Colonial Life
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Group Critical Care

PRODUCT REFERENCE PAGES [PRP]

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About this PRP…

These Product Reference Pages provide product and sales-related information for benefits counselors selling Colonial Life's coverage.

We strongly recommend that you review a sample policy for your state, along with the appropriate marketing and training support materials.

For a copy of the sample policy, call the Producer Support Line at 800-438-6423. Select the option for Customer Service and then the option for Service Operations (Account Services). Provide the producer name, producer number, state and plan code. Sample policies are not intended to be shared with potential insureds/employees.

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Product Positioning

Positioning Group Critical Care (GCC) in the Marketplace

Colonial Life has designed GCC to be an innovative, competitive and affordably priced critical illness and cancer insurance product. With multiple plan designs, flexible face amounts, multiple covered conditions and innovative features such as the Cancer Treatment and Care benefit, Group Critical Care provides options to help meet the need for financial protection against cancer, heart attacks, strokes and other critical illnesses.

Key Characteristics of Group Insurance

- The policy is owned by the employer with, generally, 100% premium funded by the employee, however employer paid options are available.
- Guaranteed Issue coverage is available at initial enrollment, when participation is met, regardless of the employee's health (no evidence of insurability is required).
- Issued based on situs state.
- Group coverage may be canceled by Colonial Life or the employer based on the termination provisions stated in the policy (it is not guaranteed renewable).
- Rates may change according to various factors including changes in group size and participation levels at renewal dates.
- Portability is also available.

Target Accounts

- Suitable for most markets – even those in which employees have excellent health coverage.
- For the professional market, Group Critical Care coverage can help fill the gaps created by loss of income or high medical bills. Group Critical Care also provides protection for non-medical expenses associated with specified diseases.
- For the smaller commercial markets, Group Critical Care can help serve as additional key-person coverage. It also provides coverage for entrepreneurs with short self-employment income history who may not yet be eligible for disability coverage.

Competitive Advantages

Group Critical Care offers numerous competitive advantages within the marketplace, at both the employer and employee levels.

Positioning GCC with Employers

For Smaller Accounts	Fully underwritten option allows for the competitively designed and priced GCC product to be sold in smaller accounts.
Multiple Plan Options	Multiple plan design options allow for the needs of each account to be met.
Guaranteed Issue Limits	Non-medical underwriting limits mean all employees, spouses and eligible dependent children can have access to coverage.
Face Amount Design	$5,000 to $100,000 face amounts allow employers to offer flexible coverage to their employees.

Spouse and Dependent Children Coverage	Available for spouse and eligible dependent children.
Cancer Treatment and Care Benefit	This new benefit helps with the extended costs associated with the treatment and care of cancer (internal or invasive) or carcinoma in situ.
Health Savings Account (HSA)-Compliant plans	HSA-compliant plan options allow employers to provide coverage that can be used alongside employees' Health Savings Accounts.
Helps Reduce Out-of-Pocket Expenses for Employees	GCC helps employers round out their benefits packages by providing employees additional financial protection when they, and covered family members, are diagnosed with a specified disease.

Positioning GCC with Employees

Guaranteed Issue	Regardless of medical history, all employees, spouses and eligible dependent children can receive coverage under guaranteed issue, within specified limits, subject to underwriting guidelines.
Coverage of 11 Conditions	We provide coverage of up to 11 total conditions including cancer (internal or invasive), heart attack (myocardial infarction), and stroke depending on the plan and plan options chosen by the employer.
Cancer Treatment and Care Benefit	This new benefit helps with the extended costs associated with the treatment and care of cancer (internal or invasive) or carcinoma in situ.
Spouse and Dependent Children Coverage	Available for spouse and eligible dependent children.
Portability	Allows employees to maintain insurance if they change jobs or retire. Employees can apply for portability of GCC coverage for themselves and covered spouses, and dependent children.
Flexibility	Face amount flexibility allows employees to choose the level of coverage they want for themselves and their covered spouses and dependent children.
HSA-Compliant Options	HSA-compliant plan options allow employees to use GCC with their HSAs.
Helps to Pay Out-of-Pocket Costs	Provides employees with additional financial protection to help cover the medical and/or non-medical costs of a specified disease.

Market Conduct Issues

To avoid potential market conduct issues, and understand how to appropriately position yourself and your product, refer to the Colonial Life Market Conduct, Privacy and Security Training Manual, your Colonial Life contract, and the Sales Organization General Policies and Guidelines Manual. To view or download the manual, visit Propr at Training > New to Colonial Life! > Sales Organization Policies and Guidelines Manual.

Remember to consider the following market conduct issues when you sell Group Critical Care coverage.

- To prevent over-insurance:
  - We do not allow stacking of this product with another Colonial Life Critical Illness product.
  - We do not allow stacking of this product that includes Cancer Benefits with another Colonial Life Cancer product.
- Be sure to use the Internal Replacement Form for your state if an applicant transfers coverage from one Colonial Life policy to another Colonial Life policy. This disclosure informs the applicant of the potential risks involved in transferring from one Colonial Life policy to another Colonial Life policy. (Refer to page 36 for transfer guidelines.)
- Use only current advertising material provided by Colonial Life. Do not create your own advertising and do not change any advertising materials provided to you.
- Always disclose the full name of the carrier(s) represented on any printed materials and/or any presentations associated with a sale.
- Do not directly or indirectly use a method to market without disclosing the purpose is to solicit insurance and that a contact will be made by the benefits counselor or the insurance company.
- Avoid using any method of marketing to recommend the purchase of insurance through force, fright, threat, or other undue pressure.
- Misrepresentation or incomplete or fraudulent comparisons of any insurance coverage or carrier should not be used to influence or attempt to influence a customer.
- Accurately communicate the coverage according to terms of the policy. Avoid using synonymous terms to refer to any disease that may imply broader coverage.
- Do not comment on the legal or tax implications of coverage without the appropriate training, qualifications or license.
- Ask all the questions on the application and carefully record the applicant's answers.
- Discuss your state's policy exclusions and limitations in detail with all applicants, especially the pre-existing condition limitation. When discussing the pre-existing condition limitation (if applicable), emphasize that this limitation applies to all individuals insured under the policy.
- Inform applicants that any provision of this policy that, on the effective date, does not agree with state laws where the policy was issued will be amended to conform to the minimum requirements of those laws.
- Do not respond to hypothetical (or perhaps real) claims situations that applicants may bring up—only a benefits person with the actual facts surrounding the particular illness can provide answers for these situations. Simply limit all comments to what the contract says.
- Be sure to provide any other underwriting or disclosure forms required during the enrollment, such as the Cancer Buyer's Guide.
- If you are a California licensee:
  - You must adhere to an advertising requirement that became effective January 1, 2005. According to the requirement, all print advertising must have the word "insurance" displayed in a type size no smaller than the largest telephone number, address or fax number. "Print advertisements" include business cards, written price quotations for insurance products, stationery, product brochures, and any other printed sales piece. Anything that you distribute to applicants must comply with this requirement. Any person in violation of this regulation will be subject to a fine levied by the commissioner in the amount of $200 for the first offense, $500 for the second offense, and $1,000 for any subsequent offense. A separate penalty will not be imposed for each piece of printed material that fails to conform to the requirements of this section.
  - Remember to sign your name on the application exactly as it appears on your California insurance license. In addition, include your California license number.

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Product Testing Procedures

Colonial Life provides the training you need to feel confident and secure when marketing our products, programs and services to customers. We make a tremendous investment in providing an excellent sales education and training program that offers many learning opportunities to help you become a high-performer. A strong, competent, and professional sales organization gives us a competitive advantage—a wonderful story to tell decision makers, brokers, and employees. Ultimately, a well-informed sales organization benefits our customers.

To help make sure all benefit counselors and their sales managers are grounded in product knowledge, you must follow these procedures for passing appropriate product tests and ordering marketing material.

Passing Appropriate Product Training Tests

Our policy has always stated that you must pass product mastery tests before you can sign and submit applications during enrollments. If, through audits, we discover that you have signed and submitted applications and have not passed the mastery tests for the products you sold, we will refer you to the Sales Contract Compliance Department. If you do not pass the required tests, the following consequences will apply, in progressive order:

- You will lose access to the Harmony® enrollment system.
- You will move from advanced commissions to as-earned commissions. (Any advances lost during the period in which advances are turned off will not be retroactively applied to your compensation. There are no exceptions.)
- You will have your contract terminated if you fail to take the tests in the timeframe specified by the home office.

Please avoid these consequences by making sure you have passed the necessary product tests before soliciting, signing, or submitting applications. Call Field Supply at 800.438.6423 if you have questions regarding the mastery tests you have passed to date.

Ordering Marketing Material

Benefit counselors and sales managers may order marketing material online or by phone. We will not send these materials to you unless you have passed the mastery tests for the applicable products.

In addition, if you log in to the online ordering system on Propr, you will not be able to view or order marketing materials unless you have already passed the training tests.

For additional information on general market conduct issues, refer to the *Market Conduct, Ethics, Privacy and Security Training,* available online at the Colonial Life College link on Propr. Your Colonial Life contract and the Sales Organization General Policies and Guidelines Manual also address market conduct behavior and issues.

To view or download the manual, visit Propr at Training > New to Colonial Life > Sales Organization Policies and Guidelines Manual.

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GCC Quick Product Summary

NOTE: This content is not state-specific. Refer to your state's certificate for exact product details.
You may print a sample certificate for your state by logging in to Propr > Products > Group Critical Care > Sample Certificates.

Supplemental group critical illness and cancer insurance pays a lump sum benefit for a covered person upon diagnosis of specified conditions and includes an option to pay extended benefits during the treatment of cancer (internal or invasive) or carcinoma in situ. This group coverage is owned by the employer but is typically funded by the employee, though employer paid options are available.

ACCOUNT SIZE	***10+ eligible lives***
FACE AMOUNT	***Employee Only Coverage: $5,000-$100,000**** ***Employee/Spouse, One-Parent or Two-Parent Family Coverage: $5,000-$75,000**** ***Spouse/Dependent Coverage*** • If covered by the employee's plan, spouse and eligible dependent child coverage is 50% of the named insured's Face Amount. **Amounts over $50,000 require Underwriting Risk Manager approval and are available at an account level.*
CRITICAL ILLNESSES COVERED	Full Critical Illness conditions: **100% of Face Value** • Heart Attack (Myocardial Infarction)* • Stroke* • End Stage Renal (Kidney) Failure* • Major Organ Failure* • Permanent Paralysis due to a Covered Accident • Coma • Blindness • Occupational Infectious HIV or Occupational Infectious Hepatitis B, C, or D **25% of Face Value** • Coronary Artery Bypass Graft Surgery (Not applicable to HSA-compliant plans for Plans 1-3)* • Coronary Artery Disease (Applicable to HSA-compliant plans for Plans 1-3)* * *Indicates benefits which are included in the Basic Critical Illness conditions*
CANCER BENEFITS	***Cancer Benefits*** • Diagnosis of Cancer (internal or invasive) – 100% of Face Amount • Diagnosis of Carcinoma in situ – 25% of Face Amount • Skin Cancer Benefit - $500 • Cancer Vaccine Benefit - $50 ***Cancer Treatment and Care Benefit*** • $500 or $1,000 per month, for 12 or 24 months during which an insured receives one of the covered treatments, as defined in the certificate

BUILT-IN FEATURES	***Portability*** To be eligible to port coverage, a named insured's coverage must be terminated for one of the following reasons: • The named insured is no longer in an eligible class • The named insured class is no longer included for insurance • If a covered person has been diagnosed as having cancer (internal or invasive) while the certificate is in force or has received at least one Cancer Treatment and Care Benefit payment, and for whom the Maximum Benefit Amount for a Cancer Treatment and Care Benefit shown on the Certificate Schedule has not been paid. Portability is not an option if: • Coverage ends because the group policy terminates or premiums are not paid, except in the case of an ongoing cancer claim as indicated by the third reason above, or • If all available benefits have been paid in full under the certificate. ***Transfer/Stacking*** • Transfers are allowed while stacking is not.
PLAN OPTIONS	There are 5 plan designs: • Plan 1: Critical Illness Benefit + Cancer Benefits + Cancer Treatment and Care Benefit • Plan 2: Critical Illness Benefit + Cancer Benefits • Plan 3: Critical Illness Benefit • Plan 4: Cancer Benefits + Cancer Treatment and Care Benefit • Plan 5: Cancer Benefits All plans have the option to include a $50 or $100 Health Screening Benefit. Plans 1-3: Include options for HSA or Non-HSA-compliant plan options, options for Basic or Full CI Conditions, and the Benefit Payable upon Subsequent Diagnosis of a Critical Illness. Plans 4 and 5 are HSA-compliant.
PLAN LEVEL ADDITIONAL COVERAGE OPTIONS	***First Diagnosis Building Benefit Rider*** • This benefit builds by $1000 each year the rider is in force up to a maximum of 10 rider years. It will pay upon diagnosis of any condition that is covered under the certificate at 100%.

ELIGIBILITY	**Account Eligibility** • Minimum of 10 enrolled lives • Available for payroll deduction only (*Non-payroll sales are not allowed.)* • Meets participation requirements on the premium effective date and on each contract renewal date to remain eligible • Employee *Actively working at the time of application, working at least 15 hours per week* *Issue ages, 16 – 74 (may vary by state)* • Spouse *Must be the spouse of an eligible employee* *Employee must purchase coverage for himself for spouse to be eligible for coverage* *Issue ages, 16 – 74* • Dependent Children *Employee must purchase coverage on himself for dependent children to be eligible for coverage* *Dependent on employee or spouse for support and maintenance, and* *Under age 26*
TARGET MARKETS	• Under 1,000-life accounts; commercial and public sector • Marketable to regular or special market accounts as listed in New Account Manual
UNDERWRITING LEVELS	• Guarantee Issue (GI) and Post-Enrollment Guaranteed Issue (PEGI) - greater of 15% or 15 eligible lives • Simplified Issue for face amounts of $5,000-$30,000 and Cancer Treatment and Care Benefit for $500/12, $500/24, or $1,000/12 months • Simplified Issue Level 1 with Cancer Treatment and Care Benefit for $1,000/24 months and face amounts of $31,000-$100,000* for employee only, $31,000-$75,000* for employee/spouse, one-parent or two-parent family * *Amounts over $50,000 require Underwriting Risk Manager approval*
PAYMENT METHOD	• Available to payroll-deduction accounts, following normal payment method guidelines • Non-payroll sales are not allowed.
AGE BENEFIT REDUCTION	• The Face Amount will reduce by 50% when the employee reaches age 75.
RATES	Premiums for Critical Illness and Cancer benefits have an age-banded structure: • 16-29 • 30-39 • 40-49 • 50-59 • 60-74 The Health Screening Benefit and Cancer Treatment and Care Benefit are composite-rated.

COVERAGE TYPES	There are 4 coverage types for employees and their families: • Named Insured (Employee) • Named Insured and Spouse • One-Parent Family • Two-Parent Family
PRE-EXISTING CONDITION LIMITATION PERIOD	12/12 in most states. (Refer to your state's proposal or sample certificate on Propr for additional information)

GCC Plan Design

	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5
Critical Illness Benefit (Includes Benefit Payable upon Subsequent Diagnosis of a Critical Illness)	•	•	•		
Cancer Benefits	•	•		•	•
Cancer Treatment and Care Benefit	•			•	

Employer Selections

Choice	Options
Which plan to offer	Five plan designs are available. The employer will choose one plan design to offer within the account.
Basic or Full Critical Illness Coverage (Plans 1-3)	The employer will choose whether to offer the Basic or Full covered critical illnesses.
HSA-compliant plan options	The employer will choose whether to offer the HSA-compliant plan design for Plans 1-3. Plans 4 and 5 are HSA-compliant.
Health Screening Benefit	The employer will choose whether to include this benefit. If included, the employer will choose between the $50 or $100 benefit.

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Employee Selections

Choice	Options
Face Amount	Employees can choose between $5,000 and $100,000 face amounts in $1,000 increments.
Cancer Treatment and Care Benefit	Employees can choose between a $500 or $1,000 monthly benefit amount and either a 12- or 24-month benefit period.
Coverage Type	Employees can choose to cover just themselves or their spouse and/or eligible dependents. Coverage types include: Named Insured, Named Insured and Spouse, One-Parent Family and Two-Parent Family.
First Diagnosis Building Benefit Rider	Employees can choose whether to purchase this rider.

Spouse/Dependent Children Coverage

Spouse/Dependent Children coverage is also available if the employee chooses. If covered by the employee's plan, the Face Amount for the Spouse and eligible Dependent Children will be 50% of the named insured's Face Amount. Covered spouses and eligible dependent children will have the same benefit amount and benefit period under the Cancer Treatment and Care Benefit as the named insured.

Benefits

Critical Illness Benefit

We will pay this benefit if a covered person is diagnosed with a critical illness, as defined in the certificate as long as the date of diagnosis is while the certificate is in force and the critical illness that is diagnosed is not excluded by name in the certificate. The benefit will be the percentage of the covered person's Face Amount shown on the certificate schedule for the critical illness diagnosed.

Critical Illness Conditions Covered

	For this Illness…	*We will pay this percentage of the Face Amount:*
Basic Conditions	• **Heart Attack (Myocardial Infarction)** • **Stroke** • **End Stage Renal (Kidney) Failure** • **Major Organ Failure**	**100%**
	• **Coronary Artery Bypass Graft Surgery** (Not applicable to HSA-compliant plans for Plans 1-3) • **Coronary Artery Disease** (Applicable to HSA-compliant plans for Plans 1-3)	**25%**
Full Conditions	**Basic Conditions Plus:** • **Permanent Paralysis due to a Covered Accident** • **Coma** • **Blindness** • **Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D**	**100%**

Benefit Payable upon Subsequent Diagnosis of a Critical Illness

The Benefit Payable upon Subsequent Diagnosis of a Critical Illness allows Colonial Life to pay for subsequent diagnoses of critical illnesses that meet the certificate guidelines. Guidelines vary based on whether a subsequent diagnosis is the result of the same or a different critical illness.

There is no Maximum Benefit Amount under the Benefit Payable upon Subsequent Diagnosis of a Critical Illness.

Subsequent Diagnosis…of a DIFFERENT Critical Illness

- If the covered person receives a benefit for a critical illness, and is later diagnosed with a different critical illness, we will pay the percentage of the Face Amount shown on the certificate schedule for the critical illness diagnosed as long as:
  - Dates of Diagnoses of critical illnesses must be separated by at least 180 days
  - The subsequent date of diagnosis is while coverage under the certificate is in force; and
  - The critical illness is not excluded by name or specific description in the certificate.

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Subsequent Diagnosis…of the SAME Critical Illness

- If a covered person receives a benefit for a critical illness, and later he is diagnosed with the same critical illness (except those listed below), we will pay 25 percent of the Face Amount as long as
  - Dates of diagnoses of critical illnesses must be separated by at least 180 days.
  - The covered person must not have received treatment during the 180 days between the dates of diagnosis for the same critical illness. Treatment does not include medications and follow-up visits to the covered person's doctor.
  - The subsequent date of diagnosis is while coverage under the certificate is in force; and
  - the critical illness is not excluded by name or specific description in the certificate

- Critical illnesses that do not qualify include:
  - Coronary Artery Bypass Graft Surgery/Coronary Artery Disease.
  - Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D.

Example #1 of a Subsequent Diagnosis of a DIFFERENT Critical Illness:

Named insured has a $40,000 Face Amount.

- He suffers a Heart Attack (Myocardial Infarction) on January 5th, 2013.

He receives $40,000, the Face Amount listed in the certificate for this critical illness (100% of $40,000).

- He has a Stroke on August 5th, 2013 (more than 180 days since he suffered a Heart Attack).

He receives $40,000, the Face Amount listed in the certificate for this critical illness.

Example #2 of a Subsequent Diagnosis of a DIFFERENT Critical Illness:

Named insured has a $40,000 Face Amount.

- He suffers a Heart Attack (Myocardial Infarction) on January 5th, 2013.

He receives $40,000, the Face Amount listed in the certificate for this critical illness (100% of $40,000).

- He has Coronary Artery Bypass Graft Surgery on August 5th, 2013 (more than 180 days since he suffered a Heart Attack).

He receives $10,000 the Face Amount listed in the certificate for this critical illness (25% of $40,000).

Example #3 of a Subsequent Diagnosis of a DIFFERENT Critical Illness (Employee with family coverage):

Named insured (employee) has a $40,000 Face Amount.

- Spouse suffers a Heart Attack (Myocardial Infarction) on February 14th, 2013.

She receives $20,000, the Face Amount listed in the certificate for this critical illness (50% of $40,000).

- Spouse suffers a Stroke on September 30th, 2013 (more than 180 days since she suffered a Heart Attack).

She receives $20,000, the Face Amount listed in the certificate for this critical illness (50% of $40,000).

- Dependent child is diagnosed with Leukemia.

He receives $20,000, the Face Amount listed in the certificate for this critical illness (50% of $40,000).

Example #1 of a Subsequent Diagnosis of the SAME Critical Illness:

Named insured has a $40,000 Face Amount.

- He suffers a Stroke on February 17th, 2013.

He receives $40,000, the Face Amount listed in the certificate for this critical illness (100% of $40,000).

- He has a second Stroke on September 1st, 2013 (more than 180 days since his first stroke).

He receives $10,000, which equals 25% of the Face Amount for this critical illness (25% of $40,000 Face Amount).

Example #2 of a Subsequent Diagnosis of the SAME Critical Illness (Employee with family coverage):

Named insured (employee) has a $40,000 Face Amount.

- Spouse suffers a Stroke on February 17th, 2013.

She receives $20,000 (50% of the employee's $40,000 Face Amount).

- She has a second Stroke on September 30th, 2013 (more than 180 days since her first stroke).

She receives $5,000 (25% of $20,000).

Cancer Benefits

	We will pay:
Diagnosis of Cancer (internal or invasive)	**100 % of Face Amount**
Diagnosis of Carcinoma in situ	**25% of Face Amount**
Skin Cancer Benefit	**$500 flat amount**
Cancer Vaccine Benefit	**$50 flat amount**

Diagnosis of Cancer Benefit

We will pay this benefit when you are diagnosed as having cancer (internal or invasive) if:

- The date of diagnosis is while the certificate is in force,
- For a cancer (internal or invasive) diagnosed during the 12 months following the coverage effective date, the cancer (internal or invasive) is not a pre-existing condition, and
- The cancer (internal or invasive) is not excluded by name or specific description in the certificate.

We will pay the percentage of the covered person's Face Amount shown on the Certificate Schedule. Payment of the Diagnosis of Cancer Benefit will not affect the amount paid under the Diagnosis of Carcinoma in situ Benefit. **We will pay this benefit only once per covered person per lifetime.**

Diagnosis of Carcinoma in Situ Benefit

We will pay this benefit when you are diagnosed as having carcinoma in situ if:

- The date of diagnosis is while the certificate is in force;
- For a carcinoma in situ diagnosed during the 12 months following the coverage effective date, the carcinoma in situ is not a pre-existing condition, and
- The carcinoma in situ is not excluded by name or specific description in the certificate.

We will pay the percentage of the covered person's Face Amount shown on the Certificate Schedule. The Diagnosis of Carcinoma in Situ Benefit will not affect the amount paid under the Diagnosis of Cancer Benefit. **We will pay this benefit only once per covered person per lifetime.**

Skin Cancer Benefit

We will pay this $500 benefit if a covered person is diagnosed with skin cancer if:

- The date of diagnosis is while the certificate is in force;
- For a skin cancer diagnosed during the Pre-existing Condition Limitation Period following the coverage effective date, the skin cancer is not a pre-existing condition; and
- The skin cancer is not excluded by name or specific description in the certificate.

We will pay this benefit only once per covered person per lifetime.

Cancer Vaccine Benefit
This $50 benefit is payable if a covered person incurs a charge for and receives any Cancer Vaccine that is approved by the Food and Drug Administration (FDA) for the prevention of cancer. The vaccine must be administered by licensed medical personnel while the certificate is in force. **We will pay this benefit only once per covered person per lifetime.**

Cancer Treatment and Care Benefit
We will pay benefits for Cancer Treatment and Care if:

- A covered person receives a covered treatment for cancer (internal or invasive) or carcinoma in situ in the United States, while the certificate is in force;
- The cancer or carcinoma in situ must not be excluded by name or specific description in the certificate; and
- The covered treatment cannot be excluded by name or specific description in the certificate.

We will pay **$500** or **$1,000** per month for **12** or **24** months (chosen by the employee) for each calendar month during which a covered person incurs charges for and receives one or more of the covered treatments listed below as a result of cancer (internal or invasive) or carcinoma in situ. The months do not need to be consecutive but will count towards the overall maximum amount of months in which the benefit is payable.

We will pay no more than one Cancer Treatment and Care Benefit per calendar month per covered person.

Covered Treatments consist of the following, as defined in the certificate:

- Chemotherapy
- Radiation
- Confinement
- Surgery
- Hospice Care

Benefit Reduction

In most states, the Face Amounts in the certificate will reduce by 50 percent on the first policy anniversary date after the named insured attains age 75. All Critical Illness, Diagnosis of Cancer and Diagnosis of Carcinoma in Situ benefits payable after that date will be based on the reduced Face Amount. *(Refer to your state's proposal or sample certificate for additional information.)*

Health Screening Benefit

Early detection and treatment may greatly improve an individual's chances of recovering from and surviving a serious illness. Group Critical Care encourages this type of prevention by paying a $50 or $100 (chosen by the employer) benefit per calendar year if the covered person incurs a charge for and has one of the following health screening tests performed while the certificate is in force.

The covered health screening tests:

- Stress test on a bicycle or treadmill
- Fasting blood glucose test
- Blood test for triglycerides
- Serum cholesterol test to determine levels of HDL and LDL
- Bone marrow testing
- Carotid doppler
- CEA (blood test for colon cancer)
- Chest x-ray
- Colonoscopy
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography

- Electrocardiogram (EKG, ECG)
- Echocardiogram (ECHO)
- Skin cancer biopsy
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- Pap smear
- PSA (blood test for prostate cancer)
- Serum protein electrophoresis (blood test for myeloma)
- Thermography
- ThinPrep pap test
- Virtual colonoscopy

We will pay a maximum of one Health Screening Benefit per covered person per calendar year. There is no waiting period for the Health Screening Benefit.

Rider

First Diagnosis Building Benefit Rider

The First Diagnosis Building Benefit Rider builds by $1,000 for each rider year the rider is in force after the rider effective date, up to a maximum of 10 rider years. For covered spouse and/or dependent children, the benefit builds by $500 for each year up to a maximum of 10 years.

We will pay the First Diagnosis Building Benefit if a covered person is diagnosed with a critical illness (other than Coronary Artery Bypass Graft Surgery, Coronary Artery Disease) or cancer (internal or invasive), as defined in the Certificate to which the rider is attached, and:

- the date of diagnosis is while this rider is in force;
- for a date of diagnosis during the Pre-Existing Condition Limitation Period following the rider effective date, the critical illness or cancer (internal or invasive) is not a pre-existing condition; and
- the critical illness or cancer (internal or invasive) is not excluded by name or specific description in the certificate.

In the event the covered person's diagnosis occurs before the end of the first rider year following the rider effective date, the First Diagnosis Building Benefit amount for that covered person will be $500 if the covered person is the named insured and $250 if the covered person is the named insured's covered spouse or dependent child, if applicable.

We will pay this benefit only once for each covered person insured by the rider.

We will not pay this benefit for skin cancer, carcinoma in situ, Coronary Artery Bypass Graft Surgery, or Coronary Artery Disease, as defined in the Certificate to which the rider is attached, or any critical illness or cancer (internal or invasive) diagnosed during the 12 months following the rider effective date if the critical illness or cancer (internal or invasive) is a pre-existing condition.

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Exclusions and Limitations

Certificate

Exclusions and limitations vary by state. For exact exclusions, review your state's certificate.

Exclusions and Limitations for Critical Illness

We will not pay benefits for a critical illness that occurs as a result of a covered person's:

Alcoholism or Drug Addiction
Addiction to alcohol or drugs, except for drugs taken as prescribed by his doctor.

Felonies or Illegal Occupations
Committing or attempting to commit a felony or engaging in an illegal occupation.

Intoxicants and Narcotics
Being intoxicated or under the influence of any narcotic unless administered on the advice of his doctor.

Psychiatric or Psychological Conditions
Having a psychiatric or psychological condition, including but not limited to affective disorders, neuroses, anxiety, stress and adjustment reactions. However, Alzheimer's Disease and other organic senile dementias are covered under the certificate.

Suicide or Injuries Which Any Covered Person Intentionally Does to Himself
Committing or trying to commit suicide or his injuring himself intentionally, whether he is sane or not.

War or Armed Conflict
Being exposed to war or any act of war, declared or undeclared, or serving in the armed forces of any country or authority. Losses as a result of acts of terrorism or nuclear release committed by individuals or groups will not be excluded from coverage unless the covered person who suffered the loss committed the act of terrorism or nuclear release.

Pre-Existing Condition Limitation
We will not pay the Critical Illness Benefit or Benefits Payable Upon Subsequent Diagnosis of a Critical Illness for any covered person when the critical illness is a pre-existing condition as defined in the certificate, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule on the date the covered person is diagnosed with a critical illness. Credit toward the satisfaction of the pre-existing condition limitation period will be given for any continuous time the covered person was covered under the pre-existing condition clause of previous coverage through another carrier if:

- The previous coverage was similar to or exceeded the coverage provided under the certificate;
- The covered person was insured under the previous coverage at the time of enrollment in the coverage provided by the certificate; and
- The covered person was insured under the coverage provided by the certificate on the Policy Effective Date shown on the Policy Rate Schedule.

The covered person is responsible for furnishing proof of his previous coverage, to include type of coverage, length the previous coverage was in force and the date the previous coverage terminated.

Exclusions and Limitations for Cancer

We will not pay any cancer benefit for a covered person's cancer (internal or invasive), carcinoma in situ, cancer treatment or care, or skin cancer that:

Pre-Existing Condition Limitation

Is a pre-existing condition, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule on the date the covered person is initially diagnosed as having cancer (internal or invasive), carcinoma in situ or skin cancer**.** No Pre-existing Condition Limitation will be applied for dependent children who are born or adopted while you are covered under this policy, and who are continuously covered from the date of birth or adoption. Credit toward the satisfaction of the pre-existing condition limitation period will be given for any continuous time the covered person was covered under the pre-existing condition clause of previous coverage through another carrier if:

- The previous coverage was similar to or exceeded the coverage provided under the certificate;
- The covered person was insured under the previous coverage at the time of enrollment in the coverage provided by the certificate; and
- The covered person was insured under the coverage provided by the certificate on the Policy Effective Date shown on the Policy Rate Schedule.

The covered person is responsible for furnishing proof of his previous coverage, to include type of coverage, length the previous coverage was in force and the date the previous coverage terminated.

Geographical Limitation

Is diagnosed or treated outside the territorial limits of the United States, its possessions, or the countries of Canada and Mexico.

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Eligibility Guidelines

Account Eligibility

Guidelines for accounts to be eligible for GCC coverage:

- Minimum account size is 10 enrolled lives.
- Available for regular or special market accounts, as listed in the New Account Manual.
- Available for payroll deduction only. Non-payroll sales are not allowed.
- An account must meet participation requirements on the premium effective date and on each contract renewal date to remain eligible.

Employee

Guidelines for employees to be eligible for GCC coverage:

- Issue ages are 16-74 (may vary by state).
- Permanent employees working a minimum of 15 hours per week.
- Actively at work on the date of enrollment and when coverage takes effect.
- No seasonal or temporary employees will be covered.
- Refer to the new account manual for additional guidelines for special market accounts.

Spouse

Guidelines for spouse to be eligible for GCC coverage:

- Issue ages are 16-74 (may vary by state).
- Must be the lawful spouse of an eligible employee.
- Employee must also purchase coverage for himself in order for the spouse to be eligible for coverage.

Dependent Children

Guidelines for dependent children to be eligible for GCC coverage:

- Chiefly dependent on you or your spouse for support; and
- Under 26 years of age.
- Employee must also purchase coverage for himself in order for the dependent children to be eligible for coverage.

Quoting

Group Critical Care proposals are located on Propr, and quotes can be acquired through the QuickQuote system. Rate sheets will also be available through online ordering. If you have questions regarding a prospect or would like to request a plan option that requires home office approval, call Group Underwriting at 1-800-438-6423.

All accounts with 1,000 or greater eligible lives require census for Home Office approval.

New Account Set-up

For new Colonial Life accounts, contact the New Account Service Center to assist you with setting up your account and establishing your Billing Control Number. Colonial Life's Account Information Form is required for the new account set-up.

For new or existing accounts, complete and submit the Simplified Master Application through Fast Forms tool located on Propr. Group Critical Care product setup in Harmony's Group Product Administration System (GPAS) must be completed once the application has been submitted, and prior to the transmission of any Group Critical Care business.

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Underwriting Guidelines

Rates

Age Banded

Age-banded premium rates are published and a census is not required.

The following requirements must be met:

- There must be at least 10 enrolled lives
- There are separate rates for tobacco and non-tobacco users.
- Premiums are unisex and age-banded according to the following bands:
  - 16-29
  - 30-39
  - 40-49
  - 50-59
  - 60-74

There are four coverage options for employees and their families:

1. Named Insured (Employee)
2. Named Insured & Spouse
3. One-Parent Family
4. Two-Parent Family

Spouse and dependent premiums are based solely on the age of the primary insured.
Rates do not increase as the insured reaches a new age band.

The standard rate guarantee period is one year.

Composite

Composite premium rates are custom at the account level based on a census.
All of the following requirements must be met:

- Prior risk manager approval
- A minimum of 1,000 eligible lives
- Minimum 25% participation
- Census must be provided to Group Underwriting
- Uni-tobacco, unisex premium rates

There are four coverage options for employees and their families:

1. Named Insured (Employee)
2. Named Insured & Spouse
3. One-Parent Family
4. Two-Parent Family

The standard rate guarantee is one year.

Sample Premiums

Sample Age Banded Monthly Premiums-Named Insured only (varies by state)

Plan 1: Critical Illness Benefit with Benefit Payable upon Subsequent Diagnosis of a Critical Illness
+ Cancer Benefits which include Diagnosis of Cancer Benefit, Diagnosis of Carcinoma in Situ Benefit, $500 Skin Cancer Benefit and $50 Cancer Vaccine
+ Cancer Treatment and Care Benefit $500 per month, 12 month benefit period
+ $50 Health Screening Benefit
+ First Diagnosis Building Benefit Rider for Critical Illness and Cancer

Cancer Benefits and Critical Illness Benefit With Benefit Payable Upon Subsequent Diagnosis of a Critical Illness

Issue Age	Non-Tobacco	Tobacco
16-29	$0.36	$0.58
30-39	$0.71	$1.11
40-49	$1.47	$2.32
50-59	$2.69	$4.26
60-74	$4.33	$7.00

$50 Health Screening Benefit	$2.90

Cancer Treatment and Care Benefit $500/12 month max

Non-Tobacco	Tobacco
$4.56	$5.43

First Diagnosis Building Benefit Rider for Critical Illness and Cancer

Issue Age	Non-Tobacco	Tobacco
16-29	$1.84	$2.95
30-39	$4.20	$6.60
40-49	$8.73	$13.91
50-59	$14.91	$23.66
60-74	$19.74	$31.18

The Harmony® enrollment system performs the calculation in automated enrollments. Here are instructions for manually calculating monthly premium.

1. Multiply the unit premium amount by the number of units (one unit equals $1,000 Face Amount) of GCC coverage purchased.

2. Add the flat amounts for the selected Cancer Treatment and Care Benefit, the $50 Health Screening Benefit and the First Diagnosis Building Benefit Rider for Critical Illness and Cancer.

3. Add any other state-specific amounts, for example, some states may have a policy fee. Check the state variations on Propr or the rate sheets in the online ordering system for your state.

Example:
Applicant age 30-39, non-tobacco, purchasing $15,000 GCC Plan 1

Units of Coverage	15
Unit Premium	X $ 0.71
Total	$ 10.65
$50 Health Screening Benefit	+ $ 2.90
Cancer Treatment and Care Benefit $500/12 months	+ $ 4.56
First Diagnosis Building Benefit Rider For Critical Illness and Cancer	+ $ 4.20
Total Monthly Premium:	**$ 22.31**

Premium Payment Methods

Because GCC is a group product, payroll deduction is the only form of premium payment available, unless the portability provision is used. If the portability option is exercised, the premium payment method is customized:

- Direct billing on a quarterly, semi-annual or annual basis.
- Monthly bank drafts.

Renewals

After the rate guarantee period of one year, Colonial Life may review the claims experience and the number of employees enrolled in the account. If any rate adjustments or plan changes are necessary, our Group Underwriters will work directly with the opener to implement rate or plan changes.

Underwriting Forms

Underwriting forms vary by state. Use the correct forms for the situs state in which you are writing business. All underwriting forms are available through the online ordering system.

Account-level Forms

Account Information Form

- The Account Information Form should be completed and submitted through the Fast Forms tools located on Proper. For additional assistance in setting up a new account please refer to the Fast Forms Reference Guide.

Group Application – Simplified Master Application

- Must be completed with the employer and submitted through the Fast Forms tools no less than 3 business days prior to the start of enrollment for a custom-rated/custom-plan group and no less than 24 hours prior to the start of the enrollment for an account enrolling for standard products/rates. Failure to do so will delay compensation and could result in declination of group enrollment forms and chargebacks.
- This application is included as a part of the policy.

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Employee-level Forms

Group Enrollment Form – Form: GCC - Enroll

- For face amounts equal to or under the Guaranteed Issue (GI) limit during initial enrollments
- For new hires enrolling after the initial enrollment when participation for Post Enrollment Guarantee Issue (PEGI) or GI was met.

Evidence of Insurability Form – Form: GCC– E of I

- For all face amounts over the Guaranteed Issue limit
- For accounts where the full underwriting level is selected
- For new hires in accounts with full underwriting or accounts that did not meet PEGI participation requirements during the initial enrollment
- For new hires applying for coverage above the GI Face Amount
- For late entrants applying for coverage after the initial enrollment

Underwriting Authorization (HIPAA) Form

- Required with each Evidence of Insurability Application

Internal Group Replacement Form (If required)

- Required when an applicant is replacing a similar Colonial Life policy with GCC.

Group Specified Disease Pre-tax Disclosure Form

- Required when an applicant applies for GCC on a pre-tax basis.

Express Enroll Forms (if Applicable)

- Required when enrolling through Express Enroll

Enrollment Platforms and Options

The enrollment platforms and options for this product will include:

- Harmony Options:
  - Agent Assisted: face-to-face, call center, or co-browsing
  - Self Enroll: requires home office approval
  - Census Enroll: Minimum of 100 eligible live, 0 to 100% employer paid
  - Census Enroll Takeover: Minimum of 100 currently enrolled lives, requires home office approval
  - Auto Enroll: Minimum of 100 eligible lives
  - Express Enroll: Minimum of 50 eligible lives, year one enrollments only
- Other options:
  - Product Hosting on 3rd Party System: 1,000 or more eligible lives, requires home office approval
  - Paper Enrollment Forms

Underwriting Levels

Group Critical Care offers flexible underwriting options including the following underwriting levels: Simplified Issue (SI), Simplified Issue Level 1, Post Enrollment Guaranteed Issue (PEGI) and Guaranteed Issue (GI).

The Pre-existing Condition Limitation will apply to all underwriting levels.

Employees must be actively working to be eligible for GCC regardless of the underwriting level chosen.

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Simplified Issue (SI)

Simplified Issue guidelines:

- Use the GCC - E of I application
- Minimum of 10 enrolled lives
- No underwriting approval required
- Employee face amounts $5,000 - $30,000
- Cancer Treatment and Care Benefit amounts of:
  - $500 for 12 months
  - $500 for 24 months
  - $1,000 for 12 months
- The First Diagnosis Building Benefit Rider, if selected

Additional Guidelines

- The First Diagnosis Building Benefit Rider is always underwritten at the Simplified Issue level regardless of the Face Amount applied for. The First Diagnosis Building Benefit Rider is not included in PEGI or GI offerings.

- If a simplified issue health question is answered as "yes" by the proposed insured, spouse or dependent, they are not eligible for coverage. If the application is submitted, it will be declined and the proposed insured will receive a letter explaining that the application has been denied based on the information provided on the application. We will not pursue additional information on these enrollment forms.

- If the proposed insured applies for One-Parent Family or Two-Parent Family coverage, he or she is required to answer the health questions for his or her dependent children. If the Simplified Issue questions are answered as "yes" for any dependent, that dependent will not be covered. The name of the child, relationship to the proposed insured, date of birth and social security number must be listed on the enrollment form. Dependent children who are listed on the application will NOT be covered under the policy unless PEGI/GI participation is met in the account.

Simplified Issue Level 1 (SI1)

Simplified Issue Level 1 guidelines:

- Use the GCC - E of I application
- Minimum of 10 enrolled lives
- Employee face amounts of $31,000 - $100,000
  - Cancer only plans (Plans 4 and 5 in most states) are limited to a maximum Face Amount of $50,000.
  - Plans that include critical Illness (Plan 1, 2 and 3 in most states) require prior approval from your Underwriting Risk Manager for face amounts above $50,000.
  - Employee Spouse, One-Parent Family and Two-Parent Family face amounts are limited to $75,000.
- Cancer Treatment and Care Benefit of $1,000 for 24 months

Additional Guidelines

- The simplified issue health questions must be completed as well as the additional Simplified Issue Level 1 health questions.

- The level of underwriting for an application will be determined based on the highest underwriting level required for the applicant's selected options.
    - For example: An applicant is applying for a $10,000 Face Amount and a Cancer Treatment and Care Benefit for $1,000 for 24 months. The $10,000 Face Amount requires Simplified Issue underwriting and the Cancer Treatment and Care Benefit ($1,000/24 months) requires simplified issue level 1 underwriting. This applicant would be underwritten as Simplified Issue Level 1 based on the higher underwriting level required for the Cancer Treatment and Care Benefit.

Post Enrollment Guaranteed Issue (PEGI)

Post Enrollment Guaranteed Issue guidelines:

- Available during the initial enrollment and for new hires during the new hire eligibility period
- Use the GCC - E of I application
- Minimum of 15 enrolled lives (See participation requirements below)

Additional Details

- Employee and family coverage types will be issued on a Guaranteed Issue basis provided participation is met. If participation is met, policies will be issued regardless of answers to health questions up to the Face Amount listed below. If participation is not met, certificates will be issued or declined based on answers to the health questions. The questions referenced under Simplified Issue, above, will be asked of each applicant.

- If participation is met and an applicant applies for an option that is above the PEGI Limits and does not qualify based on the health underwriting, the applicant will automatically be "knocked back" to the PEGI.

- If the Face Amount or Cancer Treatment and Care Benefit amount applied for exceeds the PEGI amount or if the First Diagnosis Building Benefit Rider is added, underwriting with Evidence of Insurability will be required.

Post Enrollment Guaranteed Issue Guidelines			
Number of Eligible Lives	Participation Requirement	Maximum Face Amount*	Cancer Treatment and Care Benefit Amount
15-199	Greater of 15 lives or 15%	$10,000	$500 for 12 months
200-499	15%	$15,000	$500 for 12 months
500+*	15%	$20,000	$500 for 12 months

* For accounts with 1,000+ lives, please contact Premier Client Services at 1-800-438-6423 to verify participation and face amounts.

Guaranteed Issue (GI)

Guaranteed Issue guidelines:

- Available during the initial enrollment and for new hires during the new hire eligibility period
- Use the GCC – Enroll form for face amounts up to the Guaranteed Issue limit or the GCC - E of I application for face amounts above the Guaranteed Issue limits.
- Minimum of 15 enrolled lives (See participation requirements below).
- The Pre-existing Conditions Limitation will apply.

Additional Guidelines

- Employee and family coverage types will be issued on a Guaranteed Issue basis during the initial enrollment if participation is met and for new hires during the new hire eligibility period. If participation is not met, all applications for the account will be declined. We will not pursue additional information for full underwriting.

- If participation is met and an applicant applies for an option that is above the GI Limits and does not qualify based on the health underwriting; the applicant will automatically be "knocked back" to the GI limit.

- No health questions are required to be completed for coverage up to the face amounts shown below. If the Face Amount or Cancer Treatment and Care Benefit amount applied for exceeds the GI amount or if the First Diagnosis Building Benefit Rider is added, underwriting with Evidence of Insurability will be required.

Guaranteed Issue Guidelines			
Number of Eligible Lives	Participation Requirement	Maximum Face Amount*	Cancer Treatment and Care Amount
15-199	Greater of 15 lives or 15%	$10,000	$500 for 12 months
200-499	15%	$15,000	$500 for 12 months
500+*	15%	$20,000	$500 for 12 months

- For accounts with 1,000+ lives, please contact Premier Client Services at 1-800-438-6423 to verify participation and face amounts.

Underwriting Quick Reference Chart

<table>
<tr><th colspan="2">Underwriting Quick Reference Chart</th></tr>
<tr><td>PEGI & GI</td><td>
<table>
<tr><th>Eligible Employees</th><th>Maximum Face Amount</th><th>Participation</th></tr>
<tr><td>15-199</td><td>$10K, $500/12 months</td><td>Greater of 15 enrolled lives or 15%</td></tr>
<tr><td>200-499</td><td>$15K, $500/12 months</td><td>15%</td></tr>
<tr><td>500+</td><td>$20K, $500/12 months</td><td>15%</td></tr>
</table>
</td></tr>
<tr><td>Simplified Issue</td><td>Face Amounts: $5,000-$30,000
Cancer Treatment and Care Benefit: $500/12, $500/24, or $1,000/12 months
First Diagnosis Building Benefit Rider</td></tr>
<tr><td>Simplified Issue Level 1</td><td>Face Amounts: Employee only $31,000 - $100,000*
Employee/Spouse, One-Parent or Two-Parent Family $31,000 - $75,000*
Cancer Treatment and Care Benefit: $1000/24 months
* Amounts above $50,000 require Underwriting Risk Manager approval.</td></tr>
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Height and Weight Chart

Following is a height and weight chart used for underwriting of Group Critical Care. If the weight of the applicant is greater than the maximum weight for his or her height, coverage will be declined. Height and weight is required for Simplified Issue Level 1 underwriting for the employee and spouse.

Height (Ft. In.)	Maximum Weight Knock-Out
4’ 10”	187
4’ 11”	193
5’ 0”	201
5’ 1”	207
5’ 2”	215
5’ 3”	223
5’ 4”	229
5’ 5”	236
5’ 6”	243
5’ 7”	250
5’ 8”	257
5’ 9”	265
5’ 10”	271
5’ 11”	279
6’ 0”	287
6’ 1”	295
6’ 2”	302
6’ 3”	312
6’ 4”	317
6’ 5”	325
6’ 6”	334
6’ 7”	341
6’ 8”	349
6’ 9”	358

Underwriting Authorization

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA). A portion of HIPAA, known as the Privacy Rule, requires a covered entity to have written authorization from an individual before it can use or disclose the individual’s protected health information.

As part of doing business, we obtain protected health information to underwrite policies and we get protected health information from other covered entities, such as health care providers. Because of this, we must make our authorizations compliant with the HIPAA Privacy Rule.

Colonial Life has a HIPAA-compliant underwriting authorization which is a separate document from our applications. You must submit one of these authorizations with each completed application, and the authorization must be completed in addition to the signature on the application.

An authorization is required with each application, regardless of whether or not the product is covered under the Privacy Rule. (Applications will still have the former authorization on them until we file and receive approval for HIPAA-compliant applications.) Spouse signatures are not required during the initial enrollment, but will be required at the time a claim is submitted on the spouse.

To learn more about HIPAA guidelines, log on to Propr and key in 'HIPAA' in the Search field.

Anniversary and Renewal Processing

Anniversary Processing

Anniversary processing is a manual method utilized by Group Underwriting in order to adjust the premium for an employee who has a salary rated group product when salary changes occur. This process takes place for each account that has salary rated products prior to the subsequent annual enrollment to ensure that the correct premium rates are applied for the enrollment period in case an employee makes changes.

This group product is NOT currently reviewed for anniversary processing.

Renewal Letters

Group products are reviewed for renewal each year. After the account is reviewed for renewal and the final renewal decision is made, the servicing agent will be notified by email and a letter will be sent to the Plan Administrator via U.S. Mail.

The servicing agent is responsible for communicating the renewal decision to each account. Only the servicing agent of the account receives renewal notices by email. One email/letter per account will be sent, which means you or the Plan Administrator will no longer receive a separate email/letter for each BCN. If an account has multiple BCNs, they will all be included in the same renewal notice.

To check on the status of an account renewal, please email GRPUW@Coloniallife.com.

Enrollment Administration

Multi-State Enrollments

With the Group Critical Care plan, we will issue the group contract and certificates based on the state where the employer's corporate address and or/billing location. This is commonly referred to as the situs state. Unless otherwise noted, Group Underwriting will use the state included on the Simplified Master Application as the situs state of the account. The product must be available for sale in the state where the employer's home office or principal place of business is located.

Some states are extra-territorial and require that residents in their state receive any mandated benefits regardless of the situs state of the group policy. In multi-state accounts, we will review the resident state of the insured versus the situs state and, if state law requires it, pay the benefit that is the most favorable to the insured.
In addition, there are specific restrictions for enrolling employees located in New York for group policies situsted outside of New York. See Situs State section below for further information.

If you have any questions about situs state or how benefits will be adjudicated in multi-state accounts, please call Group Underwriting at 800-438-6423.

Situs State

Situs state will determine certificate and rates for all employees.

- The home office will assign the situs state based on the employer's corporate address and/or billing location listed on Simplified Master Application unless otherwise requested and approved by Group Underwriting.
- Employees will be issued certificates based on situs state, including those employees residing in non-situs states where the Group Critical Care product is not approved.
- Benefit counselors must use marketing materials for the situs state, not the state in which the Enrollment Form is signed, except in extra-territorial states.
- If an account has employees in New York, they will not be covered under a Colonial Life policy. A Paul Revere policy will be issued to cover them.

Licensing Implications (same as for other Group Products)

- Opener and/or Broker must be licensed in the situs state.
- Benefits counselor must be licensed in the enrollment state.

Initial Enrollment

Post Enrollment Guaranteed Issue and Guaranteed Issue will only be offered to all eligible employees during the initial enrollment. After this enrollment all employees will be required to enroll as new hires or late entrants.
Prior underwriting approval is required for subsequent open enrollment periods or plan changes.

New Hires

New hires are eligible to enroll as Post Enrollment Guaranteed Issue or Guaranteed Issue if participation was met during the initial enrollment. The product must be offered to new hires within the 31-day eligibility period. After this period they will be considered late entrants.

Late Entrants

A late entrant is any employee that did not elect Group Critical Care coverage during the initial enrollment or did not sign up for coverage within the 31-day new hire eligibility period. Late entrants can enroll after the initial enrollment period with Evidence of Insurability.

Changes for Qualifying Events

After the coverage effective date, the named insured cannot make any changes to the coverage type under the certificate without Evidence of Insurability, unless the named insured has a qualifying event. A qualifying event, for the purposes of this provision, means:

- Birth or adoption of a child;
- Issuance of a court order requiring coverage of a child;
- Marriage;
- Divorce; or
- Death of a covered person.

The named insured will have 31 days from the date of occurrence of a qualifying event in which to:

- Notify us if the insured wishes to make a change;
- Complete any required enrollment form; and
- Pay any additional premium, if applicable.

Replacements

Group Critical Care coverage cannot be sold in an account in conjunction with other similar Colonial Life cancer or critical illness policies, such as Critical Illness 1.0, Cancer Assist or Cancer 1000.

Stacking of Colonial Life cancer or critical illness coverages is not allowed. For an applicant with existing Colonial Life coverages, Group Critical Care may not be sold to that applicant. If an applicant wants to cancel an existing cancer or specified disease policy to enroll in Group Critical Care, he or she may do so by:

- Completing a Request for Service Form and submitting it to the Colonial Life home office or
- Completing the transfer section on the GCC- Enroll or the GCC- E of I form with the policy number(s) in which the applicant wishes to replace; and
- Provide a signed Group Internal Replacement Form (varies by state).

The following chart shows which special risk products can be sold alongside which plan of GCC in an account:

Group Critical Care Cross Product Guidelines (plan designs may vary by state)					
	Plan 1	**Plan 2**	**Plan 3**	**Plan 4**	**Plan 5**
Group Cancer	NO	NO	YES	NO	NO
Group Critical Illness	NO	NO	NO	YES	YES
Individual Cancer	NO	NO	YES	NO	NO
Individual Critical Illness	NO	NO	NO	YES	YES

Portability

If a named insured ceases to be a member of an eligible class they may apply to port coverage. To be eligible the named insured's coverage must be terminated for one of the following reasons:

- The named insured is no longer in an eligible class.
- The named insured class is no longer included for insurance.
- If a covered person has been diagnosed as having cancer while the certificate is in force or has received at least one Cancer Treatment and Care Benefit payment, and for whom the Maximum Benefit Amount for a Cancer Treatment and Care Benefit shown on the Certificate Schedule has not been paid.

Portability is not an option if:

- Coverage ends because the group policy terminates or premiums are not paid, except in the case of an ongoing cancer claim as indicated by reason number three directly above.
- If all available benefits have been paid in full under the certificate.

Applying for portable coverage:

- Complete the GCC- Port form.
- Pay the first premium for portable coverage within 63 days after the named insured is no longer considered a member of an eligible class.

The benefits, terms and conditions of the ported coverage will remain the same as the original certificate. Please see the certificate for specific details. We will allow the applicant to decrease the Face Amount or remove a covered spouse and or dependent at the time portability is requested. The Face Amount cannot be decreased below the minimum allowed Face Amount of $5,000. Portability coverage may include any eligible family members who were covered under the original certificate at the time of termination. No upgrades to face amounts or coverage types (example: addition of spouse or dependents) are allowed at the time of portability.

Ported coverage becomes effective the day following the date the named insured ceases to be a member of an eligible class.

Ported Coverage ends for the primary insured on:

- The date the insured becomes eligible again under the specified disease policy, or
- The date any required premium is not paid by the end of the grace period, or
- The date Colonial Life cancels the ported coverage with 31-days prior notice.

Ported Coverage ends for a spouse and dependent children on:

- The date the named insured's insurance terminates, or
- The date the dependent child ceases to qualify as a dependent child as defined in the certificate, or
- The date the next premium is due after a divorce or annulled marriage.

Portability coverage may continue beyond the termination date of the policy if premiums are received. If ported coverage ends due to the failure to pay the required premium it cannot be reinstated.

Portability Rates

If an insured chooses to exercise the portability provision he will no longer pay published payroll rates. Instead the insured will pay portability rates. Premium due dates are the first day of each calendar month. The rates can be changed with written notice at least 45 days prior to the change.

Express Enroll

Express Enroll is an alternative enrollment method for first year enrollments only. Setup is done through Harmony, and the enrollment is conducted in a group meeting setting. A minimum of 50 lives is required, with a limited product offering. Refer to Propr under Enrollment Solutions for detailed product information. New hires are eligible to enroll via Express Enroll during their eligibility period. Late Entrants, employees who do not select any coverage during the initial enrollment, are not eligible. However, late entrants can enroll for any new products offered during subsequent enrollments, but they would remain ineligible for products offered during the initial enrollment. As a rule, year two enrollments using Express Enroll are prohibited unless a new product is offered.

Service Guidelines

Routine Service Requests

Certificate holders' routine requests can be handled over the telephone by calling the toll-free customer service number 800.325.4368. These include:

- Address changes
- Request for duplicate or lost certificate

Request for Service Form

Other service requests may require a completed Request for Service Form, application and/or additional form. A Request for Service Form is required when customers want to:

- Cancel existing coverage
- Remove a rider from an existing policy

The majority of these changes are simple and instructions on the Request for Service Form are easy to follow. Certificate holders simply complete the form and mail or fax it to the home office using the contact information indicated on the back of the form. The request for service form can be obtained on the online ordering site.

New application and/or additional form

A new application and/or an additional form is necessary for the following requests, which require additional field service from you.

Service Request	**Form***
Increase/decrease coverage Apply for coverage as a late entrant Add spouse and dependent children who were eligible at the initial enrollment	Evidence of Insurability Form
Remove existing spouse and dependent children	Enrollment Form
Apply for portability	Portability Application

**Regular form, state variations may require the use of a state specific form.*

Increasing Coverage, Applying as a Late Entrant, Adding Eligible Dependents

Colonial Life requires Evidence of Insurability during an approved re-enrollment when employees wish to increase coverage, apply for coverage as a late entrant, or add spouse and dependent children who were eligible at the initial enrollment. Named insureds and covered spouse and dependent children cannot increase their coverage above the plan maximum.

Porting Coverage

Named insureds eligible to apply for ported coverage must complete the Portability Application. See pages 34 -35 for specific details regarding portability.

Transferring Coverage

Careful consideration should be given when transferring an insured's existing critical Illness or cancer product to GCC. You should compare the benefits, exclusions and limitations of the products with the insured to determine the advantages and disadvantages of moving to the new plan. Some examples are:

Advantages:

- Due to guaranteed issue options the applicant may be eligible to apply for a higher Face Amount.
- Group Critical Care has additional benefits and a rider that are not found in Colonial Life's other cancer or critical illness policies.

Disadvantages:

- The loss of benefits accrued on other Colonial Life cancer policies
- The Pre-existing Condition Limitation Period will again have to be satisfied.

General exclusions and limitations may be different.

If transferring from an individual policy the insured may be losing guaranteed renewability among other benefits that are generally included in individual policies.

The following chart shows the transfer situations that you may encounter.

Type of transfer:	***If an insured currently has:***	***To transfer:***
Individual coverage to Group coverage	Individual Cancer or Critical Illness coverage	• The Employer must complete a new application (if not already offered). • The request for cancellation of existing cancer or critical illness coverage is included in the Agreement section on the GCC Enrollment Form. The applicant will list the policy numbers of the like polices to be canceled and provide a signature on the GCC Enrollment Form. The signature of the proposed insured and the list of the existing policy numbers in the Agreement Section will allow us to cancel any existing cancer and/or critical illness coverage if GCC coverage is issued. • A new 12-month (varies by state) pre-existing conditions limitation applies to the new Group Critical Care policy.
Group coverage to Group coverage	Group Cancer or Critical Illness Coverage	• The Employer must cancel their existing policy and complete a new application. • A new 12-month (varies by state) Pre-existing Conditions Limitation Period may apply to the new Group Critical Care policy.

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Claims Guidelines

Filing Procedures

Insureds must complete and submit a claim form to Colonial Life, either through the mail or by fax, with written proof of loss within 90 days after the covered loss begins or as soon as it is reasonably possible (varies by state). *Written proof of loss* must include one or more of the following: a doctor's bill, a hospital bill, or other proof of charges. Additional proof of loss is required for certain benefits under GCC. Please refer to the certificate for exact details.

In addition, Colonial Life can require that a doctor examine the insured while the claim is pending.

Also keep in mind:

- All claim forms are submitted to Colonial Life's home office. Insureds may choose to mail their forms to the home office or fax claims and medical bills to our toll-free fax number (1.800.880.9325).
- Insureds may visit coloniallife.com to select the appropriate claim form and other customer service forms.
- A signed Authorization Form must be submitted with a claim form because it allows us to contact the insured's medical providers when additional claims information is required.
- Insureds may take advantage of additional claims service options, which are referenced on page 1 of the claim form.

Additional claims service options include:

- Releasing information to individuals inquiring on an insured's behalf, such as a Colonial Life Benefits Counselor, Plan Administrator, spouse, family member or significant other.
- Updating insureds on the status of their claim through electronic messaging at their home phone number indicated on the claim form.
- The overnight delivery of payments over a certain amount may require an additional fee, which will be deducted from the insured's claim payment. (We are unable to overnight mail to a post office box.) Exact details are provided on the claim forms.

Taxability of Claim Payments

Please be advised that the information in this section should not be construed as tax advice. If you receive questions from employers or employees on the taxability of this product, refer them to their tax advisor. You can also share the following taxability fliers with them for more information on our 1099 guidelines:

Taxability of Benefits Flier Cancer and Critical Illness: Form #71403
Pre-Tax Disclosure: Form #64389

Employees can purchase a Group Critical Care policy for themselves, their spouse, and their dependents with either pre-tax dollars or post-tax dollars.

Premiums Paid with Pre-Tax Dollars
When premiums for a Colonial Life Group Critical Care policy are paid with pre-tax dollars, Colonial Life may be required to report benefits (except for the Health Screening Benefit, the Cancer Treatment and Care Benefit, and the Cancer Vaccine Benefit) to the Internal Revenue Service on a Form 1099.

Colonial Life **does not** have to report on a Form 1099:

- Any benefits paid as a reimbursement of actual medical expenses ("expense incurred benefits"); or,
- Any lump sum benefits for which the Group Critical Care policy requires the insured to have incurred a charge for the service or treatment ("indemnity with charges incurred benefits"). These include the Health Screening Benefit, the Cancer Treatment and Care Benefit, and the Cancer Vaccine Benefit.

The Health Screening Benefit, the Cancer Vaccine Benefit and the Cancer Treatment and Care Benefit under the Group Critical Care policy for New York require the insured to have incurred charges. Therefore, a 1099 will not be required for these benefits. **Note:** A few states do not have incurred charges language, so 1099s may be issued for these benefits, in those states. Please check state variations or sample certificates on Propr.

Premiums Paid with Post-Tax Dollars
If insureds pay for Colonial Life products on a post-tax basis, a Form 1099 will not be issued by Colonial Life regardless of whether these benefits are expense-incurred or indemnity.

We strongly recommend that insureds pay premiums for Group Critical Care on an after-tax basis. If insureds choose to pay their premiums on a pre-tax basis, they must sign a Pretax Disclosure Form during enrollment stating that they understand the potential tax liability associated with pre-taxing the premiums.

Insureds Covered by Medicaid
If an insured is covered by Medicaid, state and federal Medicaid regulations may require us to make certain Group Critical Care claim payments directly to the state Medicaid office. This also applies to any child or adult dependent covered under Medicaid even when the insured is not on Medicaid.

Definitions

Additional definitions may be contained in other certificate benefit provisions or any endorsement, amendment or rider.

Calendar Year means the period beginning on the coverage effective date shown on the Certificate Schedule and ending on December 31 of the same year. Thereafter, it is the period beginning on January 1 and ending on December 31 of each following year.

Coverage Effective Date means the date coverage begins as shown in the Certificate Schedule. The coverage effective date of the certificate is not the date you signed the application for coverage.

Dependent Children means your natural children, your step-children, your legally adopted children, children placed into your custody for adoption or children for whom you are ordered by a court to provide coverage who are chiefly dependent on you or your spouse for support and maintenance; and under 26 years of age.

Doctor or Physician means a person who is licensed by the state to practice a healing art and performs services for a covered person which are allowed by his license.

For purposes of this definition, Doctor or Physician does not include any covered person or anyone related to any covered person by blood or marriage, a business or professional partner of any covered person, or any person who has a financial affiliation or a business interest with any covered person.

Evidence of Insurability means a statement of your medical history which we will use to determine if you are approved for coverage.

Policy Anniversary Date means the date that occurs annually on the same day and in the same month as the First Policy Anniversary shown on the Policy Rate Schedule.
Pre-existing Condition means a sickness or physical condition for which a covered person was treated, had medical testing, received medical advice or had taken medication within 12 months before the coverage effective date.

Spouse means a person who is married to you on the day we issue your certificate.

Temporary Layoff or Leave of Absence means the named insured is temporarily absent from active employment for a period of time that has been agreed to in advance in writing by the employer. Normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

Definitions for Critical Illness Benefit

Additional definitions may be contained in other certificate benefit provisions or any endorsement, amendment or rider.

Accident means an unintended or unforeseen bodily injury sustained by a covered person, wholly independent of disease, bodily infirmity, illness, infection, or any other abnormal physical condition.

Blindness means clinically proven irreversible reduction of sight in both eyes that has persisted for a period of at least 180 consecutive days. Sight must be reduced to a corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (Snellen or E-Chart Acuity), or visual field restriction to 20º or less in both eyes.

The following are not to be construed as blindness for purposes of the certificate:

- if, in general medical opinion, any procedure, device, or implant could result in the partial or total restoration of sight;
- if the covered person has not attained age three or above on the date of diagnosis, and
- if the covered person's reduction of sight, as defined above, occurs prior to the coverage effective date of the covered person's coverage under the certificate.

Cardiologist means a doctor who is licensed to practice medicine and who is also licensed to practice by the American Board of Internal Medicine in the subspecialty of cardiovascular disease.
Coma means a continuous state of profound unconsciousness resulting from a covered accident or a covered sickness, characterized by the absence of:

- eye opening,
- motor response, and
- verbal response.

The condition must require intubation for respiratory assistance. The term "coma" does not include any medically induced coma.

Coronary Artery Bypass Graft Surgery means undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries utilizing venous or arterial grafts, excluding procedures such as, but not limited to, balloon angioplasty, valve replacement surgery, laser relief, stents or other non-surgical procedures.

Coronary Artery Disease means a narrowing or blockage of one or more coronary arteries for which a cardiologist recommends that coronary artery bypass graft surgery occur within 60 days following the date of the recommendation.

Covered Accident means an accident which:

- occurs on or after the coverage effective date shown on the Certificate Schedule;
- occurs while the certificate is in force; and
- is not excluded by name or specific description in the certificate.

Covered Sickness means a sickness which:

- occurs on or after the coverage effective date shown on the Certificate Schedule;
- occurs while the certificate is in force; and
- is not excluded by name or specific description in the certificate.

Critical Illness means one of the specified illnesses listed in the Critical Illness Benefit section of the Certificate Schedule.

Date of Diagnosis

- for Heart Attack (Myocardial Infarction), the date that the ischemic death of a portion of the heart muscle (myocardium) occurred based on the applicable criteria listed under the heart attack (myocardial infarction) definition;
- for Stroke, the date a stroke occurred based on neuroimaging or other neurodiagnostic study consistent with an acute or subacute infarction, hemorrhage, embolism, thrombosis and presence of neurological deficits persisting for a period of 30 days or greater;
- for End Stage Renal (Kidney) Failure, the date that regular hemodialysis or peritoneal dialysis begins;
- for Major Organ Failure, the date that the covered person is placed on the UNOS list for transplantation;
- for Permanent Paralysis due to a Covered Accident, the date the doctor confirms the permanent paralysis due to a covered accident continued for a period of 180 consecutive days;
- for Coma, the date a doctor confirms a coma resulting from a covered accident or a covered sickness has lasted 7 or more consecutive days;
- for Blindness, the date the doctor confirms the irreversible reduction of sight has continued for a period of 180 consecutive days;
- for Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D, the date of a positive antibody test for HIV or Hepatitis B, C or D subsequent to a prior negative test for the same condition with a lapse of between 90 and 180 days between the two tests;
- for Coronary Artery Bypass Graft Surgery, the date the covered person undergoes the open heart surgery

- for Coronary Artery Disease, the date the cardiologist recommends the covered person undergo coronary artery bypass graft surgery within the 60 days following the date of the recommendation

End Stage Renal (Kidney) Failure means chronic irreversible failure of the function of both kidneys such that the covered person must undergo at least weekly hemodialysis or peritoneal dialysis.

Heart Attack (Myocardial Infarction) means the ischemic 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 myocardial infarction must occur and must be supported by three or more of the following:

- chest pain;
- electrocardiographic (EKG) changes indicative of myocardial infarction; in the case of myocardial infarction 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 in establishing a diagnosis;
- elevation of biochemical markers of myocardial necrosis; and
- confirmatory imaging studies.

In the event of death, an autopsy, medical examiner's confirmation or death certificate identifying heart attack (myocardial infarction) as the cause of death will be accepted.

A heart attack (myocardial infarction) is not congestive heart failure, atherosclerotic heart disease, angina, coronary artery disease, cardiac arrest (including arrhythmias), or any other disease, injury or dysfunction of the cardiovascular system.

Major Organ Failure means diagnosis of major organ failure of the heart, kidney, liver, lung, or pancreas resulting in the covered person being placed on the UNOS (United Network for Organ Sharing) list for a transplant.

Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D means diagnosis of Human Immunodeficiency Virus (HIV) infection or Hepatitis B, C or D resulting from exposure to HIV-contaminated or Hepatitis B, C or D contaminated body fluids as the result of a covered accident during the normal course of performing an occupation for which remuneration is earned.
We will pay this benefit if:

- 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 covered person's occupation or profession;
- the covered accident is investigated and a written investigation report is provided to us by the covered person's employer;
- a confirmatory antibody HIV or Hepatitis B, C or D test is taken within five days of the covered accident and HIV or Hepatitis B, C or D is not present;
- all HIV or Hepatitis B, C or D tests are performed by a state certified and licensed laboratory; and
- a follow-up confirmatory antibody HIV or Hepatitis B, C or D test is taken between 90 days and 180 days after the covered accident, and the result is positive.

Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D excludes:

- HIV or Hepatitis B, C or D infection as the result of IV drug use;
- HIV or Hepatitis B, C or D infection as the result of sexual transmission; and
- HIV or Hepatitis B, C or D infection determined not to have been the result of a covered accident.]

Permanent Paralysis Due to a Covered Accident means the complete and permanent loss of the use of two or more limbs through paralysis as the result of a covered accident as defined in the certificate for a continuous period of 180 days, as confirmed by a doctor. Loss of use of two or more limbs through paralysis as the result of a stroke will not be construed as permanent paralysis due to a covered accident for purposes of the certificate.

Sickness means an illness, infection, disease or any other abnormal physical condition not caused by an accident. Sickness includes complications of pregnancy.

Stroke means an acute or sub-acute cerebrovascular incident, including infarction of brain tissue, ceresbral and subarachnoid hemorrhage, cerebral embolism and cerebral thrombosis. The diagnosis must be supported by:

- evidence of persistent neurological deficits confirmed by a neurologist at least 30 days after the event; and
- confirmatory neuroimaging studies consistent with the diagnosis of a new stroke.

The following are not to be construed as a stroke for purposes of the certificate:

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

In the event of death, an autopsy confirmation identifying stroke as the cause of death will be accepted.

Definitions for Cancer Benefits

Additional definitions may be contained in other certificate benefit provisions or any endorsement, amendment or rider.

Ambulatory Surgical Center means a place which:

- is equipped for surgical procedures performed by qualified physicians;
- provides anesthesia administered by a licensed anesthesiologist or licensed nurse anesthetist; and
- has written agreements with local hospitals to immediately accept patients who develop complications.

Cancer (internal or invasive) means a disease that 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.

The following are not to be construed as cancer (internal or invasive) for purposes of the certificate:

- pre-malignant conditions or conditions with malignant potential;
- carcinoma in situ;
- basal cell carcinoma and squamous cell carcinoma of the skin; and
- melanoma that is diagnosed as Clark's Level I or II or Breslow less than .75mm.

Carcinoma in Situ means cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue. Skin cancer will not be considered carcinoma in situ for purposes of the certificate.

Chemotherapy means treatment with chemical substances that have a cancericidal effect for the purpose of the destruction of malignant cells during the treatment of cancer (internal or invasive).

Date of Diagnosis for Cancer (internal or invasive) or Carcinoma in Situ means the date the tissue specimen, blood samples or titer(s) are taken upon which the diagnosis of cancer (internal or invasive) or carcinoma in situ is based].

Hospice means an organization that provides care for the terminally ill that:

- is licensed by a governmental agency;
- is accredited by the Joint Commission on Accreditation of Hospitals; or
- is qualified to receive benefit payments from Medicare or Medicaid.

The organization must have on its staff at least one doctor and one registered nurse and must keep complete medical records for each patient.

Hospice ***does not*** include:

- food services, meals, and dietary counseling; or
- services related to well-baby care; or
- services provided by volunteers; or
- support for the family after the death of the covered person.

Hospital means a place that:

- is run according to law on a full-time basis;
- provides overnight care of injured and sick people;
- is supervised by a doctor;
- has full-time nurses supervised by a registered nurse; and
- has at its locations or uses on a pre-arranged basis: X-ray equipment, a laboratory and an operating room where surgical operations take place.

Notwithstanding the above, a hospital is ***not***:

- a nursing home;
- an extended care facility;
- a skilled nursing facility;
- a rest home or home for the aged;
- a rehabilitation center;
- a place for alcoholics or drug addicts; or
- an assisted living facility.

Oral Chemotherapy means chemotherapy taken by mouth.

Pathologist means a doctor who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A pathologist also means an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Radiation means the following treatments for the purpose of the destruction of malignant cells during the treatment of internal or invasive (not skin) cancer:

- teleradiotherapy, using either natural or artificially propagated radiation; or
- interstitial or intracavitary application of radium or radioisotopes in sealed or non-sealed sources.

Office visits, laboratory tests, diagnostic X-rays, treatment planning, simulation, treatment devices, dosimetry, radiation physics, teletherapy, laser surgery or other procedures related to these treatments will ***not*** be considered radiation.

Skin Cancer means melanoma of Clark's Level I or II (Breslow less than .75mm); basal cell carcinoma; or squamous cell carcinoma of the skin.

Supportive* or *Protective Care Drugs and Colony Stimulating Factors *means:*

- bone marrow growth factors;
- radiation and chemotherapy protectants; and
- medications that promote bone growth.

Supportive or Protective Care Drugs must be approved for the treatment of cancer (internal or invasive) by the United States Food and Drug Administration and must be prescribed by a physician.

Surgery means the cutting into the skin or other organ to accomplish any of the following goals:

- take a biopsy of a suspicious lump that results in a diagnosis of cancer (internal or invasive) or carcinoma in situ;
- 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;
- reconstruct anatomic defects that result from treatment of cancer (internal or invasive) or carcinoma in situ; or
- restore proper function.

The following will ***not*** be considered a surgical procedure for the purposes of the certificate:

- venipuncture (drawing blood);
- lumbar puncture;
- epidural steroid injections;
- removal of skin tags;
- catherization; or
- scopes not requiring biopsy or removal of tissue.

Topical Chemotherapy means a chemotherapy drug placed directly onto the skin.

Definitions for First Diagnosis Building Benefit

Rider Year means the period shown on the Rider Schedule.

Year means 12 calendar months.

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