Choosing to plan for sudden illness

Critical Illness Insurance

ASSURANT Employee Benefits

Can your finances survive a serious illness?

Maybe it's happened to someone you know. A sudden illness such as a heart attack or stroke can cause devastating physical and financial consequences.

- 1.5 million Americans will declare bankruptcy this year, 60% due to medical bills.[1]
- An estimated 83.6 million American adults (greater than 1 in 3) have cardiovascular disease.[2]
- Fewer than 1 in 4 Americans (24%) have enough savings to cover at least 6 months' expenses.[3]

How can critical illness insurance help?

For many, a critical illness can expose an individual to an unexpected gap in protection. While health plans may help cover many of the direct costs associated with a critical illness, related expenses such as lost income, child care, travel to and from treatment, high deductibles and co-pays may quickly diminish savings.

Critical illness insurance pays a fixed benefit if you are diagnosed after your coverage effective date with a covered critical illness.

How do I know if I'm eligible to participate in this plan?

You can participate in this plan if you are a full-time employee of the policyholder or an associated company. Full-time means working 30 hours or more per week. Temporary or seasonal workers are not eligible.

This product is inappropriate for those persons who are eligible for Medicaid coverage.

Key Advantages of This Plan

- Benefits are payable directly to you to be spent any way you choose.
- Pays in addition to any other coverage you may have.
- Flexible coverage options to meet your individual needs.
- Fast and accurate claims service.
- Coverage is fully portable - if you change jobs you can take your coverage with you.

Sources:
[1] Facts About Critical Illness Insurance Coverage and Costs, 2012
[2] American Heart Association 2013
[3] 2013 research from Bankrate.com

This critical illness only insurance policy provides limited benefits. This limited policy has some specific benefit limits and is not a medical insurance policy, a Medicare Supplement policy or a high deductible health plan or a policy of Workers' Compensation insurance. Please refer to the issued insurance policy for complete details and all benefit requirements, including all limitations, exclusions, restrictions and reductions. We reserve the right to cancel the policy with advance written notice to the policyholder. Insurance policies and certain policy benefits are subject to state variations and may not be available in all states. Issued insurance contracts determine all plan features and benefits. Contact Assurant Employee Benefits for additional details.

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Critical Illness Q&A

Q. What benefits are provided under this plan?

A. If you are diagnosed with a covered critical illness, you could receive up to **$50,000 as a single sum payment** depending on the amount of coverage you elect. You must be diagnosed after your coverage effective date and qualify for the benefit as defined by the policy. Your plan also includes a Wellness Screening benefit. Each critical illness pays a specified percentage of your election amount as shown below:

Covered Illness or Procedure	Initial Diagnosis Benefit Percent of Elected Benefit Payable
Heart Attack	100%
Stroke	100%
End Stage Kidney Disease	100%
Major Organ Failure	100%
Occupational HIV/Hepatitis, B,C or D	100%
Coronary Bypass Surgery	25%

Your plan also includes expanded coverage for these additional conditions:

Cancer - Invasive Cancer	100%
Cancer - Carcinoma in Situ	25%
Cancer - Skin Cancer	5%
Blindness, Loss of Speech, or Loss of Hearing	100%
Benign Brain Tumor, Paralysis or Coma	100%
Advanced ALS (Lou Gehrig's Disease)	100%
Advanced Alzheimer's Disease	25%
Advanced Parkinson's Disease	25%

Q. What if I am diagnosed with the same condition again?

A. If you have received benefits under this plan for a covered critical illness and are diagnosed a second time with the same critical illness, you may qualify for the recurrence benefit. Recurrence benefits are available only for the critical illnesses shown below:

Covered Illness or Procedure	Recurrence Benefit Percent of Elected Benefit Payable
Heart Attack	100%
Stroke	100%
End Stage Kidney Disease	100%
Major Organ Failure	100%
Coronary Bypass Surgery	25%

The second diagnosis must occur at least 12 consecutive months after the initial diagnosis and you must not have been receiving treatment for the initial diagnosis for at least 12 consecutive months between the initial diagnosis and the second diagnosis. Once the recurrence benefit has been paid, no additional benefit will be paid for that critical illness

Q. What is the Annual Wellness Screening Benefit?

A. If you and your dependents enroll in the plan, each of you are eligible for $50 per benefit year for any one Wellness Screening test from a list of more than 20 covered tests. Covered tests include: cardiac exercise stress test; fasting blood glucose test; blood test for lipids including total cholesterol, LDL, HDL and triglycerides; breast ultrasound or mammography; CA15-3 (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; pap smear; PSA (blood test for prostate cancer); serum protein electrophoresis; carotid doppler; electrocardiogram; echocardiogram. In order to receive this benefit, the wellness screening test must be performed after your coverage effective date.

Critical Illness Q&A

Q. Can I receive benefits for more than one of these critical illnesses?

A. Yes, you can receive benefits for any covered critical illness shown but there must be at least 6 consecutive months between the diagnosis dates. You can only claim benefits once for each critical illness unless a recurrence benefit is payable.

Q. Do I have to answer any health questions to enroll for this coverage?

A. Yes, you will need to complete a simple health questionnaire for yourself and any dependents you wish to cover.

Note: If you have coverage with the prior carrier on the day before this plan takes effect, you may not have to answer health questions for coverage amounts up to those in which you or your covered dependent are currently enrolled. Please ask your benefits representative for details.

Q. Is there a pre-existing condition limitation?

A. Yes, a pre-existing condition applies to you and your dependent's coverage.

A pre-existing condition means an injury, sickness, symptom or physical finding, or any related injury, sickness, symptom or physical finding, for which you or your covered dependent consulted with or received advice from a licensed medical or dental practitioner; or received medical or dental care, treatment or services, including taking drugs, medicine, insulin or similar substances in the 12 months that end on the day before you or your covered dependent became insured under the policy. We will not pay benefits for claims resulting, directly or indirectly, from a pre-existing condition unless you or your covered dependent are initially diagnosed with a critical illness or undergo a procedure after 12 consecutive months during which you or your covered dependent are continuously insured under this plan.

See your certificate for additional pre-existing condition details.

Note: This limitation does not apply to amounts of Critical Illness coverage for which you or your covered dependent are enrolled with the prior carrier on the day before this plan takes effect. However, the pre-existing condition limitation will apply to any amount of increased coverage that is elected.

Q. When will my coverage become effective?

A. Your coverage starts on the entry date specified in the group policy, provided you are at active work on that date. Otherwise, your coverage will become effective on the day you return to full-time duties. If a family member is in a hospital on the day insurance would otherwise take effect, then insurance will take effect on the day after the family member leaves the hospital.

Q. Can I take my insurance with me if I leave my employer?

A. Yes. **Portability** allows you to continue this group critical illness coverage until age 70 after terminating current employment.

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How much does Critical Illness Cost?

Your cost depends on:

- How much coverage you select
- Your age as of the effective date. Because issue age rating applies, your premiums will not increase due to age changes.
- Whether or not you or your spouse use tobacco

You may elect coverage for yourself in units of $5,000 up to $50,000.

Employee Critical Illness Insurance Weekly (52) Premiums

Non-Tobacco User

Benefit / Issue Age	<30	30-39	40-49	50-59	60-69	70+
$5,000	$0.94	$1.27	$2.06	$3.33	$5.02	$10.66
$10,000	$1.61	$2.28	$3.84	$6.38	$9.78	$21.06
$15,000	$2.28	$3.28	$5.63	$9.44	$14.53	$31.46
$20,000	$2.94	$4.28	$7.42	$12.50	$19.28	$41.85
$25,000	$3.61	$5.29	$9.21	$15.56	$24.04	$52.25
$30,000	$4.28	$6.29	$11.00	$18.61	$28.79	$62.64
$35,000	$4.95	$7.29	$12.79	$21.67	$33.54	$73.04
$40,000	$5.62	$8.30	$14.58	$24.73	$38.30	$83.44
$45,000	$6.29	$9.30	$16.36	$27.79	$43.05	$93.83
$50,000	$6.96	$10.31	$18.15	$30.84	$47.81	$104.23

Employee Critical Illness Insurance Weekly (52) Premiums

Tobacco User

Benefit / Issue Age	<30	30-39	40-49	50-59	60-69	70+
$5,000	$1.11	$1.71	$3.29	$5.98	$10.72	$18.52
$10,000	$1.95	$3.15	$6.31	$11.69	$21.18	$36.78
$15,000	$2.79	$4.59	$9.34	$17.40	$31.63	$55.03
$20,000	$3.64	$6.04	$12.36	$23.11	$42.08	$73.28
$25,000	$4.48	$7.48	$15.38	$28.83	$52.54	$91.54
$30,000	$5.32	$8.92	$18.41	$34.54	$62.99	$109.79
$35,000	$6.16	$10.36	$21.43	$40.25	$73.44	$128.04
$40,000	$7.01	$11.81	$24.45	$45.96	$83.90	$146.30
$45,000	$7.85	$13.25	$27.48	$51.67	$94.35	$164.55
$50,000	$8.69	$14.69	$30.50	$57.38	$104.81	$182.81

Can I buy coverage for my family?

If you cover yourself, you can also purchase Critical Illness insurance for your eligible family members.

Eligible family members include your spouse and children from live birth to less than age 26. See your certificate or group insurance policy for additional eligibility details.

You can buy spouse coverage in units of $2,500 up to the lesser of 50% of your own coverage amount or $25,000.

Spouse Critical Illness Insurance Weekly (52) Premiums

Non-Tobacco User

Benefit / Issue Age	<30	30-39	40-49	50-59	60-69	70+
$2,500	$0.60	$0.77	$1.16	$1.80	$2.64	$5.47
$5,000	$0.94	$1.27	$2.06	$3.33	$5.02	$10.66
$7,500	$1.27	$1.77	$2.95	$4.85	$7.40	$15.86
$10,000	$1.61	$2.28	$3.84	$6.38	$9.78	$21.06
$12,500	$1.94	$2.78	$4.74	$7.91	$12.15	$26.26
$15,000	$2.28	$3.28	$5.63	$9.44	$14.53	$31.46
$17,500	$2.61	$3.78	$6.53	$10.97	$16.91	$36.65
$20,000	$2.94	$4.28	$7.42	$12.50	$19.28	$41.85
$22,500	$3.28	$4.79	$8.32	$14.03	$21.66	$47.05
$25,000	$3.61	$5.29	$9.21	$15.56	$24.04	$52.25

Spouse Critical Illness Insurance Weekly (52) Premiums

Tobacco User

Benefit / Issue Age	<30	30-39	40-49	50-59	60-69	70+
$2,500	$0.69	$0.99	$1.78	$3.12	$5.49	$9.39
$5,000	$1.11	$1.71	$3.29	$5.98	$10.72	$18.52
$7,500	$1.53	$2.43	$4.80	$8.84	$15.95	$27.65
$10,000	$1.95	$3.15	$6.31	$11.69	$21.18	$36.78
$12,500	$2.37	$3.87	$7.83	$14.55	$26.40	$45.90
$15,000	$2.79	$4.59	$9.34	$17.40	$31.63	$55.03
$17,500	$3.22	$5.32	$10.85	$20.26	$36.86	$64.16
$20,000	$3.64	$6.04	$12.36	$23.11	$42.08	$73.28
$22,500	$4.06	$6.76	$13.87	$25.97	$47.31	$82.41
$25,000	$4.48	$7.48	$15.38	$28.83	$52.54	$91.54

Your spouse's premiums are based on **your** age and your **spouse's** tobacco use.

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Can I buy coverage for my family? (continued)

You can buy coverage for your children too in units of $2,500 up to $5,000. A 50% limit also applies to child coverage.

Critical Illness insurance for your children also covers these childhood illnesses:

Covered Illness or Procedure	Percent of Elected Benefit Payable
Cerebral palsy, cleft lip/palate, cystic fibrosis, Down syndrome muscular dystrophy, spina bifida, Type I diabetes	100%

Child Critical Illness Insurance Weekly (52) Premiums		
Benefit	$2,500	$0.13
	$5,000	$0.25

For Critical Illness insurance for your children, choose the benefit you want for the corresponding premium. One premium covers all of your dependent children.

Critical Illness Definitions - *Core Covered Conditions*

Heart attack means that while insured under the policy, a covered person has been diagnosed with coronary artery disease that results in a current and new acute myocardial infarction due to blockage of one or more coronary arteries causing death of a portion of the heart muscle with loss of heart function. Diagnosis of the new myocardial infarction must be based on new changes consistent with an evolving infarction on electrocardiogram (EKG) and concurrent with serial measurement of cardiac biomarkers of a pattern and level of enzymes confirming an acute infarction. Old, established or silent myocardial infarctions are excluded.

Stroke means that while insured under the policy, a covered person has been diagnosed with *cerebral vascular disease* resulting in a brain tissue infarction. The basis of the diagnosis must include imaging documentation of new brain tissue infarction in association with acute onset of symptoms consistent with central nervous system neurological damage. For the purposes of this policy, stroke does not include: Transient Ischemic Attacks (TIAs); Transient Global Amnesia (TGA); or external trauma causing injury to the brain.

Cerebral vascular disease means subarachnoid hemorrhage, intracerebral hemorrhage, brain embolism, brain thrombosis, occlusion and stenosis of precerebral arteries or occlusion of cerebral arteries.

End-stage kidney disease means that while insured under the policy, a covered person has been diagnosed with a renal disease that has resulted in either: the chronic and irreversible failure of both kidneys to function and which requires regular dialysis for a minimum of 90 days; or the need for a kidney transplant. In the event a kidney is transplanted at the same time as other organs, only one benefit is payable.

Major organ failure means that while insured under the policy, a covered person is diagnosed with any end-stage disease as specified by the most current edition of the International Classification of Diseases (ICD) of the heart, liver, lung, small intestine, pancreas or bone marrow that has resulted in the chronic and irreversible failure of the organ to function and which requires the need for a transplant. In order for major organ failure resulting from an end-stage disease to be covered under this policy, the covered person must be registered with the United Network of Organ Sharing (UNOS) or be registered for matching a donor on the National Marrow Donor Program (NMDP). If multiple organs are to be replaced at the same time only one benefit is payable.

Occupational infectious disease means that a covered person is initially diagnosed while insured under the policy with Human Immunodeficiency Virus (HIV) infection or Hepatitis B, C and/or D resulting from accidental exposure to HIV or Hepatitis B, C and/or D by contaminated body fluids during the course of performing a covered person's regular occupation for which remuneration is earned. To prove occupational exposure, all of the following must be submitted: Documentation showing that within five days of the accidental exposure, the exposure was reported and recorded by the appropriate person according to legislation, regulations or standard guidelines that apply to the occupation; A negative antibody for HIV or Hepatitis B, C and/or D test, performed by a state certified and licensed laboratory within five days of exposure; and A positive antibody for HIV or Hepatitis B, C and/or D test, taken in the 90 to 180 days following the exposure. Occupational infectious disease does not include HIV or Hepatitis B, C and/or D that occurs as a result of IV drug use, sexual transmission or is determined not to be accidental. In order for a benefit to be paid, the initial diagnosis of occupational infectious disease must occur while insured under the policy.

Coronary bypass surgery means that while insured under the policy, a covered person has been diagnosed with *coronary artery disease* requiring a procedure to bypass one or more diseased, narrowed or blocked coronary arteries with arterial or venous grafts and is performed by a board certified cardiovascular surgeon. Other procedures such as percutaneous transluminal coronary angioplasty (PTCA) or laser procedures are excluded.

Coronary artery disease means acute coronary occlusion, coronary atherosclerosis, aneurysm and dissection of the coronary arteries or coronary atherosclerosis due to plaque. *Coronary bypass surgery* means that while insured under the policy, a covered person has been diagnosed with coronary artery disease requiring a procedure to bypass one or more diseased, narrowed or blocked coronary arteries with arterial or venous grafts and is performed by a board certified cardiovascular surgeon. Other procedures such as percutaneous transluminal coronary angioplasty (PTCA) or laser procedures are excluded.

State variations can exist; please contact Assurant Employee Benefits for additional information.

Critical Illness Definitions - *Expanded Coverage for Additional Conditions*

Invasive cancer means that while insured under the policy, a covered person has been diagnosed with a malignant neoplasm, which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of neighboring tissue, and which is not specifically hereafter excluded. Leukemias and lymphomas are considered invasive cancer. The following are not considered invasive cancer: pre-malignant lesions (such as intraepithelial neoplasia); benign tumors or polyps; early prostate cancer diagnosed as T1N0M0 or equivalent staging; *Cancer in situ*; any *skin cancer* (other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic); and any non-malignant, non-invasive cancer or dysplasia of all grades. Invasive cancer must be supported by a pathological diagnosis or a clinical diagnosis if pathological diagnosis is not possible.

Cancer in situ means that while insured under the policy, a covered person has been diagnosed with a cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue. *Cancer in situ* includes, but is not limited to: Early prostate cancer diagnosed as T1N0M0 or equivalent staging; and melanoma not invading the dermis. *Cancer in situ* does not include: Other skin malignancies, such as squamous cell or basal cell cancer; or pre-malignant lesions (such as intraepithelial neoplasia); or benign tumors or polyps; or Invasive cancer. *Cancer in situ* must be supported by a pathological diagnosis or a clinical diagnosis if a pathological diagnosis is not possible.

Skin cancer means that while insured under the policy, a covered person has been diagnosed with basal cell cancer or squamous cell cancer of the skin.

Blindness means that while insured under the policy, a covered person has been initially diagnosed with an irreversible reduction in sight, lasting at least 180 days, that results in a corrected visual acuity of 20/400 or less or a visual field less than 20 degrees when testing both eyes together. Benefits for blindness are not payable if the condition is a consequence of another condition for which another critical illness benefit has been paid.

Loss of speech means a covered person is initially diagnosed with total, permanent and irreversible loss of the ability to speak. The loss must be: as a result of injury or sickness affecting the speech organs; and have continued without interruption for a period of at least 6 consecutive months. *Loss of speech* does not include any loss that could be restored, totally or partially, by use of a device or implant. Benefits for loss of speech are not payable if the condition is a consequence of another condition for which another critical illness benefit has been paid. In order for a benefit to be paid, the initial diagnosis of loss of speech must occur while insured under the policy.

Complete loss of hearing means that a covered person has been initially diagnosed with a condition that results in the total and irreversible loss of hearing in both ears to a point that a covered person is unable to hear sounds at or below 70 decibels. The diagnosis must be confirmed using audiometric testing. *Complete loss of hearing* does not include loss of hearing that can be corrected to above 70 decibels by the use of any hearing aid or device. Benefits for complete loss of hearing are not payable if the condition is a consequence of another condition for which another critical illness benefit has been paid. In order for a benefit to be paid, the initial diagnosis of complete loss of hearing must occur while insured under the policy.

Benign brain tumor means a covered person has been initially diagnosed with a meningioma, lipoma or glioma arising from the brain or its meninges and is: confirmed by the examination of tissue (biopsy or surgical excision) or specific neuroradiological examination; and resulting in persistent neurological deficits including but not limited to: loss of vision, loss of hearing or balance disruption. Other conditions, including the following, are not considered a *benign brain tumor*: hematomas, cysts or granulomas; or intracranial malformations of the arteries or veins; or tumors in the pituitary gland, spine or cranial nerves, including pituitary adenoma, acoustic neuroma or craniopharyngioma. In order for a benefit to be paid, the initial diagnosis of any benign brain tumor must occur while insured under the policy.

Paralysis means that while insured under the policy, a covered person has been diagnosed with total and irreversible loss of use of two or more limbs due to injury and that is continuously present for a period of at least 180 days. *Paralysis* shall not include any impairment caused by a stroke or other sickness.

Coma means that while insured under the policy, a covered person has been diagnosed with a condition from which a covered person cannot be aroused and which requires an external life support system, both of which have persisted continuously for at least 168 hours. A medically induced coma is excluded.

Advanced ALS or Lou Gehrig's disease means a covered person has: been initially diagnosed with definite amyotrophic lateral sclerosis (ALS) according to criteria established by the World Federation of Neurology; and been determined to require either a feeding tube or non-invasive ventilation; and been unable to perform 3 or more of the activities of daily living* without the assistance of another person. In order for a benefit to be paid, the initial diagnosis of any stage of amyotrophic lateral sclerosis (ALS) or Lou Gehrig's disease must occur while insured under the policy.

Advanced Alzheimer's disease means a covered person has: been initially diagnosed with Functional Assessment Staging Scale (FAST) Stage 6 or higher for Alzheimer's related dementia; and demonstrated memory impairment; decreased ability to plan, organize, sequence; language disturbance; or other cognitive disturbance; and been unable to perform 3 or more of the activities of daily living* without the assistance of another person. In order for a benefit to be paid, the initial diagnosis of any stage of Alzheimer's disease must occur while insured under the policy.

Advanced Parkinson's disease means a covered person has: been initially diagnosed with primary idiopathic Parkinson's disease at stage 4 or higher on the Hoehn and Yahr scale; and demonstrated resting tremor, rigidity, bradykinesia and dementia despite a generally accepted drug regimen; and been unable to perform 3 or more of the activities of daily living* without the assistance of another person. In order for a benefit to be paid, the initial diagnosis of any stage of Parkinson's disease must occur while insured under the policy.

* Activities of daily living includes: bathing; washing; dressing; toileting; transferring; continence and eating as defined in the policy.

State variations can exist; please contact Assurant Employee Benefits for additional information.

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Critical Illness Definitions - *Childhood Illnesses*

Cerebral palsy means that your covered dependent child under the age of 18 has been initially diagnosed with a disorder of movement and posture resulting from an injury to or congenital abnormality of the immature central nervous system. The movement disorders typically observed are spasticity, rigidity, abnormal gait, tremor, seizures, cognitive communication, learning and behavioral difficulties, which all result from an abnormally functioning brain. In order for a benefit to be paid, the initial diagnosis of cerebral palsy must occur while insured under the policy.

Cleft lip/palate means that your covered dependent child under the age of 18 has been initially diagnosed with either a cleft lip or a cleft palate. A cleft lip means a congenital failure of the upper lip to close and results in a narrow gap in the upper lip that extends to the nostril on one side or both sides of the mouth. A cleft palate means a congenital failure to close an opening in the roof of the mouth that extends to the nasal cavity. When a combination of cleft lip and cleft palate is diagnosed, only one diagnosis is eligible for benefits. In order for a benefit to be paid, the initial diagnosis of cleft lip/palate must occur while insured under the policy.

Cystic fibrosis means that your covered dependent child under the age of 18 has been initially diagnosed with an inherited disease that causes primarily chronic lung disease and pancreatic deficiency due to abnormally thick mucous that blocks passageways. Diagnosis must be confirmed with sweat chloride tests and genetic testing. In order for a benefit to be paid, the initial diagnosis of cystic fibrosis must occur while insured under the policy.

Down syndrome means that your covered dependent child under the age of 18 has been initially diagnosed with a set of mental and physical symptoms due to trisomy 21, mosaicism for trisomy 21 or trisomy for part of chromosome 21 or translocation, including but not limited to slow mental, physical and language development with poor muscle tone, flat face with upward slant to eye, short neck and abnormally shaped ears. Diagnosis must be confirmed with genetic testing. In order for a benefit to be paid, the initial diagnosis of Down syndrome must occur while insured under the policy.

Muscular dystrophy means that your covered dependent child under the age of 18 has been initially diagnosed with either Duchenne muscular dystrophy or Becker muscular dystrophy. Duchenne muscular dystrophy is a type of chromosome X-linked inherited muscle disease resulting in progressive weakness beginning in the legs, an enlargement of the calf muscles and decreased ability to stand, walk and maintain balance. Becker muscular dystrophy is a chromosome X-linked recessive inherited muscle disorder resulting in slowly progressive muscle weakness of the legs and pelvis causing difficulty with walking, standing up, climbing and balance. Diagnosis of either type of muscular dystrophy must be confirmed by CPK blood test, muscle biopsy, electromyography and genetic testing. In order for a benefit to be paid, the initial diagnosis of muscular dystrophy must occur while insured under the policy.

Spina bifida means that your covered dependent child under the age of 18 has been initially diagnosed with congenital conditions of meningocele or myelomeningocele. Meningocele means that the lining of the spinal cord (meninges) is forced into the gaps between the vertebrae or at the base of the skull. Myelomeningocele means that the opening in the spinal column allows the spinal cord to protrude. This typically causes some degree of paralysis and loss of sensation below the level of the opening. *Spina bifida* does not include spina bifida occulta. In order for a benefit to be paid, the initial diagnosis of spina bifida must occur while insured under the policy.

Type I diabetes means that your covered dependent child under the age of 18 has been initially diagnosed with a chronic autoimmune, genetic or infectious destruction of the insulin producing cells in the pancreas and that requires continuous, lifelong insulin therapy. In order for a benefit to be paid, the initial diagnosis of Type I diabetes must occur while insured under the policy.

State variations can exist; please contact Assurant Employee Benefits for additional information.

Limitations, exclusions, restrictions and reductions

Please carefully review the Other Important Plan Provisions section for additional important plan limitations, exclusions, restrictions and reductions that may apply.

Other Important Plan Provisions

ASSURANT
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Accident

For benefits to be payable under this policy, the accident must be due to a sudden, unforeseen, external and unexpected event, which results in an injury and which occurs while you or your covered dependent are insured under this policy. This plan does not cover sickness, cerebrovascular accident (stroke) or any drug overdose unless the drugs were used as prescribed by a doctor. Sickness means a disease, illness or other condition not related to an injury, including diseases or infections resulting from bug bites, stings or infestations by microorganisms.

We will not pay benefits for you or your covered dependent relating to or resulting from: services or treatment not included in the Schedule; services or treatment for which you or your covered dependent are not charged, unless there is no charge because the facility is a United States government facility; services or treatment provided by a family member; services or treatment rendered or hospital confinement outside the United States; or dental care except for emergency dental work for broken teeth either repaired by crowns or extracted due to an accident. We will not pay benefits for you or your covered dependent if the accident or injury results, directly or indirectly, from: service in the armed forces or related auxiliaries such as the National Guard or Army Reserve of any country, combination of countries, or international organization at war, whether declared or not; war or any act of war, whether declared or not; taking part in a riot or insurrection, or an act of riot or insurrection; committing or attempting to commit an assault or felony; incarceration in a penal institution of any kind; intoxication (intoxication means the blood alcohol level for you or your covered dependent exceeds the legal limit for operating a motor vehicle in the jurisdiction in which the injury occurs); use of any drug, unless used as prescribed by a doctor; intentionally self-inflicted injury, while sane or insane; suicide or attempted suicide, while sane or insane; travel or flight in any kind of aircraft, including any aircraft owned by or for the policyholder or an associated company, except as a fare-paying passenger on a common carrier; participation in any kind of sporting activity for compensation or profit, including coaching or officiating; participation in racing, stunting, exhibition work, sport or test driving of a motor vehicle, including but not limited to cars, motorcycles and boats; participation in mountaineering, operating a glider, bungee jumping or skydiving; operating a taxi or any other delivery service for any kind of compensation or profit; any physical or mental sickness or related complications; or treatment or complications of treatment.

In the case of non-occupational coverage, we will not pay benefits if the accident or injury results, directly or indirectly, from any work you or your covered dependent do for pay or benefits.

Critical Illness

We will not pay benefits for you or your covered dependent if the critical illness or procedure is related to or resulting directly or indirectly from: services or treatment not included in the Schedule; services or treatment for which you or your covered dependent are not charged, unless there is no charge because the facility is a United States government facility; services or treatment provided by a family member; any critical illness that is diagnosed outside the United States; services or treatment provided primarily for cosmetic purposes; treatment or complications of treatment not related to a critical illness or procedure; an autologous bone marrow transplant for you or your covered dependent in which the covered person's own bone marrow is used; service in the armed forces or related auxiliaries such as the National Guard or Army Reserve of any country, combination of countries, or international organization at war, whether declared or not; war or any act of war, whether declared or not; taking part in a riot or insurrection, or an act of riot or insurrection; committing or attempting to commit an assault or felony; incarceration in a penal institution of any kind; intoxication (intoxication means the blood alcohol level for you or your covered dependent exceeds the legal limit for operating a motor vehicle in the jurisdiction in which the injury occurs); use of any drug, unless used as prescribed by a doctor; intentionally self-inflicted injury, while sane or insane; suicide or attempted suicide, while sane or insane.

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