Critical Illness Insurance

1-877-VIP-CSEA
Valuable **I**nsurance **P**rograms

Sponsored by

CSEA

Administered by

PEARL CARROLL

Important Benefits *for CSEA members*

Many individuals have had a family member, friend or acquaintance who has felt the physical, emotional and financial effects of a critical illness; a co-worker diagnosed with cancer, a friend's parent who has suffered a stroke, or a loved one who had a heart attack. Despite having good medical insurance, there are still expenses associated with a critical illness that most medical plans don't cover.

Help fill the gaps with Critical Illness Insurance

Critical Illness Insurance can help fill the gaps that traditional life, medical, and disability coverage leave, by providing funds to use any way you choose, including indirect, non-medical, and non-covered costs, such as:

- Medical co-pays and deductibles
- Prescription drug co-pays
- Mortgage/Rent payments
- Childcare bills
- Car payments
- Out-of-networks treatments
- Utility payments and other household bills

By themselves, these expenses may not seem significant but together they can add up. In fact, the average out-of-pocket expenses for individuals who experience a critical illness such as a heart attack, stroke or cancer are over $6,500*.

**MetLife's Accident and Critical Illness Insurance Impact Study, 2013*

What are the Covered Condtions?

MetLife Critical Illness Insurance covers the following medical conditions and groups them into 3 distinct categories (as defined by the group certificate):

CATEGORY 1 – Certain Cancer-Related Conditions

- Full Benefit Cancer[1]
- Partial Benefit Cancer – 25%[1,2]
- Skin Cancer- $250[3]

CATEGORY 2 – Certain Heart-Related Conditions

- Heart Attack
- Stroke[4]
- Coronary Artery Disease – 25%[2]

CATEGORY 3 – Certain Other Conditions

- Major Organ Transplant (other than bone marrow)[5]
- Kidney Failure[6]

How Do Payments Within Each Category Occur?

Either all or a portion of the Category Benefit Amount is payable, depending on the type of covered condition. If a portion of the Category Benefit Amount is paid for a covered person under the policy, the amount payable for any future claims for that person in that category will be reduced by the amount already paid.

We will reduce what we pay for a claim so that the amount we pay per calendar year, when combined with amounts for all claims we have previously paid for the same covered person during the same calendar year does not exceed the Annual Benefit Amount that was in effect for that covered person on the date of the most recent covered condition.

We will reduce what we pay for a claim so that the amount we pay, when combined with amounts for all claims we have previously paid for the same covered person, does not exceed the Total Benefit Amount that was in effect for that covered person on the date of the most recent covered condition.

100% of the Category Benefit Amount is payable for:

- Heart Attack
- Kidney Failure
- Major Organ Transplant
- Stroke
- Full Benefit Cancer

25% of the Category Benefit Amount is payable for Partial Benefit Cancer. Only one benefit is payable for Partial Benefit Cancer, per Covered Person, per lifetime.

25% of the Category Benefit Amount is payable for Coronary Artery Disease. No benefit for Coronary Artery Disease will be payable unless, while the covered person is insured under this certificate, either:

- the Coronary Artery Bypass Graft is actually performed; or
- no later than six months after the date of the Diagnosis of Coronary Artery Disease, the Covered Person dies.

Only one benefit is payable for Coronary Artery Disease, per Covered Person, per lifetime.

$250 is payable for Skin Cancer. Only one benefit for Skin Cancer is payable per covered person, per lifetime.

During any single calendar year, the member is eligible to receive payments up to the member's annual benefit amount, which is equal to the category benefit amount. Once 100% of this annual benefit amount has been paid, the member will not be eligible to receive additional payments until the next calendar year. The member is only eligible for payment in any category(ies) not yet closed.

Payment Examples

The following is a payment example for a member who purchased a **$10,000 category benefit amount** where all group policy and certificate requirements for coverage have been met:

You are diagnosed as having lung cancer.	MetLife would pay 100% of the category benefit amount = $10,000. This would close Category 1 — Cancer-Related conditions. You are still eligible for benefits for covered conditions in Categories 2 and 3.
Two years later, you have a coronary artery bypass graft.	MetLife would pay 25% of the category benefit amount = $2,500. You would still have 75% of the category benefit amount available if you experience another covered condition within Category 2 — Heart Related conditions.
Then, the following year, you suffer a debilitating stroke.	MetLife would pay the remainder of the category benefit amount for Category 2 — 75% of $10,000 = $7,500. This would close Category 2 — Heart-Related conditions. You are still eligible for benefits for covered conditions in Category 3 — Other conditions.
Three years later, you have kidney failure.	MetLife would pay 100% of the category benefit amount = $10,000. Since you have exhausted 100% of the category benefit amounts in each of the three categories, the coverage is terminated.

The above example illustrates that during the life of the Critical Illness Insurance certificate with a category benefit amount of $10,000, it is possible to receive a total of $30,000. This is the maximum amount that you could receive under a certificate with a $10,000 category benefit amount.

This example is for illustrative purposes only. The MetLife Critical Illness Insurance Policy and Certificate are the governing documents with respect to all matters of insurance, including coverage for specific illnesses. The specific facts of each claim must be evaluated in conjunction with the provisions of the applicable Policy and Certificate to determine coverage in each individual case.

Quality Preventive Care May Reduce the Risk of Critical Illness

Prevention is the best medicine. That's why as part of the critical illness insurance benefit, each year, you and your covered dependents are eligible to receive an additional $75 health screening benefit[7] which is above and beyond your lump sum benefit payment. To receive this health screening benefit, a covered Member must send MetLife evidence that they have undergone one of the following listed tests below. This benefit is limited to one test per covered person each calendar year after coverage has been in force for 12 months for that individual.

The covered tests include:

- colonoscopy;
- virtual colonoscopy;
- flexible sigmoidoscopy;
- endoscopy;
- digital rectal exam (DRE);
- fasting blood glucose test;
- fasting plasma glucose test;
- two hour post-load plasma glucose test;
- hemocult stool specimen;
- mammogram;
- pap smears or thin prep pap test;
- prostate-specific antigen (PSA) test;
- serum cholesterol test to determine LDL and HDL levels;
- blood test to determine total cholesterol;
- blood test to determine triglycerides; or
- stress test on bicycle or treadmill.

Rates

Premiums for Member and spouse/domestic partner are adjusted when they attain a new five year age bracket. The adjustment will take place on November 1, based on their age on April 30 of the following year.

Bi-Weekly Premiums

Age	10k Member	10k Spouse
< 25	$0.78	$0.74
25-29	$0.83	$0.83
30-34	$1.15	$1.15
35-39	$1.71	$1.71
40-44	$2.63	$2.68
45-49	$4.11	$4.25
50-54	$6.18	$6.60
55-59	$9.09	$10.25
60-64	$13.29	$15.55
65-69	$19.38	$23.31
70-74	$27.32	$32.49
75-79	$37.71	$43.20
80-84	$46.71	$52.15
85+	$49.98	$55.15

10k Child	
Children	$0.69

For rates over $10,000 please contact your local CSEA Insurance Representative or call 1-877-847-2732.

Effective Date

Your insurance (as well as any applicable spouse/domestic partner and/or dependent child coverage) will not become effective until your application has been approved and the 1st premium and/or payroll deduction has been paid. If a member/spouse are not actively at work on that date, coverage will take effect on the date you return to active work and your premiums will be due at that time.

When Insurance Ends

Date Your Insurance Ends

Your insurance will end on the earliest of:

- the date the Group Policy ends;
- the date You die;
- the date insurance ends for Your class;
- the date the Total Benefit Amount has been paid for You; or
- the end of the period for which the last full premium has been paid for You;

Date Dependent Insurance Ends

A Dependent's insurance will end on the earliest of:

- the date Your insurance under this Certificate ends;
- the date Dependent Insurance ends under the Group Policy for all members or for Your class;
- the date the person ceases to be a Dependent;
- the date the Total Benefit Amount has been paid for that Dependent;
- the date You cease to be in a class that is eligible for Dependent Insurance; or
- the end of the period for which the last full premium has been paid for the Dependent.

Definitions and Diagnostic Requirements

Coronary Artery Disease means the blockage or narrowing of one or more coronary arteries due to atherosclerotic heart disease for which a Physician has determined Coronary Artery Bypass Graft to be medically necessary.

Full Benefit Cancer means the presence of one or more malignant tumors characterized by the uncontrollable and abnormal growth and spread of malignant cells with invasion of normal tissue or the presence of one or more malignant tumors where there is metastasis.

Heart Attack (myocardial infarction) means the death of a portion of the heart muscle as a result of obstruction of one or more coronary arteries due to atherosclerosis, spasm, thrombus or emboli.

Kidney Failure means the total, end stage, irreversible failure of both kidneys to function, provided that a Physician has determined that such failure requires either:

- immediate and regular kidney dialysis (no less often than weekly) that is expected by such Physician to continue for at least 6 months; or
- a kidney transplant.

Major Organ Transplant means:

- the irreversible failure of a Covered Person's heart, lung, pancreas, entire kidney or any combination thereof, for which a Physician has determined that the complete replacement of such organ with an entire organ from a human donor is medically necessary, and either such Covered Person has been placed on the Transplant List or such transplant procedure has been performed; or
- the irreversible failure of a Covered Person's liver for which a Physician has determined that the complete or partial replacement of the liver with a liver or liver tissue from a human donor is medically necessary by a Physician and either such Covered Person has been placed on the Transplant List or such procedure has been performed.

Partial Benefit Cancer means one of the following conditions:

- a carcinoma in situ wherein the malignant tumor cells still lie within the tissue of the site of origin, without having invaded neighboring tissue; and
- tumors of the prostate classified as T1N0M0, including but not limited to T1aN0M0, T1bN0M0 or T1cN0M0 under TNM Staging.

Skin Cancer means any malignant growth that arises on the surface of the skin that is a:

- basal cell carcinoma;
- squamous cell carcinoma;
- melanoma classified as Clark's Level I (melanoma in situ); or
- melanoma classified as Clark's Level II.

$250 is payable for Skin Cancer that Occurs for a Covered Person while such Covered Person is insured under this Certificate. Only one benefit for Skin Cancer is payable per Covered Person per lifetime

Stroke means a cerebrovascular accident or incident producing measurable, functional and permanent neurological impairment (not including transient ischemic attacks (TIA), or prolonged reversible ischemic attacks) caused by any of the following which result in an infarction of brain tissue:

- hemorrhage;
- thrombus; or
- embolus from an extracranial source

Exclusions that Apply to Specific Covered Conditions

Major Organ Transplant

We will not pay benefits for a Major Organ Transplant if the transplant procedure that has been determined to be medically necessary involves:

- stem cell generated transplants; or
- islet cell transplants.

Stroke

We will not pay benefits for a Diagnosis of Stroke for:

- cerebral symptoms due to migraine;
- cerebral injury resulting from trauma or hypoxia; or
- vascular disease affecting the eye or optic nerve or vestibular functions.

Full Benefit Cancer

We will not pay benefits for a Diagnosis of Full Benefit Cancer for:

- any benign tumor, dysplasia, intraepithelial neoplasia or pre-malignant growth;
- any Skin Cancers unless there is metastasis;
- any condition that is Partial Benefit Cancer.

Partial Benefit Cancer

We will not pay benefits for a Diagnosis of Partial Benefit Cancer for:

- any benign tumor, dysplasia, intraepithelial neoplasia or pre-malignant growths; or
- Skin cancers.

Skin Cancer

We will not pay benefits for a Diagnosis of Skin Cancer for any benign tumors, pre-malignant growths, dysplasia or intraepithelial neoplasia.

Coronary Artery Disease

We will not pay benefits for Coronary Artery Bypass Graft if Coronary Artery Bypass Graft is performed outside the United States, Canada or Mexico.

Additional Proof Requirements for Each Covered Condition

Heart Attack

Diagnosis of Heart Attack must be made in Writing by a Physician and supported by medical records showing an elevation of enzymes, troponins or other biochemical cardiac markers, and two of the three following criteria associated with the Heart Attack for which a claim is being made:

1. typical chest pain characteristic of an acute myocardial infarction, requiring the Covered Person to be Hospitalized as an inpatient;
2. electrocardiograph (EKG) changes on one or a series of electrocardiograms taken at the time the Covered Person experiences the Heart Attack for which a claim is being made, which changes are indicative of an acute myocardial infarction, but, if the Covered Person had any prior electrocardiogram(s), the electrocardiogram(s) presented as Proof of Heart Attack must show changes from the Covered Person's last electrocardiogram, and such changes must be indicative of an acute myocardial infarction; or
3. confirmatory imaging studies such as thallium scans, or echocardiograms indicative of an acute myocardial infarction, but, if the Covered Person had any prior imaging studies, the imaging studies presented as Proof of Heart Attack must show changes from the Covered Person's last imaging studies, which changes must be indicative of a myocardial infarction.

The Covered Condition for Heart Attack will be deemed to Occur on the date the Diagnosis of Heart Attack is made.

Kidney Failure

Diagnosis of Kidney Failure must be made in Writing by a Physician and must be supported by medical records. The Covered Condition for Kidney Failure will be deemed to Occur on the date the Diagnosis of Kidney Failure is made.

Major Organ Transplant

Proof of Major Organ Transplant requires submission of medical records evidencing that the Major Organ Transplant was deemed medically necessary by a Physician, and that either:

- the Covered Person has been placed on the Transplant List; or
- the Major Organ Transplant has been performed.

The Covered Condition for Major Organ Transplant will be deemed to Occur on the earlier of:

- the date the Covered Person is placed on the Transplant List; or
- the date that the Major Organ Transplant is performed.

Stroke
Diagnosis of Stroke must be made in Writing and be based upon medical records indicating objective evidence of significant neurological impairment that is functional, measurable and permanent as demonstrated by magnetic resonance imaging, computerized tomography or other reliable imaging techniques. Such neurological impairment must be confirmed in Writing no earlier than 30 days after the cerebrovascular accident or incident by a Physician and be based upon objective evidence of significant neurological, motor or sensory impairment, which impairment must be present on the date that such Written confirmation is made. The Covered Condition for Stroke will be deemed to Occur on the date the Diagnosis of Stroke is made.

Full Benefit Cancer
Unless We accept a Clinical Diagnosis as provided in this Certificate, Diagnosis of Full Benefit Cancer must be based upon microscopic (histologic) examination of fixed tissues or preparations of blood or bone marrow. Such examination must be documented in a Written pathology report by a Physician. The Covered Condition for Full Benefit Cancer will be deemed to Occur upon the date that the Diagnosis of Full Benefit Cancer is made.

Partial Benefit Cancer
Unless We accept a Clinical Diagnosis as provided in this Certificate, Diagnosis of Partial Benefit Cancer must be based upon microscopic (histologic) examination of fixed tissue or preparations of blood or bone marrow. Such examination must be documented in a Written pathology report by a Physician. The Covered Condition for Partial Benefit Cancer will be deemed to Occur upon the date the Diagnosis of Partial Benefit Cancer is made.

Coronary Artery Disease
Proof of Coronary Artery Disease requires submission of medical records evidencing that the Coronary Artery Bypass Graft:

- was determined to be medically necessary by a Physician;
- was supported by pre-operative angiographic evidence; and
- either the Coronary Artery Bypass Graft has been performed or the Covered Person has died.

The Covered Condition for Coronary Artery Disease will be deemed to Occur on the date that the Coronary Artery Bypass Graft is determined to be medically necessary by a Physician.

Limitations

Waiting Period
On the date a Covered Person's insurance under this Certificate becomes effective, a 30 day waiting period starts with respect to such insurance. Such insurance will be void if the Covered Person experiences a Covered Condition during the waiting period.

On the date a Benefit Increase becomes effective, a waiting period starts with respect to the Benefit Increase. Such Benefit Increase will be void with respect to a Covered Person if the Covered Person experiences a Covered Condition during the waiting period.

Contributions You have paid for any insurance that is voided under this section will be returned to You without interest, except if Your Dependent Child is the Covered Person whose insurance is void under this provision. If insurance for a Dependent Child is void

under this provision, Contributions paid for that insurance will be returned to You only if there is no insurance remaining in effect for any Dependent Child under this Certificate. If You are the Covered Person whose insurance is void under this provision, and as a result You no longer have any insurance in effect under the Group Policy, insurance for Your Dependents will also be void.

If a claim is denied under this Waiting Period provision, at Your option, We will exclude the Covered Condition under the Preexisting Condition Exclusion and insurance that would otherwise be void under this Waiting Period provision will not be void. In order for You to exercise this option, You must notify Us in Writing within 30 days after We notify You that Your claim is denied under this waiting period provision.

Preexisting Condition Exclusion

Preexisting Condition means a sickness or injury for which, in the 6 months before a Covered Person becomes insured under this Certificate, or before any Benefit Increase with respect to such Covered Person, medical advice or treatment was recommended by, prescribed by or received from a Physician.

We will not pay benefits for a Covered Condition that is caused by or results from a Preexisting Condition if the Covered Condition Occurs during the first 6 months that a Covered Person is insured under this Certificate.

With respect to a Benefit Increase, We will not pay benefits for such Benefit Increase for a Covered Condition that is caused by or results from a Preexisting Condition if the Covered Condition Occurs during the first 6 months after such increase in the Total Benefit Amount.

Exclusion for Intoxication

We will not pay benefits for any Covered Condition that is caused by, contributed to by, or results from a Covered Person's involvement in an incident, where such Covered Person is intoxicated at the time of the incident and is the operator of a vehicle involved in the incident.

Intoxicated At The Time of the Incident means that a court of law has adjudged that at the time of the incident, the Covered Person's blood alcohol level was such that the Covered Person was intoxicated within the meaning of the laws of the jurisdiction in which the incident happened.

General Exclusions

We will not pay benefits for any Covered Conditions caused by, contributed to by, or resulting from a Covered Person:

- participating in a felony, riot or insurrection;
- intentionally causing a self-inflicted injury;
- committing or attempting to commit suicide;
- voluntarily taking or using any drug, if the possession, use or taking of such drug violates federal law or the law of any jurisdiction in which the Covered Person possessed, used or took such drug; or
- serving in the armed forces or any auxiliary unit of the armed forces of any country.

We will not pay benefits for Covered Conditions arising from war or any act of war, even if war is not declared.

We will not pay benefits for any Covered Condition for which Diagnosis is made outside the United States, Canada or Mexico unless the Diagnosis is confirmed in the United States, Canada or Mexico in which case the date of the Covered Condition will be the date of the Diagnosis made outside the United States, Canada or Mexico.

We will not pay benefits for any Covered Condition that does not Occur for a Covered Person while such Covered Person is insured under this Certificate.

Critical Illness Q&A

How does MetLife CII work?
You and your spouse/domestic partner can apply for a category benefit amount of up to $100,000 of coverage by filling out the enclosed enrollment form and mailing it to Pearl Carroll. You can also apply to purchase $10,000 of coverage for your dependent child(ren). As a MetLife certificate holder, if you experience one of the covered conditions within a category and meet the policy and certificate requirements, you will receive a lump-sum benefit payment to use as you see fit. The payment amount depends on the illness you experience.

Can you explain how the category benefit payments work?
A member can receive payment benefits in three different categories: The member can enroll for a category benefit amount of coverage for himself/herself, his or her spouse/domestic partner and dependent children. Assuming the member and dependents are approved for coverage, when a member or eligible dependent is diagnosed with a covered condition within any category and meets all the group policy and certificate requirements, he or she will receive a lump-sum payment to use as he or she sees fit. The lump sum benefit payment works like this: 1) For coronary artery bypass graft and partial benefit cancer, you will receive 25% of the category benefit amount. The remaining 75% will be available should you experience another covered condition within the same category. 2) For all covered conditions other than coronary artery bypass graft and partial benefit cancer (unless you have already received a partial benefit payment for a covered condition in the same category, in which case you would receive the remaining 75% of the category benefit amount), you will receive 100% of the category benefit amount. 3) After 100% of a category benefit amount has been paid, the category will close and you will not receive any additional payments within that category. If you are later diagnosed with another covered condition that falls within one of the two remaining categories, you can receive another lump sum payment for that category.++ Once 100% of the category benefit amount has been paid in each of the three categories, the coverage will be terminated.

Will I need medical insurance to apply for CII?
MetLife Critical Illness Insurance does not replace your current medical insurance. In fact, you need to have medical insurance in place to apply for this coverage.

How can this coverage benefit me?
Living with a critical illness may affect your financial security and that of your family. Despite having good medical insurance, there are still expenses associated with a critical illness that many medical plans are not designed to pay. Think about such expenses as co-pays, deductibles, out-of-network treatments, prescription drug co-pays, childcare, mortgage and utility payments. MetLife Critical Illness Insurance can help you keep your finances on track if you experience a covered condition.

Who is eligible to apply?
Any active Member who is actively at work, along with their spouse/domestic partner and dependent child(ren), may apply for MetLife CII coverage. Dependent child means the following: biological, adopted, or stepchild who is between birth and age 25 years regardless of student status.

How are premiums paid?
Premiums for MetLife CII will be paid through post-tax payroll deduction.

TO APPLY FOR COVERAGE

How Do I Apply for Coverage?

Call Pearl Carroll & Associates at **1-877-847-2732** to speak with a CSEA Insurance Representative.

[1] Please review the Outline of Coverage/Disclosure Document for specific information about cancer benefits.

[2] For some types of Cancer and Coronary Artery Disease, the insured may be eligible to receive 25% of the Category Benefit Amount. In certain states, the Covered Condition is Coronary Artery Bypass Graft. Not all Cancers are covered.

[3] Not available in all states. See your OOC/Disclosure Statement for details.

[4] In certain states, the Covered Condition is Severe Stroke.

[5] In certain states, Heart Transplant is a Category 2 heart-related Covered Condition.

[6] In certain states, Bone Marrow Transplant is a Category 1 cancer-related Covered Condition.

[7] There is a 30 day waiting period for the Health Screening Benefit. Not available to NH residents.

Plan underwritten by:

MetLife

Metropolitan Life Insurance Company New York, NY 10166

METLIFE CRITICAL ILLNESS INSURANCE (CII) IS A LIMITED BENEFIT GROUP INSURANCE POLICY. Like most group accident and health insurance policies, MetLife's CII policies contain certain exclusions, limitations and terms for keeping them in force. Product features and availability vary by state. There is a preexisting condition exclusion. In some states there is a Benefit Suspension Period between Covered Conditions in different categories or a limit on the Total Benefit payments per calendar year. A more detailed description of the benefits, limitations, and exclusions applicable to you can be found in the Disclosure Statement or Outline of Coverage/Disclosure Document available at time of enrollment. Please contact Pearl Caroll and Associates LLC at 1-877-847-2732 for more information.

MetLife's Critical Illness Insurance is not intended to be a substitute for medical coverage providing benefits for medical treatment, including hospital surgical and medical expenses. MetLife's Critical Illness Insurance does not provide reimbursement for such expenses.

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