

# Certificate of Insurance

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Your complete Certificate of Insurance includes the Certificate of Insurance, any applicable Certificate Endorsement and any applicable Guarantee Association and Complaint Notice.

# Group Critical Illness Certificate of Insurance

Securian Life Insurance Company • A Stock Company  
400 Robert Street North • St. Paul, Minnesota 55101-2098

APPLIES TO RESIDENTS OF FL, AK, AL, AR, AZ, DC, DE, GA, GUAM, HI, IA, IL, KS, KY, MA, ME, MD, MI, MN, MS, NC, ND, NE, NM, NV, NY, OK, OR, PA, RI, SC, SD, TN, UT, VA, VT, WI, WV, and WY

Effective January 1, 2021

**POLICYHOLDER:** South Broward Hospital District, d.b.a., Memorial Healthcare System

**POLICY NUMBER:** 76058

THIS CERTIFICATE IS NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE. IT DOES NOT QUALIFY AS MINIMUM ESSENTIAL HEALTH COVERAGE UNDER THE FEDERAL AFFORDABLE CARE ACT. THIS CERTIFICATE DOES NOT SATISFY THE FEDERAL REQUIREMENT THAT YOU HAVE HEALTH INSURANCE COVERAGE, WHICH BECAME EFFECTIVE JANUARY 1, 2014.

THIS IS A LIMITED BENEFIT CERTIFICATE: This certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your certificate carefully.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CONTRACT. If you are eligible for Medicare, review the Guide to Health Insurance for people with Medicare available from us.

**Notice for residents of Arizona:** This certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read this certificate carefully.

**Notice for residents of Maryland:** This certificate is a part of a group policy issued outside of Maryland and may omit some of the benefits required for a policy issued and delivered in Maryland.

**Notice for residents of North Carolina:** This Certificate of Insurance provides all of the benefits mandated by the North Carolina Insurance Code, but is issued under a group master policy located in another state and may be governed by that state's laws.

## Read Your Certificate Carefully

If you meet the eligibility and enrollment requirements herein, you are insured under the group policy shown on the specifications page. This certificate summarizes the principal provisions of the group policy that affect you. The provisions summarized in this certificate are subject in every respect to the group policy. You may examine the group policy at the principal office of the policyholder during regular working hours.

## Legal Actions

No legal action may be brought to recover on this certificate within the first sixty days after written proof of loss has been given as required by this certificate. No such action may be brought after three years from the time written proof of loss is required to be given.



Secretary



President

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## GROUP CRITICAL ILLNESS CERTIFICATE OF INSURANCE

# Certificate Specifications Page

Securian Life Insurance Company  
400 Robert Street North • St. Paul, Minnesota 55101-2098

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## GENERAL INFORMATION

**POLICYHOLDER:** South Broward Hospital District, d.b.a., Memorial Healthcare System

**POLICY NUMBER:** 76058

**ASSOCIATED COMPANIES:** All subsidiaries and affiliates reported to Securian Life by the policyholder for inclusion in the policy.

**POLICY SITUS:** The policy was issued and delivered in Florida.

**POLICY EFFECTIVE DATE:** January 1, 2021.

**This certificate and/or certificate specifications page replaces any and all certificates and/or certificate specifications pages previously issued to you under the group policy. Please replace any certificate and/or certificate specifications page previously issued to you with this new certificate and/or specifications page.**

**GROUP:** The group is composed of all active employees of the policyholder and its associated companies working in the United States in the following class:

Class 1: Active full-time and part-time employees working at least 20 hours per week.

All new employees of the employer will be added to such group and class for which they become eligible.

**NO DOUBLE COVERAGE:** If two employees of the policyholder are married to each other, each may be insured as either an employee or a dependent spouse, but not both. Only one person can insure an eligible dependent child.

**ENROLLMENT PERIOD:** 31 days from the first day of eligibility for contributory insurance.

**MINIMUM HOURS PER WEEK REQUIREMENT:** 20 hours per week.

**EMPLOYMENT WAITING PERIOD:** 30 days from the employee's date of hire.

**BENEFIT WAITING PERIOD:** None

**BENEFIT SEPARATION PERIOD:** 6 months

# **PLAN OF INSURANCE**

## **EMPLOYEE BENEFIT SCHEDULE**

### **EMPLOYEE GROUP CRITICAL ILLNESS INSURANCE:**

#### **Supplemental Group Critical Illness Insurance**

<b><u>Eligible Class</u></b>	<b><u>Employee Supplemental Group Critical Illness Insurance Benefit Plan</u></b>
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Class 1	An amount elected by the employee from the following options:  \$10,000 \$20,000 \$30,000 \$40,000
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<b><u>Eligible Class</u></b>	<b><u>Overall Supplemental Group Critical Illness Maximum Benefit Amount</u></b>
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Class 1	\$1,000,000
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#### **Health and Wellness Benefit**

<b><u>Eligible Class</u></b>	<b><u>Employee Health and Wellness Benefit</u></b>
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Class 1	\$75
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### **GENERAL PROVISIONS FOR EMPLOYEE INSURANCE**

**RETIREMENT REDUCTIONS:** All insurance terminates at retirement, except as otherwise provided for under any applicable certificate supplement.

**CONTRIBUTORY/NONCONTRIBUTORY:** Supplemental insurance is contributory insurance.

**GUARANTEED ISSUE AMOUNT:** Guaranteed issue is the maximum amount of insurance an employee can receive without evidence of insurability when first eligible under the plan provided enrollment is made within the enrollment period. The amounts are as follows:

For employees in an eligible class immediately prior to the effective date of the group policy:

#### **Supplemental Insurance**

An amount equal to the amount of supplemental insurance for which the employee was insured under the prior carrier's group policy on the day immediately preceding the effective date of this certificate.

For employees who first become eligible after the effective date of this certificate:

\$40,000

**PORTABILITY MINIMUM AMOUNT:** The lowest offered plan increment.

**PORTABILITY MAXIMUM AMOUNT:** An employee may elect from any of the offered plan increments under the supplemental insurance in the benefit schedule that do not exceed the amount of insurance in force on his or her portability date or \$40,000.

**Not all Certificate Supplements are available in all states. See Supplements to Certificate section below for details.**

## DEPENDENT BENEFIT SCHEDULE

An employee must be insured for supplemental critical illness insurance in order to elect dependent critical illness insurance.

### **SPOUSE CRITICAL ILLNESS INSURANCE**

#### **Supplemental Group Critical Illness Insurance**

**Eligible Class**

Class 1

**Spouse Supplemental Group Critical Illness Insurance Benefit Plan**

100% of the employee's amount of supplemental Group Critical Illness insurance.

**Eligible Class**

Class 1

**Overall Spouse Supplemental Group Critical Illness Maximum Benefit Amount**

100% of the employee's overall maximum benefit amount of Group Critical Illness insurance.

#### **Health and Wellness Benefit**

**Eligible Class**

Class 1

**Spouse Health and Wellness Benefit**

\$75

### **CHILD GROUP CRITICAL ILLNESS INSURANCE**

#### **Supplemental Group Critical Illness Insurance**

**Eligible Class**

Class 1

**Child Supplemental Group Critical Illness Insurance Benefit Plan**

50% of the employee's amount of supplemental Group Critical Illness insurance.

**Eligible Class**

Class 1

**Overall Supplemental Group Critical Illness Maximum Benefit Amount**

100% of the employee's overall maximum benefit amount of Group Critical Illness insurance

#### **Health and Wellness Benefit**

**Eligible Class**

Class 1

**Child Health and Wellness Benefit**

\$75

## **GENERAL PROVISIONS FOR DEPENDENT INSURANCE**

**RETIREMENT REDUCTIONS:**

All insurance terminates at retirement, except as otherwise provided for under any applicable certificate supplement.

**CONTRIBUTORY/NONCONTRIBUTORY:**

Supplemental insurance is contributory insurance.

**GUARANTEED ISSUE AMOUNT:**

Guaranteed issue is the maximum amount of insurance a spouse or child can receive without evidence of insurability when first eligible under the plan provided enrollment is made within the enrollment period. The amounts are as follows:

For a spouse or child in an eligible class immediately prior to the effective date of the group policy:

### Supplemental Insurance

An amount equal to the amount of supplemental insurance for which the spouse or child was insured under the prior carrier's group policy on the day immediately preceding the effective date of this certificate.

For a spouse or child who first becomes eligible after the effective date of this certificate:

Spouse: \$40,000

Child: \$20,000

### SPOUSE AND CHILD PORTABILITY:

Spouse benefit plan matches the employee's Group Critical Illness Benefit Plan. Child benefit plan matches the employee's Group Critical Illness Benefit Plan

### PORTABILITY MINIMUM AMOUNT:

The lowest offered plan increment.

### PORTABILITY MAXIMUM AMOUNT:

Spouse: An amount which does not exceed the lesser of the spouse's amount of insurance in force on his or her portability date or \$40,000.

Child: An amount which does not exceed the lesser of the child's amount of insurance in force on his or her portability date or \$20,000.

**Not all Certificate Supplements are available in all states. See Supplements to Certificate section below for details.**

## BENEFITS FOR COVERED CONDITIONS

The benefit amount payable for a covered condition is a percentage of an insured's amount of insurance or the amount as shown in the schedule below subject to the overall maximum benefit amount.

<b>Covered Condition</b>	<b>Initial Occurrence Benefit</b>	<b>Recurrence Benefit</b>
Addison's disease*	10%	None
Alzheimer's disease*	25%	None
amyotrophic lateral sclerosis (ALS) and other motor neuron disease*	100%	None
benign brain tumor	100%	100%
blindness*	100%	None
bone marrow failure requiring bone marrow or stem cell transplant*	100%	None
coma	100%	100
coronary artery disease needing surgery or angioplasty	25%	25%
full benefit cancer	100%	100%
heart attack	100%	100%
kidney failure*	100%	None
loss of hearing*	100%	None
loss of speech*	100%	None
major organ failure	100%	100%
multiple sclerosis*	100%	None
myasthenia gravis*	50%	None
occupational HIV infection*	100%	None
paralysis*	100%	None
Parkinson's disease*	25%	None
partial benefit cancer	25%	25%
severe burns	100%	100%
skin cancer (non-melanoma and carcinoma-in-situ of the skin)	\$1,000	None
stroke	100%	100%

systemic lupus erythematosus (nephritis cerebritis)*	50%	None
systemic sclerosis (scleroderma)*	10%	None

\*Not all benefits are medically able to meet the definition of recurrence, including Addison's disease, Alzheimer's disease, amyotrophic lateral sclerosis (ALS) and other motor neuron disease, blindness, bone marrow failure requiring bone marrow or stem cell transplant, kidney failure, loss of hearing, loss of speech, multiple sclerosis, myasthenia gravis, occupational HIV infection, paralysis, Parkinson's disease, systemic lupus erythematosus (nephritis & cerebritis), systemic sclerosis (scleroderma).

## ADDITIONAL INFORMATION

### ANNUAL OPEN ENROLLMENTS:

During the policyholder's annual open enrollment an employee may make the following election changes without providing evidence of insurability.

- An employee may elect employee critical illness insurance for the first time or increase existing critical illness insurance to any level offered under the plan.
- An employee may elect spouse critical illness insurance.
- An employee may elect child critical illness insurance.

Coverage will be effective on the January 1 following the annual enrollment, subject to the actively at work requirement for employees and the hospitalization/non-confinement requirement for dependents.

**Special Enrollment Periods:** Upon mutual agreement between the policyholder and us, one or more special enrollment periods may be offered to eligible employees. These special enrollment periods (if offered) will be in addition to the annual enrollment opportunities described above. In the event that a special enrollment period is offered, the details of the special enrollment, including enrollment dates, and allowed changes, will be communicated to you in advance of the special enrollment period and documented in the group policy on file with the policyholder and us.

### QUALIFIED STATUS CHANGES:

An employee who experiences one of the qualified status change events listed below may make the following election changes without providing evidence of insurability, provided enrollment is made within 31 days of the status change.

- An employee may elect employee critical illness insurance for the first time or increase existing critical illness insurance to any level offered under the plan.
- An employee may elect spouse critical illness insurance.
- An employee may elect child critical illness insurance.

Coverage will be effective on the date of the election. All increases are subject to the actively at work requirement for employees and the hospitalization/non-confinement requirement for dependents.

Qualified status change for purposes of the enrollment opportunities described above means marriage, birth or adoption of a child.

## SUPPLEMENTS TO THE CERTIFICATE

Health and Wellness  
Portability  
Trauma

Applies to all states  
Applies to all states except Vermont  
Applies to all states except New York

## General Definitions

Any use in this certificate or any attached certificate supplement of a term defined in this section is to be given the meaning defined in this section unless otherwise defined in another provision of this certificate or certificate supplement.

### application

Your application or enrollment for insurance under the group policy.

### associated company

Any company which is a subsidiary or affiliate of the policyholder which is designated by the policyholder and agreed to by us to participate under the group policy.

### benefit separation period

The period of time shown on the specifications page that begins with the diagnosis date of a covered condition for which a benefit is payable.

### child/children

Your or your spouse's:

- (1) natural child;
- (2) adopted child; or
- (3) stepchild.

Children are eligible from the moment of live birth (stillborn or unborn children are not eligible) to the end of the calendar year in which they attain age 26. Children age 26 or older are also eligible if they are physically or mentally incapable of self-support, were incapable of self-support prior to age 26, and are financially dependent on the employee for more than one-half of their support and maintenance.

Adopted child includes children that are placed with you, or for whom you have filed a petition to adopt. Children placed with you, or for whom you have filed a petition to adopt within 60 days of the adopted child's date of birth, are eligible from the moment of live birth (stillborn or unborn children are not eligible). Coverage for an adopted child placed with you, or for whom you have filed a petition to adopt more than 60 days after the child's date of birth, is effective from the moment of placement or filing of the petition. However, coverage will not continue if the placement is disrupted prior to legal adoption or if the child is removed from placement. Placed/placement means physical placement in your or your spouse's care. If physical placement is prevented due to the medical needs of the child, "placed" means the date you or your spouse sign an agreement for adoption of the child and assume financial responsibility for the child.

### contributory insurance

Insurance for which you are required to make premium contributions.

### covered condition

A covered condition is a critical illness or traumatic event as defined herein and any supplement attached hereto.

### critical illness

Any illness that meets the requirements of a critical illness as defined herein.

### dependent

Your children or spouse.

If both parents of a child qualify as eligible employees under the group policy, the child shall be considered a dependent of only one parent for purposes of this certificate. If any child qualifies as an eligible employee under the group policy, he or she is not eligible to be insured as a dependent child.

### employee

An individual who is employed by the policyholder or by an associated company. A sole proprietor will be considered the employee of the proprietorship. A partner in a partnership will be considered an employee so long as the partner's principal work is the conduct of the partnership's business. The term employee does not include temporary employees nor corporate directors who are not otherwise employees.

### employer

The policyholder or any designated associated companies.

### employment waiting period

The period, if any, of continuous employment with the employer that the employee must satisfy prior to becoming eligible for coverage under this certificate. You are not eligible to become insured until the first day following the waiting period. Any such waiting period is shown on the specifications page.

### evidence of insurability

Evidence satisfactory to us of the insurability of the prospective insured and any other underwriting information we require.

### family member

A parent, spouse, child, sibling, grandparent, aunt, uncle, first cousin, niece or nephew. This includes adopted, in-law, and step relatives.

### guaranteed issue amount

The amount of insurance that can be obtained without providing evidence of insurability based on plan requirements as shown on the specifications page. All other eligibility requirements must be met.

## **initial occurrence**

The initial occurrence is the date the insured is diagnosed for the first time, after the effective date of coverage, with a covered condition.

If the covered condition is full benefit cancer, the subsequent diagnosis of full benefit cancer which is separate and unrelated that occurs after the first diagnosis will be treated as an initial occurrence.

If the covered condition is partial benefit cancer, the subsequent diagnosis of partial benefit cancer which is separate and unrelated that occurs after the first diagnosis will be treated as an initial occurrence.

## **insured**

An employee or dependent covered for insurance under this certificate.

## **non-contributory insurance**

Insurance for which you are not required to make premium contributions.

## **non-work day**

A day on which you are not regularly scheduled to work, including scheduled time off for vacations, personal holidays, weekends and holidays, and approved leaves of absence for non-medical reasons.

Non-work day does not include time off for medical leave of absence, temporary layoff, employer suspension of operations in total or in part, strike, and any time off due to sickness or injury including sick days, short-term disability, or long term disability.

## **permanent neurological deficit with persisting clinical signs and symptoms**

Signs and symptoms of dysfunction in the nervous system that are present on clinical examination by a specialist and expected to last throughout the insured's life.

The following neurological symptoms are covered under this definition: numbness, paralysis, localized weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, cognitive impairment, delirium and coma.

### The following are not covered under this definition:

- (1) an abnormality seen on brain or other scans without definite related clinical signs and symptoms;
- (2) neurological signs occurring without symptomatic abnormality such as brisk reflexes without other symptoms; and
- (3) symptoms of psychological or psychiatric origin.

## **physician**

A medical doctor or other person recognized by law or regulation in the United States or United States territory where services are rendered as a physician. The person must be licensed as required by the United States jurisdiction where care is given and must be operating in the scope of his or her license.

A physician cannot be a person who:

- (1) ordinarily resides in your household;
- (2) is a family member; or
- (3) is a member of your eligible group.

## **policyholder**

The owner of the group policy as shown on the specifications page.

## **separate and unrelated**

A full benefit cancer or partial benefit cancer that is:

- (1) not a metastasis of a previously diagnosed full benefit cancer; and
- (2) distinct from any previously diagnosed full benefit cancer or partial benefit cancer.

## **specialist**

A person who:

- (1) is licensed and recognized as a medical doctor (M.D. or D.O. only) by the state or US Territory in which he/she practices;
- (2) is practicing within the scope of his/her license; and
- (3) has the medical training and board-certification in the specialty or sub-specialty needed to diagnose and treat the specific diseases or conditions covered under the policy.

A specialist cannot be a person who:

- (1) ordinarily resides in your household;
- (2) is a family member; or
- (3) is a member of your eligible group.

## **specifications page**

The summary of the plan specifics available under the group policy.

## **spouse**

Your legally married spouse.

## **we, our, us**

Securian Life Insurance Company.

## you, your, certificate holder

An insured employee.

## Critical Illness Definitions

### Addison's disease

An endocrine disorder characterized by primary failure of the adrenal gland to produce cortisol, steroid hormones, and aldosterone. There must be a diagnosis by a specialist of Addison's disease with clear confirmatory laboratory evidence of Addison's disease in the blood or urine. Adrenal insufficiency due to steroid hormone use is not covered under this definition.

The date of diagnosis is the date the diagnosis of Addison's disease is made by a specialist satisfying the policy definition above.

### Alzheimer's disease

A definite diagnosis of Alzheimer's disease by a specialist. The Mini-mental Exam Score (MMSE) must be less than 20 out of 30 or an equivalent of this score using other standardized clinically accepted cognitive Alzheimer's tests. There must also be permanent clinical loss of the ability to do all of the following:

- (1) remember;
- (2) reason; and
- (3) perceive, understand, express and give effect to ideas.

Other causes of dementia including but not limited to the following are excluded:

- (1) psychiatric illnesses;
- (2) alcohol related brain damage;
- (3) stroke and vascular dementia;
- (4) Parkinson's disease; or
- (5) coma.

The date of diagnosis is the date a specialist diagnoses the insured with Alzheimer's disease satisfying the policy definition above.

### amyotrophic lateral sclerosis (ALS) and other motor neuron disease

A definite diagnosis by a specialist of spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease) or primary lateral sclerosis. There must be permanent neurological defect with persisting clinical signs and symptoms that has persisted for a continuous period of at least 90 days.

The date of diagnosis is the date the diagnosis of a covered motor neuron disease is made by a specialist satisfying the policy definition above.

## benign brain tumor

A non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies.

This brain tumor must cause one (1) of the following:

- (1) permanent neurological deficit with persisting clinical signs and symptoms for a continuous period of at least 90 consecutive days; or
- (2) a specialist reports that surgery or radiation therapy is necessary to treat the brain tumor.

The following conditions are excluded: Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, and tumors of the spinal cord.

The date of diagnosis is the date the diagnosis of benign brain tumor is made by a specialist satisfying the policy definition above.

### bone marrow failure requiring bone marrow or stem cell transplant

Bone marrow failure of sufficient severity where a specialist deems that the insured needs a transplant of bone marrow or stem cells. There must be a diagnosis of bone marrow failure requiring transplant and the insured must be included on an official USA bone marrow registry program such as National Marrow Donor Program (NMDP). If an insured has bone marrow failure due to another covered condition, the benefit paid will be the greater of the covered condition benefits; if the benefit amount for both covered conditions is the same, you can choose the covered condition benefit to be paid.

For the above definition, the following are not covered:

- (1) transplant of any other tissues or cells;
- (2) stem cell injections for orthopedic conditions; or
- (3) registration on an official USA transplant waiting list as a donor.

The date of diagnosis is the date the insured is listed on an official transplant list satisfying the policy definition above.

### coronary artery disease needing surgery or angioplasty

Coronary artery disease with blockages in one or more coronary artery(s) demonstrated on cardiac catheterization coronary angiography that requires the insured to undergo either coronary artery bypass surgery or coronary angioplasty. A specialist must report that the insured requires surgical intervention on the coronary artery(s) following clinically accepted cardiovascular surgery guidelines, either for prognostic benefit or for symptomatic coronary artery disease that cannot be adequately managed on optimal medical therapy.

Diagnostic coronary angiography is not considered a 'surgical intervention' under this definition and it is specifically excluded.

Actual undergoing of cardiac surgery is not required to meet the policy definition. However, individuals are not eligible for a recurrence benefit for multiple subsequent recommendations to undergo coronary artery bypass.

The date of diagnosis is the date the insured is diagnosed by a specialist with coronary artery disease that satisfies the policy definition above.

### **full benefit cancer**

A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissue. The term cancer includes leukemia, lymphoma, sarcoma, and Hodgkin's disease unless excluded below.

The following cancers are not considered full benefit cancer and are excluded:

- (1) all tumors which are histologically described as benign, non-malignant, pre-malignant, borderline, low malignant potential, dysplasia (all grades), or intraepithelial neoplasia;
- (2) any lesion described as Ta by the AJCC Staging System or as carcinoma in-situ classified as (Tis) by the AJCC Staging System;
- (3) all non-melanoma skin cancers unless there are lymph node or distant metastases;
- (4) prostate cancer that is classified as T1 by the AJCC Staging System and has a Gleason Score that is less than or equal to 6, without lymph node or distant metastasis;
- (5) any melanoma that is less than or equal to 1.0 mm in Breslow thickness, without lymph node or distant metastasis; and
- (6) early thyroid cancer that is classified as T1 by the AJCC Staging System and is less than or equal to 2 cm in diameter, without lymph node or distant metastasis.

Full benefit cancer must be diagnosed according to a pathological or clinical diagnosis. For purposes of full benefit cancer, pathological diagnosis means a diagnosis on a pathology report of Full Benefit Cancer based on a microscopic study of fixed tissue or preparations from the blood system. This type of diagnosis must be done by a specialist whose diagnosis of malignancy conforms to the standards set by the American College of Pathology. The diagnosis must be confirmed with a valid pathology report from a certified pathologist and a report from a specialist.

For purposes of full benefit cancer, clinical diagnosis means a diagnosis based on the study of symptoms and diagnostic test results.

We will accept a clinical diagnosis of full benefit cancer only if all three (3) of the following conditions are met:

- (1) a pathological diagnosis cannot be made because it is medically inappropriate or life threatening;
- (2) there is medical evidence to support the diagnosis; and
- (3) a report from a specialist who is treating or advising the insured for full benefit cancer.

The date of diagnosis is the date of biopsy or other test that generates a definite diagnosis of cancer that satisfies the policy definition above.

### **heart attack**

Death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis must be made by a specialist, supported by all three (3) of the following criteria and be diagnostic of a new acute myocardial infarction:

- (1) symptoms clinically accepted as consistent with the diagnosis of an acute myocardial infarction;
- (2) new characteristic electrocardiographic changes; and
- (3) the characteristic rise above laboratory accepted normal values of biochemical cardiac specific markers such as CK-MB or cardiac troponins.

Angina and all other forms of acute coronary syndromes are not covered.

The date of diagnosis is the date of the heart attack that satisfies the policy definition above.

### **kidney failure**

The total and permanent failure of both kidneys which requires the insured to undergo regular renal dialysis at least weekly or for which the insured needs a kidney transplant and is included on an official USA transplant waiting list such as the United Network for Organ Sharing (UNOS). Permanent regular renal dialysis or kidney transplant must be deemed medically necessary by a specialist.

Acute reversible kidney failure that only needs temporary renal dialysis is not covered.

The date of diagnosis is the earlier of the date permanent regular renal dialysis is deemed medically necessary by a specialist or the date the insured is listed on an official transplant waiting list satisfying the policy definition above.

### **major organ failure**

The failure of heart, liver, lung, pancreas, or small bowel. A specialist must state that the insured needs a transplant of these above mentioned organs and the insured is included on an official USA transplant waiting list such as the United Network for Organ Sharing (UNOS). The transplant must be deemed necessary by a specialist to treat organ failure in the insured. If an insured is on the UNOS list for a combined transplant (example: heart and lung), a single benefit will be paid.

For the above definition, the following is not covered:

- (1) transplant of any other organs, tissues or cells; or
- (2) registration on an official USA transplant waiting list as a donor.

The date of diagnosis is the date the insured is listed on an official transplant list satisfying the policy definition above.

### **multiple sclerosis (MS)**

A diagnosis made by a specialist of definite multiple sclerosis. Both of the following two (2) criteria must be present:

- (1) there must be current neurologic abnormalities evident on physical examination consistent with the diagnosis of clinically definite MS; and
- (2) the diagnosis must also be confirmed with objective neurological investigations, such as lumbar puncture, evoked visual responses, evoked auditory responses or magnetic resonance imaging (MRI) showing evidence of lesions of the central nervous system.

The date of diagnosis is the date the diagnosis of multiple sclerosis is made by a specialist satisfying the policy definition above.

### **myasthenia gravis**

A chronic neuromuscular autoimmune disease characterized by fluctuating muscle weakness, double vision, and difficulty swallowing. There must be a diagnosis by a specialist of myasthenia gravis with confirmatory evidence of myasthenia such as the detection of antibodies to the neuromuscular junction (connection between the nerve and muscle) or abnormal electromyography (EMG).

The date of diagnosis is the date the diagnosis of myasthenia gravis is made by a specialist satisfying the policy definition above.

### **occupational HIV infection**

Infection with the human immunodeficiency virus (HIV) resulting from an unexpected, unintended, and unforeseen incident which occurred in the United States and which exposed the insured to HIV-contaminated blood or bodily fluids during the course of the duties of the insured's normal occupation.

Payment under this condition requires satisfaction of all four (4) of the following:

- (1) the incident causing the infection of HIV must have occurred after your effective date of coverage;
- (2) the incident was reported to the employer within 24 hours of the incident;
- (3) a blood test must be carried out within 14 days of the incident that is negative and shows no evidence of either HIV virus or HIV antibodies; and

- (4) seroconversion must be proven with another blood HIV test within 180 days of the incident that is positive indicating presence of infection by HIV or AIDS.

The following are excluded:

- (1) HIV infection acquired via sexual transmission; and
- (2) HIV infection acquired via intravenous (IV) drug use.

The date of diagnosis is the date the positive presence of HIV infection is made by a specialist satisfying the definition above.

### **Parkinson's disease**

A definite diagnosis of idiopathic Parkinson's disease by a specialist. There must be resting tremor, rigidity, bradykinesia and gait disturbance compatible with the diagnosis of Parkinson's Disease as assessed by a specialist.

Drug-induced or toxic causes of Parkinson's are excluded.

The date of diagnosis is the date a specialist diagnoses the insured with Parkinson's disease satisfying the policy definition above.

### **partial benefit cancer**

A diagnosis of one of the four (4) cancers defined below.

- (1) any lesion described as carcinoma in-situ (cancer which has not spread to neighboring tissue) and that is classified as (Tis) by the AJCC Staging System, of all organs except skin;
- (2) early malignant prostate cancer that is classified as T1 by the AJCC Staging System and has a Gleason that is less than or equal to 6, without lymph node or distant metastasis;
- (3) early malignant melanoma that is less than or equal to 1.0 mm in Breslow thickness, without lymph node or distant metastasis; or
- (4) early malignant thyroid cancer that is classified as T1 by the AJCC Staging System and is less than or equal to 2 cm in diameter, without lymph node or distant metastasis.

The diagnosis must be diagnosed according to a pathological diagnosis. For purposes of partial benefit cancer, pathological diagnosis means a diagnosis on a pathology report of partial benefit cancer based on a microscopic study of fixed tissue or preparations from the blood system. This type of diagnosis must be done by a specialist whose diagnosis of malignancy conforms to the standards set by the American College of Pathology. The diagnosis must be confirmed with a valid pathology report from a certified pathologist and a report from a specialist. The following cancers are excluded:

- (1) all tumors which are histologically described as benign, non-malignant, pre-malignant, borderline, low malignant potential, dysplasia (all grades) or intraepithelial neoplasia;
- (2) non-melanoma skin cancer;
- (3) carcinoma in-situ of the skin; and
- (4) melanoma in-situ.

The date of diagnosis is the date of biopsy or other test that generates a definite diagnosis of cancer that satisfies the policy definition above.

#### **skin cancer (non-melanoma and carcinoma-in-situ of the skin)**

A diagnosis of one of the two (2) cancers listed below.

- (1) carcinoma in-situ of the skin (melanoma in-situ or non-melanoma in-situ); or
- (2) non-melanoma skin cancer

The diagnosis must be confirmed with a valid pathology report from a certified pathologist and a report from a specialist, or, where appropriate, by a suitable clinical diagnosis.

All lesions which are histologically described as benign, non-malignant, pre-malignant, dysplasia, or atypical moles are not considered skin cancer (non-melanoma and carcinoma-in-situ of the skin).

The date of diagnosis is the date of biopsy or other pathological test, or the date of an appropriate clinical diagnosis that generates a diagnosis of cancer that satisfies the policy definition above.

#### **stroke**

A cerebrovascular incident resulting in permanent death of brain tissue due to intracranial hemorrhage or cerebral infarction due to embolism or thrombosis in an intracranial vessel. This event must result in permanent neurological deficit with persisting clinical signs and symptoms evidenced on physical examination by a physician at least 30 days after the event. The diagnosis must also be supported by findings on brain imaging and must be consistent with the diagnosis of a new stroke.

The following are excluded:

- (1) transient ischemic attacks (TIA) or reversible ischemic neurologic deficit (RIND);
- (2) brain damage due to an accident or injury;
- (3) disorders of the blood vessels affecting the eye including infarction of the optic nerve or retina;
- (4) ischemic disorders of the peripheral vestibular system; and
- (5) asymptomatic silent stroke found on imaging.

The date of diagnosis is the date of stroke, as confirmed by neurological evidence that satisfies the policy definition above.

#### **systemic lupus erythematosus (nephritis & cerebritis)**

A definite diagnosis of systemic lupus erythematosus (SLE) made by a specialist and based on clinically accepted criteria. There must also be evidence of lupus cerebritis or lupus nephritis where one (1) of the following is present:

- (1) a specialist must make the diagnosis of definite lupus nephritis that has caused significant permanent impairment of kidney function as evidenced by a calculated glomerular filtration rate of less than 30 ml/min, as measured on two occasions, one month apart; or
- (2) a specialist must make the diagnosis of definite lupus cerebritis that has caused permanent neurological deficit with persisting clinical signs and symptoms that are present for at least 90 days.

Headaches and psychiatric abnormalities are not considered under this definition as evidence of permanent neurological deficit with persisting clinical signs and symptoms.

Discoid lupus and medication induced lupus are excluded.

The date of diagnosis is the date the diagnosis of systemic lupus erythematosus is made by a specialist satisfying the policy definition above.

#### **systemic sclerosis (scleroderma)**

A systemic connective tissue disease causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs. A specialist must make the definite diagnosis of systemic sclerosis. This diagnosis must be supported by biopsy and serological evidence and the disorder must have reached systemic proportions to involve the heart, lungs or kidneys.

The following are excluded:

- (1) localized scleroderma (linear scleroderma or morphea); and
- (2) eosinophilic fasciitis.

The date of diagnosis is the date the diagnosis of systemic sclerosis is made by a specialist satisfying the policy definition above.

## **General Information**

### **What is your agreement with us?**

If you meet the eligibility and enrollment requirements, you are insured under the group policy shown on the specifications page. Your application is deemed a part of this certificate. This certificate summarizes the principal provisions of the group policy that affect your insurance coverage. The provisions summarized in this certificate are subject in every respect to the group policy.

Any statements made in your application will, in the absence of fraud, be considered representations and not warranties. Also, any statement made will not be used to void your insurance nor defend against a claim unless the statement is contained in the application.

This certificate is issued in consideration of your application and the payment of any required premium.

### **Can this certificate be amended?**

Yes. We retain the right to amend this certificate at any time without your consent. Any amendment will be without prejudice to any claim incurred for benefits prior to the date of the amendment.

### **Who is eligible for insurance?**

You are eligible for group critical illness insurance if you:

- (1) are a member of the eligible group of an eligible class as defined in the specifications page;
- (2) work for the employer for at least the number of hours per week shown as the minimum hours per week requirement on the specifications page;
- (3) have satisfied the employment waiting period as shown on the specifications page; and
- (4) meet the actively at work requirement as shown in the section entitled "What is the actively at work requirement?".

### **Are your dependents eligible for insurance?**

Yes. If you are insured for group critical illness coverage, your dependents are eligible for insurance.

### **What is the actively at work requirement?**

To be eligible to become insured or to receive an increase in the benefit amount, you must be actively at work, fully performing your customary duties for your regularly scheduled number of hours at the employer's normal place of business, or at other places the employer's business requires you to travel.

If you are not working due to illness or injury, you do not meet the actively at work requirement. If you are receiving sick pay, short-term disability benefits or long-term disability benefits, you do not meet the actively at work requirement.

If you are not actively at work on the date coverage would otherwise begin, or on the date an increase in your benefit amount would otherwise be effective, you will not be eligible for the coverage or increase until you return to active work. However, if the absence is on a non-work day, coverage will not be delayed provided you were actively at work on the work day immediately preceding the non-work day.

Except as otherwise provided for in this certificate, you are eligible to continue to be insured only while you remain actively at work.

Any insurance or increase in insurance which is elected or put in force while you are not actively at work will not be eligible for claim payment. You or your beneficiary will receive a refund of premium for any contributory insurance for which you were not eligible.

### **Are employees of associated companies eligible for insurance under the group policy?**

Yes. Employees of associated companies are eligible for insurance under the group policy subject to the employee and associated company meeting all eligibility requirements. The policyholder represents any associated company in all transactions pertaining to the group policy. The policyholder's acts or omissions and every notice given by us to the policyholder shall be binding on every associated company. When an associated company ceases its participation under the policy, the policy shall be considered to be terminated for all employees of the associated company. All provisions related to policy termination will apply to such employees.

### **Are retired employees eligible for insurance?**

If the policyholder's plan of insurance, as shown on the specifications page, does not specifically provide insurance for retired employees, a retired employee shall not be eligible to become insured, nor to have his or her insurance continued. If the policyholder's plan of insurance specifically provides insurance for retired employees, the minimum hours per week and actively at work requirements will not apply to such persons.

### **What is the dependent non-confinement requirement?**

If a dependent is hospitalized or confined because of illness or disease on the date his or her insurance would otherwise become effective, his or her effective date shall be delayed until he or she is released from such hospitalization or confinement. This does not apply to a newborn child. In no event will insurance on a dependent be effective before your insurance is effective.

### **Can your coverage be continued during sickness, injury, leave of absence or temporary layoff?**

Yes. Insurance may be continued on an insured employee who is not actively at work due to sickness, injury, leave of absence or temporary layoff, subject to the employer's practices and procedures, including the employer's limits on the length of continuation allowed for the type of absence. Continuation is contingent upon continued premium payment and is subject to the following maximum time frames:

- (1) if you are on a non-medical leave of absence or temporary layoff, insurance cannot be continued beyond 12 months from the last day you were actively at work; or
- (2) if you are on a medical leave of absence, insurance cannot be continued beyond the later of 12 months from the last day you were actively at work or attained age 65.

Continuation of insurance must be in accordance with practices and procedures that preclude individual selection.

Coverage during a leave of absence and upon return from a leave of absence shall meet all state and federal requirements. The above limits will be expanded if necessary in order to meet such requirements.

## Enrollment

### When can you elect or make changes to your insurance?

You must enroll in order to be insured for contributory coverage under the group policy. You can enroll for coverage within 31 days of when you first become eligible. After that period, you can only enroll for coverage or make changes during your annual open enrollment or within 31 days of a qualified status change event, as defined by the policyholder's plan rules.

### When will we require evidence of insurability?

Evidence of insurability is never required.

### When does your insurance become effective?

Your insurance becomes effective on the date all of the following conditions have been met:

- (1) you meet all eligibility requirements, including the actively at work requirement; and
- (1) for contributory insurance, you apply for the insurance on forms which are approved by us.

### When does insurance for a dependent become effective?

Insurance on a dependent becomes effective on the date when all of the following conditions have been met:

- (1) your insurance becomes effective;
- (2) the dependent meets all eligibility requirements; and
- (3) for contributory insurance, you apply for dependent coverage on forms which are approved by us.

### When will changes in your coverage amount be effective?

Requested increases in the amount of your contributory insurance are effective on the first day of the month following receipt of your request. Requested decreases in the amount of your contributory insurance are effective on the first day of the month following receipt of your request for a decrease.

In addition, elections made during an enrollment period will not become effective prior to the effective date for that enrollment.

## Premiums

### When and how often are your premium contributions due?

Unless the policyholder and we have agreed to some other premium payment procedure, any premium contributions you are required to make for contributory insurance are to be paid by you to the policyholder on a periodic basis.

### How is the premium determined?

The premium will be the applicable premium rate in force on the date premiums are due. The premium may also be computed by any other method on which the policyholder and we agree.

Premium rates are subject to change according to the provisions of the group policy.

### Can a premium be paid after the date it is due?

Yes. The group policy has a 31-day grace period. If a premium is not paid on or before the date it is due, that premium may be paid during the 31-day period following the due date. The insurance under the group policy will remain in effect during the 31-day grace period.

## Covered Condition Benefits

### What is the benefit amount for a covered condition?

The benefit amount for a covered condition will be a percentage of the insured's amount of insurance shown on the specifications page, subject to the overall maximum benefit.

### What is the initial occurrence benefit?

Subject to the conditions of this certificate, the initial occurrence benefit is payable upon diagnosis of the initial occurrence of a covered condition while an insured's coverage is in force.

### Can more than one initial occurrence benefit be paid?

Yes. An insured may be eligible for multiple initial occurrence benefits up to the overall maximum benefit amount shown on the specifications page. If an insured is diagnosed with an initial occurrence of a different covered condition that occurs more than 30 days after an initial occurrence of a covered condition was diagnosed, a separate initial occurrence benefit may be paid. If an insured is diagnosed with a covered condition and a subsequent diagnosis occurs within 30 days, the benefit paid will be the greatest of the covered condition benefits as shown on the specifications page; if the benefit amount for all covered conditions is the same, you can choose the critical illness benefit to be paid. Except as described below for recurrence benefits, no benefit will be payable for a diagnosis of a covered condition that satisfies the same covered condition definition for which an initial occurrence benefit has been paid.

## What is the recurrence benefit?

The recurrence benefit will be paid, as shown on the specifications page, if an initial occurrence benefit has been paid and an insured is diagnosed again for the same covered condition. The total amount of benefits paid will not exceed the overall maximum benefit amount shown in the specifications page.

## What are the requirements for a recurrence benefit?

For any recurrence benefit, all four (4) of the following requirements must be satisfied:

- (1) the subsequent covered condition is one of the covered conditions that qualifies for a recurrence benefit;
- (2) the subsequent covered condition satisfies the requirements as stated in the covered condition definitions section and any additional requirements stated below;
- (3) the subsequent covered condition is diagnosed after the benefit separation period; and
- (4) the subsequent diagnosis must be for a recurrence of a covered condition while the insured's coverage is in force.

For certain covered conditions, additional requirements must be satisfied as follows:

### *Full Benefit Cancer*

The full benefit cancer for which an initial occurrence benefit was paid, was completely treated, and is in full remission prior to the date of the subsequent diagnosis as evidenced by clinical, radiological, and biochemical proof.

This recurrence benefit will pay out if the second cancer is either a recurrence of the same cancer or a new cancer that meets the definition of full benefit cancer.

### *Partial Benefit Cancer*

The partial benefit cancer for which an initial occurrence benefit was paid, was completely treated, and is in full remission prior to the date of the subsequent diagnosis as evidenced by clinical, radiological, and biochemical proof.

This recurrence benefit will pay out if the second cancer is either a recurrence of the same cancer or a new cancer that meets the definition of partial benefit cancer.

### *Major Organ Failure*

If you were paid an initial benefit for major organ failure, then a recurrence benefit for a second major organ failure of the same organ or a different major organ may be paid if a specialist reports that you had no evidence of major organ failure at some point after the initial occurrence and prior to the date of the subsequent diagnosis, as supported by clinical, radiological, and biochemical proof.

## Can an insured receive more than one recurrence benefit?

Yes. Multiple recurrence benefits are payable for an insured, but only one recurrence benefit is available per covered condition. The total amount of benefits paid shall not exceed the overall maximum benefit amount shown in the specifications page.

## What special rules apply if this insurance is replacing similar insurance issued by a prior carrier?

This section explains how the replacement of the prior group critical illness policy will affect people who were insured under the prior policy and are now insured under the Securian Life policy.

For the amount of insurance that was in effect with the prior carrier, each insured who was covered under the prior policy on the date that it ended and who is eligible for insurance under the new Securian Life policy will be:

- (1) insured under the Securian Life policy on the policy effective date; and
- (2) credited for the time such insured has been continuously insured under the prior policy on the date it ended in determining whether a covered condition is subject to the benefit waiting period in this certificate.

## Exclusions and Limitations

### Is there an overall maximum benefit amount?

Yes. The total of all benefit payments for an insured cannot exceed the overall maximum benefit amount shown on the specifications page.

### Are there any other exclusions that apply?

Yes. In no event will we pay benefits where the insured's covered condition is caused directly or indirectly by, results in whole or in part from, or for which there is contribution from any of the following:

- (1) self-inflicted injury, self-destruction, or autoeroticism, whether sane or insane;
- (2) suicide or attempted suicide, whether sane or insane;
- (3) an insured's participation in, or attempt to commit, a crime, assault, felony, or any illegal activity, regardless of any legal proceedings thereto;
- (4) the use of alcohol;
- (5) the use of prescription drugs, non-prescription drugs, illegal drugs, medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected;
- (6) motor vehicle collision or accident where the insured is the operator of the motor vehicle and the insured's blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or

- (7) war or any act of war, whether declared or undeclared.

### **Are there any additional limitations that apply?**

Yes. Benefits are not payable for any care, treatment or diagnostic measures which were received outside of the United States or a United States territory.

## **Claims**

### **What notice of claim must be provided?**

Written notice of claim must be given to us within 20 days after the diagnosis of a covered condition, or as soon thereafter as reasonably possible. Notice given by or on the insured's behalf to us at our home office or to any authorized agent of ours, with information to identify the insured, shall be deemed notice to us.

### **Will claim forms be provided?**

Upon receipt of notice of claim, we will provide a claim form. If the claim form is not provided within 15 days after the insured has given notice of claim, we will deem the insured to have complied with the requirements for filing proof of a covered condition if the insured submits, within the time period for filing proof of a covered condition, written proof of the occurrence, character and extent of the covered condition for which claim is made which is satisfactory to us.

### **When is proof of a covered condition required?**

Written proof of a covered condition satisfactory to us must be provided to us within 90 days of the diagnosis of a covered condition. Failure to provide proof of a covered condition within this time will not invalidate or reduce a claim if it was not reasonably possible to provide proof within this 90 day period. However, proof must be provided within 1 year of the diagnosis, except in the absence of legal capacity.

### **When will the benefit be paid?**

We will pay a benefit for a covered condition after receipt at our home office of written proof of a covered condition which meets all policy requirements and is satisfactory to us. You are responsible for all costs associated with claim form(s) completion and the submission of your claim.

### **To whom will benefits be paid?**

All benefits including dependent's benefits will be paid to you, if you are living. If you die before the claim is paid, benefits will be paid to your estate.

### **What are our physical examination rights?**

After an insured has filed a claim and provided at his or her expense all requested claim forms and records, we have the right to have the insured examined by a physician of our choice and at our expense. This right may be exercised as often as reasonably necessary while an insured has a claim pending with us.

## **Termination**

### **When does your coverage terminate?**

Coverage ends on the earliest of the following:

- (1) the date you no longer meet the eligibility requirements;
- (2) 31 days (the grace period) after the due date of any premium which is not paid;
- (3) the last day for which premium contributions have been paid following your request to cancel your coverage; or
- (4) the date the group policy ends, unless coverage is continued according to the terms of the Portability Certificate Supplement.

### **When does an insured dependent's coverage terminate?**

An insured dependent's coverage ends on the earliest of the following:

- (1) the date the dependent no longer meets the eligibility requirements;
- (2) 31 days (the grace period) after the due date of any premium contribution which is not paid;
- (3) the last day for which premium contributions have been paid following your written request that insurance on your eligible dependents be terminated; or
- (4) the date you are no longer covered under the group policy, unless the dependent's coverage is continued according to the terms of the Portability Certificate Supplement.

You must notify us or your employer when you no longer have dependents eligible for coverage under this certificate so that premiums may be discontinued. All premiums paid for dependents who are no longer eligible for coverage under this certificate will be refunded without any payment of claim.

### **Can your coverage be reinstated?**

If coverage terminates due to non-payment of premium, it may be reinstated.

Reinstatement must occur while the insured is living and within 6 months from the date of coverage termination. To reinstate, all back due premiums must be paid. After all back due premiums are paid, your coverage will be reinstated as if there were no lapse in coverage. Any loss that occurred during the lapse period will be covered. No evidence of the insured's insurability will be required for reinstatement within the first 31 days following termination but satisfactory evidence of insurability will be required from the 32nd day to 6 months from the date of termination.

## **Additional Information**

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### **Can your insurance coverage be contested?**

Yes. If an insured experiences a covered condition within two years of the original effective date of coverage or increase in coverage, we will verify the accuracy of the information provided during the application process. If we discover a material misrepresentation, the affected coverage will be rescinded and an otherwise valid claim will be denied. This two year period will be extended by fraud or as otherwise allowed by applicable laws.

### **Is the policyholder required to maintain records?**

Yes. The policyholder is required to maintain adequate records of any information necessary for us to administer the policy, and shall provide access to such records when required for us to administer the policy. If a clerical error is made in keeping records on the insurance under the group policy, it will not affect otherwise valid insurance.

A clerical error does not continue insurance which is otherwise stopped, make insurance effective when it should not have been or change the amount of insurance provided by the provisions of the policy and no claim shall be paid on amounts affected by a clerical error. If an error causes a change in premium payment, a fair adjustment will be made.

### **Will the provisions of this certificate conform with applicable state law?**

Yes. If any provision in this certificate, or in the provisions of the group policy, is in conflict with the applicable laws of the state governing the certificates or the group policy, the provision will be deemed to be amended to conform to such laws.

### **What if an insured's age has been misstated?**

If an insured's age has been misstated, all amounts payable will be adjusted to that amount which the premium would have purchased at the correct age. This will be determined by applying the ratio of the paid premium over the required premium to the initial amount of insurance.

### **Can this insurance be assigned?**

No. Insurance coverage under the group policy cannot be assigned.

### **What is the policy interpretation right and authority?**

The following applies only when the administration of the policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

Securian Life has the exclusive right and authority, in its sole discretion, to interpret the group policy and decide all matters arising thereunder. Securian Life's exercise of that authority shall be conclusive and binding on all persons unless it can be shown that the determination was arbitrary and capricious.

# Health and Wellness Benefit Certificate Supplement

Securian Life Insurance Company  
400 Robert Street North • St. Paul, Minnesota 55101-2098

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## General Information

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This certificate supplement is subject to every term, condition, exclusion, limitation, and provision of the certificate unless otherwise expressly provided for herein.

### What does this supplement provide?

This supplement provides for an additional benefit to be paid if you or your covered spouse or covered child undergo one of the health and wellness screenings listed below.

### What are the conditions to receive a benefit payment?

You are eligible to receive a health and wellness benefit payment under this supplement if:

You or a covered spouse or covered child undergo one of the following screenings while not in a hospital on an inpatient basis:

- annual physical exam;
- biopsies for cancer;
- blood test to determine total cholesterol;
- blood test to determine triglycerides;
- bone marrow testing;
- breast MRI;
- breast ultrasound;
- breast sonogram;
- carotid Doppler;
- clinical testicular exam;
- colonoscopy;
- digital rectal exam (DRE);
- Doppler screening for cancer;
- Doppler screening for peripheral vascular disease;
- echocardiogram;
- electrocardiogram (EKG);
- endoscopy;
- fasting blood glucose test;
- fasting plasma glucose test;
- flexible sigmoidoscopy;
- hemoccult stool specimen;
- hemoglobin A1C;
- human papillomavirus (HPV) vaccination;
- lipid panel;
- mammogram;
- oral cancer screening;
- pap smears or thin prep pap test;
- pharmacologic stress testing;
- prostate-specific antigen (PSA) test;
- serum cholesterol test to determine LDL and HDL levels;
- serum protein electrophoresis;
- skin cancer biopsy;
- skin exam for cancer screening;
- stress test on bicycle or treadmill;
- tests for sexually transmitted infections (STI's);
- thermography;
- two hour post-load plasma glucose test;
- ultrasounds for cancer detection;
- ultrasound screening of the abdominal aorta for abdominal aortic aneurysms; or
- virtual colonoscopy.

Employer sponsored wellness screening benefits conducted at the employer's place of business are not eligible for payment.

## Payment of Benefit

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### What is the benefit amount?

The benefit amount for a covered health and wellness screening for you, your covered spouse and covered child is shown on the specifications page.

### Is there a waiting period to receive health and wellness benefits?

No. There is no waiting period.

### When will the health and wellness benefit be payable?

We will pay the health and wellness benefit after receipt at our home office of proof satisfactory to us that you or your covered spouse or covered child have undergone one of the covered screenings listed in this supplement. The benefit will be paid in a single sum.

### To whom do we pay the benefit?

Benefits will be paid according to the claims section of your certificate.

### Is there a limit to how many payments you can receive annually?

Yes. You can only receive one health and wellness benefit per year, and your covered spouse can only receive one health and wellness benefit per year. Regardless of the number of children covered under the certificate, only one child health and wellness benefit will be paid per year.

**Are benefits under this supplement subject to the overall maximum benefit amount?**

No. Benefits paid under this supplement do not reduce the overall maximum benefit payable under the group policy.

## **Termination**

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**When does your coverage under this supplement terminate?**

Your coverage ends on the earliest of the following:

- (1) the date your coverage under the certificate terminates; or
- (2) the date this supplement terminates.



Secretary



President

# Portability Certificate Supplement

Securian Life Insurance Company

400 Robert Street North • St. Paul, Minnesota 55101-2098

## General Information

This certificate supplement is subject to every term, condition, exclusion, limitation and provision of the certificate unless otherwise expressly provided for herein.

### What does this supplement provide?

This supplement provides for continuation of insurance if an insured no longer meets the eligibility requirements of the certificate, except as provided for herein.

To continue coverage under the provisions of this supplement, the insured must make a written request and make the first premium contribution within 31 days after insurance provided by the group policy would otherwise terminate. Evidence of insurability will not be required. Coverage will remain in effect during the 31 day election period but not beyond this unless all portability election requirements are met. Upon satisfactory completion of all portability election requirements, coverage provided by this supplement will then be deemed effective retroactive to the beginning of the 31-day period. This date is considered to be the insured's portability date and the insured is then considered to have portability status.

### Who is eligible to continue insurance under this supplement?

An insured employee is eligible to continue group critical illness insurance under the terms of this supplement if he or she no longer meets the eligibility requirements of the certificate due to any of the following:

- (1) the employee terminates employment, including retirement;
- (2) the employee's number of working hours are reduced;
- (3) the employee is no longer in a class eligible for insurance or is on a leave or layoff; or
- (4) a class or group of employees insured under the policy are no longer considered eligible and there is no successor plan for that class or group. Successor plan means an insurance policy or policies provided by us or another insurer that replaces insurance provided under the policy.

An insured dependent is eligible to continue group critical illness insurance under this supplement if he or she no longer meets the eligibility requirements of the certificate due to any of the following:

- (1) the employee terminates employment, including retirement;
- (2) the employee's number of working hours are reduced;
- (3) the employee is no longer in a class eligible for insurance or is on a leave or layoff;

- (4) a class or group of employees insured under the policy are no longer considered eligible and there is no successor plan for that class or group. Successor plan means an insurance policy or policies provided by us or another insurer that replaces insurance provided under the policy;
- (5) legal separation or divorce;
- (6) the dependent ceases to be an eligible dependent; or
- (7) the employee's death.

Regardless of whether an insured is otherwise eligible under this supplement to continue, an insured will not be eligible to request coverage under this supplement if he or she:

- (1) has attained the age of 120;
- (2) is an employee and was not actively at work due to sickness or injury on the date immediately preceding his or her portability date;
- (3) loses eligibility due to a class or group of employees no longer being eligible under the policy and there is a successor plan for that class or group of employees; or
- (4) loses eligibility due to termination of the group policy.

### What insurance can be continued under this supplement?

Group critical illness insurance may be continued under this supplement. If an employee elects to continue his or her own coverage according to the provisions of this supplement, he or she may also elect to continue insurance for any other individual insured under his or her certificate.

If a former spouse continues his or her own coverage according to the provisions of this supplement, he or she may also elect to continue insurance on any insured children, provided the employee is not otherwise insuring the children.

Benefits will be paid in accordance with the provisions of the certificate with the following exception: in the event a spouse or child ports his or her own coverage, benefits will be paid to the spouse or child who ports their coverage, if living, otherwise in accordance with the "To whom will benefits be paid?" item under the Claims section of the certificate.

All certificate supplements will terminate upon porting.

### What is the amount of insurance that can be continued under this supplement?

The amount of insurance that can be continued under this supplement is shown on the specifications page.

**Can an insured request a change in the amount of insurance continued under this supplement?**

Yes. The insured employee, and a dependent who ports coverage on his or her own as provided for under the terms of this supplement, may elect to reduce the amount of critical illness insurance subject to the minimum amount of insurance shown on the specifications page. The amount of insurance continued under this supplement will never increase.

**How will premiums be paid?**

Premiums will be paid directly to us on a monthly, quarterly, semi-annual, or annual basis and will be subject to an administrative charge per billing period.

**Can the premium rate change?**

Yes. The premium rates for ported coverage may be different than the premium rates for active employees, and are not subject to the premium rate provision of the policy.

**What happens if an insured again becomes eligible under the certificate?**

If an insured is continuing coverage under the terms of this supplement, and again meets the eligibility requirements of the certificate the insured shall no longer be considered to have portability status. Insurance may be continued only under the terms of the certificate, not including this supplement, unless and until the insured no longer meets the eligibility requirements of the certificate and again returns to portability status as provided for herein.

**When will insurance continued under this supplement terminate?**

An insured's insurance being continued under this supplement will terminate on the earliest of the following:

- (1) the insured's 120th birthday;
- (2) the date the insured again meets the eligibility requirements of the certificate, not including the terms of this supplement;
- (3) the date upon which the insured's overall maximum benefit amount of insurance has been paid;
- (4) in the case of a dependent child or a spouse, the date your coverage is no longer being continued under this supplement or the date the spouse or child ceases to be eligible as defined under the terms of your certificate, unless the spouse or child has ported coverage on their own as provided for under the terms of this supplement;
- (5) the date the group policy is terminated;
- (6) 31 days after the due date of any premium contribution which is not made;
- (7) 31 days after we give written notice of our intent to terminate ported coverage for a group or class of individuals; or
- (8) the date the insured requests to terminate his or her coverage being continued under this supplement.



Secretary



President

# Trauma Benefit Certificate Supplement

Securian Life Insurance Company  
400 Robert Street North • St. Paul, Minnesota 55101-2098

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## General Information

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This certificate supplement is subject to every term, condition, exclusion, limitation, and provision of the certificate unless otherwise expressly provided for herein.

### What does this supplement provide?

This supplement provides benefits for additional covered conditions. It provides a benefit payment for an initial occurrence for a traumatic event, subject to the overall maximum benefit amount shown on the specifications page if an insured suffers a traumatic event while coverage is in force.

### What is a traumatic event?

A traumatic event occurs when an insured suffers an illness or accidental injury and as a result the insured suffers one of the traumas defined below.

### What is an accidental injury?

An accidental injury is a bodily injury which:

- (1) is sustained as a direct result of an unintended, unexpected and unforeseen accident that occurs while the insured's coverage under this certificate is in force; and
- (2) directly and independently of all other causes, causes a covered loss.

### What is the trauma benefit amount?

The trauma benefit amount is shown on the specifications page.

## Trauma Definitions

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### coma

A state of unconsciousness with no reaction to external stimuli or internal needs. The coma must have resulted in permanent neurological deficit with persisting clinical signs and symptoms that are present on exam at least 3 months from the onset of the coma. Medically induced coma and coma resulting directly from alcohol or drug abuse are excluded.

The date of diagnosis is the date the insured entered the coma, as made by a specialist satisfying the definition above.

### blindness

The permanent loss of vision in both eyes as a result of illness or accidental injury. The diagnosis of either:

- (1) sight in the better eye reduced to a best corrected visual acuity of less than 20/200; or
- (2) visual field restriction to 20 degrees or less in both eyes; and
- (3) must be clinically confirmed by a specialist.

The blindness must not be correctable by aides or surgical procedures.

The date of diagnosis is the date the diagnosis of blindness is made by a specialist satisfying the definition above.

### loss of hearing

The bilateral and permanent loss of hearing as a result of illness or accidental injury such that sounds at or below 90 decibels cannot be heard at all frequencies. The diagnosis must be made by a specialist as diagnosed by audiometric testing. The deafness must not be correctable by aides or surgical procedures.

The date of diagnosis is the date the diagnosis of hearing loss is made by a specialist satisfying the definition above.

### loss of speech

The total and permanent loss of the ability to produce intelligible speech as a result of permanent damage to the larynx or its nerve supply from the speech centers of the brain caused by accidental injury, tumor or illness. It does not include loss of speech due to stroke, full benefit cancer or psychiatric causes. The loss of speech must not be correctable by aides or surgical procedures.

The date of diagnosis is the date the diagnosis of speech loss is made by a specialist satisfying the definition above.

### paralysis

The total and irreversible loss of use of two or more limbs through paralysis as a result of accidental injury or illness. This includes quadriplegia, hemiplegia, and paraplegia. The paralysis must be supported by appropriate neurological evidence. A specialist must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 90 days. Paralysis due to stroke or psychiatric related causes is excluded.

The date of diagnosis is the date the diagnosis of paralysis is made by a specialist satisfying the definition above.

**severe burns**

The diagnosis by a specialist that at least 20% of the body surface area has sustained third degree burns involving the full thickness of the skin.

The date of diagnosis is the date the diagnosis of severe burns is made by a specialist satisfying the definition above.

## Termination

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**When does coverage under this supplement terminate?**

This coverage ends on the earliest of the following:

- (1) the date an insured's coverage under the certificate terminates; or
- (2) the date this supplement terminates.



Secretary



President

**Securian Life Insurance Company** • A Stock Company

400 Robert Street North • St. Paul, Minnesota 55101-2098

**GROUP CRITICAL ILLNESS CERTIFICATE OF INSURANCE**