**Imprimus Labels and Packaging**
**Summary of Benefits: Critical Illness Protection**
**Plan Effective Date: 01/01/2024**

## Help protect yourself from costly medical expenses with UnitedHealthcare.

Critical Illness Protection Plan helps protect employees from costly expenses associated with the diagnosis of a serious illness. All benefits are paid directly to the insured and can be used towards any expense.

## Your Critical Illness Protection Plan highlights:

Eligibility: All Active Full Time Employees working a minimum of 30 hours per week. Employee must purchase coverage in order to purchase dependent coverage. Dependent children are covered to age 26.

| Maximum Benefit Amount | Option A | Option B | Option C |
|---|---|---|---|
| Employee | $10,000 | $20,000 | $30,000 |
| Spouse | $10,000 | $20,000 | $30,000 |
| Child(ren) | $5,000 | $10,000 | $15,000 |

| Plan Provisions | |
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| Reoccurrence Benefit ** | Benefit Payable for the same Covered Condition |

| Covered Conditions | Percentage of the Insured's Maximum Benefit Amount Payable |
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| **Base Conditions** | |
| Benign Brain Tumor | 100% |
| Cancer – Invasive | 100% |
| Cancer – Non-Invasive | 25% |
| Chronic Renal Failure | 100% |
| Coma | 100% |
| Coronary Artery Disease | 25% |
| Heart Attack | 100% |
| Heart Failure | 100% |
| Major Organ Failure | 100% |
| Permanent Paralysis | 100% |
| Ruptured Aneurysm | 100% |
| Stroke | 100% |
| **Additional Covered Conditions ** ** | |
| Advanced Alzheimer's | 100% |
| Advanced Multiple Sclerosis | 100% |
| Advanced Parkinson's | 100% |
| Amyotrophic lateral sclerosis (ALS) | 100% |
| Complete Blindness | 100% |
| Complete Loss of Hearing | 100% |
| **Child Only Covered Conditions** (One condition payable per Covered Child) ** | |
| Cerebral Palsy | 25% of the Employee's maximum benefit |
| Cleft Lip / Palate | 25% of the Employee's maximum benefit |
| Cystic Fibrosis | 25% of the Employee's maximum benefit |
| Down Syndrome | 25% of the Employee's maximum benefit |
| Muscular Dystrophy | 25% of the Employee's maximum benefit |
| Spina Bifada | 25% of the Employee's maximum benefit |

***Reoccurrence does not apply to Additional Covered Conditions, Child Only Covered Conditions and Rabies*

| Additional Benefits | |
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| Wellness Benefit | $75 |

| Wellness Benefit Covered Exams | |
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| Blood test for triglycerides | Hemoccult stool analysis |
| Bone marrow testing | Mammography |
| Breast ultrasound | Pap smear |
| CA 15-3 (blood test for breast cancer) | PSA (blood test for prostate cancer) |
| CA 125 (blood test for ovarian cancer) | Serum Protein Electrophoresis (blood test for myeloma) |
| CEA (blood test for colon cancer) | Serum cholesterol test to determine level of HDL and LDL |
| Chest X-ray | Stress test on a bicycle or treadmill |
| Colonoscopy | Thermography |
| Fasting blood glucose test | Virtual Colonoscopy |
| Flexible sigmoidoscopy | |

*Benefit paid upon completion of a covered wellness exam or health screening test. One covered test per calendar year per Employee and Spouse*

## Frequently Asked Questions about your Critical Illness Protection Plan (CIPP)

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| Am I eligible for coverage? | You are eligible if you are working a minimum of 30 hours per week and considered benefit eligible by your employer. |
| What does Critical Illness Coverage provide me | Critical Illness coverage provides protection against the expense of serious medical conditions. |
| Who pays for my Critical Illness coverage? | Your employer has made CIPP coverage available to all eligible employees on a voluntary basis, which means you pay your premiums if you elect the coverage. |
| When does my coverage go into effect? | You must be Actively at Work with your employer, as defined in your plan, on the date your coverage is scheduled to take effect. Otherwise, your coverage takes effect when you return to Active Work. |
| Can I receive a benefit for more than one of the covered conditions? | Each Covered Condition is payable at least one time for dates of diagnoses that occur while coverage is in force. Your Certificate of Coverage may require a separation period be met between the dates of diagnoses. *(Note: This is commonly referred to as additional occurrence.)* |

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| If I have received a benefit for a covered condition (i.e., Heart Attack) and then get diagnosed again with that same condition, will another benefit be payable? | You may be eligible for another benefit payment for the **same** Covered Condition. This is referred to as Reoccurrence Benefit, and certain Conditions are eligible.<br><br>Reoccurrence allows you to receive a benefit when:<br>• You are diagnosed for a covered condition we have already paid a benefit for;<br>• the date of diagnosis of the reoccurrence is at least 6 Months following the previous date of diagnosis; and<br>• there has been no treatment for that condition during the 6 Months period prior to the subsequent diagnosis date.<br><br>Coverage must be in force on the date the reoccurrence is diagnosed. A second opinion or reconfirmation of a diagnosis is not considered reoccurrence. |
| Is Cancer eligible for a reoccurrence benefit? | Cancer conditions may be eligible for a Reoccurrence Benefit if:<br>• the dates of diagnosis are separated by at least 6 Months and;<br>• there has been no active treatment for cancer during the 6 Months period prior to the subsequent diagnosis date.<br><br>Coverage must be in force on the date the reoccurrence is diagnosed. A second opinion or reconfirmation of a diagnosis is not considered reoccurrence. |
| What is considered “treatment” when you look at treatment free for a reoccurrence benefit. | Treatment refers to any consultation, advice, tests, attendance, or observation, supplies or equipment, including the prescription or use of prescription drugs or medicines.<br>Maintenance medication or therapy is not considered to be treatment. |
| I suffered a heart attack before I elected the Critical Illness Protection Plan. Would I be eligible for a benefit? | We do not pay for events that occurred before the effective date of coverage.<br><br>However, if a subsequent diagnosis of that condition were to occur while coverage is in effect, a benefit may be payable. |
| If a diagnosis of a Child Only Covered Condition is made during pregnancy, would we be eligible to receive a benefit for that condition if I choose to cover them as a dependent? | Dependent Children are eligible for coverage from the moment of live birth.<br><br>If the diagnosis occurs prior to birth, that condition would be payable provided the child survives to live birth and becomes insured as a dependent child. |

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| I enrolled my 5 year old child, who was diagnosed at birth with one of the Child Only Covered conditions. Would we be eligible to receive a benefit for that condition? | For a condition to be payable, coverage must be in force on the date of diagnosis. Therefore, in this situation, because diagnosis was made prior to the coverage effective date, a benefit would not be payable. |
| If my child is diagnosed with more than one of the Child Only Covered Conditions, would a benefit be payable for each one of the conditions? | If a child is diagnosed with more than one of the Child Only Covered Conditions, only one of the conditions in this category would be payable. |

**Other Important Details:**

**This Summary of Benefits sheet is an overview of the coverage being offered and is provided for illustrative purposes only. This is not a contract.** It in no way changes or affects the policy as actually issued. Only the insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the Summary of Benefits sheet and the insurance policy, the terms of the insurance policy apply.

Once a group policy is issued to your employer, a certificate of coverage will be available to explain your benefits in detail.

**If you need to file a claim:**

- Contact the employer
- Complete, sign and date the necessary forms.
- Send the completed forms via fax or mail to the contact details listed on the claim form. You may also email the completed forms to **fpcustomersupport@uhc.com**.

**Exclusions and Limitations*:**

This Policy does not cover any loss caused by or resulting from (directly or indirectly):

1. an act [or accident of war, declared or undeclared, whether civil or international, and any substantial armed conflict between organized forces of a military nature];
2. loss sustained while on active duty as a member of the armed forces of any nation [except during any time period coverage is extended under the Continuation during Leave of Absence provision];
3. any intentionally self-inflicted Injury;
4. active participation in a riot;
5. committing or attempting to commit a felony, or participating or attempting to participate in a felony;
6. use of alcohol or the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance, whether or not prescribed by a Physician;
7. cosmetic or elective surgery; or
8. attempted suicide, while sane or insane.

- We also will not pay a benefit for a Critical Illness:

1. for which the Covered Person's Date of Diagnosis for any type of Critical Illness, as defined in the Policy, was prior to his Effective Date of insurance;

2. that was diagnosed outside of the United States or Canada, unless the diagnosis was confirmed by a Physician practicing within the United States or Canada.

Some state variations may apply
**The above list is intended for illustrative purposes only. State specific exclusions and language may apply. Please refer to your Certificate of Coverage for detailed information.*

**Cosmetic or Elective Surgery Exclusion:** We will not cover any loss under the Policy if it is due to Cosmetic Surgery or Elective Surgery.

**Cosmetic Surgery** means surgery performed to modify or improve the appearance of a physical feature or defect. For purposes of excluding benefits, Cosmetic Surgery does not mean Reconstructive Surgery performed to correct or repair abnormal structures of the body caused by:

1. congenital defects;
2. developmental abnormalities;
3. trauma;
4. infection;
5. tumors; or
6. disease;

when intended to either improve function or create a normal appearance to the extent possible.

Reconstructive Surgery includes:

1. dental or orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures; and
2. surgery and prosthetic devices to restore and achieve symmetry incident to a mastectomy.

**Elective Surgery** means:

1. Cosmetic Surgery; and
2. any other surgery that is:
   a. not for the purpose of correcting or repairing abnormal structures of the body;
   b. not for the purpose of improving function; or
   c. if intended to improve appearance or create a normal appearance, is not caused by a condition listed in 1-6 above.

For purposes of excluding benefits, Elective Surgery does not include:

1. Caesarean section;
2. any surgery related to Complications of Pregnancy; or
3. bariatric surgery performed in conjunction with a diagnosis of morbid obesity.