
- death of an Insured.

Qualifying Life Event coverage changes made in accordance with the Start of Coverage provisions must be consistent with the Qualifying Life Event.

For further information regarding Qualifying Life Events, please refer to your Employer's Human Resource policy.

Regular Occupation

The occupation you are routinely performing. We will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer at a specific location.

Sickness

An illness or disease.

Spouse

The person who is your partner through lawful marriage, civil union, domestic partnership (established by a declaration acceptable to us), or your legally separated Spouse.

Your Spouse may not be Insured as both a Spouse and an Employee.

Surgical Procedure

The cutting into the skin or other organ to accomplish any of the following goals:
- further explore the condition for the purpose of diagnosis;
- take a biopsy of a suspicious lump;
- remove diseased tissues or organs;
- remove an obstruction;
- reposition structures to their normal position;
- redirect channels;
- transplant tissue or whole organs;
- implant mechanical or electronic devices;
- repair an area that has been injured or affected by trauma, overuse, or Sickness; or
- restore proper function.

For purposes of this certificate, the following do not meet the Glossary definition of Surgical Procedure:
- venipuncture (drawing blood);
- lumbar puncture;
- epidural steroid injections;

- removal of skin tags; and
- foreign body removal from the eye.

Unum Insurance Company	Referred to as "Unum" and "we," "us," or "our."
Writing or **Written**	A record on or transmitted by paper, electronic, or telephonic means consistent with applicable law.

IMPORTANT NOTICES

Questions regarding your policy or coverage should be directed to:

Unum Insurance Company
(877) 225-2712

If you:
(a). need the assistance of the governmental agency that regulates insurance; or
(b). have a complaint you have been unable to resolve with your insurer, you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi.

Questions regarding Grievances, including what a Grievance is and how to file, should be directed to:

Unum Insurance Company
2211 Congress Street
Portland, Maine 04122
ATTN: Customer Relation

Customer Relations Complaint Line (toll free): 1-800-321-3889, Option 2

You may also contact the Indiana Department of Insurance by mail, telephone or electronically:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204-2787

Consumer Hotline: (800) 622-4461; (317) 232-2396

http://www.in.gov/idoi/3008.htm

Unum Insurance Company
2211 Congress Street, Portland, ME 04122
(877) 225-2712
services.unum.com

Be Well Benefit

We encourage our Insureds to maintain a healthy lifestyle. For those who take precautionary measures by receiving routine health screenings, we offer a Be Well Benefit. This is an annual cash benefit that may be claimed after completing an eligible Be Well Screening, and may be used to help with monetary expenditures such as transportation, missed work, or other incidentals.

For the purpose of determining your coverage and eligibility for the Be Well Benefit, all terms and provisions of your Certificate of Coverage apply unless modified below.

Policyholder: Old National Bancorp

Policy Number: 943878 011

Policy Effective Date: January 1, 2024

Be Well Benefit Effective Date: January 1, 2024

Eligible Group(s)

All Full-Time Employees in Active Employment in the United States working a minimum of 30 hours per week.

Paying for Coverage

The Be Well Benefit is automatically included in the cost of your Critical Illness Insurance coverage.

Be Well Benefit

For You	For your Spouse	For your Children
$50	$50	$50

Be Well Benefit Payment Conditions

Each Insured is eligible to receive a maximum of one Be Well Benefit per Calendar year.

The Be Well Benefit will become payable provided the following conditions are met:
- the date of the Be Well Screening is after the Be Well Benefit Effective Date; and
- an Insured's coverage is in force.

Be Well Screenings

Cholesterol and Diabetes	Eligible screenings include, but may not be limited to: blood test for triglycerides, fasting plasma glucose (FPG), fasting blood glucose test, hemoglobin A1C(HbA1c), Serum cholesterol test to determine total, HDL and LDL cholesterol levels, two hour post-load plasma glucose.
Cancer	Eligible screenings include, but may not be limited to: colonoscopy, virtual colonoscopy, CEA (blood test for colon cancer), low-dose computerized tomography (CT) (imaging study for lung cancer), double-contrast barium enema, fecal immunochemical testing, fecal DNA testing, PSA (blood test for prostate cancer), bone marrow testing, serum protein electrophoresis (blood test for myeloma), dermatological screenings for skin cancer, flexible sigmoidoscopy, hemoccult stool analysis, pap smear, thin prep pap test, cytology

	(PAP) smear, CA 15-3 (blood test for breast cancer), CA-125 (blood test for ovarian cancer), BRCA1 or BRCA2 testing.
Cardiovascular Function	Eligible screenings include, but may not be limited to: echocardiogram, electrocardiogram, stress test on a bicycle or treadmill, myocardial perfusion imaging.
Imaging Studies	Eligible screenings include, but may not be limited to: chest x-ray, carotid ultrasound (Doppler), mammography, breast ultrasound, breast MRI, breast thermography, transvaginal ultrasound, bone density scans, aortic ultrasound.
Annual Examinations by a Physician	Eligible examinations include sports physicals, annual exams for adults, and well-child visits.
Immunizations	Eligible immunizations include, but may not be limited to: HPV, Hepatitis B, chicken pox, MMR, meningitis, tetanus, pneumonia, influenza.

Unum Insurance Company
2211 Congress Street, Portland, ME 04122
(877) 225-2712
services.unum.com

Portability of Critical Illness Insurance

Portability allows you, your Spouse and Children to continue coverage when coverage under the Employer's group Policy would otherwise end due to an Eligible Portability Event. The certificate in force at the time of an Insured's Eligible Portability Event will reflect the terms and conditions of the coverage that can be continued.

Portability of Critical Illness Insurance is made a part of the Critical Illness Insurance Policy and is subject to all of the provisions, limitations and exclusions of the Policy and certificate, unless changed by this document. Additionally, defined terms found within Portability of Critical Illness Insurance have been capitalized and have the same meaning as the terms in the Glossary section of the Certificate of Coverage.

Any future changes made in the Employer's group Policy will not apply to coverage an Insured has ported, unless required by law.

If you have any questions about portable coverage, please contact your Employer or us.

Policyholder: Old National Bancorp

Policy Number: 943878 011

Policy Effective Date: January 1, 2024

Portability Effective Date: January 1, 2024

Portability Provisions

Eligible Portability Events

You are eligible to port coverage on the date of the following Eligible Portability Events:
- your employment with your Employer ends; or
- you are no longer in an Eligible Group.

However, you will not be considered eligible to port coverage at the time of an Eligible Portability Event if the Employer's Policy is cancelled by us.

Portable Coverage Available

The amount of coverage in force for each Insured on the date of your Eligible Portability Event is available to port subject to the following:

For you
The maximum amount of coverage available to port is your in force Coverage Amount at the time of your Eligible Portability Event.

For your Spouse
The maximum amount of coverage available to port is your Spouse's in force Coverage Amount at the time of your Eligible Portability Event.

For your Children
The maximum amount of coverage available to port is your Children's in force Coverage Amount at the time of your Eligible Portability Event.

If you wish to make a change to an Insured's in force coverage at time of port, please refer to Changes to Ported Coverage for guidelines in changing coverage.

Coverage for any Insured cannot be increased above the amount currently in force at the time you apply for portable coverage.

Applying for Portable Coverage

If you choose to apply for portable coverage for yourself, you may also port coverage for your Spouse and Children.

You must apply for portable coverage and pay the first premium within 31 days from the date of an Eligible Portability Event.

Applications for Portability are available from your Employer.

Ported Coverage Effective Date

Once premiums and all forms have been received, ported coverage is effective on the day after coverage would have otherwise ended under your Employer's Policy.

Changes to Ported Coverage

You may decrease coverage for an Insured subject to the Coverage Amounts available at any time.

Ported coverage cannot be increased at any time for any Insured.

Decreases in coverage will take effect on the first of the month following the date we process the change.

Any decrease in coverage will not affect a Payable Claim that occurs prior to the decrease.

End of Ported Coverage

If you choose to cancel your ported coverage, coverage for all Insureds will end on the first of the month following the date you provide notification to us.

For you

Otherwise, your ported coverage will end on the earliest of:

- the date you fail to pay the required premium within 31 days of a premium due date;
- the date you are rehired by your Employer or return to an Eligible Group and are covered under the Employer's group Policy;
- the date coverage provided under Portability is cancelled by us for any reason upon 45 days notice; or
- the date you die.

For your Spouse

Your Spouse's ported coverage will end on the earliest of:

- the date your ported coverage ends;
- the date your Spouse is no longer eligible for coverage;
- the date your Spouse no longer meets the definition of a Spouse;
- the date of your Spouse's death; or
- the date of divorce or annulment.

If your Spouse's coverage ends as a result of your death, divorce or annulment, your Spouse has the option to port coverage in accordance with Portability for your Spouse and Children in the Event of your Death, Divorce or Annulment.

For your Children

Your Children's ported coverage will end on the earliest of:

- the date your ported coverage ends;
- the date your Children are no longer eligible for coverage; or
- the date your Children no longer meet the definition of Children.

Once ported coverage ends, it cannot be reinstated.

In the event the Employer's group Policy is terminated, Insureds who have continued their coverage under Portability of Critical Illness Insurance prior to the Employer's group Policy termination date will not be affected.

Paying for

You must make all premium contributions for ported coverage. We will bill you directly for

Ported Coverage any premium due.

Rates for Ported Coverage Premium will be based on the rates for Portability in effect on the date you apply to port coverage.

Portability rates may be changed by us at any time. We will provide Written notice at least 45 days before any change is to take effect.

Portability for your Spouse and Children in the Event of your Death, Divorce or Annulment

Eligible Portability Events for your Spouse Your Spouse is eligible to port Spouse and Children coverage on the date of the following Eligible Portability Events for your Spouse:
- your death; or
- divorce or annulment.

Portable Coverage Available The amount of coverage in force for each Insured, on the date of the Eligible Portability Event for your Spouse, is available to port subject to the following:

For your Spouse
The maximum amount of coverage available to port is your Spouse's in force Coverage Amount at the time of the Eligible Portability Event for your Spouse.

For your Children
The maximum amount of coverage available to port is your Children's in force Coverage Amount at the time of the Eligible Portability Event for your Spouse.

If your Spouse wishes to make a change to an Insured's in force coverage at time of port, please refer to Changes to Ported Coverage for guidelines in changing coverage.

Coverage for any Insured cannot be increased above the amount currently in force at the time your Spouse applies for portable coverage.

Applying for Portable Coverage If your Spouse chooses to apply for portable Spouse coverage, your Spouse may also apply for portable Children coverage.

Your Spouse must apply for portable coverage and pay the first premium within 31 days from the date of the Eligible Portability Event for your Spouse.

Applications for Portability are available from us.

Ported Coverage Effective Date Once premiums and all forms have been received, ported coverage is effective on the day after coverage would have otherwise ended under the Employer's Policy.

Changes to Ported Coverage Your Spouse may decrease their Spouse and Children coverage subject to the Coverage Amounts available at any time.

Ported coverage cannot be increased at any time for any Insured.

Decreases in coverage will take effect on the first of the month following the date we process the change.

Any decrease in coverage will not affect a Payable Claim that occurs prior to the decrease.

End of Ported Coverage If your Spouse chooses to cancel ported coverage, your Spouse and Children's coverage will end on the first of the month following the date your Spouse provides notification to us.

For your Spouse
Otherwise, your Spouse's ported coverage will end on the earliest of:
- the date your Spouse fails to pay the required premium within 31 days of a premium due date;

- the date your Spouse is no longer eligible for coverage;
- the date coverage provided under Portability is cancelled by us for any reason upon 45 days notice; or
- the date of your Spouse's death.

For your Children

Your Children's ported coverage will end on the earliest of:

- the date your Spouse's ported coverage ends;
- the date your Children are no longer eligible for coverage; or
- the date your Children no longer meet the definition of Children.

Once ported coverage ends, it cannot be reinstated.

In the event the Employer's group Policy is terminated, Insureds who have continued their coverage under Portability of Critical Illness Insurance prior to the Employer's group Policy termination date will not be affected.

Paying for Ported Coverage

Your Spouse must make all premium contributions for Spouse and Children ported coverage. We will bill your Spouse directly for any premium due.

Rates for Ported Coverage

Premium will be based on the rates for Portability in effect on the date your Spouse applies to port Spouse and Children coverage.

Portability rates may be changed by us at any time. We will provide Written notice at least 45 days before any change is to take effect.

GROUP CRITICAL ILLNESS

THE FOLLOWING NOTICES AND CHANGES TO YOUR COVERAGE ARE REQUIRED BY CERTAIN STATES. PLEASE READ CAREFULLY.

State variations apply and are subject to change. Consult your Employer or plan administrator for the most current state provisions that may apply to you.

Full effect will be given to your state's civil union, domestic partner and same sex marriage laws to the extent they apply to you under a group insurance policy issued in another state.

If you have a complaint about your insurance you may contact us at 1-800-321-3889, or the department of insurance in your state of residence. Links to the websites of each state department of insurance can be found at www.naic.org.

Si usted tiene alguna queja acerca de su seguro puede comunicarse con nosotros a traves del numero 1-800-321-3889, o al departamento de seguros de su estado de residencia. Puede encontrar enlaces a los sitios web de los departamentos de seguros de cada estado en www.naic.org.

The states of **Florida and Maryland** require us to advise residents of these states that if your Certificate was issued in a jurisdiction other than the state in which you reside, it may not provide all of the benefits required by the laws of your residence state.

The state of **Montana** requires us to notify you that the provisions in the Policy, including those in the Certificate of Coverage, conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the Insured resides on or after the Policy Effective Date.

If you are a resident of one of the states noted below, and the provisions referenced below appear in your certificate in a form less favorable to you as an Insured, they are amended as follows:

For residents of Alaska:

The **Filing a Claim** provision for Claim Forms in the **Claims Provisions** section of the certificate is amended so that claim forms will be sent to you within 10 working days from the date we receive the notice of a claim.

The **Claim Procedures** provision in the **Claims Provisions** section of the certificate is amended so that notification of a claim decision and payment issued for a Payable Claim is within 30 days after receipt of satisfactory Written Proof of Loss.

A **Payment of Interest** provision has been added to the **Claims Provisions** section of the certificate as follows:

> Any benefit payment issued after 30 days from the date we receive satisfactory Written Proof of Loss will accrue simple interest on the net benefit amount at the rate of 15% per year. Interest will accrue beginning on the day following the date that the benefit payment was due and ending on the date we make that benefit payment.
>
> For purposes of this provision, a benefit payment is considered paid on the date payment is mailed or transmitted electronically.

The **Overpayment of Claims** provision in the **Claim Provision** section of the certificate is amended by limiting the right to recover overpayments to 365 days from the date the claim was paid. This provision reads as follows:

> We have the right to recover any overpayments made on a prior claim up to 365 days from the date the claim was paid. However, in the event that we have clear and documented proof of Fraud or other intentional misconduct, we have the right to recover any overpayments at any time. In any event, we will provide Written notice at least 30 days before we seek recovery of an overpayment. Written notice will include adequate information to identify the specific claim and the specific reason for the recovery.

You must reimburse us in full. We will work with you to develop a reasonable method of repayment if you are financially unable to repay us in a lump sum. This may include reducing or withholding future payments.

We will not recover more money than the amount we paid you.

For residents of Arkansas:

The **Children** definition in the **Glossary** section of the certificate is amended for a Child who is incapable of self-sustaining employment due to permanent intellectual or physical incapacity as follows:

Coverage for your Child may be continued past age 26 if your Child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance. You must submit proof of the Child's incapacity and dependency to us in order to continue coverage that would have otherwise ended due to age. Ongoing proof of incapacity and dependency must be provided when requested by us.

For residents of Colorado

The **Exclusions** provision in the **Critical Illness Details** section of the certificate is amended by providing that any exclusion for claims caused by, contributed to by, or occurring as a result of injuring oneself intentionally or attempting or committing suicide, whether sane or not is applied only if you were sane when the event occurred.

For residents of Idaho

The *Date of Diagnosis* for **Amyotrophic Lateral Sclerosis (ALS)**, a Covered Condition found under Progressive Diseases in the **Critical Illness Details** section of the certificate, is amended as follows:

The date a Physician diagnoses the Insured with Amyotrophic Lateral Sclerosis (ALS)

The *Date of Diagnosis* for **Dementia (including Alzheimer's Disease)**, a Covered Condition found under **Progressive Diseases** in the **Critical Illness Details** section of the certificate, is amended as follows:

The date the Insured is Cognitively Impaired due to Dementia (including Alzheimer's Disease) as diagnosed by a Physician.

The *Date of Diagnosis* for **Multiple Sclerosis (MS)**, a Covered Condition found under **Progressive Diseases** in the **Critical Illness Details** section of the certificate, is amended as follows:

The date a Physician diagnoses the Insured with Multiple Sclerosis (MS). The diagnosis must be supported one or more of the following:

- two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;
- well-defined neurological abnormalities lasting more than six months, confirmed by MRI of the nervous system, showing multiple lesions of demyelination; or
- a single attack, confirmed by repeated MRI of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

The *Date of Diagnosis* for **Parkinson's Disease**, a Covered Condition found under **Progressive Diseases** in the **Critical Illness Details** section of the certificate, is amended as follows:

The date a Physician diagnoses the Insured with Parkinson's Disease. The Insured must exhibit two or more of the following clinical manifestations for a period of at least 90 days:

- muscle rigidity;
- tremor; and
- bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses).

Spina Bifida, a Covered Condition found under **Additional Critical Illnesses for your Children** in the **Critical Illness Details** section of the certificate, is amended as follows:

1) the provision name reads "Severe Spina Bifida"

2) the Condition Definition reads:
A birth defect of the spine where there is incomplete closing of the backbone and membranes around the spinal cord, resulting in hernial protrusion of the meninges or spinal cord.

For purposes of this benefit, a diagnosis of spina bifida occulta does not meet the Condition Definition for Spina Bifida.

The **Exclusions** provision in the **Critical Illness Details** section of the certificate is amended as follows:

We will not pay benefits for a claim that is caused by, contributed to by, or occurs as a result of any of the following:

- participation in a felony;
- injuring oneself intentionally or attempting or committing suicide, whether sane or not;
- active participation in a riot or insurrection. This does not include civil commotion or disorder, injury as an innocent bystander, or Injury for self-defense;
- participating in war or any act of war, whether declared or undeclared;
- combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations;
- voluntary use of alcohol or drugs or treatment for alcoholism or drug addiction unless taken as prescribed or directed by the Insured's Physician.

Additionally, no benefits will be paid for a Date of Diagnosis that occurs prior to the Coverage Effective Date.

The **Pre-existing Condition** provision in the **Critical Illness Details** section of the certificate is amended so that the number of months prior to the Insured's coverage effective date referenced in that section is no more than 6 months.

For residents of Minnesota

The **Exclusions** provision in the **Critical Illness Details** section of the certificate is amended so that any exclusion for claims caused by, contributed to by, or occurring as the result of injuring oneself intentionally or attempting or committing suicide, whether sane or not, is amended by removing the phrase, "or attempting or committing suicide.

For residents of Montana

For purposes of the *Date of Diagnosis'* in **"Cerebral Palsy"**, **"Cleft Lip or Cleft Palate"**, **"Down Syndrome"**, or **"Spina Bifada"** under the **Additional Critical Illnesses for your Children** in the **Critical Illness Details** section of the certificate, Children are defined as any Children born to age 26.

The **Exclusions** provision in the **Critical Illness Details** section of the certificate is amended so that any exclusions for claims caused by, contributed to by, or occurring as the result of:

- injuring oneself intentionally or attempting or committing suicide, whether sane or not,
- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician;
- being intoxicated;

are removed.

The **Pre-existing Condition** provision in the **Critical Illness Details** section of the certificate is amended so that the number of months prior to the Insured's Coverage Effective Date referenced in that section is no more than 6 months and the rest of the text reads as follows:.

An Insured has a Pre-existing Condition if, within the 6 months just prior to their Coverage Effective Date, they have an Injury or Sickness for which:

- medical advice, treatment, care or services, or diagnostic measures were received or recommended to be received during that period;
- drugs or medications were taken, or prescribed to be taken during that period; or
- symptoms existed

The **Overpayment of Claims** provision in the **Claim Provision** section of the certificate is amended by limiting the right to recover overpayments to 12 months from the date of payment. This provision reads as follows:

We have the right to recover any overpayments for up to 12 months due to:

- Fraud;
- Misstatement of Information;
- any error we make in processing a claim; or
- Earnings.

The 12 months we have to recover overpayments will begin:

- for Fraud, on the date the Department of Insurance (DOI) determines insufficient evidence of Fraud exists. If we suspect a claim is overpaid as the result of Fraud, we will report the activity and evidence to the DOI;
- for reasons other than Fraud, including error, omissions, misstatement, misrepresentation, or concealment of information, on the date we have actual knowledge of the invalid claim, overpayment, or other incorrect payment. We will not request reimbursement of an unpaid claim not the result of fraud more than 24 months from the date of payment, regardless of the date we obtain actual knowledge of the invalid claim, overpayment, or other incorrect information.

You must reimburse us in full. We will work with you to develop a reasonable method of repayment if you are financially unable to repay us in a lump sum. This may include reducing or withholding future payments.

The **Representations in Applications** provision in the **General Provisions** section of the certificate is amended to read:

In the absence of Fraud, any statements made by you will be considered a representation and not a warranty. We will not use such statements to avoid insurance, reduce benefits, or deny a claim unless it is included in an application signed by you, and a copy of the signed application has been provided to you or your beneficiary.

For purposes of the definition of **Children** in the **Glossary** section of the certificate, Children are defined as any Children born to age 26.

For residents of New Hampshire

The **Contestability** provision in the **Policy Provisions** section of the Policy has been amended to remove reference to Fraud. Language has been replaced to read as follows:

However, in the event of nonpayment of premium by the Insured or the Policyholder, we can take action at any time under the provision titled Cancellation or Modification of this Policy by Us and as permitted by applicable law.

The minimum hours requirement of the **Eligible Groups** provision in the **Critical Illness Highlights** section of the certificate is amended to cover eligible employees working at least 15 hours per week.

The days an Insured must be confined to a Hospital, in the Condition Definition for **Infectious Disease**, a Covered Condition found under **Supplemental Critical Illnesses** in the **Critical Illness Details** section of the certificate, is amended to read 7 or more consecutive days.

The time period for a follow-up confirmatory antibody test to be taken, in the Date of Diagnosis for **Occupational Human Immunodeficiency Virus (HIV) or Hepatitis**, a Covered Condition found under **Supplemental Critical Illnesses** in the **Critical Illness Details** section of the certificate, is amended to read between 180 and 270 days.

The **Exclusions** provision in the **Critical Illness Details** section of the certificate is amended so that any exclusion for claims caused by, contributed to by, or occurring as the result of being engaged in an illegal occupation or activity, is amended by removing the phrase, "or activity."

The Exclusions provision in the Critical Illness Details section of the certificate is amended so that any exclusions for claims caused by, contributed to by, or occurring as the result of:

- being intoxicated;

is removed.

The **Pre-existing Condition** provision in the **Critical Illness Details** section of the certificate is amended so that the number of months prior to the Insured's Coverage Effective Date referenced in that section is no more than 6 months. The number of months after the Insured's Coverage Effective Date referenced in that section is no more than 6 months.

The **Claim Procedures** provision in the **Claims Provisions** section of the certificate is amended so that notification of a claim decision and payment issued for a Payable Claim is within 30 days.

The **Appeal Procedures** provision in the **Claims Provisions** section of the certificate is amended to reflect that the appeals specialist is a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate or the supervisor of the person making the initial determination.

The **Assignment** provision in the **General Provisions** section of the certificate is amended to reflect that in no event may an Insured's assignee be a healthcare provider.

The **Contestability** provision in the **General Provisions** section of the certificate has been amended to remove reference to Fraud. The last sentence has been replaced to read as follows:

> However, in the event of nonpayment of an Insured's premium, we can take action at any time under the provision titled Cancellation or Modification to the Policy and this Certificate of Coverage and as permitted by applicable law.

The **Additional Services** provision in the **General Provisions** section of the certificate and in the **Policy Provisions** section of the Policy is removed.

The **Injury** definition in the **Glossary** section of the certificate is amended to read "Any damage or harm to the body."

The **Be Well Benefit** is called the **Health Screening Benefit**.

For residents of South Dakota

The **Exclusions** provision in the **Critical Illness Details** section of the certificate is amended so that any exclusions for claims caused by, contributed to by, or occurring as the result of:

- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician;
- being intoxicated;

are removed.

The **Pre-existing Condition** provision in the **Critical Illness Details** section of the certificate is amended so that the number of months prior to the Insured's coverage effective date referenced in that section is no more than 6 months.

For residents of Texas

The **Payment of Benefits** provision in the **Claim Provisions** section of the certificate is amended as follows:

Payment of Benefits
Benefits for which we are liable will be paid after we complete the Claims Procedures. All benefits will be paid to you, unless we receive Written authorization to pay them elsewhere. This is an assignment of benefits. Benefits for Children who are receiving financial and medical benefits through the Texas Department of Human Services will be paid to the Texas Department of Human Services whenever:

- the Texas Department of Human Services is paying benefits pursuant to Chapters 31 and 32 of the Human Resources Code, i.e., financial and medical assistance service programs administered pursuant to the Human Resources Code;
- the parent who is covered by this certificate has possession or access to the Child pursuant to a court order, or is not entitled to access or possession of the and is required by the court to pay child support; and
- we are notified at the time of claim that the Child is receiving financial and medical assistance.

In addition, benefits for Children may also be paid to a possessory or managing conservator of the Child if the appointment for that Child was issued by a court in this or another state. In the event of your death, any unpaid benefits will be paid to your beneficiary in accordance with the Beneficiary Designation and Change provision or, if required, to the Texas Department of Human Services.

In the event of your Spouse's death, should your Spouse have survived you and continued coverage, any unpaid benefits for your Spouse, will be paid to your surviving Spouse's beneficiary in accordance with the Beneficiary Designation and Change provision.

For residents of Utah

The **Exclusions** provision in the **Critical Illness Details** section of the certificate is amended by providing that any exclusion for claims caused by, contributed to by, or occurring as the result of committing or attempting to commit a felony; being engaged in an illegal occupation or activity; or active participation in a riot, insurrection, or terrorist activity is applied only if you were a voluntary participant.

The **Pre-existing Condition** provision in the **Critical Illness Details** section of the certificate is amended so that the first and second numbers are no more than 6.

The **Pathological Diagnosis** definition in the **Glossary** section of the certificate is amended as follows:

A diagnosis made by a Physician based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of malignancy diagnosis must be in accordance with the standards set up by the American Board of Pathology.

The **Physician** definition in the **Glossary** section of the certificate is amended as follows:

A person performing tasks that are within the limits of his or her medical license.

We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as a Physician for a claim that you send to us.

For residents of Vermont

The minimum hours requirement of the **Eligible Groups** provision in the **Critical Illness Highlights** section of the certificate is amended to cover eligible employees working at least 17.5 hours per week.

The **Exclusions** provision in the **Critical Illness Details** section of the certificate is amended by providing that any exclusion for claims caused by, contributed to by, or occurring as the result of oneself intentionally or attempting or committing suicide, whether sane or not is applied only if you were sane when the event occurred.

The **Exclusions** provision in the **Critical Illness Details** section of the certificate is amended so that any exclusions for claims caused by, contributed to by, or occurring as the result of:

- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician; and
- being intoxicated;

are removed.

The **Autopsy** provision in the **Claim Provisions** section of the certificate is amended so that when we request an Autopsy where it is allowed by law, and not prohibited by the Insured's religion, it will be at our expense.

The **Fraud** provision in the **General Provisions** section of the certificate is amended as follows:

We want to make sure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. We promise to focus on all means necessary to support fraud detection, investigation, and prosecution.

Anyone who knowingly, and with intent to injure, defraud, or deceive us may be guilty of Fraud as determined by a court of law. This includes filing a claim or providing information that contains any false, incomplete, or misleading information.

These actions will result in denial of a claim, and are subject to prosecution and punishment to the full extent under state and federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

The **Covered Accident** definition in the **Glossary** section of the certificate is amended as follows:

A bodily Injury sustained by an Insured, which is the direct cause of the loss, independent of disease or bodily infirmity and which:

- occurs on or after the Coverage Effective Date;
- occurs while coverage is in force; and
- is not excluded by name or specific description in this certificate.

ERISA

Additional Summary Plan Description Information

If the Policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions, together with your Certificate of Coverage, constitute the summary plan description. The summary plan description and the Policy constitute the Plan. Benefit determinations are controlled exclusively by the Policy, your Certificate of Coverage and the information contained in this document.

Name of Plan:
Old National Bancorp Plan

Name and Address of Employer:
Old National Bancorp
1 Main Street
P.O. BOX 718
Evansville, Indiana
47705

Plan Identification Number:
a. Employer IRS Identification #: 35-1539838
b. Plan #: 502

Type of Welfare Plan:
Critical Illness

Type of Administration:
The Plan is administered by the Plan Administrator. Benefits are administered by the insurer and provided in accordance with the insurance policy issued to the Plan.

ERISA Plan Year Ends:
December 31

Plan Administrator, Name, Address, and Telephone Number:
Old National Bancorp
1 Main Street
P.O. BOX 718
Evansville, Indiana
47705
(800) 731-2265

Old National Bancorp is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

Agent for Service of Legal Process on the Plan:
Old National Bancorp
1 Main Street
P.O. BOX 718
Evansville, Indiana
47705

Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

Funding and Contributions:
The Plan is funded by insurance issued by Unum Insurance Company, 2211 Congress Street, Portland, Maine 04122, under 943878 011. Contributions to the Plan are made as stated under Paying for Coverage in the Certificate of Coverage.

Employer's Right to Amend the Plan

The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying policies), at any time and for any reason or no reason. Any amendment, modification, or termination must be in Writing and endorsed on or attached to the Plan.

Employer's Right to Request Policy Change

The Employer can request a Policy change. A change to the Policy will be made valid once approved by one of our officers. The change must be in Writing and endorsed on or attached to the Policy.

Cancellation of the Policy by the Employer

The Employer may cancel the Policy by providing us Written notice. In any event of cancellation, coverage will continue through the end of the day the cancellation takes effect.

A cancellation of the Policy will not affect a Payable Claim.

Cancellation or Modification of the Policy by Us

In addition, we may cancel or modify the Policy if the Policy terms are not met, the Employer fails to satisfy its obligations, premium is not paid, a change in the Employer or in the law impacts the benefits payable or the risks insured or, depending on the Policy, at our election after any rate guarantee period.

In any event, we will provide Written notice to the Employer prior to any cancellation or modification date. The Employer may cancel the Policy if it chooses not to accept the Policy modifications made by us.

A cancellation of the Policy will not affect a Payable Claim.

Your Rights Under ERISA

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon Written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Privacy Notice

This Privacy Notice applies to Unum Group's United States insurance operations and is being provided on behalf of its affiliates listed below ("Unum" "we"), as required by the Gramm-Leach Bliley Act and state insurance laws. This Notice describes how we collect, share, and protect nonpublic personal information (NPI).

COLLECTING INFORMATION
We collect NPI about our customers to provide them with insurance products and services, perform underwriting, provide stop loss coverage, and administer claims. The types of NPI we collect for these purposes may include telephone number, address, Social Security number, date of birth, occupation, income, and medical history, including treatment. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations and service providers.

SHARING INFORMATION
We share the types of NPI described above primarily with people who perform insurance, business and professional services for us, such as helping us perform underwriting, provide stop loss coverage, pay claims, detect fraud, and to provide reinsurance or auditing. We may share NPI with medical providers for insurance and treatment purposes and with insurance support organizations. The organizations may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes, with parties for a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

We do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services.

The law allows us to share NPI as described above (except health information) with affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. When required by law, we ask your permission before we share NPI for marketing purposes.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Unum companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

SAFEGUARDING INFORMATION
We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.

ACCESS TO INFORMATION
You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing, providing your full name, address, telephone number and policy number, to the address below. We will reply within 30 business days of receipt. If you request, we will send copies of the NPI to you or make available to you at our office. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

CORRECTION OF INFORMATION
If you believe the NPI we have about you is incorrect, please write to us and include your full name, address, telephone number and policy number if we have issued a policy, and the reason you believe the NPI is inaccurate. We will reply within 30 business days of receipt. If we agree with you, we will correct the NPI and

notify you and insurance support organizations that may have received NPI from us in the preceding 7 years. We will also, if you ask, notify any person who may have received the incorrect NPI from us in the past 2 years.

If we disagree with you, we will tell you we are not going to make the correction and the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct and the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI to be accessible. We will include your statement any time the disputed NPI is reviewed or disclosed. We will also give the statement to insurance support organizations that gave us NPI and to any person designated by you, if we disclosed the disputed NPI to that person in the past two years.

COVERAGE DECISIONS
If we decide not to issue coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI. You may submit a written request for the reason(s) for our decision within 90 business days of our decision. We will reply within 21 business days of receipt with the specific reasons, if not initially furnished, and specific items of information that supported our decision.

CONTACTING US
For additional information about Unum's commitment to privacy and to view a copy of our HIPAA Privacy Notice, please visit: unum.com/privacy or coloniallife.com. You may also write to: Privacy Officer, Unum, 2211 Congress Street, B267, Portland, Maine 04122 or at Privacy@unum.com.

We reserve the right to modify this notice. We will provide you with a new notice if we make material changes to our privacy practices.

Unum is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance Company of America, Unum Insurance Company, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, Colonial Life & Accident Insurance Company, The Paul Revere Life Insurance Company and Starmount Life Insurance Company.

unum.com MK-1883 (06-2020)

NOTICE OF PROTECTION PROVIDED BY THE INDIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This Notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. This safety net was created under Indiana law, which determines who and what is covered and the amounts of coverage.

ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies. (For the purposes of this Notice, the terms "insurance company" and "insurer" mean and include health maintenance organizations ("HMOs")).

Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only for companies placed in rehabilitation or liquidation on or after July 1, 2018. The benefits that ILHIGA is obligated to cover are not to exceed the lesser of (a) the contractual obligations for which the member insurer is liable or would have been liable if the member insurer were not an insolvent insurer, or (b) the limits indicated below:

Life Insurance

- $300,000 in death benefits
- $100,000 in net cash surrender or net cash withdrawal values

Health Insurance

- $500,000 for health plan benefits (see definition below)
- $300,000 in disability income and long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities

- $250,000 in present value of annuity benefits (including net cash surrender and net cash withdrawal values)

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to health benefit plans and covered unallocated annuities.

"Health benefit plan" is defined in IC 27-8-8-2(o), and generally includes hospital or medical expense policies, certificates, HMO subscriber contracts or certificates or other similar health contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as accident-only, credit, dental only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than the contractual obligations in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this Notice.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity to which it relates.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
3502 Woodview Trace, Suite 100
Indianapolis, IN 46268
(317) 636-8204

Indiana Department of Insurance
311 W. Washington Street, Suite 103
Indianapolis IN 46204
(317) 232-2385

The policy or contract that this Notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.

Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance or HMO coverage. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this Notice and Indiana law, Indiana law will control.

Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.

Unum Insurance Company
2211 Congress Street
Portland, ME 04122

INDIANA
INTERNAL GRIEVANCE AND EXTERNAL GRIEVANCE REVIEW PROCEDURE

CAREFULLY READ THE INFORMATION IN THIS DOCUMENT AND KEEP IT FOR FUTURE REFERENCE. IT HAS IMPORTANT INFORMATION ABOUT HOW TO APPEAL DECISIONS WE MAKE ABOUT YOUR BENEFITS

If you or your authorized representative have questions about a Grievance, want to file a Grievance or want to appeal a Grievance decision, you or your authorized representative can contact us by calling our Customer Relations Complaint Line, toll free, at 1-800-321-3889, Option 2. Written notice may also be provided to: Unum Insurance Company, 2211 Congress Street, Portland, ME 04122, ATTN: Customer Relations.

You may also contact the Indiana Department of Insurance by calling the Consumer Hotline at 1-800-622-4461 or by writing to: State of Indiana Department of Insurance, Consumer Services Division, 311 West Washington Street, Suite 300, Indianapolis, Indiana 46204.

Definitions

GRIEVANCE means any dissatisfaction expressed orally or in writing to us by you or by your authorized representative regarding the provision of services, claims practices, matters pertaining to the contractual relationship between:

a) an Insured and us; or
b) your Employer and us; or

a decision to rescind coverage under the Policy should you have a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

EXTERNAL GRIEVANCE REVIEW means a review conducted by a certified Independent Review Organization which is certified by the Indiana Office of the Commissioner of Insurance.

APPEAL means a formal request by you or your authorized representative for reconsideration of a decision not resolved to your satisfaction under the Grievance Procedures.

ADVERSE DETERMINATION means a reduction or denial of payment for treatment based on our review of the information provided and a determination by us that the treatment does not meet the requirements for the covered benefit.

Internal Grievance

Upon receipt of a Grievance, we will provide acknowledgement, either orally or in writing, to you or your authorized representative within 5 business days.

A Grievance will be resolved within 20 business days after we receive all information necessary to complete our review. If additional information is needed, we will notify you or your authorized representative in writing of a 10 business day extension. This notice of extension will be sent to you before the end of the 20th business day. In the event of an extension, the Grievance will be resolved within 30 business days from the date we receive the Grievance.

Once the Grievance has been resolved, we will notify you in writing within 5 business days. Notification will include:

1. a statement of the decision along with the reasons, policies, and procedures that are the basis of the decision;
2. notice of your or your authorized representative's right to appeal the decision; and
3. the department, address and telephone number through which you or your authorized representative can contact us to obtain additional information about the decision or the right to appeal.

Resolution of Appeals

If you or your authorized representative is not satisfied with the resolution of a Grievance, you or your authorized representative may Appeal the decision by notifying us at the above listed phone number or address. Upon receipt of an Appeal, we will provide acknowledgement, either orally or in writing, to you or your authorized representative within 5 business days.

In the case of an appeal of a Grievance decision of a determination that a service or proposed service is not appropriate or medically necessary or is experimental or investigational, we will appoint a panel of one or more qualified individuals to resolve your appeal. The panel will include one or more individuals who:

1. have knowledge of the medical conditions, procedures, or treatment at issue;
2. are licensed in the same profession and have a similar specialty as the provider who proposed or delivered the health care procedure, treatment, or service;
3. are not involved in the matter giving rise to the appeal or in the initial investigation of the Grievance; and
4. do not have a direct business relationship with the Insured or the health care provider who previously recommended the health care procedure, treatment, or service giving rise to the Grievance.

We will allow an Insured the opportunity to appear in person before, or if unable to appear in person, to appropriately communicate with the panel appointed.

A decision on an Appeal of a Grievance will be made as soon as reasonably possible but not later than 45 days after the Appeal of the Grievance is filed.

Once a decision on the Appeal has been made, we will notify you in writing within 5 business days. Notification will include:

1. a statement of the decision along with the reasons, policies and procedures that are the basis of the decision;
2. notice of your or your authorized representative's right to an External Grievance Review by an Independent Review Organization; and
3. the department, address and telephone number through which you or your authorized representative can contact us to obtain additional information about the decision or the right to an independent review.

External Grievance Review

You or your authorized representative may file a written request for an External Grievance Review regarding: (1) an Adverse Determination of appropriateness; (2) an Adverse Determination of medical necessity; (3) a determination that a proposed service is experimental or investigational; (4) or our decision to rescind coverage. This request must be made within 120 days after receiving notification of our Appeal decision.

After receiving your request for an External Grievance Review, we will promptly forward the Grievance, along with all relevant information to an approved Independent Review Organization (IRO). For each external grievance filed with us, a different IRO will be selected from the list of independent review organizations that are certified by the Indiana Department of Insurance; and the choice of an IRO will be rotated among all certified independent review organizations before repeating a selection.

The IRO chosen will assign a medical review professional who is board certified in the applicable specialty for resolution of an external grievance. The IRO and the medical review professional conducting the external review may not have a material professional, familial, financial, or other affiliation with any of the following:

1. us;
2. any officer, director, or management employee of us;
3. the health care provider or the health care provider's medical group that is proposing the service;
4. the facility at which the service would be provided;
5. the development or manufacture of the principal drug, device, procedure, or other therapy that is proposed for use by the treating health care provider; or
6. you or your authorized representative requesting the External Grievance Review.

However, the medical review professional may have an affiliation under which the medical review professional provides health care services to covered individuals of the insurer and may have an affiliation that is limited to staff privileges at the health facility, if the affiliation is disclosed to you or your authorized representative and us before commencing the review and neither you or your authorized representative nor us objects.

You or your authorized representative will not pay any of the costs associated with the services of an independent review organization. All costs will be paid by us.

You or your authorized representative will:

1. not be subject to retaliation for exercising your right to an External Grievance;
2. be permitted to utilize the assistance of other individuals, including health care providers, attorneys, friends, and family members throughout the review process;
3. be permitted to submit additional information relating to the proposed service throughout the review process; and
4. cooperate with the IRO by:
    a. providing any requested medical information; or
    b. authorizing the release of necessary medical information.

We will cooperate with the IRO by promptly providing any information requested by the IRO.

If at any time during the external review, you or your authorized representative submits additional information which may result in us reconsidering our adverse decision, we will request that the IRO cease the External Grievance Review until our reconsideration is completed. We will complete our reconsideration within 15 days after the information is submitted. If our reconsideration continues to be adverse, you may request that the IRO resume the External Grievance review. We will forward the additional submitted information to the IRO within 2 business days after receipt of the information and request that the External Grievance review resumes to completion.

The IRO will make a decision to uphold or reverse our decision within 15 business days of the filed request based on information gathered from:

1. you or your authorized representative;
2. us;
3. the treating health care provider; and
4. any additional information that the IRO considers necessary and appropriate.

The IRO will apply standards of decision making that are based on objective clinical evidence and the terms of your critical illness policy.

The IRO will notify you or your authorized representative and us of their decision within 72 hours from the date of their decision.

Upon receipt of a notice of an IRO's decision to reverse our decision, we shall immediately approve the coverage that was the subject of the decision, except for those services which may be specifically excluded under the Policy.

An external grievance decision is binding on us. You and your authorized representative may not file a subsequent request for external review involving the same decision for which you have already received an external grievance decision.

Expedited External Grievance Review

There may be situations where the normal External Grievance Review process may not apply. An Expedited External Grievance Review can be requested for a Grievance related to an illness, disease, condition, injury, or a disability if the time frame for a standard review would jeopardize your life or health or your ability to reach and maintain maximum function. For these situations, written request for an Expedited External Grievance Review must be made within 120 days after receiving notification of our Appeal decision.

After receiving your request for an Expedited External Grievance Review, we will promptly forward the Grievance, along with all relevant information to an approved Independent Review Organization (IRO) based on the standards for selection above.

You or your authorized representative will not pay any of the costs associated with the services of an Independent Review Organization. All costs will be paid by us.

You or your authorized representative will:

1. not be subject to retaliation for exercising your right to an External Grievance;
2. be permitted to utilize the assistance of other individuals, including health care providers, attorneys, friends, and family members throughout the review process;
3. be permitted to submit additional information relating to the proposed service throughout the review process; and

4. cooperate with the IRO by:
    a. providing any requested medical information; or
    b. authorizing the release of necessary medical information.

We will cooperate with the IRO by promptly providing any information requested by the IRO.
If at any time during the external review, you or your authorized representative submits additional information which may result in us reconsidering our adverse decision, we will request that the IRO cease the External Grievance Review until our reconsideration is completed. We will complete our reconsideration within 72 hours after the information is submitted. If our reconsideration continues to be adverse, you may request that the IRO resume the External Grievance review. We will forward the additional submitted information to the IRO within 2 business days after receipt of the information and request that the External Grievance review resumes to completion.

An IRO will make a decision to uphold or reverse our decision within 72 hours of the filed request based on information gathered from:
1. you or your authorized representative;
2. us;
3. the treating health care provider; and
4. any additional information that the IRO considers necessary and appropriate.

The IRO will apply standards of decision making that are based on objective clinical evidence and the terms of your critical illness policy.

The IRO will notify you or your authorized representative and us of their decision within 72 hours from the date of their decision.

Upon receipt of a notice of an IRO's decision to reverse our decision, we shall immediately approve the coverage that was the subject of the decision, except for those services which may be specifically excluded under the Policy.

An external grievance decision is binding on us. You and your authorized representative may not file a subsequent request for external review involving the same decision for which you have already received an external grievance decision.