

# YOUR CRITICAL ILLNESS INSURANCE PLAN

For Employees of  
McLeod Health

# GROUP CRITICAL ILLNESS INSURANCE CERTIFICATE OF COVERAGE

## RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

Claims: 888-238-4840 Customer Service: 877-236-7564

**POLICYHOLDER:** McLeod Health  
**GROUP POLICY NUMBER:** 69558-1CCI2  
**POLICY EFFECTIVE DATE:** January 1, 2020  
**GOVERNING JURISDICTION:** South Carolina

### THIS IS LIMITED BENEFIT INDEMNITY COVERAGE

**Benefits are paid for Critical Illnesses as defined in the Certificate. The Policy does not constitute comprehensive health insurance coverage (often referred to as "major medical insurance coverage"). In addition, the Policy does not satisfy the requirement of minimum essential coverage under the Affordable Care Act. Benefits are paid under the Policy for Critical Illnesses as indemnity insurance and are not intended to cover medical expenses.**

ReliaStar Life Insurance Company certifies that we have issued the group Policy listed above to the Policyholder. The Policy is available for you to review if you contact the Policyholder for more information. **This is your Certificate as long as you are eligible for coverage and you become insured. Please read it carefully and keep it in a safe place.** This Certificate replaces any other Certificates we may have given you for the same level of coverage under the Policy.

This Certificate summarizes and explains the parts of the Policy which apply to you. The Certificate is part of the group Policy but by itself is not a policy. Your coverage may be changed under the terms and conditions of the Policy. The Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the Policy, all days begin at 12:01 a.m. standard time at the Policyholder's address and end at 12:00 midnight standard time at the Policyholder's address. The coverage under the Policy is conditionally renewable according to the terms and provisions of the Policy.

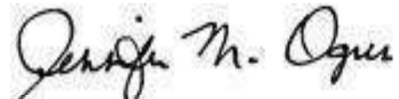
In this Certificate, "you" and "your" refer to an Employee who is eligible for coverage under the Policy; "we", "us" and "our" refer to ReliaStar Life Insurance Company.

**Please read your Certificate carefully.**

Signed for ReliaStar Life Insurance Company at its home office in Minneapolis, Minnesota on the Policy effective date.



Carolyn M. Johnson  
President



Jennifer M. Ogren  
Secretary

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## **SCHEDULE OF BENEFITS**

**EMPLOYER:** McLeod Health

**GROUP POLICY NUMBER:** 69558-1CCI2

### **ELIGIBLE CLASS(ES)**

All Employees in Active Employment with the Employer in the United States.

You must be an Employee of the Employer and in an eligible class.

Temporary and seasonal workers are excluded from coverage.

### **MINIMUM HOURS REQUIREMENT**

Employees Budgeted to work 20 hours per week.

### **ELIGIBILITY WAITING PERIOD FOR ALL ELIGIBLE EMPLOYEES WHO ARE HIRED ON THE FIRST DAY OF THE MONTH**

Persons in an eligible class on or before the Policy effective date: None

Persons entering an eligible class after the Policy effective date: None

### **ELIGIBILITY WAITING PERIOD FOR ALL ELIGIBLE EMPLOYEES WHO ARE NOT HIRED ON THE FIRST DAY OF THE MONTH**

Persons in an eligible class on or before the Policy effective date: End of month in which You begin Active Employment.

Persons entering an eligible class after the Policy effective date: End of month in which You begin Active Employment.

### **WAIVER OF ELIGIBILITY WAITING PERIOD**

If you have been continuously employed by the Employer for a period of time equal to your Eligibility Waiting Period, we will waive your Eligibility Waiting Period when you enter an eligible class.

### **CREDIT FOR PRIOR SERVICE**

We will apply any prior period of work with the Employer toward the Eligibility Waiting Period to determine your eligibility date.

### **WHO PAYS FOR THE COVERAGE**

You pay the cost of your coverage.

### **BENEFIT AMOUNT**

Choice of \$10,000 or \$15,000 or \$20,000 or \$25,000 or \$30,000

## CRITICAL ILLNESS BENEFITS

### Base module

Covered illness/condition	Percent of BENEFIT AMOUNT payable
Heart Attack	100%
Cancer	100%
Stroke	100%
Major Organ Transplant	100%
Coronary Artery Bypass	25%
Carcinoma in Situ (CIS)	25%

### Total maximum benefit amount for base module

2 times the BENEFIT AMOUNT

### Enhanced cancer module

Covered illness/condition	Percent of BENEFIT AMOUNT payable
Benign Brain Tumor	100%
Skin Cancer	10%
Bone Marrow Transplant	25%
Stem Cell Transplant	25%

### Total maximum benefit amount for enhanced cancer module

2 times the BENEFIT AMOUNT

### Quality of life module

Covered illness/condition	Percent of BENEFIT AMOUNT payable
Permanent Paralysis	100%
Loss of Sight, Hearing or Speech	100%
Coma	100%
Multiple Sclerosis	100%
Amyotrophic Lateral Sclerosis (ALS)	100%
Parkinson's Disease	100%
Advanced Dementia, including Alzheimer's Disease	100%
Infectious Disease	100%
Occupational HIV or Hepatitis B or C	100%

### Total maximum benefit amount for quality of life module

2 times the BENEFIT AMOUNT

## DEFINITIONS

**Active Employment** means you are working for the Employer for earnings that are paid regularly and you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under the MINIMUM HOURS REQUIREMENT shown in the SCHEDULE OF BENEFITS.

Your work site must be one of the following:

- The Employer's usual place of business;
- An alternative work site at the direction of the Employer, including your home; or
- A location to which your job requires you to travel.

Normal vacation is considered Active Employment.

Temporary and seasonal workers are excluded from coverage.

**Advanced Dementia** means a clinically established diagnosis of Alzheimer's Disease, or other type of permanent and progressive advanced dementia, with severe cognitive decline and with findings consistent with a Global Deterioration Scale (GDS) or Functional Assessment Staging (FAST) Stage 3 or more, or a Clinical Dementia Rating Scale (CDR) of 1.

**Amyotrophic Lateral Sclerosis (ALS)** means the diagnosis of a motor neuron disease, marked by progressive muscular weakness and atrophy with spasticity and hyperreflexia due to a loss of motor neurons of the spinal cord, medulla and cortex.

**Benign Brain Tumor** means the diagnosis of a non-cancerous brain tumor confirmed by the examination of tissue (biopsy or surgical excision) or specific neurological examination. The tumor must result in persistent neurological deficits including, but not limited to:

- Loss of vision;
- Loss of hearing; or
- Balance disruption.

For purposes of the Policy, the following are not considered Benign Brain Tumors:

- Tumors of the skull;
- Pituitary adenomas; and
- Germinomas.

Benign Brain Tumor does not include diagnosis of any of the following conditions prior to your coverage effective date:

- Neurofibromatosis I;
- Neurofibromatosis II;
- Von Hippel Lindau;
- Tuberous Sclerosis;
- Li Fraumani Syndrome;
- Cowden Disease; and
- Turcot Syndrome.

**Bone Marrow Transplant** means the clinical diagnosis of the need for a surgical transplant when you have been added to the *Be The Match* registry for a bone marrow transplant.

Bone Marrow Transplant includes a clinical diagnosis and actual transplant that occurs before you are able to be added to the *Be The Match* registry.

**Cancer** means the diagnosis of a group of diseases characterized by the uncontrolled growth and/or spread of abnormal cells. Cancer is limited to malignancies of solid tissue, blood or lymph tissue and includes leukemia, lymphoma and Hodgkin's disease.

The diagnosis of Cancer must be established according to the criteria of the American Board of Pathology or the American Joint Committee on Cancer. This requires looking at the suspect tumor, tissue or specimen at the microscopic level such that malignancy may be determined. A clinical diagnosis of Cancer will be accepted as evidence that Cancer exists when a pathological diagnosis cannot be made because it is medically inappropriate or life-threatening.

For the purposes of the Policy, the following are not considered Cancer:

- Basal cell carcinoma and squamous cell carcinoma of the skin;
- Carcinoma In Situ;
- Melanoma that is diagnosed as Breslow's classification less than 0.75mm;
- Pre-malignant conditions or polyps; and
- Any other histologically benign or nonmalignant condition.

**Carcinoma in Situ (CIS)** means the diagnosis of tumor cells tending toward malignancy but that do not invade the underlying tissue (i.e. malignant cells confined to the epithelium without penetration of the basement membrane). This diagnosis must be confirmed by a study of the suspect tissue in a pathologic specimen that meets the American Joint Committee on Cancer or the American Board of Pathology criteria.

For purposes of the Policy, the following are not considered Carcinoma In Situ:

- Basal cell carcinoma and squamous cell carcinoma of the skin;
- Melanoma that is diagnosed as Breslow's classification less than 0.75mm; and
- Pre-malignant conditions or conditions with malignant potential.

**Certificate** means the document that explains the parts of the Policy which apply to eligible Insured Persons. It may include riders, endorsements or amendments.

**Coma** means the diagnosis of a continuous state of profound unconsciousness, characterized by having a Glasgow scale of 3; defined as the absence of:

- Eye opening;
- Verbal response; and
- Motor response.

The condition must require intubation for respiratory assistance and must not be medically induced.

"Continuous state of profound unconsciousness" means 14 consecutive days or longer.

**Coronary Artery Bypass** means the diagnosis of severe left main or multi-vessel coronary artery disease (such as a SYNTAX score  $\geq 23$ ) for which is advised an open heart coronary artery bypass surgery - a surgical procedure that requires an incision through the chest and an incision in the heart and/or attached blood vessels.

**Critical Illness** means any of the following as defined:

- Advanced Dementia; or
- Amyotrophic Lateral Sclerosis (ALS); or
- Benign Brain Tumor; or
- Bone Marrow Transplant; or
- Cancer; or
- Carcinoma in Situ; or
- Coma; or
- Coronary Artery Bypass; or

- Heart Attack; or
- Infectious Disease; or
- Loss of Hearing; or
- Loss of Sight; or
- Loss of Speech; or
- Major Organ Transplant; or
- Multiple Sclerosis; or
- Occupational HIV; or
- Occupational Hepatitis B or C; or
- Parkinson's Disease; or
- Permanent Paralysis; or
- Skin Cancer; or
- Stem Cell Transplant; or
- Stroke.

**Different Diagnosis** means any of the following:

- A diagnosis of a Critical Illness that is for a different illness/condition than a previously diagnosed illness/condition. Note: A Cancer that has spread to a different area of the body is not a different illness/condition than the previously diagnosed Cancer.
- A subsequent diagnosis of a Critical Illness that is for the same illness/condition (including a Cancer that has spread to a different area of the body) as a Critical Illness for which benefits were payable under the Policy, and that occurs more than 12 months after the date of the previous diagnosis.
- A subsequent diagnosis of a Critical Illness that is for the same illness/condition (including a Cancer that has spread to a different area of the body) as an illness/condition diagnosed prior to your coverage effective date under the Policy, and that occurs more than 12 months after the date of the previous diagnosis.

**Exception:** A subsequent diagnosis of the same illness/condition under the quality of life module, other than Coma and Infectious Disease, is not considered a Different Diagnosis regardless of the time period between diagnoses.

- A diagnosis of Skin Cancer is considered a Different Diagnosis from Cancer.
- A diagnosis of Carcinoma in Situ is considered a Different Diagnosis from Cancer.
- A diagnosis of Skin Cancer is considered a Different Diagnosis from Carcinoma in Situ.

**Doctor** means a person other than you or any family member, who is licensed to practice medicine in the state in which treatment is received and who is providing treatment or advice in accordance with the license. State law may require consideration of professional services of a practitioner other than a medical doctor. If so, then this definition includes persons recognized as qualified to treat the condition for which claim is made by the state in which treatment is received.

**Eligibility Waiting Period** means the continuous period of time (shown in the SCHEDULE OF BENEFITS) that you must be in Active Employment in an eligible class before you are eligible for coverage under the Policy.

**Employee** means a person who is a citizen or legal resident of the United States in Active Employment with the Employer in the United States.

**Employer** means the Policyholder and includes any division, subsidiary or affiliated company named in the Policy.



**Heart Attack** means the diagnosis of a clinical picture of myocardial infarction that was caused by a blockage of one or more coronary arteries. The medical evidence must be consistent with the diagnosis of heart muscle death. Significant electrocardiogram (EKG) changes must be seen, and one or both of the following must confirm the acute myocardial infarction (Heart Attack):

- Cardiac enzyme changes as typically seen with myocardial damage found in the blood (elevated CK-MB isoenzyme fraction or elevated troponins)
- Confirmatory imaging test, such as a nuclear imaging test or echocardiogram that is consistent with a myocardial infarction.

A sudden cardiac arrest is not in itself considered a Heart Attack.

**Hospital** means an institution that is run for the care and treatment of sick or injured persons as in-patients and which, on its premises or in facilities available to the Hospital on a pre-arranged basis, fully meets each of the following requirements:

- It is operated in accordance with the laws pertaining to hospitals in the jurisdiction in which it is located;
- It is under the supervision of a medical staff and has one or more Doctors available at all times;
- It provides 24 hours a day service by registered graduate nurses (RNs); and
- It is not an institution or any part of an institution used as: a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a free-standing surgical center; a rehabilitative facility; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care, or care or treatment for persons suffering from mental diseases or disorders, or care for the aged, or drug or alcohol addiction.

**Infectious Disease** means the diagnosis of a severe infectious disease that results in you being confined to a Hospital for five (5) or more consecutive days or confined to a transitional care facility for fourteen (14) or more consecutive days.

Examples include, but are not limited to:

- Polio;
- Rabies;
- Meningitis;
- Lyme's Disease;
- Bovine spongiform encephalopathy (Mad Cow Disease);
- Flesh eating bacteria;
- Methicillin-resistant Staphylococcus aureus (MRSA);
- Sepsis;
- Tuberculosis;
- Bacterial pneumonia;
- Diphtheria;
- Encephalitis.
- Legionnaire's Disease;
- Malaria;
- Necrotizing Fasciitis;
- Osteomyelitis;
- Tetanus; and
- Ebola Virus Disease.

**Insured Person** means an Employee who is eligible for coverage under the Policy, becomes covered according to the terms of the Policy, and whose coverage remains in effect according to the terms of the Policy.

**Loss of Hearing** means the diagnosis of profound deafness in both ears that is not correctable.

**Loss of Sight** means the diagnosis of clinically proven irreversible reduction of sight in both eyes with:

- Sight in the better eye reduced to a best corrected visual acuity of less than 6/60 (metric acuity) or 20/200 (Snellen or E-Chart Acuity); or
- Visual field restriction to 20 degrees or less in both eyes.

**Loss of Speech** means the clinical diagnosis of total and permanent loss of the ability to speak.

**Major Organ Transplant** means the irreversible failure of your heart, lung, pancreas, entire kidney or liver, or any combination thereof, determined by a Physician specialized in care of the involved organ. Acceptance to the UNOS (United Network for Organ Sharing) list is required for this determination. If you receive the transplant prior to placement on the network, the network requirement will be waived.

**Multiple Sclerosis** means the unequivocal diagnosis of multiple sclerosis following more than one episode of well-defined neurological symptoms and signs and confirmed by a neurological exam and MRI scan of the brain or spinal fluid analysis. Symptoms must persist for 6 months to ensure that the condition is permanent.

**Occupational HIV** means the diagnosis of HIV (Human Immunodeficiency Virus) caused by an accidental needle stick or other accidental sharp injury or accidental mucous membrane exposure to blood or bloodstained bodily fluid while at work and performing normal occupational duties. Such exposure must have occurred during the 12 months preceding the first diagnosis of HIV.

**Occupational Hepatitis B or C** means the diagnosis of Hepatitis B or C caused by an accidental needle stick or other accidental sharp injury or accidental mucous membrane exposure to blood or bloodstained bodily fluid while at work and performing normal occupational duties. Such exposure must have occurred during the 12 months preceding the first diagnosis of Hepatitis B or C.

**Parkinson's Disease** means the diagnosis of a chronic, progressive neurodegenerative disorder characterized by any combination of four cardinal signs: rest tremor; rigidity; bradykinesia; and gait disturbance.

**Permanent Paralysis** means the diagnosis of total and permanent loss of the use of two or more limbs (arms or legs or combination) due to accident or sickness for a continuous period of at least 60 days.

Permanent Paralysis does not include paralysis as the result of a Stroke.

**Policy** means the written group insurance contract between us and the Policyholder.

**Policyholder** means the Employer to which the Policy is issued and who sponsors the coverage for its Employees.

**Same Diagnosis** means either of the following:

- A subsequent diagnosis of a Critical Illness that is for the same illness/condition (including a Cancer that has spread to a different area of the body) as a Critical Illness for which benefits were payable under the Policy, and that occurs within 12 months of the date of the previous diagnosis.
- A subsequent diagnosis of a Critical Illness that is for the same illness/condition (including a Cancer that has spread to a different area of the body) as an illness/condition diagnosed prior to your coverage effective date under the Policy, and that occurs within 12 months of the date of the previous diagnosis.

**Exception:** A subsequent diagnosis of the same illness/condition under the quality of life module, other than Coma and Infectious Disease, is considered the Same Diagnosis regardless of the time period between diagnoses.

**Skin Cancer** means the diagnosis of tumor cells tending toward malignancy and which invade the underlying tissue.

The Skin Cancer diagnosis must be confirmed by a study of the suspect tissue in a pathologic specimen that meets the American Joint Committee on Cancer or the American Board of Pathology criteria.

Skin Cancer includes:

- Basal cell carcinoma and squamous cell carcinoma of the skin; and
- Melanoma that is diagnosed as Breslow's classification less than 0.75mm.

**Stem Cell Transplant** means the clinical diagnosis of a blood or bone marrow malignancy for which the need for a surgical stem cell transplant has been advised.

**Stroke** means the diagnosis of an acute cerebral event including infarction of brain tissue, cerebral and subarachnoid hemorrhage, cerebral embolism and cerebral thrombosis. The diagnosis of Stroke must be based on confirmatory neuroimaging studies and evidence of persistent neurological impairment confirmed at the time of discharge from a Hospital.

Stroke does not include:

- Transient ischemic attacks (TIA)
- Ischemic disorders of the vestibular system;
- Brain injury related to trauma or infection; or
- Brain injury associated with hypoxia/anoxia or hypotension.

## GENERAL PROVISIONS

### ELIGIBILITY

If you are working for the Employer in an eligible class (shown on the SCHEDULE OF BENEFITS), the date you are eligible for coverage is the later of the following:

- The Policy effective date.
- The day after you complete your Eligibility Waiting Period, unless waived.

### EFFECTIVE DATE OF COVERAGE

You will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date you are eligible for coverage, if you apply for coverage on or before that date.
- The date you apply for coverage.
- The date you return to Active Employment, if you are not in Active Employment when your coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, and paid time off for nonmedical-related absences.

### EFFECTIVE DATE OF CHANGES TO COVERAGE

Once your coverage begins, any increased or additional coverage will take effect on the latest of the following:

- The date of the increased or additional coverage, if you are in Active Employment.
- The date you return to Active Employment, if you are not in Active Employment due to injury or sickness.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

### TERMINATION OF COVERAGE

Your coverage under the Policy ends on the earliest of the following dates:

- The date the Policy terminates.
- The date you are no longer in an eligible class.
- The date your eligible class is no longer covered.
- The date you voluntarily cancel your coverage.
- The end of the period for which you paid premiums, if you stop making a required premium contribution, subject to the grace period.
- The end of the Policyholder's grace period, if the Policyholder does not remit premium to us by the end of such period.
- The last day you are in Active Employment.
- The date the total maximum benefit amount has been paid for all modules.

We will provide coverage for a payable claim that occurs while you are covered under the Policy.

### POLICY TERMINATION

The Policy can be terminated either by us or by the Policyholder.

We may terminate the Policy for any of the following reasons:

- There is less than 15% participation of those eligible persons who pay all or part of their premium for the Policy.
- The Policyholder does not promptly provide us with information that is reasonably required.
- Fewer than 25 persons are insured under the Policy.
- The premium is not paid in accordance with the provisions of the Policy.
- We determine that there is a significant change in the size, occupation or age of the eligible class(es) as a result of a corporate transaction such as a merger, divestiture, acquisition, sale or reorganization of the Policyholder and/or its persons.
- We stop providing the type of coverage under this Policy to all groups in the Policy issue state.

We reserve the right to review and terminate all class(es) covered under the Policy if any class(es) cease(s) to be covered.

If the Policyholder fails to pay the full premium due by the end of the grace period, the Policy will terminate according to the GRACE PERIOD provision.

If we terminate the Policy for reasons other than the Policyholder's failure to pay premiums, written notice will be mailed to the Policyholder at least 60 days prior to the termination date.

The Policyholder may terminate the Policy by written notice delivered to us at our home office prior to the termination date. When both the Policyholder and we agree, the Policy can be terminated on an earlier date.

If the Policyholder or we terminate the Policy, coverage will end at 12:00 midnight standard time at the Policyholder's address on the termination date.

If the Policy is terminated, the termination will not affect a payable claim.

## **PORTABILITY**

Portability means you have the option to continue your coverage after it would otherwise terminate if certain conditions are met.

To continue your coverage, you must apply for portability and pay the first premium within 31 days of the date your coverage would otherwise terminate due to any of the following:

- You retire or terminate employment with the Employer, if coverage remains in effect under the Policy for other Insured Persons.
- The Policyholder terminates coverage under the Policy for all Insured Persons, and does not replace it with a similar insurance plan.
- You are no longer eligible for coverage under the Policy.

You can decrease, but not increase, the ported coverage amount. Ported coverage is subject to all the terms of the Policy and this Certificate.

Premiums will be billed directly to you. Continued premium payment is required to keep coverage in force. The initial premium will be based on the portability premium rates in effect at the time you apply for portability. We may change the portability premium rates at any time upon 60 days written notice to you.

Coverage continued under this provision will end on the earliest of the following:

- The end of the period for which you paid premiums, if you stop making a required premium contribution, subject to the grace period.
- The date you die.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

## **GRACE PERIOD**

The Policyholder has a grace period of 75 days for the payment of any premium due except the first. During the grace period the Policy will remain in force. If full payment is not received by us by the end of the grace period, the Policy will automatically terminate at the end of the grace period. The Policyholder is required to pay a pro rata premium for any period the Policy was in force during the grace period. There is no grace period if the Policyholder gives us advance written notice of termination, or if we have given the Policyholder advance written notice of termination as described under the POLICY TERMINATION provision.

If you are on portability, you also have a grace period of 31 days for the payment of any premium due. During the grace period your coverage will remain in force. If full payment is not received by us by the end of the grace period, your coverage will automatically terminate at the end of the grace period. A pro rata premium payment is required for any period your coverage was in force during the grace period.

### **REPRESENTATIONS NOT WARRANTIES**

We consider any statements the Policyholder and you make in an application or enrollment form to be representations and not warranties. No statements made by you will be used to reduce or deny any claim or to cancel your coverage unless both of the following are true:

- The statement is in writing and is signed by you.
- A copy of that statement is given to you or your personal representative.

### **INCONTESTABILITY**

Except in the case of fraud, no statement made by you in an application or enrollment form relating to your insurability will be used to contest the insurance for which the statement was made after the coverage has been in force for two years during your lifetime.

### **CLERICAL ERROR**

Clerical error or omission by us or by the Policyholder will not:

- Prevent you from receiving coverage, if you are entitled to coverage under the terms of the Policy.
- Cause coverage to begin or continue for you when the coverage would not otherwise be effective.

If the Policyholder gives us information about you that is incorrect, we will do both of the following:

- Use the facts to decide whether you are eligible for coverage under the Policy and in what amounts.
- Make a fair adjustment of the premium.

### **MISSTATEMENT OF AGE**

If premiums are based on your age and you have misstated your age, we will make a fair adjustment of benefits to reflect the amount that the premium paid would have purchased at your true age. We may require satisfactory proof of your age before paying any claim.

### **ASSIGNMENT**

No assignment of benefits under the Policy is valid unless otherwise specified in the Policy.

### **AGENCY**

For purposes of the Policy, the Policyholder acts on its own behalf or as your agent. Under no circumstances will the Policyholder be deemed our agent.

### **CONFORMITY WITH STATE STATUTES**

Any provision of the Policy which, on the Policy effective date and each subsequent Policy anniversary date, conflicts with any law that applies in the jurisdiction where the Policy is issued is automatically amended to conform to the minimum requirements of such law.

### **CHANGES TO POLICY OR CERTIFICATE**

No agent, representative or employee of ours or of any other entity may change or waive the terms of the Policy, or of any Certificate or rider issued under it, except in writing signed by one of our executive officers and endorsed or attached to the Policy.

If there is a conflict between the terms of this Certificate or any attached rider and the Policy, the Policy controls.

## CRITICAL ILLNESS BENEFITS

We will pay the BENEFIT AMOUNT as shown on the SCHEDULE OF BENEFITS if you are diagnosed with a Critical Illness after your coverage effective date. The percentage of BENEFIT AMOUNT payable is listed for the Critical Illness on the SCHEDULE OF BENEFITS.

To be eligible for a benefit payment, the diagnosis must be a Different Diagnosis as defined in the DEFINITIONS section of this certificate. A subsequent diagnosis of a Critical Illness that is for the same illness/condition as a Critical Illness for which benefits were payable under the Policy may be eligible as a Different Diagnosis as defined.

A Critical Illness that meets the definition of a Same Diagnosis is not eligible for benefits.

Benefits are payable up to the total maximum benefit amount shown on the SCHEDULE OF BENEFITS for each module. This includes multiple payments within each module for Different Diagnoses. Payment of the total maximum benefit amount from one module will not impact the total maximum benefit amount for the other module(s). The total maximum benefit amount is the maximum amount payable to you for each module in the Certificate during your lifetime.

Any partial benefits paid will reduce the total maximum benefit amount for that module.

When the total maximum benefit amount has been paid for a module, no further benefits are payable for that module. When the total maximum benefit amount has been paid for all modules, no further benefits are payable and your coverage (including all riders) terminates.

### BASE MODULE

**Benefits for Heart Attack, Cancer, Stroke, Major Organ Transplant, Coronary Artery Bypass and Carcinoma in Situ (CIS)** are payable when we receive due proof of such condition which is diagnosed after your coverage effective date (including the effective date of any changes to coverage).

A diagnosis of Heart Attack or Coronary Artery Bypass must be made by a cardiologist or a Doctor familiar with the specific condition. A diagnosis of Stroke must be made by a neurologist or a Doctor familiar with the diagnosis of Stroke.

If you are on the UNOS (United Network for Organ Sharing) list for a combined transplant, only one Major Organ Transplant benefit will be payable for the diagnosis.

### QUALITY OF LIFE MODULE

A Critical Illness under this module, other than Coma and Infectious Disease, is not eligible for multiple benefit payments.

**Benefits for Permanent Paralysis, Loss of Sight, Loss of Hearing, Loss of Speech, Coma, Multiple Sclerosis, Amyotrophic Lateral Sclerosis (ALS), Advanced Dementia, including Alzheimer's Disease and Infectious Disease** are payable when we receive due proof of such condition which is diagnosed after your coverage effective date (including the effective date of any changes to coverage).

A diagnosis of Loss of Sight must be certified by an ophthalmologist or a Doctor familiar with the diagnosis of Loss of Sight.

A diagnosis of Loss of Hearing must be made by an otolaryngologist or a Doctor familiar with the diagnosis of Loss of Hearing.

A diagnosis of Advanced Dementia must be made by a board certified or board eligible neurologist or a Doctor familiar with the diagnosis of Advanced Dementia.

A diagnosis of Multiple Sclerosis must be made by a neurologist or a Doctor familiar with the diagnosis of the specific condition. Genetic testing does not qualify as a diagnosis.

Only one benefit for Infectious Disease is payable if the diagnosis of one or more Infectious Diseases is made during the same period of confinement.

**Benefits for Parkinson's Disease** are payable when we receive due proof of such condition which is diagnosed after your coverage effective date (including the effective date of any changes to coverage) or you become incapacitated, meaning:

- Exhibiting 2 or more of the following clinical manifestations:
  - Muscle rigidity;
  - Tremor; and
  - Bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses); **and**
- Resulting in the inability to perform independently 2 or more of the following activities of daily living:
  - Eating;
  - Bathing;
  - Dressing;
  - Toileting;
  - Transferring; and
  - Maintaining continence.

A diagnosis of Parkinson's Disease must be made by a psychiatrist or neurologist or a Doctor trained in the diagnosis of Parkinson's Disease.

**Benefits for Occupational HIV or Hepatitis B or C** are payable when we receive due proof of such condition which is diagnosed after your coverage effective date (including the effective date of any changes to coverage). The accident must be reported in accordance with the established occupational procedures for such accidents. You must have undergone a blood test within five days of the accident. Such blood test must indicate the absence of HIV or antibodies to such a virus, or Hepatitis B or C. The accident follow-up must include a subsequent blood test within 12 months following the accidental exposure indicating the presence of HIV or antibodies to such a virus, or Hepatitis B or C. The date of diagnosis is the date on which the follow-up blood test results are received.

## **ENHANCED CANCER MODULE**

**Benefits for Benign Brain Tumor, Skin Cancer, Bone Marrow Transplant and Stem Cell Transplant** are payable when we receive due proof of such condition which is diagnosed after your coverage effective date (including the effective date of any changes to coverage).



## **CLAIMS**

### **NOTICE OF CLAIM**

Written notice of your claim should be given to us within 30 days after the date of loss (date of diagnosis). The notice may be given to us at our home office or to our authorized agent or administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

### **CLAIM FORM**

The claim form is available from the Employer or you can request a claim form from us. If you do not receive the form from us within 15 days of your request, you may send us written proof of claim without waiting for the form. If such written proof of claim covers the occurrence, character and extent of the loss within the time period below for proof of claim, you will be deemed to have complied with the requirements for providing proof of claim.

### **FILING A CLAIM**

The claim form(s) may require completion by you and the Employer and your attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

### **PROOF OF CLAIM**

You must send us written proof of your claim within 90 days after the date of loss. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, in any event, you must provide proof of claim no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

### **PHYSICAL EXAMINATION**

We may require you to be examined by one or more Doctors or other medical practitioners of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so while your claim is pending. We may also require you to be interviewed by our authorized representative. Failure to comply with this request may result in denial or termination of benefits.

### **BENEFIT PAYMENTS**

Benefits are payable to you unless otherwise specified. Once a claim has been approved, we will make payment as soon as possible but no more than 60 days after receipt of proof of claim. Any accrued benefits that are payable at your death will be paid to the first survivor(s) who is/are living on the date of your death, in the following order:

1. Your spouse.
2. Your natural and adopted children, in equal shares.
3. Your grandchildren, in equal shares.
4. Your parents, in equal shares.
5. Your siblings, in equal shares.
6. Your estate.

If a survivor entitled to receive a payment dies before receiving it, we will make payment to that person's estate.

"Spouse" in this provision means your lawful spouse.

Any payment we make in good faith will discharge our liability as to the extent of such payment. We will pay the benefits in one sum or in a method comparable to one sum.

**LEGAL ACTION**

You can start legal action regarding a claim no earlier than 60 days after written proof of claim has been given to us, and no later than six years from the time proof of claim is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your coverage.

# SPOUSE CRITICAL ILLNESS RIDER

## RELIASTAR LIFE INSURANCE COMPANY 20 Washington Avenue South, Minneapolis, Minnesota 55401

**POLICYHOLDER:** McLeod Health

**GROUP POLICY NUMBER:** 69558-1CCI2

This rider is made a part of the Critical Illness Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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### SCHEDULE OF BENEFITS

#### WHO PAYS FOR THE COVERAGE

You pay the cost of coverage under this rider.

#### SPOUSE BENEFIT AMOUNT

50% of Employee BENEFIT AMOUNT

#### SPOUSE CRITICAL ILLNESS BENEFITS

##### Base module

Covered illness/condition	Percent of BENEFIT AMOUNT payable
Heart Attack	100%
Cancer	100%
Stroke	100%
Major Organ Transplant	100%
Coronary Artery Bypass	25%
Carcinoma in Situ (CIS)	25%

##### Total maximum benefit amount for base module

2 times the BENEFIT AMOUNT

### Enhanced cancer module

Covered illness/condition	Percent of BENEFIT AMOUNT payable
Benign Brain Tumor	100%
Skin Cancer	10%
Bone Marrow Transplant	25%
Stem Cell Transplant	25%

### Total maximum benefit amount for enhanced cancer module

2 times the BENEFIT AMOUNT

### Quality of life module

Covered illness/condition	Percent of BENEFIT AMOUNT payable
Permanent Paralysis	100%
Loss of Sight, Hearing or Speech	100%
Coma	100%
Multiple Sclerosis	100%
Amyotrophic Lateral Sclerosis (ALS)	100%
Parkinson's Disease	100%
Advanced Dementia, including Alzheimer's Disease	100%
Infectious Disease	100%
Occupational HIV or Hepatitis B or C	100%

### Total maximum benefit amount for quality of life module

2 times the BENEFIT AMOUNT

### SPOUSE CRITICAL ILLNESS BENEFITS

The benefit percentages for your Spouse are the same as the benefit percentages for you as shown in the SCHEDULE OF BENEFITS section of the Certificate.

### DEFINITIONS

General terms defined in the DEFINITIONS section of the Certificate regarding medical conditions and eligibility apply to your Spouse.

**Spouse** means your lawful spouse.

## GENERAL PROVISIONS

### ELIGIBILITY

If you are covered under the Policy, then your Spouse under age 70 is eligible under this rider on the latest of the following:

- The Policy effective date.
- The date this rider is available to the eligible class of Insured Persons to which you belong.
- Your Critical Illness coverage effective date.
- The date of your marriage.

If your Spouse is covered under the Policy as an Employee, then your Spouse is not eligible for coverage under this rider.

### EFFECTIVE DATE

Your Spouse will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date your Spouse is eligible for coverage, if you apply for Spouse coverage on or before that date.
- The date you apply for Spouse coverage.
- The date you return to Active Employment, if you are not in Active Employment when your Spouse's coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, and paid time off for nonmedical-related absences.

### EFFECTIVE DATE OF CHANGES TO COVERAGE

Once your Spouse's coverage begins, any increased or additional coverage will take effect on the latest of the following:

- The date of the increased or additional coverage, if you are in Active Employment.
- The date you return to Active Employment, if you are not in Active Employment due to injury or sickness.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

### TERMINATION

This rider terminates on the earliest of the following:

- The date your Certificate terminates.
- The date this rider is terminated for all Insured Persons under the Policy.
- The date you voluntarily cancel this rider.
- The date your Spouse is no longer an eligible Spouse as defined by this rider. See the PORTABILITY FOLLOWING DEATH OR DIVORCE provision below.
- The end of the period for which premiums are paid, if the next required premium contribution is not paid, subject to the grace period.
- The date your Spouse's total maximum benefit amount has been paid for all modules.

### PORTABILITY

If you are approved by us to continue your coverage under the Certificate's PORTABILITY provision, then this rider can also be continued during portability.

## **PORTABILITY FOLLOWING DEATH OR DIVORCE**

If you die or divorce, your Spouse can apply to continue Spouse coverage if certain conditions are met. Your Spouse must have been insured under this rider on the date of your death or divorce, and your Spouse must apply for portability and pay the first premium within 31 days of the date of your death or divorce.

If your Spouse is approved by us for portability, your Spouse will become the owner of the Spouse coverage that was previously provided under this rider. Your Spouse can decrease, but not increase, the ported coverage amount. Ported coverage is subject to all the terms of the Policy and Certificate.

Premiums will be billed directly to your Spouse. Continued premium payment is required to keep coverage in force. The initial premium will be based on the portability premium rates in effect at the time your Spouse applies for portability. We may change the portability premium rates at any time upon 60 days written notice to your Spouse.

Coverage continued under this provision will end on the earliest of the following:

- The end of the period for which your Spouse paid premiums, if your Spouse stops making a required premium contribution, subject to the grace period.
- The date your Spouse dies.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

## **CRITICAL ILLNESS BENEFITS**

We will pay the BENEFIT AMOUNT as shown on this rider's SCHEDULE OF BENEFITS if your Spouse is diagnosed with a Critical Illness after your Spouse's coverage effective date. The percentage of BENEFIT AMOUNT payable is listed for the Critical Illness on this rider's SCHEDULE OF BENEFITS.

The benefits for your Spouse are the same as the benefits for you as shown in the CRITICAL ILLNESS BENEFITS section of the Certificate.

To be eligible for a benefit payment, the diagnosis must be a Different Diagnosis as defined in the DEFINITIONS section of the Certificate. A subsequent diagnosis of a Critical Illness that is for the same illness/condition as a Critical Illness for which benefits were payable under the Policy, may be eligible as a Different Diagnosis as defined.

A Critical Illness that meets the definition of a Same Diagnosis is not eligible for benefits.

Benefits are payable up to the total maximum benefit amount shown on this rider's SCHEDULE OF BENEFITS for each module. This includes multiple payments within each module for Different Diagnoses. Payment of the total maximum benefit amount from one module will not impact the total maximum benefit amount for the other module(s). The total maximum benefit amount is the maximum amount payable for each module in this rider during your Spouse's lifetime.

Any partial benefits paid will reduce the total maximum benefit amount for that module.

When the total maximum benefit amount for your Spouse has been paid for a module, no further benefits are payable for that module. When the total maximum benefit amount has been paid for all modules, no further benefits are payable and this rider terminates.

Payment of any benefits for your Spouse's Critical Illness will not impact the available BENEFIT AMOUNT for your Critical Illness coverage. Payment of any benefits for your Critical Illness will not impact the available BENEFIT AMOUNT for your Spouse's Critical Illness coverage as long as your coverage remains in force.

## **CLAIMS**

### **NOTICE OF CLAIM**

Written notice of your claim should be given to us within 30 days after the date of loss (date of diagnosis). The notice may be given to us at our home office or to our authorized agent or administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

### **CLAIM FORM**

The claim form is available from the Employer or you can request a claim form from us. If you do not receive the form from us within 15 days of your request, you may send us written proof of claim without waiting for the form. If such written proof of claim covers the occurrence, character and extent of the loss within the time period below for proof of claim, you will be deemed to have complied with the requirements for providing proof of claim.

### **FILING A CLAIM**

The claim form(s) may require completion by you and the Employer and your Spouse's attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

### **PROOF OF CLAIM**

You must send us written proof of your claim within 90 days after the date of loss. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, in any event, you must provide proof of claim no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

### **PHYSICAL EXAMINATION**

We may require your Spouse to be examined by one or more Doctors or other medical practitioners of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so while the claim is pending. We may also require your Spouse to be interviewed by our authorized representative. Failure to comply with this request may result in denial or termination of benefits.

### **BENEFIT PAYMENTS**

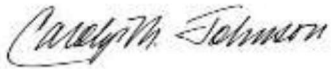
Benefits under this rider are payable to you. Once a claim has been approved, we will make payment as soon as possible but no more than 60 days after receipt of proof of claim. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For PORTABILITY FOLLOWING DEATH OR DIVORCE, benefits are payable to your Spouse, and any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment. We will pay the benefits in one sum or in a method comparable to one sum.

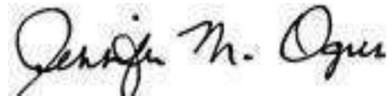
## LEGAL ACTION

You can start legal action regarding a claim no earlier than 60 days after written proof of claim has been given to us, and no later than three years from the time proof of claim is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your Spouse's coverage.

Executed at our Home Office:  
20 Washington Avenue South  
Minneapolis, MN 55401



Carolyn M. Johnson  
President



Jennifer M. Ogren  
Secretary



# CHILDREN'S CRITICAL ILLNESS RIDER

## RELIASTAR LIFE INSURANCE COMPANY 20 Washington Avenue South, Minneapolis, Minnesota 55401

**POLICYHOLDER:** McLeod Health

**GROUP POLICY NUMBER:** 69558-1CCI2

This rider is made a part of the Critical Illness Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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### SCHEDULE OF BENEFITS

#### WHO PAYS FOR THE COVERAGE

You pay the cost of coverage under this rider.

#### CHILDREN'S BENEFIT AMOUNT

50% of Employee BENEFIT AMOUNT

#### CHILDREN'S CRITICAL ILLNESS BENEFITS

##### Base module

Covered illness/condition	Percent of BENEFIT AMOUNT payable
Heart Attack	100%
Cancer	100%
Stroke	100%
Major Organ Transplant	100%
Coronary Artery Bypass	25%
Carcinoma in Situ (CIS)	25%

##### Total maximum benefit amount for base module

2 times the BENEFIT AMOUNT

### Enhanced cancer module

Covered illness/condition	Percent of BENEFIT AMOUNT payable
Benign Brain Tumor	100%
Skin Cancer	10%
Bone Marrow Transplant	25%
Stem Cell Transplant	25%

### Total maximum benefit amount for enhanced cancer module

2 times the BENEFIT AMOUNT

### Quality of life module

Covered illness/condition	Percent of BENEFIT AMOUNT payable
Permanent Paralysis	100%
Loss of Sight, Hearing or Speech	100%
Coma	100%
Multiple Sclerosis	100%
Amyotrophic Lateral Sclerosis (ALS)	100%
Parkinson's Disease	100%
Advanced Dementia, including Alzheimer's Disease	100%
Infectious Disease	100%
Occupational HIV or Hepatitis B or C	100%

### Total maximum benefit amount for quality of life module

2 times the BENEFIT AMOUNT

### CHILDREN'S CRITICAL ILLNESS BENEFITS

The benefit percentages for your Children are the same as the benefit percentages for you as shown in the SCHEDULE OF BENEFITS section of the Certificate.

### DEFINITIONS

General terms defined in the DEFINITIONS section of the Certificate regarding medical conditions and eligibility apply to your Children.

**Child** or **Children** means a child from live birth but less than 26 years of age who is one of the following:

- Your natural or adopted child (including a child placed for adoption).
- Your stepchild.

The child must also meet all of the following conditions:

- Not be on full-time active duty in the armed forces of any country or subdivision thereof.
- Legally reside in the United States or its territories or possessions.
- Not be insured under the Policy as an Employee or Spouse.

This definition includes your Child age 26 or older who is incapable of self-sustaining employment due to physical or intellectual disability. Written proof of the Child's incapacity must be furnished to us at our home office within 31 days after the Child reaches the limiting age. We may require, at reasonable intervals, but not more than once a year after the two year period following attainment of the limiting age, evidence satisfactory to us that the incapacity is continuing.

Coverage will continue while the Child remains incapable of self-sustaining employment due to physical or intellectual disability and continues to meet the definition of Child except for the age limit.

**Critical Illness** has the same meaning as in the Certificate. This definition does not include premature birth or stillbirth caused or contributed to by a Critical Illness.

**Spouse** means your lawful spouse.

## GENERAL PROVISIONS

### ELIGIBILITY

If you are covered under the Policy, then your Children are eligible under this rider on the latest of the following:

- The Policy effective date.
- The date this rider is available to the eligible class of Insured Persons to which you belong.
- Your Critical Illness coverage effective date.
- The date you acquire a Child by marriage, birth or adoption.

If your Child is covered under the Policy as an Employee, then your Child is not eligible for coverage under this rider.

If both you and your Spouse are covered under the Policy as an Employee, then only one of you may cover your Children under this rider. If the parent who is covering the Children stops being insured as an Employee then the other parent may apply for Children's coverage under this rider within 60 days.

### EFFECTIVE DATE

Your Children will be covered at 12:01 a.m. standard time at the Policyholder's address on the later of the following dates:

- The date your Employee coverage is effective.
- The date your Children are eligible for coverage.

Your eligible newborn Child is automatically covered for the first 30 days after birth. This includes an adopted newborn Child who is placed with you within 30 days of birth. The coverage amount(s) will be the same as for your other eligible Children. If you do not already have Children's coverage under this rider, then coverage for the newborn will be at the lowest level available. If you do not already have Children's coverage under this rider, then Child coverage beyond the 30<sup>th</sup> day is subject to the conditions regarding application and Active Employment and having no approved Employee claims under the Policy.

If you have coverage under this rider and you acquire a new eligible Child due to birth, marriage or adoption, then the newly eligible Child will be covered automatically from the date of the event. If an adopted newborn Child is placed with you within 30 days of birth, the "event" will be the date of birth. If an adopted Child is placed with you more than 30 days after birth, the "event" will be the date of placement. No additional premium is required.

### **EFFECTIVE DATE OF CHANGES TO COVERAGE**

Once your Children's coverage begins, any increased or additional coverage will take effect on the latest of the following:

- The date of the increased or additional coverage, if you are in Active Employment.
- The date you return to Active Employment, if you are not in Active Employment due to injury or sickness.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

### **TERMINATION**

Coverage for each Child ends on the earliest of the following:

- The date this rider terminates.
- The date the Child reaches age 26, unless he/she is disabled as defined under the definition of Child. Coverage of a disabled Child ends when there is no longer evidence satisfactory to us that the disability is continuing.
- The date your Child's total maximum benefit amount has been paid for all modules.

This rider terminates on the earliest of the following:

- The date your Certificate terminates.
- The date this rider is terminated for all Insured Persons under the Policy.
- The date you voluntarily cancel this rider.
- The date you no longer have any eligible Children covered under this rider. See the PORTABILITY FOLLOWING DEATH provision below.
- The end of the period for which premiums are paid, if the next required premium contribution is not paid, subject to the grace period.

### **PORTABILITY**

If you are approved by us to continue your coverage under the Certificate's PORTABILITY provision, then this rider can also be continued during portability.

### **PORTABILITY FOLLOWING DEATH**

If you die and your Spouse is approved by us for portability under the Spouse Critical Illness Rider, then this rider can be continued under your Spouse's coverage. Following portability of this rider, Children may be covered only if they would have been eligible for coverage under the eligibility rules in force prior to the death of the Employee.

Premiums will be billed directly to your Spouse. Continued premium payment is required to keep coverage in force. The initial premium will be based on the portability premium rates in effect at the time your Spouse applies for portability. We may change the portability premium rates at any time upon 60 days written notice to your Spouse.

Coverage continued under this provision will end on the earliest of the following:

- The end of the period for which your Spouse paid premiums, if your Spouse stops making a required premium contribution, subject to the grace period.
- The date your Spouse dies.
- The date there are no longer any eligible Children covered under this rider.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

## **CRITICAL ILLNESS BENEFITS**

The benefits for your Children are the same as the benefits for you as shown in the CRITICAL ILLNESS BENEFITS section of the Certificate.

To be eligible for a benefit payment, the diagnosis must be a Different Diagnosis from any previously diagnosed Critical Illness. A subsequent diagnosis of a Critical Illness that is for the same illness/condition as a Critical Illness for which benefits were payable under the Policy may be eligible as a Different Diagnosis as defined.

A Critical Illness that meets the definition of a Same Diagnosis is not eligible for benefits.

Benefits are payable up to the total maximum benefit amount shown on this rider's SCHEDULE OF BENEFITS for each module. This includes multiple payments within each module for Different Diagnoses. Payment of the total maximum benefit amount from one module will not impact the total maximum benefit amount for the other module(s). The total maximum benefit amount is the maximum amount payable for each module in this rider during your Child's lifetime.

Any partial benefits paid will reduce the total maximum benefit amount for that module.

When the total maximum benefit amount for each Child has been paid for a module, no further benefits are payable for that Child for that module. When the total maximum benefit amount for a Child has been paid for all modules, no further benefits are payable for that Child. When the total maximum benefit has been paid for all Children for all modules, no further benefits are payable and this rider terminates.

Payment of any benefits for your Child's Critical Illness will not impact the available BENEFIT AMOUNT for your Critical Illness. Payment of any benefits for your Critical Illness will not impact the available BENEFIT AMOUNT for your Child's Critical Illness as long as your coverage remains in force.

A diagnosis of any Critical Illness must be made after your Child's live birth and by a Doctor familiar with the diagnosis of the specific condition.

## **CLAIMS**

### **NOTICE OF CLAIM**

Written notice of your claim should be given to us within 30 days after the date of loss (date of diagnosis). The notice may be given to us at our home office or to our authorized agent or administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

## **CLAIM FORM**

The claim form is available from the Employer or you can request a claim form from us. If you do not receive the form from us within 15 days of your request, you may send us written proof of claim without waiting for the form. If such written proof of claim covers the occurrence, character and extent of the loss within the time period below for proof of claim, you will be deemed to have complied with the requirements for providing proof of claim.

## **FILING A CLAIM**

The claim form(s) may require completion by you and the Employer and your Child's attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

## **PROOF OF CLAIM**

You must send us written proof of your claim within 90 days after the date of loss. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, in any event, you must provide proof of claim no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

## **PHYSICAL EXAMINATION**

We may require your Child to be examined by one or more Doctors or other medical practitioners of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so while the claim is pending. We may also require you to be interviewed by our authorized representative. Failure to comply with this request may result in denial or termination of benefits.

## **BENEFIT PAYMENTS**


Benefits under this rider are payable to you. Once a claim has been approved, we will make payment as soon as possible but no more than 60 days after receipt of proof of claim. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For PORTABILITY FOLLOWING DEATH, benefits will be paid to your Spouse, and any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment. We will pay the benefits in one sum or in a method comparable to one sum.

## **LEGAL ACTION**

You can start legal action regarding a claim no earlier than 60 days after written proof of claim has been given to us, and no later than three years from the time proof of claim is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your coverage.

Executed at our Home Office:  
20 Washington Avenue South  
Minneapolis, MN 55401



Carolyn M. Johnson  
President



Jennifer M. Ogren  
Secretary

# CONTINUATION OF INSURANCE RIDER

## RELIASTAR LIFE INSURANCE COMPANY 20 Washington Avenue South, Minneapolis, Minnesota 55401

**POLICYHOLDER:** McLeod Health

**GROUP POLICY NUMBER:** 69558-1CCI2

This rider is made a part of the Critical Illness Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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### DEFINITIONS

**Covered Person** means:

- You, if you are covered for Critical Illness insurance under the Policy.
- Your Spouse who is covered under your Spouse Critical Illness Rider.
- Your Children who are covered under your Children's Critical Illness Rider.

**Leave of Absence** means you are absent from Active Employment for a period of time under a leave granted in writing by the Employer that is in accordance with the Employer's formal leave policies. Your normal vacation time is not considered a Leave of Absence.

### GENERAL PROVISIONS

#### ELIGIBILITY

If you are covered under the Policy, then you are eligible for this rider on the latest of the following:

- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your Critical Illness coverage effective date.

#### EFFECTIVE DATE

You will be covered at 12:01 a.m. standard time at the Policyholder's address on the date you are eligible for this rider.

#### TERMINATION

This rider terminates on the earliest of the following:

- The date your Critical Illness insurance terminates.
- The date this rider is terminated for all Employees under the Policy.
- The date this rider is terminated for the eligible class of Employees to which you belong.

## **CONTINUATION OF INSURANCE**

If you stop Active Employment due to:

- Employer-approved Leave of Absence,
- then insurance coverage may be continued under the Policy beyond the date you are no longer in Active Employment, limited to the time period(s) described below.

During this continued coverage period, the amount of continued insurance equals the amount in effect the day prior to the continuation period. That amount will reduce or stop according to the Certificate and riders in effect the day prior to the continuation period.

Premiums are due during the continuation period on the same basis as on the day prior to the continuation period. Contact the Employer for more information.

If an eligible claim occurs while coverage is being continued under this rider, then benefits will be paid as described in the Certificate and riders.

### **EMPLOYER-APPROVED LEAVE(S) OF ABSENCE**

#### **Family and Medical Leave**

If you are on a Leave of Absence as described under the Family and Medical Leave Act of 1993 and any amendments ("FMLA") or applicable state family and medical leave law ("State FML"), and the Employer's human resource policy provides for continuation of insurance during an FMLA or State FML Leave of Absence, then insurance coverage for all Covered Persons may be continued until the end of the later of:

- The leave period permitted by FMLA.
- The leave period permitted by state FML.

This continuation of coverage includes all riders that were in effect on the date before the FMLA or State FML Leave of Absence began.

#### **Other Leave of Absence**

If you are on a Leave of Absence for any other reason, then insurance coverage for all Covered Persons may be continued until the last day of the month which next follows the date which is 6 months after the date you stopped Active Employment.

This continuation of coverage includes all riders that were in effect on the date before the Leave of Absence began.

### **CONCURRENT LEAVES OF ABSENCE**

If you would be eligible for more than one type of continuation under this rider during any one period that you are not in Active Employment, we will consider such periods to be concurrent for the purpose of determining how long your coverage may continue under the Policy.

### **TERMINATION OF CONTINUATION**

Coverage continued under this rider will end on the earliest of the following:

- The end of the continuation period as indicated above.
- The end of the period for which premiums are paid if the next premium is not paid by its due date, subject to the grace period.
- The date you are eligible under the Policy due to Active Employment.
- The date of your death.
- The date you become covered under another group critical illness or specified disease insurance policy as an employee or member.
- The date the Policy terminates.
- The date coverage for all Employees under the Policy terminates.



In no event will coverage for any Covered Person be continued beyond the date coverage would otherwise end according to the termination provision(s) of the Certificate and riders.

When this continuation ends, insurance under the Policy will stay in force only if all of the following conditions are met:

- Critical Illness insurance is in force for Employees under the Policy; and
- You are in an eligible class for coverage under the Policy; and
- Your premium payments are resumed.

The amount of insurance will be subject to the Certificate and riders in effect on the date your premium payments are resumed.

### **RETURN TO ACTIVE EMPLOYMENT**

If coverage is not continued during an FMLA or State FML Leave of Absence, and you return to Active Employment immediately following the end of the FMLA or State FML Leave of Absence and while coverage is in force for Employees under the Policy, then coverage for all Covered Persons may be reinstated effective the date you return to Active Employment. The amount(s) of coverage will be subject to the SCHEDULE OF BENEFITS in effect on the date you return to Active Employment. We will not apply a new Eligibility Waiting Period for the same or lesser amount(s) of coverage.


If coverage is not continued during your Leave of Absence for active military service, and you return to Active Employment while coverage is in force for Employees under the Policy, then coverage for all Covered Persons may be reinstated in accordance with USERRA and applicable state law.

If coverage is not continued during any other period that is eligible for continuation under the Policy, and you return to Active Employment while coverage is in force for Employees under the Policy, then the terms of the Certificate and riders will apply.

Executed at our Home Office:  
20 Washington Avenue South  
Minneapolis, MN 55401



Carolyn M. Johnson  
President



Jennifer M. Ogren  
Secretary

# WELLNESS BENEFIT RIDER

## RELIASTAR LIFE INSURANCE COMPANY 20 Washington Avenue South, Minneapolis, Minnesota 55401

**POLICYHOLDER:** McLeod Health

**GROUP POLICY NUMBER:** 69558-1CCI2

This rider is made a part of the Critical Illness Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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### SCHEDULE OF BENEFITS

#### WHO PAYS FOR THE COVERAGE

The cost of coverage under this rider is automatically included in the cost of your coverage and the cost of your Spouse's coverage and the cost of your Children's coverage.

#### WELLNESS BENEFIT

You:	\$50
Your Spouse:	\$50
Your Children:	50% of your wellness benefit amount, to a maximum of \$100 for all Children in one calendar year

### DEFINITIONS

General terms are defined in the DEFINITIONS section of the Certificate and riders.

#### Covered Person means:

- You, if you are covered for Critical Illness insurance under the Policy.
- Your Spouse who is covered under your Spouse Critical Illness Rider.
- Your Children who are covered under your Children's Critical Illness Rider.

## **GENERAL PROVISIONS**

### **ELIGIBILITY**

If you are working for the Employer in an eligible class (shown in the Certificate's SCHEDULE OF BENEFITS), you are eligible for this rider on the latest of the following dates:

- The Policy effective date.
- The date this rider is available to the eligible class of Insured Persons to which you belong.
- Your Critical Illness coverage effective date.

### **EFFECTIVE DATE**

Each Covered Person will be covered at 12:01 a.m. standard time at the Policyholder's address on the date the Covered Person is eligible for coverage under this rider.

### **TERMINATION**

This rider will terminate on the earliest of the following:

- The date your Certificate terminates.
- The date this rider is terminated for all Insured Persons under the Policy.
- For your Spouse's coverage, the date the Spouse Critical Illness Rider terminates.
- For each Child's coverage, the date your Child's coverage under the Children's Critical Illness Rider terminates.

### **PORTABILITY**

If you are approved by us to continue your coverage under the Certificate's PORTABILITY provision, then this rider will also be continued during portability.

### **PORTABILITY FOLLOWING DEATH OR DIVORCE**

If you die or divorce and your Spouse is approved by us for portability under the Spouse Critical Illness Rider, then this rider can also be continued under your Spouse's coverage.

### **ASSIGNMENT**

At the time of claim under this rider, you can assign the payment of a benefit under this rider to a third party who is not the Policyholder.

## **BENEFITS**

We will pay you a wellness benefit (shown on the SCHEDULE OF BENEFITS) if a Covered Person has a health screening test.

A wellness benefit is limited to one annual payment per Policy year per Covered Person.

Health screening tests include, but are not limited to:

- |                                    |                                       |
|------------------------------------|---------------------------------------|
| - Blood test for triglycerides     | - Stress test on bicycle or treadmill |
| - Pap smear or thin prep pap test; | - Fasting blood glucose test          |
| - Flexible sigmoidoscopy           | - Thermography                        |

- CEA (blood test for colon cancer)
- Bone marrow testing
- Serum cholesterol test for HDL & LDL levels
- Hemoccult stool analysis
- Serum Protein Electrophoresis (myeloma)
- Breast ultrasound, sonogram, MRI
- Chest x-ray
- Mammography
- Colonoscopy
- CA 15-3 (breast cancer)
- PSA (prostate cancer)
- Electrocardiogram (EKG)
- Routine eye exam
- Routine dental exam
- Well child/preventive exams for ages 1 through 18
- Biometric screenings

## **EXCLUSIONS**

The EXCLUSIONS section of the Certificate and riders does not apply to this rider.

## **CLAIMS**

The PHYSICAL EXAMINATION provision does not apply to this rider.

### **NOTICE OF CLAIM**

Written notice of your claim must be given to us during the same Policy year the health screening test occurs or within 30 days of the end of the Policy year, whichever is later. The notice may be given to us at our home office or to our authorized agent or administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

### **CLAIM FORM**

The claim form is available from the Employer or you can request a claim form from us. If you do not receive the form from us within 15 days of your request, you may send us written proof of claim without waiting for the form. If such written proof of claim covers the occurrence, character and extent of the loss within the time period below for proof of claim, you will be deemed to have complied with the requirements for providing proof of claim.

### **FILING A CLAIM**

The claim form(s) may require completion by you and the Employer and the Covered Person's attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

### **PROOF OF CLAIM**

You must send us written proof of your claim within 90 days after the date of the health screening test. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, in any event, you must provide proof of claim no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

### **BENEFIT PAYMENTS**

Benefits under this rider are payable to you unless otherwise specified. Once a claim has been approved, we will make payment as soon as possible but no more than 60 days after receipt of proof of claim. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For PORTABILITY FOLLOWING DEATH OR DIVORCE, benefits are payable to your Spouse, and any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment. We will pay the benefits in one sum.

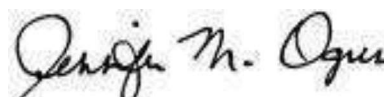
### **LEGAL ACTION**

You can start legal action regarding a claim no earlier than 60 days after written proof of claim has been given to us, and no later than three years from the time proof of claim is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your coverage.

Executed at our Home Office:  
20 Washington Avenue South  
Minneapolis, MN 55401



Carolyn M. Johnson  
President



Jennifer M. Ogren  
Secretary