Group Critical Illness Certificate of Insurance

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

This certificate applies to insureds in the state of TX.

POLICYHOLDER:	AHS Management Company, Inc. dba Ardent Health Services
POLICY NUMBER:	76387
POLICY EFFECTIVE DATE:	January 1, 2025
CERTIFICATE EFFECTIVE DATE:	This certificate represents the plan in effect as of January 1, 2025.
	This certificate replaces any and all certificates previously issued to you under the group policy. Please replace any certificate previously issued to you with this new certificate.
ASSOCIATED COMPANIES:	All subsidiaries and affiliates reported to Securian Life by the policyholder for inclusion in the policy.
POLICY SITUS STATE:	The policy was issued and delivered in Tennessee.

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 PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010. YOU SHOULD CONFIRM WITH YOUR TAX ADVISOR THAT THIS INSURANCE DOES NOT IMPACT ELIGIBILITY TO CONTRIBUTE TO AN HSA, IF APPLICABLE TO YOU.

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 published by Medicare.gov and available from us.

The Company may change the required premiums as a condition of any renewal of this group policy.

Read Your Certificate Carefully

If you meet the eligibility and enrollment requirements herein, you are insured under the group policy shown in the Certificate Specification section. This certificate is not a contract nor does it modify or amend the group policy. 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. The group policy is the contract between the policyholder and Securian Life. 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.

Renée D. Montz
Secretary

President

GROUP CRITICAL ILLNESS CERTIFICATE OF INSURANCE • NONPARTICIPATING

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

Securian Life Insurance Company
To get information or file a complaint with your insurance company:
Call: Consumer Complaints, toll free at: 1-855-651-3500
Email: ConsumerComplaints@securian.com
Mail: 400 Robert Street North, St. Paul, MN 55101-2098

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:
Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros. Si no lo hace, podría perder su derecho para apelar.

Securian Life Insurance Company
Para obtener información o para presentar una queja ante su compañía de seguros:
Llame a: Consumer Complaints, teléfono gratuito al 1-855-651-3500
Correo electrónico: ConsumerComplaints@securian.com
Dirección postal: 400 Robert Street North, St. Paul, MN 55101-2098

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:
Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

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ENTIRE CONTRACT

If you meet the eligibility and enrollment requirements as shown herein, you are insured under the group policy**.** 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 (if any) 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 a copy of the written instrument containing the statement has been provided to you, or in the event of your death or incapacity, to your beneficiary or personal representative.

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

CERTIFICATE SPECIFICATIONS

Group:
The group is composed of all active employees of the policyholder working in the United States in the following class:

Class 1: All eligible active employees

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

Associated companies' eligibility:
Employees of associated companies may be eligible for insurance under the group policy. The policyholder must report any associated companies to us for inclusion 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.

Minimum hour per week requirement:
The number of hours your employer requires you to be actively at work in order to be eligible for coverage under this certificate. Your minimum hour per week requirement is 20 hours per week.

Employment waiting period:
The period of continuous employment with the employer that you must satisfy prior to becoming eligible for coverage under this certificate. Your employment waiting period is the period commencing with your date of employment and ending with the first day of the month next following or coinciding with your completion of 30 days of continuous employment. You are not eligible to become insured until the first day following the waiting period.

Benefit Waiting Period:
None.

Eligibility:
You are eligible for group critical illness insurance if you meet all the following requirements:

(1) are a member of the eligible group and of an eligible class;
(2) work for the employer for at least the number of hours per week shown as the minimum hours per week requirement;
(3) have satisfied the waiting period, if any; and
(4) meet the actively at work requirement.

Dependent eligibility:
If you are insured for group critical illness insurance coverage, your dependents are eligible for insurance.

Enrollment period:
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.

You will become insured on the date you meet all eligibility requirements.

Effective date of coverage:
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
(2) for contributory coverage, application is made in accordance with the application methods agreed upon by the policyholder and us.

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.

Double coverage:
If you are eligible as an employee under the policy, or insured under the portability provisions, you are not eligible as a dependent. Only you can insure an eligible dependent child.

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-workday, coverage will not be delayed provided you were actively at work on the workday immediately preceding the non-workday.

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.

Dependent non-confinement requirement:
If a dependent is hospitalized or confined because of an illness or injury on the date their insurance would otherwise become effective, their effective date shall be delayed until they are 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.

Continuation during a leave of absence:
Insurance may be continued when you are not actively at work due to illness, 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.
(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.

Changes in your coverage amount:
Requested increases in the amount of your contributory insurance are effective on the date as shown below in the Annual open enrollment and Qualified status changes sections. 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.

Change of insurance carriers
If you are not actively at work due to illness or injury on the date the policyholder changes its insurance carrier to us, and you were covered under the policyholder's prior policy at the time coverage under us became effective, we will provide coverage under our insurance policy.

Coverage provided under our insurance policy is subject to payment of premiums.

Guaranteed issue:
Guaranteed issue is the maximum amount of insurance you, your spouse, or child can receive without evidence of insurability when first eligible under the plan provided enrollment is made within the enrollment period.

For an employee:
- Supplemental insurance: All supplemental insurance is guaranteed issue.

For a spouse:
- Supplemental insurance: All supplemental insurance is guaranteed issue.

For a child:
- Supplemental insurance: All supplemental insurance is guaranteed issue.

For an eligible employee and eligible dependent who was covered for Critical Illness under the employer's plan immediately prior to the policy effective date shown above, the guaranteed issue for critical illness is the amount of insurance in force under that prior plan immediately prior to the policy effective date.

Evidence of insurability:
Evidence of insurability will be required if:

(1) the amount of insurance requested is greater than the guaranteed issue limit; or
(2) the insurance is contributory and you enroll after the required period shown in the Plan of Insurance section; or
(3) you request an increase in your insurance.

Annual open enrollment:
During the policyholder's annual open enrollment, you may elect or change your and your dependent's critical illness insurance benefit plan. All coverage is guaranteed issue.
Coverage will be effective on the January 1 following the annual open enrollment, subject to the actively at work requirement for employees and the hospitalization/non-confinement requirement for dependents.

Qualified Status Changes:
If you experience one of the qualified status change events listed below you may elect or change your and your dependent's critical illness insurance benefit plan provided enrollment is made within 31 days of the status change. All coverage is guaranteed issue.
Qualified status change for purposes of the enrollment opportunities described above means marriage or establishment of a legal partnership, birth of a child, filing of a petition to adopt a child, entering into a suit in which you are seeking to adopt a child, adoption of a child, placement of a foster child or acquisition of a stepchild.

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

Employee Benefit Schedule

Employee Supplemental Group Critical Illness Insurance

Eligible Class	Employee Supplemental Group Critical Illness Insurance Benefit Plan
Class 1	An amount elected by you from the following options: $10,000, $20,000, or $30,000.

Contributory/Non-Contributory: Supplemental critical illness insurance is contributory insurance.

Retirement Termination: All insurance terminates at employee's retirement, except as otherwise outlined in this certificate.

Spouse Benefit Schedule

You must be insured for supplemental critical illness insurance in order to elect spouse critical illness insurance.

Spouse Supplemental Group Critical Illness Insurance

Eligible Class	Spouse Supplemental Group Critical Illness Insurance Benefit Plan
Class 1	100% of your amount of supplemental critical illness insurance.

Contributory/Non-Contributory: Supplemental critical illness insurance is contributory insurance.

Retirement Termination: All insurance terminates at employee's retirement, except as otherwise outlined in this certificate.

Child Benefit Schedule

You must be insured for supplemental critical illness insurance in order to elect child critical illness insurance.

Child Supplemental Group Critical Illness Insurance

Eligible Class	Child Supplemental Group Critical Illness Insurance Benefit Plan
Class 1	50% of your amount of supplemental critical illness insurance.

Contributory/Non-Contributory: Supplemental critical illness insurance is contributory insurance.

Retirement Termination: All insurance terminates at employee's retirement, except as otherwise outlined in this certificate.

Automatic Child Coverage: If you currently have dependent child coverage and you have a newborn child, grandchild, adopted child, or stepchild, then your newborn child, grandchild, adopted child, or stepchild will be automatically covered for the amount of child coverage outlined in the Plan of Insurance section from date of live birth, adoption, or the date you acquire a stepchild.

If you currently have dependent child coverage and you have a foster child, child of legal ward, a child of court-appointed guardianship, or a child of court-ordered custody or administrative order placed with you , the child will be automatically covered for the amount of child coverage outlined in the Plan of Insurance section from date the child becomes eligible according to the definition of child outlined within the Definition Section of this certificate.

If you currently do not have dependent child coverage and you have a newborn child, grandchild, adopted child, or stepchild, your newborn child, grandchild, adopted child, or stepchild will automatically be covered for the amount of child coverage outlined in the Plan of Insurance section for the first 61 days following the date of live birth, the date of adoption, or the date you acquire a stepchild, unless you previously declined to enroll for dependent child coverage for your eligible children. The coverage will terminate at the end of the 61 day period unless you apply for dependent child coverage within the 61 days of the live birth, the date of adoption, or the date you acquire a stepchild, and pay the additional premium for coverage.

If you currently do not have dependent child coverage and you have a foster child, child of legal ward, a child of court-appointed guardianship, or a child of court-ordered custody or administrative order placed with you, the child will automatically be covered for the amount of child coverage outlined in the Plan of Insurance section for the first 61 days as of the date the child is eligible according to the definition of child outlined within the Definitions section of this certificate, unless you previously declined to enroll for dependent child coverage for your eligible children. The coverage will terminate at the end of the 61 day period unless you apply for dependent coverage within 61 days of the child becoming eligible according to the definition of child outlined within the Definition Section of this certificate.

NOTE: If you had previously declined to enroll in dependent child coverage for your eligible children, you may still elect child coverage for any newly eligible child according to the enrollment period rules shown within the Certificate Specifications section of this certificate.

PLAN OF INSURANCE – ADDITIONAL BENEFITS

Employee Additional Benefit Schedule

Employee Supplemental Wellness Screening Benefit

Eligible Class	Supplemental Wellness Screening Benefit
Class 1	$50

Employee Portability Benefit

Eligible Class	Portability Benefit
Class 1	**Minimum Amount:** The lowest level of coverage. **Maximum Amount:** An amount that does not exceed the lesser of your amount of coverage in force on your portability date or $30,000.

Spouse Additional Benefit Schedule

Spouse Supplemental Wellness Screening Benefit

Eligible Class	Supplemental Wellness Screening Benefit
Class 1	$50

Spouse Portability Benefit

Eligible Class	Portability Benefit
Class 1	**Minimum Amount:** The lowest level of coverage. **Maximum Amount:** An amount that does not exceed the lesser of your spouse's amount of insurance in force on their portability date or $30,000.

Child Additional Benefit Schedule

Child Supplemental Wellness Screening Benefit

Eligible Class	Supplemental Wellness Screening Benefit
Class 1	$50

Child Portability Benefit

Eligible Class	Portability Benefit
Class 1	**Minimum Amount:** The lowest level of coverage. **Maximum Amount:** An amount that does not exceed the lesser of your child's amount of coverage in force on their portability date or $15,000.

INITIAL OCCURRENCE AND RECURRENCE BENEFITS

The benefit amount for a covered critical illness condition will be a percentage of the insured's amount of insurance or the amount as shown in the Plan of Insurance section listed above.

Initial Occurrence Benefit
The initial occurrence benefit is payable upon meeting the diagnosis requirements of a covered condition for the first time after the effective date and while coverage is in force.

If the covered condition is invasive or non-invasive cancer, any subsequent diagnosis of invasive or non-invasive cancer which is separate and unrelated to a previously diagnosed invasive or non-invasive cancer will be treated as an initial occurrence.

An insured may be eligible for multiple initial occurrence benefits shown in the Plan of Insurance section. If an insured is diagnosed with an initial occurrence of a different covered critical illness condition, a separate initial occurrence benefit may be paid.

A second benefit will not be paid for the same covered critical illness condition except as described under the Recurrence Benefit provision.

Recurrence Benefit
The recurrence benefit will be paid, as shown on the Plan of Insurance section, if an initial occurrence benefit has been paid and an insured is diagnosed again for the same covered critical illness condition.

For any recurrence benefit, all of the following requirements must be satisfied:

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

Before a recurrence benefit is payable, the benefit separation period requirement must be met. The benefit separation period for a recurrence benefit is the period of time that begins with the diagnosis date of a covered condition for which a benefit is payable. Your benefit separation period is 1 month.

Multiple recurrence benefits are payable for an insured, but only one recurrence benefit is available per covered condition.

For *Invasive Cancer* or, *Non-Invasive Cancer*, additional requirements must be met in order to receive benefits. The additional requirements are as follows:

- *Invasive or non-invasive Cancer*
  The 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 subsequent cancer is a recurrence of the same cancer. If the subsequent cancer is a new cancer that is completely unrelated to the original initial covered invasive or non-invasive benefit cancer, then it will be treated as a new initial covered invasive or non-invasive benefit cancer.

The replacement of the prior group critical illness policy will affect people who were insured under the prior policy and are now insured under our critical illness policy.

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

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

COVERED CRITICAL ILLNESS CONDITION BENEFITS

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

Covered Critical Illness Condition	Initial Occurrence Benefit	Recurrence Benefit
Alzheimer's disease*	25%	None
Amyotrophic lateral sclerosis (ALS) and other motor neuron disease*	25%	None
Aneurysm	25%	25%
Benign brain tumor	100%	100%
Blindness*	100%	None
Cerebral palsy*	100%	None
Coma	25%	25%
Coronary artery disease needing surgery or angioplasty	25%	25%
COVID-19 disease of specified severity	$3,000	$3,000
Cystic fibrosis*	100%	None
End stage renal disease (kidney failure)	100%	100%
Heart attack	100%	100%
Heart valve disease	25%	25%
Infertility*	25%	None
Invasive cancer	100%	100%
Major organ failure	100%	100%
Multiple sclerosis*	25%	None
Muscular dystrophy*	100%	None
Non-Invasive cancer	25%	25%
Occupational Hepatitis	100%	100%

Occupational HIV infection*	100%	None
Paralysis	100%	100%
Parkinson's disease*	25%	None
Poliomyelitis (Polio)*	100%	None
Sepsis	25%	25%
Sickle cell anemia*	100%	None
Skin cancer (non-melanoma and carcinoma in-situ of the skin)	$250	None
Stroke	100%	100%

*****Not all benefits are medically able to meet the definition of recurrence, including Alzheimer's disease, Amyotrophic lateral sclerosis (ALS) and other motor neuron diseases, Blindness, Cerebral palsy, Cystic fibrosis, Infertility, Multiple sclerosis, Muscular dystrophy, Occupational HIV infection, Parkinson's disease, Poliomyelitis (polio), Sickle cell anemia.

DEFINITIONS

Any term used in this certificate is given the meaning as defined in this section unless otherwise defined in another provision of this certificate.

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 reported to and agreed to by us to participate under the group policy.

child or children
Your or your spouse's:

(1) natural child;
(2) adopted child;
(3) stepchild;
(4) foster child;
(5) grandchild;
(6) legal ward;
(7) a child in your or your spouse's court-appointed guardianship**;**
(8) a child in your or your spouse's court-ordered custody; or administrative order; or
(9) a child for whom you have been ordered to provide medical support.

Children are eligible from the moment of live birth (stillborn or unborn children are not eligible) to the attainment of age 26. Children age 26 or older are eligible as a dependent child provided the child is physically or mentally incapable of self-support, was incapable of self-support prior to age 26 and remains physically dependent on you for their support and maintenance. Coverage on a qualified dependent child age 26 or older that continues beyond limiting age shall remain at the child premium rate. If you are a newly eligible employee, you may insure your child who is over the age of 26 provided the child is physically or mentally incapable of self-support, was incapable of self-support prior to age 26 and remains financially dependent on you for their support and maintenance.

Adopted child includes children for whom you or your spouse have filed a petition to adopt, or for whom you or your spouse are a party to a suit in which you are seeking to adopt the child. Children for whom you or your spouse 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 is effective from the earliest of adoption, placement for adoption, the date of a suit seeking adoption, or filing of the petition to adopt.

Foster child includes a child from the moment of placement in the foster home.

Grandchild means a grandchild:

(1) who is unmarried;
(2) younger than 26 years of age; and
(3) is dependent on you for federal income tax purposes at the time application for coverage of the grandchild is made

confined or confinement
The assignment to a bed as a resident inpatient in a hospital (including an intensive care unit of a hospital) or confinement in an observation area within a hospital for a period of no less than 18 continuous hours.

contributory insurance
Insurance for which you are required to make premium contributions.

covered condition
A covered condition is a critical illness as defined herein.

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

dependent
Your spouse or child(ren).

If your spouse is eligible as an employee under the group policy, they are not eligible to be insured as a dependent 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, they are 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.

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, grandchild, aunt, uncle, first cousin, niece, or nephew. This includes adopted, in-law, and step relatives.

guaranteed issue amount
Insurance that can be obtained without providing evidence of insurability based on plan requirements as shown in the Certificate Specification section of this certificate. All other eligibility requirements must be met. All insurance under this certificate is guaranteed issue.

hospital
A short-term, acute care general facility that:

(1) is legally licensed and operated as a hospital;
(2) provides overnight care of injured and sick people;
(3) requires that every patient be supervised by a physician;
(4) provides 24-hour nursing service by or under the supervision of a registered nurse;
(5) has on-site or pre-arranged use of x-ray equipment, laboratory, and surgical facilities; and
(6) maintains permanent medical history records.

A hospital is not a rehabilitation center, nursing home, rest home, extended-care facility, convalescent home, hospice care facility, skilled nursing facility, assisted living facility, a substance use facility, or a mental health facility, even if such facilities are affiliated with or adjoined to a hospital.

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

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

If the covered condition is non-invasive cancer, the subsequent diagnosis of non-invasive 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.

legal partner
The person with whom you have entered into a legally sanctioned domestic partnership or civil union partnership that grants the partners the same rights, responsibilities, and obligations as married couples in accordance with applicable law. Legal partner does not include any person who is eligible as an employee.

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

Non-workday 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 illness 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 physician 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 person who is licensed to practice medicine in the United States or United States territory in which treatment is received and who is providing treatment or advice in accordance with the license. Relevant law may require or allow for consideration of professional services of a practitioner other than a medical doctor. If so, such practitioner must be licensed as required by the jurisdiction where care is given and must be operating in the scope of their license. Other than for a dentist providing emergency dental care, we will not recognize you, your family member, a person who ordinarily resides in your household, or a business or professional partner, or any person who has a financial affiliation or business interest with you as a physician for a claim submitted to us.

policyholder
The owner of the group policy.

separate and unrelated
An invasive cancer or non-invasive cancer that is:

(1) not a metastasis of a previously diagnosed invasive cancer; and
(2) distinct from any previously diagnosed invasive cancer or non-invasive cancer.

spouse
Your legally married spouse. For the purposes of this certificate, spouse shall also include legal partner. Spouse does not include any person who is eligible as an employee.

substance use disorder
The pattern of pathological use of alcohol, psychoactive drugs, or substances characterized by:

(1) impairments in social and/or occupational functioning;
(2) debilitating physical condition;
(3) inability to abstain from or reduce consumption of the substance; or
(4) the need for daily substance use to maintain adequate functioning.

telemedicine
The use of telecommunication and information technologies (including, but not limited to, audio or video communications) for the evaluation, diagnosis, or treatment of the insured as would be practiced in person. This does not include requests for prescription refills or medical records.

we, our, us
Securian Life Insurance Company.

year
The benefit year beginning on any month within the calendar year or plan year. The calendar year and/or plan year is determined by the policyholder. In no event will a calendar year and/or plan year be more than 12 months.

you, your, certificate holder
An insured employee.

Critical Illness Condition Definitions

Alzheimer's disease

A definite diagnosis of Alzheimer's disease by a physician. 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) alcohol related brain damage;
(2) coma;
(3) Parkinson's disease;
(4) psychiatric illnesses; or
(5) stroke and vascular dementia.

The date of diagnosis is the date a physician 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 physician 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 physician satisfying the policy definition above.

Aneurysm

A bulge in a blood vessel caused by a weakness in the blood vessel wall, usually where it branches.

Abdominal aortic aneurysm means an aneurysm located in the abdominal (lower) part of the aorta that is:

(1) 5 centimeters or larger in size;
(2) less than 5 centimeters and is rapidly expanding; or
(3) a dissecting aneurysm or a ruptured aneurysm.

Thoracic aortic aneurysm means an aneurysm located in the thoracic (upper) part of the aorta that is:

(1) 5 centimeters or larger in size;
(2) less than 5 centimeters and is rapidly expanding; or
(3) a dissecting aneurysm or a ruptured aneurysm.

Other dissecting or ruptured aneurysm means:

(1) carotid aneurysm located in the portion of the carotid artery that is in the neck;
(2) cerebral aneurysm located in an artery in the brain; and
(3) any aneurysm in a major branch of the aorta in the chest or abdomen, such as the pulmonary artery, celiac artery, common hepatic artery, or renal artery.

Aneurysms of the arm or leg are excluded.

A dissecting aneurysm is a condition where a tear or split develops in a layer of an artery wall causing bleeding into and along the layers of the artery wall.

A ruptured aneurysm is a condition in which an aneurysm bursts and causes bleeding inside the body.

A physician must make the definite diagnosis of an aneurysm and there must be diagnostic imaging confirming aneurysm.

The date of diagnosis is the date the diagnosis of an aneurysm is made by a physician 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 result in 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 physician reports that surgery or radiation therapy is necessary to treat the brain tumor.

The following conditions are excluded:

(1) abscesses;
(2) granulomas;
(3) hematomas;
(4) malformations in the arteries or veins of the brain;
(5) pituitary tumors; and
(6) tumors of the spinal cord.

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

Blindness

The permanent loss of vision in both eyes is:

(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

The diagnosis of permanent loss of vision in both eyes must be clinically confirmed by a physician. 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 physician satisfying the definition above.

Cerebral palsy

A non-progressive neurological disorder affecting the developing brain.

A physician must make the definite diagnosis of cerebral palsy. The disease must have caused permanent motor deficits with muscle dysfunction and activity limitation.

The date of diagnosis is the date the diagnosis of cerebral palsy is made by a physician satisfying the policy definition above.

Coma

A state of unconsciousness with no reaction to external stimuli or internal needs. The coma must result in a coma lasting 4 or more consecutive days. The coma must have resulted in permanent neurological deficit.

A physician must diagnose the insured as comatose.

Medically induced coma and coma resulting directly from substance use are excluded.

The date of diagnosis is the date the insured entered the coma, as made by a physician satisfying the 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 physician 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 physician with coronary artery disease that satisfies the policy definition above.

COVID-19 disease of specified severity

A respiratory disease with potential multi-organ effects caused by the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2).

The diagnosis of COVID-19 disease of specified severity must be supported by typical symptoms of COVID-19 and at least one of the following diagnostic tests performed by a physician:

(1) positive SARS-CoV-2 RT-PCR test;
(2) positive SARS-CoV-2 antigen testing; or
(3) other laboratory testing clinically accepted at the time of claim to be diagnostic of active COVID-19 infection.

For the above definition, the following are not covered:

(1) home testing;
(2) isolated positive COVID-19 antibody testing (indicating prior exposure to the virus, but not diagnostic of active infection);
(3) asymptomatic infection or milder degrees of COVID-19 infection not resulting in hospitalization of specified length; or
(4) hospitalizations not directly related to COVID-19.

The disease must be of sufficient severity as to have directly required inpatient hospitalization of at least 2 days. In the event an insured dies as a direct result of COVID-19 before the minimum period of hospitalization has been met, a benefit will be payable.

The date of diagnosis is the date the diagnosed of by a physician with COVID-19 disease of specified severity satisfying the policy definition above.

Cystic fibrosis

A disorder characterized by abnormal transport of chloride and sodium causing organ dysfunction.

A physician must make the definite diagnosis of cystic fibrosis based on clinically accepted tests at the time of claim. The disease must cause ongoing symptoms indicating involvement of the lungs, pancreas, liver, or intestines.

The date of diagnosis is the date the diagnosis of cystic fibrosis is made by a physician satisfying the policy definition above.

End stage renal disease (kidney failure)

The total and permanent failure of both kidneys (leaving the insured with no functioning kidneys), which requires the insured to undergo regular renal dialysis at least weekly or for which the insured is recommended for a kidney transplant.

Permanent regular renal dialysis or kidney transplant must be deemed medically necessary by a physician.

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

The date of diagnosis is the date the insured is diagnosed with end stage renal disease (kidney failure) or a transplant is deemed necessary by a physician 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.

A definite diagnosis must be made by a physician, supported by 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; and
(2) 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.

Heart valve disease

A disease that affects one or more heart valves which then causes the heart not to work properly, resulting in insufficiency (regurgitation) or stenosis.

A definite diagnosis of heart valve disease must be made by a physician and supported, by the following criteria:

(1) symptoms clinically accepted as consistent with the diagnosis of heart valve disease; and
(2) a diagnostic procedure, such as, echocardiography, electrocardiogram (EEG), chest x-ray, cardiac MRI, excercise test or stress test, or cardiac catheterization supporting the diagnosis of heart valve disease.

The date of diagnosis is the date the diagnosis of heart valve disease is made by a physician satisfying the policy definition above.

Infertility

The inability to achieve pregnancy (conceive) after one year or longer of attempting, provided the insured is between the ages of 18 to 50.

The insured must undergo a diagnostic procedure that affirms the underlying cause of infertility. Covered diagnostic procedures include the following as recommended and performed by a physician:

- diagnostic laparoscopy;
- endometrial biopsy;
- hamster egg penetration assay;
- hormone evaluation;
- Huhner's test;
- hysterosalpingogram;
- hysteroscopy;
- imaging related to reproductive testing;
- laparoscopy;
- ovarian reserve testing;
- semen analysis; or
- testicular biopsy.

This benefit is not available to an insured who has transitioned through menopause or has undergone a voluntary procedure resulting in sterilization (vasectomy, tubal ligation, hysterectomy, etc.).

This benefit is payable once per lifetime.

The date of diagnosis is the date the diagnosis of infertility is made by a physician that satisfies the policy definition above.

Invasive 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 invasive 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.

Invasive cancer must be diagnosed according to a pathological or clinical diagnosis. For purposes of invasive cancer, pathological diagnosis means a diagnosis on a pathology report of invasive cancer based on a microscopic study of fixed tissue or preparations from the blood system.

If a previously diagnosed non-invasive cancer becomes invasive locally or with metastases, the insured is eligible to receive the invasive cancer benefit (subject to all the other listed requirements).

A definite diagnosis must be done by a physician 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 physician.

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

We will accept a clinical diagnosis of invasive 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 physician who is treating or advising the insured for invasive cancer.

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

Major organ failure

The permanent and irreversible failure of bone marrow, heart, liver, lung, pancreas, or small or large intestine.

If an insured has multiple organ failures (example: heart and lung), only a single benefit will be paid.

For the above definition, the following is not covered:

(1) transplant of any other organs, parts of organs, tissues, or cells;
(2) stem cell injections for orthopedic conditions; and
(3) registration on a transplant waiting list as a donor.

The date of diagnosis is the date the insured is diagnosed with permanent and irreversible major organ failure, and a transplant is deemed necessary by a physician that satisfies the policy definition above.

Multiple sclerosis (MS)
A diagnosis made by a physician 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 physician satisfying the policy definition above.

Muscular dystrophy
A muscle disorder causing motor dysfunction.

A physician must make the definite diagnosis of muscular dystrophy based on clinically accepted tests at the time of claim. The disease must cause permanent muscle weakness evident on physical examination.

The date of diagnosis is the date the diagnosis of muscular dystrophy is made by a physician satisfying the policy definition above.

Non-invasive 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 non-invasive cancer, pathological diagnosis means a diagnosis on a pathology report of non-invasive cancer based on a microscopic study of fixed tissue or preparations from the blood system.

This type of diagnosis must be done by a physician 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 physician.

The following cancers are excluded:

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

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

Occupational Hepatitis
An infection with hepatitis (B, C, or D) resulting from an unexpected, unintended, and unforeseen incident which exposed the insured to blood or bodily fluids during the course of the duties of the insured's normal occupation.

Payment under this condition requires satisfaction of the following:

(1) the incident causing the infection of hepatitis (B, C, or D) must have occurred after the insured's 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 in a clinical setting within 14 days of the incident and must shows no evidence of hepatitis (B, C, or D); and
(4) presence of hepatitis (B, C, or D) antibodies and/or antigens must be proven with another blood test performed in a clinical setting within 180 days of the incident that is positive indicating an infection by hepatitis (B, C, or D).

Hepatitis A is excluded from this benefit.

The date of diagnosis is the date the diagnosis of hepatitis (B, C, or D) is made by a physician satisfying the policy definition above.

Occupational HIV infection

Infection with the human immunodeficiency virus (HIV) resulting from an unexpected, unintended, and unforeseen incident 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 of the following:

(1) the incident causing the infection of HIV must have occurred after the insured's 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 physician satisfying the definition above.

Paralysis

Paralysis refers to the total, permanent, and irrevocable loss of movement.

This includes:

(1) quadriplegia: paralysis of both upper limbs (from the shoulder down including total paralysis of both hands) and both lower limbs (from the waist down including total paralysis of both feet).
(2) paraplegia: paralysis of both lower limbs (from the waist down including total paralysis of both feet).
(3) hemiplegia: paralysis of both the upper limb (from the shoulder down including total paralysis of the hand) and lower limb (from the waist down including total paralysis of the foot) on one side of the body.

Paralysis must be permanent with support by appropriate neurological evidence 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 physician satisfying the definition above.

Parkinson's disease

A definite diagnosis of idiopathic Parkinson's disease by a physician.

There must be supporting signs including resting tremor, rigidity, bradykinesia, or gait disturbance compatible with the diagnosis of idiopathic Parkinson's disease as assessed by a physician.

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

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

Poliomyelitis (Polio)

An acute infection caused by the polio virus that must result in paralysis that is evident by physical examination.

A definite diagnosis of poliomyelitis must be made by a physician and there must be laboratory confirmation of the polio virus as the cause for symptoms.

Post-polio syndrome which is the recurrence of paralysis years after the original infection has resolved is not covered under this definition.

The date of diagnosis is the date the diagnosis of poliomyelitis is made by a physician satisfying the policy definition above.

Sepsis

A condition that occurs when the body's overwhelming response to an infection of the bloodstream damages tissue. Sepsis can lead to decreased organ function, organ failure, and death.

To be diagnosed with sepsis, the insured must have a probable or confirmed infection and all the following criteria:

(1) a change in mental status;
(2) the sepsis proven by a positive blood culture;
(3) the first number in a blood pressure reading is less than or equal to 100 millimeters of mercury (mm Hg); and
(4) a respiratory rate higher than or equal to 22 breaths a minute.

A physician must make a definite diagnosis of sepsis.

The date of diagnosis is the date the diagnosis of sepsis is made by a physician satisfying the policy definition above.

Sickle cell anemia

An inherited blood disorder of hemoglobin production that results in abnormally shaped (sickled) red blood cells, leading to multiple symptoms such as pain, fatigue, frequent infections, and delayed growth.

A physician must make the definite diagnosis of sickle cell anemia. Sickle cell anemia does not mean sickle cell trait (asymptomatic carriers of a single abnormal hemoglobin gene) and any other disorder of hemoglobin production is not covered under this definition.

The date of diagnosis is the date the diagnosis of sickle cell anemia is first confirmed by a physician satisfying 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 physician, 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) asymptomatic silent stroke found on imaging;
(2) disorders of the blood vessels affecting the eye including infarction of the optic nerve or retina;
(3) ischemic disorders of the peripheral vestibular system; and
(4) transient ischemic attacks (TIA) or reversible ischemic neurologic deficit (RIND).

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

EXCLUSIONS

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) intentionally self-inflicted injury, self-destruction, or autoeroticism, whether sane or insane;
(2) suicide or attempted suicide, whether sane or insane;
(3) the insured's participation in, or attempt to commit, a crime, assault, felony, or any illegal activity, regardless of any legal proceedings thereto;
(4) the insured's use of alcohol;
(5) the insured's use of prescription drugs, non-prescription drugs, illegal drugs, medications, poisons, gases, fumes, or other substances taken, absorbed, inhaled, ingested, or injected unless taken or used as prescribed by a physician, or an over-the-counter drug as directed by the manufacturer;
(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.

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

CERTIFICATE TERMINATION

Your coverage ends on the earliest of the following:

(1) the date you no longer meet the eligibility requirements; or
(2) 31 days (the grace period) after the due date of any premium which is not paid; or
(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.

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

(1) the date the dependent no longer meets the eligibility requirements; or
(2) 31 days (the grace period) after the due date of any premium contribution which is not paid; or
(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 Benefit.

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.

Extension of Benefits
If an insured is totally disabled or confined in a hospital on the date the group policy terminates, an extension of benefits will be provided until the earliest of:

(1) 90 days after the date the group policy ends;
(2) the date the insured ceases to be totally disabled; or
(3) the date the insured is no longer confined in a hospital

This Extension of Benefits terminates upon the earliest of the following:

(1) the date you recover so that you are no longer totally disabled;
(2) the date you receive the maximum benefit for the covered critical illness condition; or
(3) 90 days after the date coverage would otherwise terminate.

ADDITIONAL BENEFITS

If you are insured under the provisions applicable to critical illness insurance coverage under this certificate you are eligible for insurance under the following Additional Benefits below. In addition, your spouse or your dependent children are eligible if they are insured under this certificate. Insurance under these Additional Benefits become effective on the date you, your spouse, or your dependent child becomes insured under this certificate as outlined in the Certificate Specification section. Coverage under these Additional Benefits are subject to all terms, conditions, exclusions, limitations, and provisions of this certificate unless otherwise expressly provided for herein.

Wellness Screening Benefit

This benefit provides for an additional benefit to be paid to you if you, your covered spouse, or your covered child undergo one of the wellness screening activities listed below while not in a hospital on an inpatient basis. The payable amount of the Wellness Screening Benefit is shown in the Plan of Insurance – Additional Benefits section of the certificate. We will pay the benefit after receipt at our home office of proof satisfactory to us that you, your covered spouse, or your covered child have undergone one of the covered screenings or preventive cares listed in this benefit. The benefit will be paid in a single sum. Benefits will be paid according to the Claims section of the certificate.

Wellness screenings or Preventive care

- annual physical exam;
- mental health screening recommended and performed by a physician;
- biopsies for cancer;
- blood chemistry panel;
- blood test to determine total cholesterol;
- blood test to determine triglycerides;
- bone marrow testing;
- BRCA1/BRCA2 genetic testing;
- breast MRI;
- breast ultrasound;
- breast sonogram;
- CA 15-3 breast cancer test;
- CA 125 ovarian cancer test;
- carotid Doppler;
- CEA colon cancer test;
- chest x-ray;
- clinical testicular exam;
- colonoscopy;
- dental exam;
- digital rectal exam (DRE);
- DNA stool analysis;
- doppler screening for cancer;
- doppler screening for peripheral vascular disease;
- double-contrast barium enema;
- echocardiogram;
- electrocardiogram (EKG);
- electroencephalogram (EEG);
- endoscopy;
- eye exam;
- fasting blood glucose test;
- fasting plasma glucose test;
- flexible sigmoidoscopy;
- hearing exam;
- hemoccult stool specimen;
- hemoglobin A1C;
- herpes simplex virus (HSV) test;
- human papillomavirus (HPV) test;
- lipid panel;
- lung cancer CT;
- mammogram;
- non-diagnostic vascular screening;
- nucleic acid test (NAT);
- oral cancer screening;
- pandemic testing (excluding at home testing);
- 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;
- stress test on bicycle or treadmill;
- successful completion of smoking cessation program;
- tests for sexually transmitted infections (STI's);
- thermography;
- two-hour post-load plasma glucose test;
- ultrasounds;
- urinalysis;
- vaccinations approved by the FDA; or
- virtual colonoscopy.

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

Benefit Limitations

You, your spouse, and each child can receive one Wellness Screening Benefit per year.

Termination
Insurance continued under this benefit will terminate on the earliest of the following:

(1) the date requested by the policyholder to cancel the wellness screening coverage for its plan; or
(2) the terminating events outlined in the Certificate Termination section.

Portability Benefit

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

To continue insurance under this benefit, an insured must make a written request and make the first premium payment 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 continuation requirements are met. Upon satisfactory completion of all portability election requirements, coverage provided by this benefit 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 then is considered to have portability status.

If you elect to continue your own coverage according to the provisions of this benefit, you may elect to continue insurance for any other individual insured under your certificate. If your former spouse continues their own coverage they may elect to continue insurance on any insured children, provided you are not otherwise insuring the children. Benefits will be paid according to the Claims section of the certificate.

Eligibility
You are eligible to continue group critical illness insurance under the terms of this benefit if you no longer meet the eligibility requirements due to any of the following:

(1) Your termination of employment, including retirement;
(2) your number of working hours are reduced;
(3) you are no longer in a class eligible for insurance or 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.

Your dependents are eligible to continue group critical illness insurance under this benefit if they no longer meet the eligibility requirements due to any of the following:

(1) your termination of employment, including retirement;
(2) your number of working hours are reduced;
(3) you are no longer in a class eligible for insurance or 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) divorce;
(5) the dependent ceases to be an eligible dependent; or
(6) your death.

Regardless of whether an insured is otherwise eligible under this benefit to continue, an insured will not be eligible to request coverage under this benefit if they:

(1) have attained age 120;
(2) are an employee and were not actively at work due to illness or injury on the date immediately preceding the portability date, unless you had continued your coverage according to the provisions of the Continuation of Insurance Benefit;
(3) lose 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;
(4) lose eligibility due to termination of the group policy ; or
(5) do not reside in the United States or United States Territory.

If an insured is continuing coverage under the terms of this benefit, and again meets the eligibility requirements of the plan 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 benefit, unless and until the insured no longer meets the eligibility requirements of the plan and again returns to portability status as provided for herein.

Benefit Amounts
The benefit amounts that can be continued under this additional benefit shall be the amounts shown on the Plan of Insurance section applicable to the insured based on the benefit plan selected by you.

An insured employee, and a dependent who ports coverage on their own as provided under the terms of this Additional Benefit may change the benefit plan to one that provides a lower benefit amount but may not change the benefit plan to one that provides a higher benefit amount.

Additional Benefits
The Wellness Screening Benefit will continue upon porting.

Premiums
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.

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.

Termination
No individual may elect coverage under this benefit on or after the date of termination of the group policy.

An insured's Insurance continued under this benefit will remain in force until terminated 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 benefit;
(3) in the case of a dependent spouse or child the date your coverage is no longer being continued under this benefit or the date the spouse or child ceases to be eligible as defined under the terms of your plan, unless the spouse or child has ported coverage on their own as provided for under the terms of this benefit;
(4) the date the group policy is terminated;
(5) 31 days after the due date of any premium contribution which is not made;
(6) 31 days after we give written notice of our intent to terminate ported coverage for a group or class of individuals; or
(7) the date the insured requests to terminate their coverage being continued under this benefit.

Premiums

Premium due date
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.

Premium determination
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.

Grace period
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.

Reinstatement
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.

Claims

We are providing notice that Securian Financial Group, Inc. is subject to economic and trade sanctions, laws, and regulations. These laws and regulations, including the laws and regulations administered and enforced by the United States Department of the Treasury's Office of Foreign Assets Control (OFAC), prevent Securian Financial Group, Inc. from providing coverage to, and from paying benefits to, entities and individuals where prohibited by applicable law. In addition, these laws and regulations prohibit certain activities with respect to certain countries.

Notice of claim
Written notice of claim must be given to us within 365 days of the date of a loss. Failure to give notice within the time prescribed does not invalidate or reduce any claim if it is shown that it was not reasonably possible to give the notice within that time and notice was given as soon as was 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.

We will acknowledge receipt of the claim, commence any investigation of the claim and request all items, statements and forms that we reasonably believe, at that time, will be required from you, not later than the 15th day after the date we receive notice of claim.

Claim forms
Upon receipt of notice of claim, we will provide a claim form to you. 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 loss if the insured submits, within the time period for filing proof of the loss, written proof of the occurrence, character, and extent of the loss for which claim is made which is satisfactory to us.

Proof of loss
Written proof of a loss satisfactory to us must be provided to us within 180 days of the date of the loss or as soon as reasonably possible. Failure to provide proof of the loss within this time will not invalidate or reduce a claim if it was not reasonably possible to provide proof within this 180 day period. However, proof must be provided within 15 months of the date proof of loss is required, except in the absence of legal capacity.

Physical examination and autopsy
After an insured has filed a claim and provided at their 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.

We, at our own expense, may reasonably require during the pendency of a claim an autopsy in case of death, where it is not forbidden by law.

Payment of claims
We will pay a benefit for a loss within 60 days after receipt at our home office of written proof of the loss which meets all policy requirements and is satisfactory to us. All benefits including dependent's benefits will be paid to you, if you are living, or to your assignee. This benefit will be paid in a single sum or by any other method agreeable to us and the beneficiary. You are responsible for all costs associated with claim form(s) completion, records, and the submission of your claim.

We may pay benefits for a dependent child to a person other than you if an order providing for the appointment of a possessory or managing conservator of the dependent child has been issued by a court. The person must provide us with written notice that he or she is a possessory or managing conservator of the dependent child on whose behalf the claim is made and a certified copy of the court order designating that individual as the possessory or managing conservator of the dependent child, or any other evidence that the person is eligible to receive benefits for the dependent child.

Recovery of overpayment
We have the right to recover from you or the recipient of benefits, any benefit amount paid that we determine to be an overpayment under this certificate. You or the recipient of benefits has the obligation to refund to us any amount of overpayment.

If benefits are overpaid on any claim, you or the recipient of benefits must refund us within 90 days. If the refund is not made in a timely manner, we have the right to offset future benefits payable under this certificate by an amount equal to the overpayment.

Beneficiary
If you die before the claim is paid, benefits will be paid to your assignee, or in the absence of an assignee your estate.

Payment to Texas Health and Human Services Commission
We will pay benefits to the Texas Health and Human Services Commission on behalf of an insured child upon written notice to us if:

(1) you are required to pay child support by a court order issued in Texas or is not entitled to possession or access to the insured child and is required by court order to pay child support;
(2) the Texas Health and Human Services Commission is paying benefits on behalf of the insured child on behalf of the insured child under Chapter 31 and 32 of the Texas Human Resources Code; and
(3) notification is given to us in writing with a submitted claim that such benefits should be paid directly to the Texas Health and Human Services Commission.

ADDITIONAL INFORMATION

Changes to policy or certificate
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.

Contestability
If an insured experiences a loss 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, which affects the risks assumed, 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.

Maintaining records
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.

Clerical or administrative errors
If a clerical or administrative error is made in keeping records on or administering the insurance under this certificate, it will not affect otherwise valid insurance.

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

Misstatement of Age
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 benefit amount.

Conformity of state laws
The provisions of this certificate will conform to state law. 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.

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to $500,000 for health benefit plans, with some exceptions.
  - Up to $300,000 for disability income benefits.
  - Up to $300,000 for long-term care insurance benefits.
  - Up to $200,000 for all other types of health insurance.
- **Life insurance**
  - Up to $100,000 in net cash surrender or withdrawal value.
  - Up to $300,000 in death benefits.
- **Individual annuities:** Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.
- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.
- **Individual aggregate limit:** Up to $300,000 per person, regardless of the number of policies or contracts. A limit of $500,000 may apply for people with health benefit plans.
- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:

Texas Life and Health Insurance Guaranty Association
1717 West 6th Street, Suite 230
Austin, Texas 78703-4776
1-800-982-6362 or www.txlifega.org

For questions about insurance, contact:

Texas Department of Insurance
PO Box 12030
Austin, Texas 78711
1-800-252-3439 or www.tdi.texas.gov

Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

Securian Life Insurance Company • A Stock Company

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

GROUP CRITICAL ILLNESS CERTIFICATE OF INSURANCE • NONPARTICIPATING