August 14, 2013

Ms. René S. Yoder
HR Services
New Mexico State University
P.O. Box 30001
Las Cruces, NM 88003-8001

RE: Revised Employee Coverage Eligibility

Dear Ms. Yoder:

Thank you so much for continuing to include Aflac group coverage in New Mexico State University's employee benefits offering. We take customer service very seriously at every level and appreciate the opportunity to serve you and your employees.

We understand that NMSU has added a benefit-eligible employee category. ***Term Appointment Employees*** working 30 hours per week or more are the new eligible class. This means that benefit-eligible NMSU employees now include all full-time regular employees working at least 20 hours per week ***and all active full-time non-regular term appointment employees working at least 30 hours per week.***

Effective July 1, 2013, our Underwriting team has agreed to make Aflac group coverage available to this new employee category to the same extent we make coverage available to other categories of NMSU employees who are eligible for Aflac group coverage. ***Please consider this letter our pledge to administratively honor this coverage extension.***

If you have any questions or concerns, please call me at 803.461.4328, or email me at jhennessy@aflac.com. Again, thank you.

Sincerely,

James J. Hennessy
Second Vice President, Compliance

CONTINENTAL AMERICAN INSURANCE COMPANY

[2801 Devine Street, Columbia, South Carolina 29205
800.433.3036]

CERTIFICATE OF INSURANCE FOR GROUP CRITICAL ILLNESS INSURANCE POLICY

This coverage is only for the Critical Illnesses listed in the Benefit Schedule of this Certificate. It does not provide benefits for any other sickness or condition.

NEW MEXICO STATE UNIVERSITY (NMSU) ("the Policyholder," "Employer") applied for coverage under this Group Insurance Policy (the "Plan"). This Plan is issued by Continental American Insurance Company (the "Company," "we," "us," or "our"). For the purpose of this Plan, "you" (including "your" and "yours") may refer to the primary Insured or the primary Insured's covered Dependents. Based on the Application and based on the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages. Your Enrollment Form is maintained on file and made part of this Certificate. (Please note that male pronouns—such as *he, him,* and *his*—are used for both males and females, unless the context clearly shows otherwise.)

You will notice that certain words and phrases (including some medical terms and the names of Plan documents) in this document are capitalized. These refer to terms with very specific definitions as they apply to this insurance Plan.

Please read your Certificate carefully.

We certify that you are insured under the Group Critical Illness Policy (the "Plan").The Plan was issued to your Employer, the Policyholder. This coverage provides benefits for loss resulting from Critical Illness. The Certificate is subject to the definitions, exclusions, and other provisions of the Plan.

Certain provisions of the Plan are summarized in this Certificate. All provisions of the Plan, whether contained in your Certificate or not, apply to the insurance referred to by the Certificate.

The Certificate Effective Date is shown in the Certificate Schedule. This Certificate Effective Date means that we have accepted the Application for coverage under this plan. This is also the date Plan premiums are due. Refer to the Effective Date section below for further details about the Effective Date for coverage. This Certificate will remain in effect for the period for which the premium has been paid. This Certificate may be continued for further periods as stated in the Plan. This Certificate, on its Effective Date, automatically replaces any Certificate or Certificates previously issued to you under the Plan.

NO RECOVERY FOR PRE-EXISTING CONDITIONS — READ CAREFULLY. For benefits to be payable, the date of diagnosis for any Critical Illness must occur while this coverage is in force. This includes all benefits under Section IV – Benefit Provisions.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.
If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare.

Table of Contents

Section I — Eligibility, Effective Date, and Termination

Section II — Premium Provisions

Section III — General Definitions/Benefit Definitions

Section IV — Benefit Provisions

Section V — Limitations and Exclusions

Section VI — Claim Provisions

Section VII — General Provisions

Section VIII — Benefit Schedule

Section IX — Incorporation of Rider Provisions

Section X — Certificate Schedule

Section I – Eligibility, Effective Date, and Termination

Eligibility

You are an eligible Employee under this Plan if you meet the following four requirements. You are:

1. An Employee of the Policyholder,
2. Engaged in at least 20 hours per week of full-time work,
3. Included in the Employee class eligible for coverage, as shown on the Master Application, **and**
4. Under age 70.

If this coverage is offered only to Employees, references in this Plan to "Dependent," "Dependent Child," "Dependent Children," and "Spouse" or "Domestic Partner" do not apply.

Dependents are eligible for coverage under this Plan. A ***Dependent*** is:

- Your Spouse or Domestic Partner **or**
- The Dependent Child of you or your Spouse or Domestic Partner. ***Dependent Children*** are your or your Spouse's or Domestic Partner's natural Children, stepchildren, legally Adopted Children, or Children Placed for Adoption who are younger than age 26. (Please see the **Definitions** section for details.)

If an eligible Dependent is unable to engage in the normal activities of a person in good health of like age and sex on the date the insurance would otherwise become effective, coverage will not be effective until the date such person is able to engage in the normal activities of a person in good health of like age and sex. This will not apply to an eligible Dependent Child who is incapable of self-sustaining employment by reason of mental or physical incapacity, and who is primarily dependent on you for support and maintenance.

Insureds* are those who might be eligible for coverage in the following categories under this Plan:

- **Employee Coverage —** We insure only the Employee.
- **Employee and Spouse or Domestic Partner Coverage —** We insure the Employee and Spouse or Domestic Partner.

We will not insure anyone specifically excluded from coverage by Endorsement to the Certificate or by Application, even if that person would otherwise be eligible for coverage.

Details for adding Insureds to Plan coverage are outlined in the following section:* ***Effective Date**.*

Effective Date

There's a Certificate Effective Date that appears in your Certificate Schedule. This date means that we have accepted your Enrollment Form. This is also the date Plan premiums are due. When we accept your Enrollment Form, and when we have received the required premium for your coverage, we make your coverage retroactive to the date you actually signed your Enrollment Form. This means that your date of coverage may be different from the Certificate Effective Date in your Certificate Schedule. It's your date of coverage — the date you signed your Enrollment Form — that determines satisfaction of Waiting Period requirements and Pre-existing Conditions requirements. You must be Actively at Work on the date you sign the Enrollment Form. If you are not Actively at Work, you will have an opportunity to apply for coverage on the date you return to an Actively-at-Work status.

The Effective Date for an existing Spouse or Domestic Partner or Dependent Child when you originally apply for coverage is:

- The date you sign the Enrollment Form **if** that Spouse or Domestic Partner or Dependent Child is not confined to a Hospital. The Spouse or Domestic Partner and Dependent Child must otherwise be eligible for coverage on the date you sign the Enrollment Form. Further, for a Spouse or Domestic Partner to be eligible for coverage, your Spouse or Domestic Partner:
    - Has been included on an Enrollment Form for coverage, **and**
    - Has been included in the premium payment.
- The date the Spouse or Domestic Partner or Dependent Child is no longer confined to a Hospital (**if** that Spouse or Domestic Partner or Dependent Child was confined to a Hospital on the date you signed the Enrollment Form) **and**:
    - Is eligible for coverage on that date,
    - Has been included on an Enrollment Form for coverage, **and**
    - Has been included in the premium payment.

A day is measured from 12:01 a.m. standard time at the Spouse's or Domestic Partner's or Dependent Child's place of residence.

A Spouse or Domestic Partner may be added to the Plan after your Effective Date. To add your Spouse or Domestic Partner to the Plan, you must complete an Enrollment Form. The Company will assign the Effective Date for a Spouse's or Domestic Partner's coverage after approving the Enrollment Form.

Newborn Children will be covered from the moment of birth. No notice or additional premium is required.

When a parent is required by a court or administrative order to provide health coverage for a Child, we will:

- Allow the parent to enroll a Child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;
- Enroll the Child for coverage upon submitted Enrollment Form of the Child's other parent, the state agency administering the Medicaid Program, or the child support enforcement program, if the parent enrolled fails to make application for coverage for the Child;
- Not eliminate coverage of the Child unless we are provided written evidence that:
    - the court administrative order is no longer in effect, **or**
    - the Child is or will be enrolled in comparable health coverage through another insurer that will take effect on the date of disenrollment from this plan.

When you have health coverage on a noncustodial Child we will:

- Provide any necessary information to the custodial parent for the Child to obtain benefits through this coverage;
- Provide any necessary information to the noncustodial parent and the noncustodial parent's provider, given consent from the custodial parent; **and**
- Make claim payments in accordance with the New Mexico State Law to the custodial parent, the provider, or the state Medicaid Agency.

Termination of Your Insurance

Your insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The 31st day after the premium due date, if the premium has not been paid.
- The date you no longer meet the Plan's definition of an Employee.
- The date you no longer belong to an eligible class.

Insurance for a covered Spouse or Domestic Partner or Dependent Child will terminate on the earliest of any of the bullet points listed above, **or**:

- The premium due date following the date the covered Spouse or Domestic Partner or Dependent Child no longer qualifies as a Dependent.
- The premium due date following the date we receive your written request to terminate coverage for your Spouse or Domestic Partner or all Dependent Children.

If your coverage terminates, we will provide coverage for claims arising from Critical Illnesses that were first Diagnosed while your coverage was in force.

Portability Privilege

When you end employment with the Employer and your coverage would otherwise terminate, you may elect to continue your coverage under this Plan. You may continue the coverage that you had on the date your employment ended, including any in-force Spouse/Domestic Partner or Dependent Child coverage.

To keep your Certificate in force, you must:

- Apply to the Company in writing within 31 days after the date your insurance would otherwise terminate, **and**
- Pay the required premium to the Company no later than 31 days after the date the Certificate would otherwise terminate and on each premium due date thereafter.

Coverage will end:

- 31 days after the date you fail to pay any required premium, **or**
- The date this Group Plan is terminated, whichever occurs first.

If you qualify for this Portability Privilege, then the Company will apply the same Benefits, Plan Provisions, and Premium Rate as shown in your previously issued Certificate.

Section II – Premium Provisions

Premium Payments

Aggregate premiums for the Plan are to be paid to the Company at our Home Office in Columbia, South Carolina. Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period.

Grace Period

This Plan has a 31-day Grace Period. If a renewal premium is not paid on or before its due date, the premium may be paid during the next 31 days. During the Grace Period, the Plan will stay in force, unless the Policyholder has given the Company written notice of its intention to discontinue the Plan.

Section III – General Definitions/Benefit Definitions

When the terms below are used in this Plan, the following definitions will apply:

Actively at Work refers to your ability to perform your regular employment duties for a full, normal workday. You may perform these activities either at your Employer's regular place of business or at a location where you may be required to travel to perform the regular duties of your employment.

Cancer (internal** or **invasive) is defined as an illness meeting **either** of the following definitions:

- A malignant tumor characterized by:
  - The uncontrolled growth and spread of malignant cells, **and**
  - The invasion of distant tissue.
- A disease meeting the Diagnosis criteria of malignancy, as established by the American Board of Pathology. The Doctor must have studied the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen.

Cancer includes leukemia and melanoma.

The following are **not** internal or invasive Cancers:

- Pre-malignant tumors or polyps
- Carcinoma in Situ
- Any skin cancers (except melanomas)
- Basal cell carcinoma and squamous cell carcinoma of the skin
- Melanoma that is Diagnosed as
  - Clark's Level I or II or
  - Breslow less than .77mm

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

Cancer or Carcinoma in Situ must be Diagnosed in one of two ways:

1. ***Pathological Diagnosis*** is a Diagnosis based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This Diagnosis must be made by a certified Pathologist whose malignancy Diagnosis conforms to the American Board of Pathology standards.
2. ***Clinical Diagnosis*** is based only on the study of symptoms. The Company will accept a Clinical Diagnosis **only if:**
   - A Doctor cannot make a Pathological Diagnosis because it is medically inappropriate or life-threatening,
   - Medical evidence exists to support the Diagnosis, **and**
   - A Doctor is treating you for Cancer or Carcinoma in Situ.

Coronary Artery Bypass means open-heart surgery to correct the narrowing or blockage of one or more coronary arteries with bypass grafts. This excludes any non-surgical procedure, such as, but not limited to, balloon angioplasty, laser relief, or stents.

Critical Illness is a sickness or disease that first manifests while your coverage is in force and after any applicable Waiting Period. Any loss due to Critical Illness must begin while your coverage is in force. Critical Illness includes **only** the following:

- Cancer
- Heart Attack (due to coronary artery disease or acute coronary syndrome)
- Stroke
  - Ischemic Stroke due to advanced arteriosclerosis of the arteries of the neck or brain
  - Hemorrhagic Stroke due to uncontrolled high blood pressure, malignant hypertension, brain aneurysm, or arteriovenous malformation
- Sudden Cardiac Arrest (due to cardiac rhythm abnormalities or acute coronary syndrome)
- Kidney Failure
- Major Organ Transplant

Date of Diagnosis is defined for each Critical Illness as follows:

- **Cancer and/or Carcinoma in Situ:** The date tissue specimens, blood samples, or titer(s) are taken. (Diagnosis of Cancer and/or Carcinoma in Situ is based on such specimens.) This includes the recurrence of a previously Diagnosed Cancer as long as you:
    - Are free from any Signs or Symptoms for a consecutive 12-month period before the Date of Diagnosis (for the reoccurrence),
    - Are currently Treatment-Free from that Cancer, **and**
    - Have been Treatment-Free from that Cancer for 12 consecutive months.
- **Heart Attack:** The date the infarction (death) of a portion of the heart muscle occurs. This is based on the criteria listed under the Heart Attack definition.
- **Ischemic or Hemorrhagic Stroke:** The date the Stroke occurs (based on documented neurological deficits and neuroimaging studies).
- **Sudden Cardiac Arrest:** The date the pumping action of the heart fails (based on the Sudden Cardiac Arrest definition).
- **Kidney Failure:** The date a Doctor recommends that you begin renal dialysis.
- **Major Organ Transplant or Coronary Artery Bypass:** The date the surgery occurs.

Dependent means your Spouse/Domestic Partner or your Dependent Child. ***Dependent Children*** are your or your Spouse's or Domestic Partner's natural Children, stepchildren, foster Children, legally Adopted Children, or Children Placed for Adoption who are younger than age 26.

Immediate Coverage for Newborn or Adopted Children: The Plan automatically covers Newborn Children from the moment of birth. The Plan automatically covers Adopted Children from the date of filing the petition for adoption.

Children Placed for Adoption are Children for whom you have entered a decree of adoption or for whom you have instituted adoption proceedings. A decree of adoption must be entered within one year from the date proceedings were initiated, unless extended by order of the court. You must continue to have custody pursuant to the decree of the court.

There is an exception to the age-26 limit listed above. This limit will not apply to any Child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. You or your Spouse or Domestic Partner must furnish proof of this incapacity and dependency to the Company within 31 days following the Child's 26th birthday.

***Diagnosis** (also **Diagnosed**)* refers to the definitive and certain identification of an illness that:

- Is made by a Doctor, **and**
- Is based on clinical or laboratory investigations, as supported by your medical records.

The illness **must** meet the requirements outlined in this Certificate for the particular Critical Illness being Diagnosed. **Diagnosis must be made and treatment must be received in the United States.**

Doctor is defined as a person who is:

- Legally qualified to practice medicine,
- Licensed as a Doctor by the state where Treatment is received, **and**
- Licensed to treat the type of condition for which a claim is made.

A Doctor does **not** include you or your Family Member (as defined below).

Domestic Partner is defined as a person who is:

- Party to a valid domestic partnership,
- Has not terminated that domestic partnership, **and**
- Meets the requisites for a valid domestic partnership.

For two persons to enter into a valid domestic partnership, it is necessary that:

- Both persons have a common residence,
- Neither person is married or a member of another domestic partnership,
- The two persons are not related by blood in a way that would prevent them from being married to each other,
- Both persons are at least 18 years of age, **and**
- Both persons are competent to consent to the domestic partnership.

Employee is a person who meets eligibility requirements under **Section I – Eligibility**, and who is covered under this Plan. The Employee is the primary Insured under this Plan.

Family Member includes your ***Spouse*** (who is defined as your legal wife or husband) or Domestic Partner (defined above), as well as the following members of your immediate family:

- son
- daughter
- mother
- father
- sister
- brother

This includes Step-Family Members and Family-Members-in-law.

Heart Attack (Myocardial Infarction) is the death of a portion of the heart muscle (myocardium) caused by a blockage of one or more coronary arteries due to coronary artery disease or acute coronary syndrome.

Heart Attack does **not** include:

- Any other disease or injury involving the cardiovascular system.
- Cardiac Arrest not caused by a Myocardial Infarction.

Diagnosis of a Heart Attack must include **all** of the following:

- New and serial electrocardiographic (EKG) findings consistent with Myocardial Infarction;
- Elevation of cardiac enzymes above generally accepted laboratory levels of normal (in the case of creatine phosphokinase (CPK), a CPK-MB measurement must be used); **and**
- Confirmatory imaging studies, such as thallium scans, MUGA scans, or stress echocardiograms.

Kidney Failure (Renal Failure) refers to end-stage renal failure, which is the chronic, irreversible failure of both kidneys to function.

Kidney Failure is covered **only** if one of the following occurs:

- Regular renal dialysis, hemo-dialysis, or peritoneal dialysis (at least weekly) are necessary to treat the Kidney Failure; **or**
- The Kidney Failure results in kidney transplantation.

The Company will not cover Kidney Failure caused by a traumatic event, including surgical trauma.

Maintenance Drug Therapy is a course of systemic medication given to a patient after a Cancer goes into full remission because of primary treatment. Maintenance Drug Therapy includes ongoing hormonal therapy, immunotherapy, or chemo-prevention therapy. Maintenance Drug Therapy is meant to decrease the risk of Cancer recurrence; it is not meant to treat or suppress a Cancer that is still present.

Major Organ Transplant means undergoing surgery as a recipient of a covered transplant of a human heart, lung, liver, kidney, or pancreas.

Pathologist is a Doctor who is licensed:

- To practice medicine, **and**
- By the American Board of Pathology to practice pathologic anatomy.

A Pathologist also includes an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology. Pathologist does **not** include you or a Family Member (as defined above).

Signs and/or Symptoms are the evidence of disease or physical disturbance observed by a Doctor or other medical professional. The Doctor (or other medical professional) must observe these Signs while acting within the scope of his license.

Stroke means the death of a portion of the brain producing neurological sequelae, including infarction of brain tissue, hemorrhage, and embolization from an extra-cranial source. There must be evidence of permanent neurological deficit.

Stroke must be either:

- Ischemic Stroke due to advanced arteriosclerosis of the arteries of the neck or brain, **or**
- Hemorrhagic Stroke due to uncontrolled high blood pressure, malignant hypertension, brain aneurysm, or arteriovenous malformation.

Stroke does **not** include:

- Transient ischemic attacks (TIAs).
- Head injury.
- Chronic cerebrovascular insufficiency.
- Reversible ischemic neurological deficits.

Stroke will be covered **only** if you submit evidence of the permanent neurological damage by providing:

- Computed Axial Tomography (CAT scan) images, **or**
- Magnetic Resonance Imaging (MRI).

Successor Insured means that if you die while covered under a Certificate, then your surviving Spouse or Domestic Partner becomes the primary Insured if that Spouse or Domestic Partner is also insured under this Plan. If the Certificate does not cover a surviving Spouse or Domestic Partner, the Certificate will terminate on the next premium due date.

Sudden Cardiac Arrest is the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction, due to cardiac rhythm abnormalities or acute coronary syndrome. For the purposes of this Plan, a death is a Sudden Cardiac Arrest when the sole cause of death is the result of cardiac rhythm abnormalities or acute coronary syndrome (as shown on the death certificate) from one of the following:

- Cardiovascular collapse
- Sudden Cardiac Arrest
- Cardiac arrest
- Sudden cardiac death

Sudden Cardiac Arrest is **not** a Heart Attack.

Total Disability (or ***Totally Disabled)*** means you are:
- Unable to Work (defined later in this section),
- Not working at any job for pay or benefits, **and**
- Under the care of a Doctor for the treatment of a covered Critical Illness.

Treatment (or ***Medical Treatment)*** is the consultation, care, or services provided by a Doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines.

Treatment-Free From Cancer is the period of time that you have not received consultation, care, or services from a Doctor—including receiving diagnostic measures and taking prescribed medicines. Treatment does **not** include Maintenance Drug Therapy or routine follow-up visits to verify whether Cancer/Carcinoma in Situ has returned.

Unable to Work means either:
- **During the first 365 days of Total Disability**, you are unable to work at the occupation you were performing when your Total Disability began; **or**
- **After the first 365 days of Total Disability**, you are unable to work at any gainful occupation for which you are suited by education, training, or experience.

Waiting Period is the number of days that must pass after the Effective Date before we will pay benefits for a Critical Illness. We will not pay benefits for a Critical Illness if the Date of Diagnosis for that Critical Illness begins during the Waiting Period.

Section IV – Benefit Provisions

The language in this provision matches that of the Plan. As this Certificate is issued to the primary Insured**,** we included the use of "you" and "yours."*

The benefit amounts payable under this section are shown in the Benefit Schedule. The appropriate benefit amounts we will pay for the Dependent are shown in the Certificate Schedule.

**Remember, for the purpose of this Plan, "you" (including "your" and "yours") may refer to the primary Insured or the primary Insured's covered Dependent, to include Spouse or Domestic Partner.*

Critical Illness Benefit

We will pay this benefit when you are Diagnosed with one of the Critical Illnesses shown in the Benefit Schedule. We will pay this benefit if:
- The Date of Diagnosis is after the Waiting Period,
- The Date of Diagnosis is while your coverage is in force, **and**
- The Certificate does not exclude the illness or condition by name or by specific description.

If the date of a Critical Illness Diagnosis occurs during the Waiting Period, you may return the Certificate for a full premium refund.

If the Schedule shows a Reduced Face Amount Date, the Certificate's benefit amount will change to the Reduced Face Amount on that date. Benefits will be based on the benefit amount in effect on the Critical Illness Date of Diagnosis.

The Company will pay benefits for a Critical Illness in the order the events occur. The Company will deduct any previously-paid partial benefits from the appropriate Critical Illness Benefit.

Payment of benefits is subject to the following:

- The Company will pay benefits for each **different** Critical Illness after the first when the following two conditions are met:
    1. The Date of Diagnosis for the new Critical Illness is separated from the prior, different Critical Illness by at least 6 months, or you are Treatment-Free From Cancer for at least 12 months, **and**
    2. The new Critical Illness is not caused by or affected by a Critical Illness for which benefits have been paid.
- Once benefits have been paid for a Critical Illness, the Company will pay additional benefits for that **same** Critical Illness when the Dates of Diagnosis are separated by at least 12 months, or—for cancer—you have been Treatment-Free From Cancer for at least 12 months. Cancer that has spread (metastasized), even though there is a new tumor, will not be considered an additional occurrence unless you have been treatment-free for 12 months.

Heart Event Benefit

Category I — Specified Surgeries of the Heart

Specified Surgeries of the Heart (Open-Heart Surgery) means open-chest surgery, where the heart is exposed and/or manipulated for open cardiothoracic situations.

We will only pay benefits under Category I for the following Open-Heart Surgery procedures:

- **Coronary Artery Bypass Surgery** is a surgical procedure performed to relieve angina and to reduce the risk of death from coronary artery disease. This also includes Coronary Artery Bypass Graft Surgery and Bypass Surgery.
    - **Off-Pump Coronary Artery Bypass (OPCAB)** is a form of bypass surgery that does not stop the heart or use the heart–lung machine.
    - **Coronary Artery Bypass Grafting (CABG)** is used to treat a narrowing of the coronary arteries when the blockages are hard to reach or are too long or too hard for angioplasty. A blood vessel, usually taken from the leg or chest, is grafted onto the blocked artery, creating a bypass around the blockage. If more than one artery is blocked, a bypass can be done on each artery, but only one benefit is payable.
- **Mitral Valve Replacement or Repair** refers to a cardiac surgery procedure in which a patient's mitral valve is repaired or replaced by a different valve.
- **Aortic Valve Replacement or Repair** is a cardiac surgery procedure in which a patient's aortic valve is repaired or replaced by a different valve.
- **Surgical Treatment of Abdominal Aortic Aneurysm** is a procedure to prevent aneurysm rupture. The operation consists of opening the abdomen, finding the aorta, and removing (excising) the aneurysm. Abdominal aortic aneurysm is a ballooning or widening of the main artery (the aorta) as it courses down through the abdomen. At the point of the aneurysm, the aneurysm generally measures 3 cm or more in diameter.

Category I Benefits exclude all procedures not specifically listed above, including procedures such as, but not limited to, angioplasty, laser relief, stents or other surgical and non-surgical procedures.

Category II — Invasive Procedures and Techniques of the Heart

We will only pay benefits under Category II for the following procedures:

- **AngioJet Clot Busting** is a procedure used to clear blood clots from coronary arteries before angioplasty and stenting. A high-pressure saline solution is delivered through the artery to the clot, breaking the clot apart, and simultaneously drawing it out.
- **Balloon Angioplasty** (or **Balloon Valvuloplasty)** is a procedure used to open a clogged blood vessel. A thin tube is threaded through an artery to the narrowed heart vessel, where a small balloon at its tip is inflated. A balloon opens the narrowing by compressing atherosclerotic plaque against the vessel wall. The balloon is then deflated and removed.
- **Laser Angioplasty** refers to a procedure similar to Balloon Angioplasty. For this procedure, a laser tip is used to burn/break down plaque in the clogged blood vessel.

- **Atherectomy** is a procedure used to open blocked coronary arteries or clear bypass grafts. The procedure requires use of a device on the end of a catheter to cut or shave away atherosclerotic plaque.
- **Stent Implantation** refers to a procedure whereby a stainless steel mesh coil is implanted in a narrowed part of an artery to keep it propped open.
- **Cardiac Catheterization** (also **Heart Catheterization)** is a diagnostic and occasionally therapeutic procedure that provides a comprehensive examination of the heart and surrounding blood vessels.
- **Automatic Implantable** (or **Internal) Cardioverter Defibrillator (AICD)** refers to the initial placement of the AICD. AICDs are used for treating irregular heartbeats. The defibrillator is surgically placed inside the patient's chest where it monitors the heart's rhythm. When it identifies a serious arrhythmia, it produces an electrical shock to disrupt the arrhythmia.
- **Pacemakers**, in this context, refers to the initial placement of a pacemaker. Pacemakers are implanted to ensure regular heart beats by sending electrical signals to the heart. This electrical device is placed under the skin. A lead extends from the device to the right side of the heart. Most pacemakers are used to correct a slow heart rate.

Subject to the re-occurrence benefit, only one Category II benefit is payable. Benefits will not be paid for multiple procedures listed under the Category II benefit.

Category II Benefits exclude all procedures not specifically listed above.

We will pay the appropriate Heart Event Benefit if:

- The Date of Treatment is after the Waiting Period,
- Treatment is incurred while this coverage is in force,
- Treatment is recommended by a Doctor, **and**
- Treatment is not excluded by name or specific description.

We will pay Heart Event Benefits according to the appropriate percentages of the Face Amount shown in the Certificate Schedule. Benefits are not payable for loss if these conditions result from another Specified Critical Illness.

Benefits for Category II will reduce the benefit amounts payable for Category I benefits. Benefits will be paid only at the highest benefit level. If procedures from Category I and Category II are performed at the same time, benefits are only eligible at the 100% (higher) event and will not exceed the Face Amount shown on the Certificate Schedule. You are only eligible to receive one payment for each benefit category listed on the schedule page. The dates of loss for covered procedures must be separated by at least 6 months for benefits to be payable for multiple covered procedures.

Payment of initial, re-occurrence, or additional occurrence benefits are subject to the Benefits section of your Certificate.

Health Screening Benefit (Calendar Year Limit)

We will pay the amount shown in the Benefit Schedule for Health Screening Tests performed after the Waiting Period and while your coverage is in force. We will pay this benefit once per calendar year. Benefits are paid for Covered Dependent Children at 100% of the Employee benefit amount. Payment of this benefit will not reduce the Critical Illness Benefit available under this Certificate.

Health Screening Tests include, but are not limited to, the following:

- stress test on a bicycle or treadmill
- fasting blood glucose test
- blood test for triglycerides
- serum cholesterol test to determine level of HDL and LDL
- bone marrow testing
- breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- chest X-ray
- colonoscopy
- flexible sigmoidoscopy
- hemocult stool analysis
- mammography
- pap smear
- PSA (blood test for prostate cancer)
- serum protein electrophoresis (blood test for myeloma)
- thermography

There is no limit to the number of years you may receive benefits for Health Screening Tests, as long as this Plan is in force. This benefit is only payable for Health Screening Tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. We will pay the Health Screening Benefit regardless of the results of the test.

Section V – Limitations and Exclusions

This Plan contains a 30-day Waiting Period. This means that we will not pay benefits to you if you were Diagnosed before your coverage was in force 30 days from the Effective Date. If a Critical Illness is first Diagnosed during the Waiting Period, we will only pay benefits for loss beginning after coverage has been in force for 6 months. Or, you may elect to void the Certificate from the beginning and receive a full premium refund.

Pre-Existing Conditions Limitation*

Pre-existing Condition is a sickness or physical condition that existed within the 6-month period before your Effective Date. For this Pre-existing Condition, a medical professional must have advised, Diagnosed, or treated you.

We will **not** pay benefits for any Critical Illness resulting from or affected by a Pre-existing Condition if the Critical Illness was Diagnosed within the 6-month period after your Effective Date.

The Company will not reduce or deny a claim for benefits for any Critical Illness that was Diagnosed more than 6 months after your Effective Date.

A Critical Illness will no longer be considered Pre-existing at the end of 6 consecutive months that start after your Effective Date.

**Benefits are payable for the reoccurrence of a previously Diagnosed Cancer and/or Carcinoma in Situ as long as you:*

- *Have been free from Signs or Symptoms of that Cancer for a consecutive 12-month period before the Date of Diagnosis (for the reoccurrence),* ***and***
- *Have been Treatment-Free from that Cancer for the 12 consecutive months before the Date of Diagnosis (for the reoccurrence).*

Exclusions

We will not pay for loss due to **any** of the following:

- **Self-Inflicted Injuries —** injuring or attempting to injure yourself intentionally or taking action that causes you to become injured
- **Suicide —** committing or attempting to commit suicide, while sane or insane
- **Illegal Acts —** participating or attempting to participate in an illegal activity, or working at an

illegal job
- **Participation in Aggressive Conflict** of any kind, including:
    - War (declared or undeclared) or military conflicts
    - Insurrection or riot
    - Civil commotion or civil state of belligerence
- **Illegal Substance Abuse, which includes:**
    - Abuse of legally-obtained prescription medication
    - Illegal use of non-prescription drugs

Section VI – Claim Provisions

Notice of Claim

You must give written notice of a claim:
- Within 60 days after Diagnosis of a Critical Illness, **or**
- As soon as reasonably possible.

Notice must include your name and the Certificate number. Notice can be mailed to the Company at:

P.O. Box 427, Columbia, South Carolina, 29202

Claim Forms

When the Company receives notice of a claim, we will send you forms so that you can file Proof of Loss (details included in the **Proof of Loss** section below). If the Company does not provide the forms within 15 working days, you can meet Proof of Loss requirements by providing a written statement about the nature and extent of the loss. You will also need to provide a statement by the treating Doctor. You must provide this information within the time limit stated in the **Proof of Loss** section.

Proof of Loss

Proof of Loss refers to documentation that supports a claim (this information is often found in standardized medical documents, such as hospital bills and operative reports). You must provide Proof of Loss to the Company at:

P.O. Box 427, Columbia, South Carolina, 29202

You must provide Proof of Loss documentation within 90 days after the date of Diagnosis of a Critical Illness. However, the Company will not invalidate or reduce any claim if it was not reasonably possible for you to provide this proof within the required time. You must provide the proof as soon as reasonably possible. The Company will not accept proof any later than one year and three months after Diagnosis of the Critical Illness, except in the absence of your legal mental capacity.

Claims Payment Timeframe

Once we receive proper Proof of Loss, the Company will pay, deny, or settle all clean claims* immediately after receiving the appropriate information.

****Clean claims** contain all information/documentation that is needed to process your claim. These claims do not require further information from the provider, certificateholder, or Employer/administrator.*

Payment of Claims

We will pay all benefits to you unless otherwise assigned. For any benefits that remain unpaid at the time of death, we will pay those benefits in the following order:
1. To any approved assignee,
2. To your beneficiary,
3. To your surviving Spouse or Domestic Partner, **or**
4. To your estate.

Conformity With State Statutes

This Plan was issued on its Effective Date in the state noted on the Master Application. Any Plan provision that conflicts with that state's statutes is amended to conform to the minimum requirements of

those statutes.

Additional Coverage With the Company

If you are covered by more than one of our Critical Illness Certificates, we will only pay benefits for covered Critical Illness under one Critical Illness Certificate. You may choose which Certificate you wish to keep in force by sending us written notice of your choice. We will return the premiums paid for any of our other Critical Illness Certificates during the period there was more than one Certificate in force.

Subrogation — Medicaid Payments

Benefits paid on behalf of a Child or other insured person under the policy will be paid to the New Mexico Human Services Department when:

- The Human Services Department has paid or is paying benefits on behalf of the Child or other insured person under the state's Medicaid program pursuant to Title XIX of the federal Social Security Act,
- Payment for the services in question has been made by the Human Services Department to the Medicaid provider, **and**
- We are notified that you receive benefits under the Medicaid program and that benefits must be paid directly to the Human Services Department.

Section VII – General Provisions

Questions or Comments: If you have any questions about this Plan, its benefits, the filing of claims, a complaint, or a compliment, please call us at the toll free number listed on the front of this Plan.

Entire Contract Changes

The *Entire Contract of Insurance* is made up of:

- The Plan
- The Enrollment Form
- Certificates
- The Master Application
- Riders (if any)

All statements (excluding fraudulent ones) that the Policyholder or an Insured has made in the Master Application or on the Enrollment Form will be considered representations, **not** warranties.

Physical Examination and Autopsy

The Company may have an Insured examined as often as reasonably necessary while a claim is pending. In the case of death, the Company may also require an autopsy, unless prohibited by law. The Company will cover all costs for exams or autopsy.

Legal Action

You cannot take legal action against us for benefits under this Plan:

- Within 60 days after you have sent us written Proof of Loss, **or**
- More than 3 years from the time written proof is required to be given.

Time Limit on Certain Defenses

After two years from your Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on your Enrollment Form. This does not apply to fraudulent misstatements.

Misstatement of Age

If an age has been misstated on the Enrollment Form, the benefits will be those that the paid premium would have purchased at the correct age.

Required Information

The Policyholder will furnish all information and proofs which the Company may reasonably require with regard to the Plan.

Section VIII – Benefit Schedule*

Face Amount:	$xx.xx
Reduced Face Amount:	$xx.xx
Reduced Face Amount Date:	First Renewal Date after age 70
Waiting Period:	30 Days
Percentage for Partial Benefits:	25% of applicable Face Amount

**Benefits are paid for Covered Dependent Children at 25% of the Employee benefit amount.*

Critical Illness Benefits

The applicable benefit amount (Face Amount or Reduced Face Amount) is payable for the following Critical Illnesses:

- Cancer (internal or invasive)
- Heart Attack (due to coronary artery disease or acute coronary syndrome)
- Kidney Failure
- Major Organ Transplant
- Stroke
    - Ischemic Stroke due to advanced arteriosclerosis or arteriosclerosis of the arteries of the neck or brain
    - Hemorrhagic Stroke due to uncontrolled high blood pressure, malignant hypertension, brain aneurysm, or arteriovenous malformation
- Sudden Cardiac Arrest (due to rhythm abnormalities or acute coronary syndrome)

Heart Event Benefits

Category I — Specified Surgeries of the Heart
Benefits under this category are paid at 100% of the Face Amount.

Category II — Invasive Procedures and Techniques of the Heart
Benefits under this category are paid at 10% of the Face Amount.

Benefits for Category II will reduce the benefit amounts payable for Category I benefits. Benefits will be paid only at the highest benefit level. If procedures from Category I and Category II are performed at the same time, benefits are only eligible at the 100% (higher) event and will not exceed the Face Amount.

The dates of loss for Category I or Category II covered procedures must be separated by at least 6 months for benefits to be payable for multiple covered procedures.

Heart Event Benefits reduce by 50% at age 70.

Partial Benefits

Carcinoma in Situ:
When this Partial Benefit is paid, it will reduce the Cancer Benefit by 25%.

Coronary Artery Bypass Surgery
When this Partial Benefit is paid, it will reduce the Heart Attack Benefit by 25%.

Health Screening Benefit Amount

$50 per Insured per calendar year.

Health Screening Benefits are paid for Covered Dependent Children at 100% of the Employee benefit amount.

[Section IX – Incorporation of Rider Provisions

The attached listed Certificate Riders are made a part of this Plan.

Rider Name	Form Number
[ADDITIONAL BENEFITS RIDER TO CERTIFICATE OF INSURANCE FOR CRITICAL ILLNESS	CAI2835NMSU]]

Section X – Certificate Schedule

INSURED [John A. Doe]	GROUP POLICY NUMBER [1234]
EFFECTIVE DATE [January 1, 2012]	CERTIFICATE NUMBER [56789]
INITIAL PREMIUM* [$109.75 Monthly]	FIRST RENEWAL DATE [January 1, 2013]

*Initial premium includes the premium for any Riders purchased at the same time as the coverage provided by your Certificate.