

YOUR CRITICAL ILLNESS INSURANCE PLAN

For Employees of
Washington County School District

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

SPECIFIED DISEASE COVERAGE

THE CERTIFICATE PROVIDES LIMITED BENEFITS

**BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER
MEDICAL EXPENSES**

OUTLINE OF COVERAGE

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the “Guide to Health Insurance for People With Medicare” available from the company.

- (1) Specified disease coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. Persons covered under Medicaid should not purchase it. Read the Shopper's Guide to Cancer Insurance to review the possible limits on benefits in this type of coverage.
- (2) Read Your Certificate Carefully. This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR CERTIFICATE CAREFULLY!**
- (3) Specified disease coverage is designed to provide, to persons insured, restricted coverage paying benefits **ONLY** when certain losses occur as a result of specified diseases. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.
- (4) The policy provides a lump-sum benefit if a covered person is diagnosed with any of the covered illnesses/conditions listed on the Schedule of Benefits. Commonly covered conditions include: **heart attack, cancer, stroke, major organ transplant, coronary artery bypass, and carcinoma in situ (CIS)**. At the Policyholder's option, the policy may also include benefits for any of the following:
 - Sudden cardiac arrest; type 1 diabetes; severe burns; transient ischemic attacks (TIA); ruptured or dissection aneurysm; abdominal aortic aneurysm; thoracic aortic aneurysm; open heart surgery for valve replacement or repair; transcatheter heart valve replacement or repair; coronary angioplasty; implantable (or internal) cardioverter defibrillator (ICD) placement; pacemaker placement
 - Benign brain tumor; skin cancer; bone marrow transplant; stem cell transplant
 - Permanent paralysis; loss of sight, hearing or speech; coma; Multiple Sclerosis; Amyotrophic Lateral Sclerosis (ALS); Parkinson's Disease; Advanced Dementia, including Alzheimer's Disease; Huntington's Disease (Huntington's Chorea); Muscular Dystrophy; infectious disease; Addison's Disease; Myasthenia Gravis; Systemic Lupus Erythematosus (SLE); systemic sclerosis (scleroderma)

Please consult your certificate and riders for specific information about how terms are used, any requirements that describe qualifying for a particular loss, and the benefit amounts. If you pay all or part of the cost of coverage, then the enrollment materials you received also contain a description of benefits available under the policy.

- (5) In order for a benefit to be payable, the specified disease must be diagnosed after the covered person's coverage effective date. **A pre-existing condition exclusion may apply to a specified disease diagnosed during the first six months that coverage (or an increase in coverage) is in force. Coverage may reduce based on age.** Benefit payment is contingent on proof of loss which may require additional information be provided prior to claim determination. The Policyholder may choose to have an eligibility waiting period, during which time no coverage is in force.

The exclusions that apply to all provisions for specified disease coverage are provided in the “Exclusions” section of the certificate and any riders. The “Schedule of Benefits”, the Benefits section(s) and the “Exclusions” section of the certificate and any riders provide specific information about the conditions for receiving benefits and any limitations. If you pay all or part of the cost of coverage, then the enrollment materials you received also contain a description of the exclusions and limitations under the policy.

- (6) Your coverage will continue under the policy, while the policy remains in force, as long as you continue to meet the eligibility requirements and all premiums due are paid. You may have the option to continue your coverage by direct payment of premiums to ReliaStar Life Insurance Company after you no longer meet the eligibility requirements.

The eligibility requirements for a spouse and children may include age limitations, as provided in the riders. If you pay all or part of the cost of coverage, then the enrollment materials you received also contain a description of any age limitations under the policy.

- (7) The Policyholder may change the terms of the policy at any time with ReliaStar Life Insurance Company's agreement. The Policyholder or ReliaStar Life Insurance Company may terminate the policy at any time. ReliaStar Life Insurance Company reserves the right to change premiums at any time according to the terms of the policy.

**GROUP CRITICAL ILLNESS INSURANCE
CERTIFICATE OF COVERAGE**

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

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

POLICYHOLDER: Washington County School District
GROUP POLICY NUMBER: 72849-7CCI2
POLICY EFFECTIVE DATE: August 1, 2022
GOVERNING JURISDICTION: Utah

THIS IS LIMITED BENEFIT INDEMNITY COVERAGE

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

Notice to Buyer: This is a specified disease Certificate. This Certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover medical expenses. Read your Certificate carefully with the outline of coverage and the “Shopper’s Guide to Cancer Insurance.”

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

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

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

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

Please read your Certificate carefully.

RIGHT TO EXAMINE CERTIFICATE

If you contribute to the cost of your coverage, you may cancel your coverage for any reason within 30 days after your receipt of your initial Certificate of coverage under the Policy, provided no benefits have been paid. Contact the Policyholder to cancel your coverage and receive any premium refund.

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



Robert L. Grubka
President



Melissa A. O'Donnell
Secretary

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Arizona Residents:

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

SCHEDULE OF BENEFITS

EMPLOYER: Washington County School District

GROUP POLICY NUMBER: 72849-7CC12

ELIGIBLE CLASS(ES)

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

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

Temporary and seasonal workers are excluded from coverage.

Insured Persons who are continuing coverage under the PORTABILITY provision are also an eligible class.

MINIMUM HOURS REQUIREMENT

Employees: 30 hours per week.

ELIGIBILITY WAITING PERIOD

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

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

WAIVER OF ELIGIBILITY WAITING PERIOD

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

CREDIT FOR PRIOR SERVICE

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

WHO PAYS FOR THE COVERAGE

You pay the cost of your coverage.

BENEFIT AMOUNT

Choice of \$15,000 or \$30,000

CRITICAL ILLNESS BENEFITS

Base module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Heart Attack	100%	2 times the BENEFIT AMOUNT
Cancer	100%	2 times the BENEFIT AMOUNT
Stroke	100%	2 times the BENEFIT AMOUNT
Major Organ Transplant	100%	2 times the BENEFIT AMOUNT
Coronary Artery Bypass	25%	2 times the BENEFIT AMOUNT
Carcinoma in Situ (CIS)	25%	2 times the BENEFIT AMOUNT

Major organ module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Type 1 Diabetes	100%	2 times the BENEFIT AMOUNT
Severe Burns	100%	2 times the BENEFIT AMOUNT
Transient Ischemic Attacks (TIA)	10%	2 times the BENEFIT AMOUNT
Ruptured or Dissecting Aneurysm	10%	2 times the BENEFIT AMOUNT
Abdominal Aortic Aneurysm	10%	2 times the BENEFIT AMOUNT
Thoracic Aortic Aneurysm	10%	2 times the BENEFIT AMOUNT
Open Heart Surgery for Valve Replacement or Repair	25%	2 times the BENEFIT AMOUNT
Transcatheter Heart Valve Replacement or Repair	10%	2 times the BENEFIT AMOUNT
Coronary Angioplasty	10%	2 times the BENEFIT AMOUNT
Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement	25%	2 times the BENEFIT AMOUNT
Pacemaker Placement	10%	2 times the BENEFIT AMOUNT

Enhanced cancer module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Benign Brain Tumor	100%	2 times the BENEFIT AMOUNT
Skin Cancer	10%	2 times the BENEFIT AMOUNT
Bone Marrow Transplant	25%	2 times the BENEFIT AMOUNT
Stem Cell Transplant	25%	2 times the BENEFIT AMOUNT

Quality of life module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Permanent Paralysis	50%	1 times the BENEFIT AMOUNT
Loss of Sight	50%	1 times the BENEFIT AMOUNT
Loss of Hearing	50%	1 times the BENEFIT AMOUNT
Loss of Speech	50%	1 times the BENEFIT AMOUNT
Coma	50%	2 times the BENEFIT AMOUNT
Multiple Sclerosis	25%	1 times the BENEFIT AMOUNT
Amyotrophic Lateral Sclerosis (ALS)	25%	1 times the BENEFIT AMOUNT
Parkinson's Disease	25%	1 times the BENEFIT AMOUNT
Advanced Dementia, including Alzheimer's Disease	50%	1 times the BENEFIT AMOUNT
Infectious Disease	25%	2 times the BENEFIT AMOUNT

DEFINITIONS

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

Your work site must be one of the following:

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

Normal vacation is considered Active Employment.

Abdominal Aortic Aneurysm means the diagnosis of an enlargement of the abdominal aorta of 5 cm or more, or of 4 cm or greater and rapidly expanding, for which a surgical repair has been advised.

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

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

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

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

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

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

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

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

Bone Marrow Transplant means the clinical diagnosis of the need for a surgical transplant when you have been added to the *Be The Match* registry for a bone marrow transplant. It also includes a clinical diagnosis and actual transplant that occurs before you are able to be added to the *Be The Match* registry.

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

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

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

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

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

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

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

Certificate means this document, which describes the benefits and rights of Insured Persons under the Policy. It may include riders or endorsements.

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

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

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

You must be in a continuous state of profound unconsciousness for 14 consecutive days or longer. In the event you die while you are in a Coma and confined to a Hospital, this time period will be considered to have been met regardless of the actual number of days in a continuous state of profound unconsciousness.

"Confined to a Hospital" means that on the advice of a Doctor, you are assigned to a bed as a resident inpatient in a Hospital. There must be a charge for room and board, other than in any government, military or veterans' facility for which there is no charge for room and board.

Coronary Angioplasty means a diagnosis of significant coronary artery disease which is causing symptoms and for which a cardiologist advises a procedure, done through the blood vessels, to open a blocked coronary artery and/or remove a blood clot. This includes coronary balloon angioplasty, angiojet clot removal, and rotational and orbital atherectomy procedures.

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

Critical Illness means any of the following as defined:

- Abdominal Aortic Aneurysm; or
- Advanced Dementia; or
- Amyotrophic Lateral Sclerosis (ALS); or
- Benign Brain Tumor; or
- Bone Marrow Transplant; or
- Cancer; or
- Carcinoma in Situ; or
- Coma; or
- Coronary Angioplasty; or
- Coronary Artery Bypass; or
- Heart Attack; or
- Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement; or
- Infectious Disease; or
- Loss of Hearing; or
- Loss of Sight; or
- Loss of Speech; or
- Major Organ Transplant; or
- Multiple Sclerosis; or
- Open Heart Surgery For Valve Replacement or Repair; or
- Pacemaker Placement; or
- Parkinson's Disease; or
- Permanent Paralysis; or
- Ruptured or Dissecting Aneurysm; or
- Severe Burns; or
- Skin Cancer; or
- Stem Cell Transplant; or
- Stroke; or
- Thoracic Aortic Aneurysm; or
- Transcatheter Heart Valve Replacement or Repair; or
- Transient Ischemic Attacks (TIA); or
- Type 1 Diabetes.

Different Diagnosis means any of the following:

- A diagnosis of a Critical Illness that is for a different illness/condition than a previously diagnosed illness/condition.
- A diagnosis that is related to an illness/condition that existed prior to your coverage effective date if:
 - The subsequent diagnosis of the Critical Illness is for the same illness/condition as an illness/condition diagnosed prior to your coverage effective date under the Policy.
- A diagnosis that is related to a Critical Illness for which we previously paid benefits if:
 - The subsequent diagnosis of the Critical Illness 1) is for the same illness/condition as a Critical Illness for which benefits were payable under the Policy, and 2) occurs more than 6 months after the date of the previous diagnosis.

Note: A second or confirmatory medical opinion is not a Different Diagnosis.

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

Note: A diagnosis of Carcinoma in Situ is considered a Different Diagnosis from Cancer.

Note: A diagnosis of Skin Cancer is considered a Different Diagnosis from Cancer or Carcinoma in Situ.

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

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

Employee means a person who is a citizen or legal resident of the United States, and who is in Active Employment with the Employer in the United States. The term includes a person whose coverage is being continued under the PORTABILITY provision, even if the person is no longer in Active Employment with the Employer.

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

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

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

In the event of death, an autopsy report and/or death certificate identifying heart attack or myocardial infarction as a cause of death will be accepted as evidence of a Heart Attack.

A Sudden Cardiac Arrest is not in itself considered a Heart Attack.

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

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

Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement means the diagnosis of ventricular tachycardia or fibrillation, or deemed at high risk for cardiac arrest, for which the initial placement of an implantable cardioverter-defibrillator (ICD) has been advised.

Infectious Disease means the diagnosis of an infectious disease that results in you being confined to a Hospital for five (5) or more consecutive days or confined to a transitional care facility for five (5) or more consecutive days. In the event you die while confined as the result of being diagnosed with an infectious disease, we will consider this time period to have been met regardless of the actual number of days confined.

Infectious Diseases include, but are not limited to:

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

"Confined/confinement" means that on the advice of a Doctor, your assignment to a bed as a resident inpatient in a Hospital or transitional care facility. There must be a charge for room and board, other than in any government, military or veterans' facility for which there is no charge for room and board. "Transitional care facility" means a facility which provides a bridge between the Hospital and home for restorative and rehabilitation care. It must provide skilled nursing care and must be either located in a community nursing home or a Hospital. Confined/confinement also includes assignment to an observation unit in a Hospital, if you stay for at least 24 consecutive hours.

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

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

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

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

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

Major Organ Transplant means the irreversible failure of your heart, lung, pancreas, an entire kidney or the entire liver, or any combination of these conditions, as determined by a Doctor specialized in care of the involved organ. Acceptance to the UNOS (United Network for Organ Sharing) list is required for this determination, except for kidney failure. If you receive the transplant prior to placement on the network, the network requirement will be waived. If your Doctor determines you are not healthy enough to be placed on the UNOS list or you are rejected from the list, the network requirement will be waived. "Kidney failure" means chronic, irreversible failure of one or both kidneys for which a Doctor recommends either of the following:

- Regular hemodialysis or peritoneal dialysis (at least weekly) in order to sustain life, which is expected to continue for at least 6 months.
- Renal transplantation.

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

Open Heart Surgery For Valve Replacement or Repair means the diagnosis of severe valvular heart disease for which open heart surgery – a surgical procedure that requires an incision through the chest and an incision in the heart and/or attached blood vessels – has been advised.

Pacemaker Placement means the diagnosis of symptomatic sinus node dysfunction, high-grade atrioventricular (AV) block, or other serious cardiac arrhythmia for which the initial placement of a permanent pacemaker has been advised.

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

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

Policy means the written group insurance contract between the Policyholder and us, including the Certificates delivered to Insured Persons. It may include riders and endorsements.

Policyholder means the Employer to which the Policy is issued, as shown on the first page of this Certificate, and which sponsors the coverage for its Employees.

Ruptured or Dissecting Aneurysm means the diagnosis of a balloon-like bulge in an artery that ruptures or dissects as confirmed by an ultrasound, CT scan, angiogram or MRI.

Same Diagnosis means any of the following:

- A second or confirmatory medical opinion of a diagnosis for an illness/condition.
- A diagnosis that is related to a Critical Illness for which we previously paid benefits if:
 - The subsequent diagnosis of a Critical Illness, 1) is for the same illness/condition as a Critical Illness for which benefits were payable under the Policy, and 2) occurs within 6 months of the date of the previous diagnosis.

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

Severe Burns means the diagnosis of cosmetic disfigurement of the surface of a body area not less than 35 square inches that is a full-thickness or third-degree burn. A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic or telephonic media, and which is consistent with applicable law.

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

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

Skin Cancer includes:

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

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

Stroke means the diagnosis of an acute cerebral event including infarction of brain tissue, cerebral and subarachnoid hemorrhage, cerebral embolism and cerebral thrombosis. The diagnosis of Stroke must be based on confirmatory neuroimaging confirmed at the time of discharge from a Hospital, or by autopsy report or death certificate in the event of death.

Stroke does not include:

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

Thoracic Aortic Aneurysm means the diagnosis of an enlargement of the thoracic aorta of 5.5 cm or more, or causing symptoms, or of 4.5 cm or greater and rapidly expanding, for which surgical repair has been advised.

Transcatheter Heart Valve Replacement or Repair means the diagnosis of significant valvular heart disease for which a procedure, performed through the blood vessels, to repair or replacement of one or more of the heart valves has been advised.

Transient Ischemic Attacks (TIA) means the diagnosis of a transient episode of neurologic dysfunction caused by focal brain, spinal cord, or retinal ischemia, without acute infarction, that is confirmed via documented neurological deficit and neuroimaging studies.

Type 1 Diabetes means an auto-immune destruction of insulin-producing cells in the pancreas that results in total loss of insulin production.

Written or Writing means a record which is on or transmitted by paper or electronic or telephonic media, and which is consistent with applicable law.

GENERAL PROVISIONS

ELIGIBILITY

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

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

Once a claim for benefits under the Policy has been approved, you are not eligible for any increased or additional coverage.

ENROLLMENT

If you are eligible for coverage, you must enroll for any coverage before it will become effective. The Employer or we will provide you with the forms or information needed to complete your enrollment. You may enroll when you become newly eligible, or following a qualifying life event as allowed by the Employer, or during an enrollment period chosen by the Employer and approved by us.

EFFECTIVE DATE OF COVERAGE

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

- The date you are eligible for coverage, if you enroll for coverage on or before that date.
- The first day of the month that is on or next follows the date you enroll for coverage.
- The August 1st that is on or next follows the last day of an annual enrollment period, if you enroll during an annual enrollment period chosen by the Employer and approved by us.
- The first day of the month that is on or next follows the date you return to Active Employment, if you are not in Active Employment when your coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, and paid time off for non-medical-related absences.

EFFECTIVE DATE OF CHANGES TO COVERAGE

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

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

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

CHANGE OF INSURANCE CARRIERS

If you are not in Active Employment due to injury or sickness on the effective date of the Employer's coverage under our Policy, and you were covered under the Employer's prior group policy of critical illness or specified disease insurance at the time the Employer's coverage under our Policy became effective, we will provide continuity of coverage under our Policy. In order for this provision to apply, the prior policy's coverage must be similar to our Policy.

If you are not in Active Employment due to injury or sickness on the effective date of our Policy, and you would otherwise be eligible to become insured under our Policy, we will provide limited coverage under our Policy. Coverage under this provision will begin on our Policy effective date and will continue until the earliest of the following:

- The date you return to Active Employment.
- The end of any period of continuance or extension provided under the prior policy.
- The date coverage would otherwise end, according to the provisions of our Policy.

Your coverage under this provision is subject to payment of premiums.

Any benefits payable under this provision will be paid as if the prior policy had remained in force. We will reduce our payment by any amount for which the prior carrier is liable.

If your coverage ends under this provision, or if you were not covered under the Employer's prior policy on the date that policy terminated, the EFFECTIVE DATE OF COVERAGE provision under our Policy will apply.

TERMINATION OF COVERAGE

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

- The date the Policy terminates. See the PORTABILITY provision.
- The last day of the month during which you are no longer in an eligible class. See the PORTABILITY provision.
- The last day of the month during which your eligible class is no longer covered. See the PORTABILITY provision.
- The last day of the month during which you voluntarily cancel your coverage.
- The end of the period for which premiums are paid, if the next premium is not paid by its due date, subject to the GRACE PERIOD provision.
- The last day of the month during which you are no longer in Active Employment. See the PORTABILITY provision.
- The date the total maximum benefit amount has been paid for all Critical Illnesses.

We will pay benefits for a loss that occurs while you are covered under the Policy even if the Policy has since terminated.

POLICY TERMINATION

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

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

- There is less than 15% participation of those eligible persons who pay all or part of their premium for the Policy.
- There is less than 100% participation of those eligible persons for a Policyholder paid plan.
- The Policyholder does not promptly provide us with information that is reasonably required.
- Fewer than 25 persons are insured under the Policy.
- The premium is not paid in accordance with the provisions of the Policy.
- We determine that there is a significant change in the size, occupation or age of the eligible class(es) as a result of a corporate transaction such as a merger, divestiture, acquisition, sale or reorganization of the Policyholder and/or its persons.
- We stop providing the type of coverage under this Policy to all groups in the Policy issue state.

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

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

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

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

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

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

PORTABILITY

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

You may continue your coverage if it would otherwise terminate due to any of the following:

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

The Employer or we will provide you with the information needed to continue your coverage under this provision. Continuation of coverage must be elected within 31 days of when it would otherwise terminate. Coverage continued under this provision is subject to all the terms of this Certificate.

You may not increase the continued coverage amount. Continued premium payment is required to keep coverage in force. Premiums will be billed directly to you. The initial premium will be based on the portability premium rates in effect at the time you are eligible to continue your coverage under this provision. We may change the portability premium rates at any time upon 60 days Written notice to you.

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

- The end of the period for which premiums are paid if the next premium is not paid by its due date, subject to the GRACE PERIOD provision.
- The date you die.
- The date the total maximum benefit amount has been paid for all Critical Illnesses.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days Written notice of termination.

GRACE PERIOD

The Policyholder has a grace period of 60 days for the payment of any premium due except the first premium payment. During the Policyholder's grace period, the Policy will remain in force. If the full premium payment is not received by us by the end of the grace period, the Policy will automatically terminate at the end of the grace period. The Policyholder is required to pay a pro rata premium for any period the Policy was in force during the grace period. There is no grace period if the Policyholder gives us advance Written notice of termination, or if we have given the Policyholder advance Written notice of termination as described under the POLICY TERMINATION provision.

If you are continuing your coverage under the PORTABILITY provision, you have a grace period of 31 days for the payment of any premium due. During your grace period, your coverage will remain in force. If the full premium payment is not received by us by the due date, we will give Written notification to you that if the premium is not paid by the end of the grace period, all coverage will terminate on the last day of the grace period. If we fail to give such Written notice, coverage will continue in effect until the date such notice is given. We may extend the grace period by giving Written notice of such intent to you, and such notice will specify that all coverage will terminate on that date if the premium remains unpaid. A pro rata premium payment is required for any period your coverage was in force during the grace period.

REPRESENTATIONS NOT WARRANTIES

All statements made by the Policyholder and you are considered representations and not warranties.

INCONTESTABILITY

We will not use any statements made by you to avoid insurance, reduce benefits or defend a claim unless the statement is included in a Written application or enrollment form relating to your insurability. Except for fraud, we will not use such statements to contest insurance after it has been in force for two years from its effective date. Fraud in the procurement of coverage under the Policy is only contestable after the coverage has been in force for two years from its effective date if permitted by applicable law in the governing jurisdiction. The statement on which any contest is based must be material to the risk accepted or the hazard assumed by us.

CLERICAL ERROR

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

- Prevent you from being covered, if you are entitled to coverage under the terms of the Policy.
- Cause coverage to begin or continue for you when the coverage would not otherwise be effective.
- End insurance validly in effect.

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

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

MISSTATEMENT OF AGE

If premiums are based on your age and you have misstated your age, then your correct age will be used to determine if any insurance is in effect and, as appropriate, the premium and/or benefits will be adjusted. We may require satisfactory proof of your age before paying any claim.

MISSTATEMENT OF TOBACCO USE STATUS

If premiums are based on your tobacco use status and you have misstated your tobacco use status, then your correct tobacco use status will be used to adjust the premium and/or benefits as appropriate. The amount payable at the time of claim will be the amount that the premium would have purchased using the correct tobacco use status. During the first two years your coverage under the Policy is effective, we will make this adjustment instead of contesting your insurance for this misstatement.

ASSIGNMENT

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

AGENCY

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

CONFORMITY WITH STATE STATUTES

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

CHANGES TO POLICY OR CERTIFICATE

The Policy may be amended at any time by Written agreement between the Policyholder and us. No change in the Policy will be valid until approved by one of our executive officers. Such approval must be in Writing and will be endorsed or attached to the Policy. Changes requiring regulatory approval will not be valid until approved by the appropriate regulatory body. We will issue new Certificates or riders or endorsements to effect such changes, and only those forms Signed by one of our executive officers will be valid.

No agent, representative or employee of ours or of any other entity, except one of our executive officers, may approve a change to waive any terms of the Policy.

CRITICAL ILLNESS BENEFITS

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

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

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

Benefits are payable up to the total maximum benefit amount shown on the SCHEDULE OF BENEFITS for each Critical Illness. This includes multiple payments for Different Diagnoses. The total maximum benefit amount is the maximum amount payable to you for each Critical Illness in the Certificate during your lifetime.

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

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

BASE MODULE

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

A diagnosis of Heart Attack or Coronary Artery Bypass must be made by a cardiologist or a Doctor familiar with the specific condition, or as indicated by an autopsy report or a death certificate. A diagnosis of Stroke must be made by a neurologist or a Doctor familiar with the diagnosis of Stroke, or as indicated by an autopsy report or a death certificate.

If you are on the UNOS (United Network for Organ Sharing) list for a combined transplant, only one Major Organ Transplant benefit will be payable for the diagnosis. Acceptance on the UNOS list is not required in the case of kidney failure. The "date of diagnosis" for this benefit will be the later of the following:

- The date of diagnosis of the Critical Illness, if it is determined you are not healthy enough to be placed on the UNOS list or you are rejected from the list.
- The date you are placed on the UNOS list for a combined transplant.
- The date of your transplant if the UNOS list requirement was waived.

MAJOR ORGAN MODULE

Benefits for Type 1 Diabetes, Severe Burns, Transient Ischemic Attacks (TIA), Ruptured or Dissecting Aneurysm, Abdominal Aortic Aneurysm, Thoracic Aortic Aneurysm, Open Heart Surgery for Valve Replacement or Repair, Transcatheter Heart Valve Replacement or Repair, Coronary Angioplasty, Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement and Pacemaker Placement are payable when we receive due proof of such condition which is diagnosed on or after your coverage effective date (including the effective date of any changes to coverage).

A diagnosis of Type 1 Diabetes must: 1) be made by a board-certified or board-eligible endocrinologist or other specialist in the treatment of diabetes, 2) be based on blood tests, and 3) require insulin administration for a continuous period of at least 3 months.

A diagnosis of Ruptured or Dissecting Aneurysm, or Transient Ischemic Attacks (TIA) must be confirmed by a neurologist or a Doctor familiar with the diagnosis of the specific condition.

A diagnosis of Abdominal Aortic Aneurysm, or Thoracic Aortic Aneurysm, or Open Heart Surgery for Valve Replacement or Repair, or Transcatheter Heart Valve Replacement or Repair, or Coronary Angioplasty, or Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement, or Pacemaker Placement must be made by a cardiologist or a Doctor familiar with the diagnosis of the specific condition.

One benefit for Open Heart Surgery for Valve Replacement or Repair is payable if the diagnosis is for replacement or repair of one or more valves.

One benefit for Transcatheter Heart Valve Replacement or Repair is payable if the diagnosis is for replacement or repair of one or more valves.

QUALITY OF LIFE MODULE

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

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

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

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

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

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

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

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

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

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

ENHANCED CANCER MODULE

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

CLAIMS

NOTICE OF CLAIM

Written notice of your claim should be given to us within 30 days after the date of loss (date of diagnosis). The notice may be given to us at our home office or to our authorized administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible. If we do not accept your late notice and you believe we were not prejudiced by the failure, please refer to the LEGAL ACTION provision.

CLAIM FORM

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

FILING A CLAIM

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

PROOF OF CLAIM

You must send us Written proof of your claim within 90 days after the date of loss. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. If we do not accept your late proof of claim and you believe we were not prejudiced by the failure, please refer to the LEGAL ACTION provision.

PHYSICAL EXAMINATION

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

BENEFIT PAYMENTS

Benefits are payable to you unless otherwise specified. Once a claim has been approved, we will make payment as soon as possible, but no more than 30 days after receipt of proof of claim. Any accrued benefits that are payable at your death will be paid to the first survivor(s) who is/are living on the date of your death, in the following order:

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

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

“Spouse” in this provision means your lawful spouse.

If a survivor entitled to receive a payment has a special needs trust established, we will make payment to that person’s trust instead of to the person directly.

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

LEGAL ACTION

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

SPOUSE CRITICAL ILLNESS RIDER

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

POLICYHOLDER: Washington County School District

GROUP POLICY NUMBER: 72849-7CC12

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

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SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE

You pay the cost of coverage under this rider.

SPOUSE BENEFIT AMOUNT

Choice of \$7,500 or \$15,000

The BENEFIT AMOUNT for your Spouse will not exceed 50% of your Employee BENEFIT AMOUNT.

SPOUSE CRITICAL ILLNESS BENEFITS

Base module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Heart Attack	100%	2 times the BENEFIT AMOUNT
Cancer	100%	2 times the BENEFIT AMOUNT
Stroke	100%	2 times the BENEFIT AMOUNT
Major Organ Transplant	100%	2 times the BENEFIT AMOUNT
Coronary Artery Bypass	25%	2 times the BENEFIT AMOUNT
Carcinoma in Situ (CIS)	25%	2 times the BENEFIT AMOUNT

Major organ module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Type 1 Diabetes	100%	2 times the BENEFIT AMOUNT
Severe Burns	100%	2 times the BENEFIT AMOUNT
Transient Ischemic Attacks (TIA)	10%	2 times the BENEFIT AMOUNT
Ruptured or Dissecting Aneurysm	10%	2 times the BENEFIT AMOUNT
Abdominal Aortic Aneurysm	10%	2 times the BENEFIT AMOUNT
Thoracic Aortic Aneurysm	10%	2 times the BENEFIT AMOUNT
Open Heart Surgery for Valve Replacement or Repair	25%	2 times the BENEFIT AMOUNT
Transcatheter Heart Valve Replacement or Repair	10%	2 times the BENEFIT AMOUNT
Coronary Angioplasty	10%	2 times the BENEFIT AMOUNT
Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement	25%	2 times the BENEFIT AMOUNT
Pacemaker Placement	10%	2 times the BENEFIT AMOUNT

Enhanced cancer module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Benign Brain Tumor	100%	2 times the BENEFIT AMOUNT
Skin Cancer	10%	2 times the BENEFIT AMOUNT
Bone Marrow Transplant	25%	2 times the BENEFIT AMOUNT
Stem Cell Transplant	25%	2 times the BENEFIT AMOUNT

Quality of life module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Permanent Paralysis	50%	1 times the BENEFIT AMOUNT
Loss of Sight	50%	1 times the BENEFIT AMOUNT
Loss of Hearing	50%	1 times the BENEFIT AMOUNT
Loss of Speech	50%	1 times the BENEFIT AMOUNT
Coma	50%	2 times the BENEFIT AMOUNT
Multiple Sclerosis	25%	1 times the BENEFIT AMOUNT
Amyotrophic Lateral Sclerosis (ALS)	25%	1 times the BENEFIT AMOUNT
Parkinson's Disease	25%	1 times the BENEFIT AMOUNT
Advanced Dementia, including Alzheimer's Disease	50%	1 times the BENEFIT AMOUNT
Infectious Disease	25%	2 times the BENEFIT AMOUNT

SPOUSE CRITICAL ILLNESS BENEFITS

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

DEFINITIONS

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

Spouse means your lawful spouse.

GENERAL PROVISIONS

ELIGIBILITY

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

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

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

ENROLLMENT

If you have a Spouse eligible for Spouse coverage, you must enroll for any Spouse coverage before it will become effective. The Employer or we will provide you with the forms or information needed to complete your enrollment. You may enroll for Spouse coverage when you become newly eligible, or following a qualifying life event as allowed by the Employer, or during an enrollment period chosen by the Employer and approved by us.

EFFECTIVE DATE OF COVERAGE

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

- The date your Spouse is eligible for coverage, if you enroll for Spouse coverage on or before that date.
- The first day of the month that is on or next follows the date you enroll for Spouse coverage.
- The August 1st that is on or next follows the last day of an annual enrollment period, if you enroll for Spouse coverage during an annual enrollment period chosen by the Employer and approved by us.
- The first day of the month that is on or next follows the date you return to Active Employment, if you are not in Active Employment when your Spouse's coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved non-medical leave of absence and paid time off for non-medical-related absences.

EFFECTIVE DATE OF CHANGES TO COVERAGE

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

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

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

TERMINATION

Coverage for your Spouse under this rider terminates on the earliest of the following:

- The date your Critical Illness insurance terminates. See the PORTABILITY FOLLOWING DEATH OR DIVORCE provision below if termination is due to death or regarding Spouse coverage previously continued by your Spouse.
- The date coverage under this rider is terminated for all Active Employees under the Policy. See the PORTABILITY provisions below regarding Spouse coverage previously continued by you or your Spouse.
- The date coverage under this rider is terminated for the eligible class of Active Employees to which you belong. See the PORTABILITY provisions below regarding Spouse coverage previously continued by you or your Spouse.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates.
- The last day of the month during which you voluntarily cancel coverage under this rider.
- The last day of the month during which your Spouse is no longer an eligible Spouse as defined by this rider. See the PORTABILITY FOLLOWING DEATH OR DIVORCE provision below.
- The end of the period for which premiums for this rider are paid, if the next premium is not paid by its due date, subject to the GRACE PERIOD provision.
- The date your Spouse's total maximum benefit amount has been paid for all Critical Illnesses.

We will pay benefits for a loss that occurs while your Spouse is insured under this rider even if the rider has since terminated.

PORTABILITY

If you continue your coverage under the Certificate's PORTABILITY provision, then your Spouse's coverage under this rider may also be continued at the same time. Continued premium payment is required to keep your Spouse's coverage under this rider in force. You may not increase the continued Spouse coverage amount. Continued Spouse coverage under this provision is subject to all the terms of this rider.

PORTABILITY FOLLOWING DEATH OR DIVORCE

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

If your Spouse continues coverage under this provision, your Spouse will become the owner of their Spouse coverage under this rider. Your Spouse may decrease the continued Spouse coverage amount based on the amounts available on this rider's SCHEDULE OF BENEFITS. Your Spouse may not increase the continued Spouse coverage amount. Coverage continued under this provision is subject to all the terms of this rider.

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

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

- The end of the period for which premiums for this rider are paid if the next premium is not paid by its due date, subject to the GRACE PERIOD provision.
- The date your Spouse voluntarily cancels coverage under this rider.
- The date your Spouse dies.
- The date your Spouse's total maximum benefit amount has been paid for all Critical Illnesses.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days Written notice of termination.

GRACE PERIOD

Refer to the GRACE PERIOD provision in the Certificate if you are continuing coverage under the Certificate's PORTABILITY provision.

If your Spouse is continuing coverage under the PORTABILITY FOLLOWING DEATH OR DIVORCE provision, your Spouse has a grace period of 31 days for the payment of any premium due. During this grace period, your Spouse's coverage will remain in force. If the full premium payment is not received by us by the due date, we will give Written notification to your Spouse that if the premium is not paid by the end of the grace period, then all coverage under this rider will terminate on the last day of the grace period. If we fail to give such Written notice, coverage will continue in effect until the date such notice is given. We may extend the grace period by giving Written notice of such intent to your Spouse, and such notice will specify that all coverage will terminate on that date if the premium remains unpaid. A pro rata premium payment is required for any period your Spouse's coverage was in force during the grace period.

CRITICAL ILLNESS BENEFITS

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

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

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

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

Benefits are payable up to the total maximum benefit amount shown on this rider's SCHEDULE OF BENEFITS for each Critical Illness. This includes multiple payments for Different Diagnoses. The total maximum benefit amount is the maximum amount payable for each Critical Illness in this rider during your Spouse's lifetime.

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

When the total maximum benefit amount for your Spouse has been paid for a Critical Illness, no further benefits are payable for that Critical Illness. When the total maximum benefit amount has been paid for all Critical Illnesses, no further benefits are payable and your Spouse's coverage under this rider terminates.

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

CLAIMS

NOTICE OF CLAIM

Written notice of your claim should be given to us within 30 days after the date of loss (date of diagnosis). The notice may be given to us at our home office or to our authorized administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible. If we do not accept your late notice and you believe we were not prejudiced by the failure, please refer to the LEGAL ACTION provision.

CLAIM FORM

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

FILING A CLAIM

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

PROOF OF CLAIM

You must send us Written proof of your claim within 90 days after the date of loss. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. If we do not accept your late proof of claim and you believe we were not prejudiced by the failure, please refer to the LEGAL ACTION provision.

PHYSICAL EXAMINATION

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

BENEFIT PAYMENTS

Benefits under this rider are payable to you. Once a claim has been approved, we will make payment as soon as possible but no more than 30 days after receipt of proof of claim. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For PORTABILITY FOLLOWING DEATH OR DIVORCE, benefits are payable to your Spouse, and any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

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

LEGAL ACTION

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

Executed at our home office:
20 Washington Avenue South
Minneapolis, MN 55401



Robert L. Grubka
President



Melissa A. O'Donnell
Secretary

CHILDREN'S CRITICAL ILLNESS RIDER

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Washington County School District

GROUP POLICY NUMBER: 72849-7CC12

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

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SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE

You pay the cost of coverage under this rider.

CHILDREN'S BENEFIT AMOUNT

50% of Employee BENEFIT AMOUNT

CHILDREN'S CRITICAL ILLNESS BENEFITS

Base module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Heart Attack	100%	2 times the BENEFIT AMOUNT
Cancer	100%	2 times the BENEFIT AMOUNT
Stroke	100%	2 times the BENEFIT AMOUNT
Major Organ Transplant	100%	2 times the BENEFIT AMOUNT
Coronary Artery Bypass	25%	2 times the BENEFIT AMOUNT
Carcinoma in Situ (CIS)	25%	2 times the BENEFIT AMOUNT

Major organ module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Type 1 Diabetes	100%	2 times the BENEFIT AMOUNT
Severe Burns	100%	2 times the BENEFIT AMOUNT
Transient Ischemic Attacks (TIA)	10%	2 times the BENEFIT AMOUNT
Ruptured or Dissecting Aneurysm	10%	2 times the BENEFIT AMOUNT
Abdominal Aortic Aneurysm	10%	2 times the BENEFIT AMOUNT
Thoracic Aortic Aneurysm	10%	2 times the BENEFIT AMOUNT
Open Heart Surgery for Valve Replacement or Repair	25%	2 times the BENEFIT AMOUNT
Transcatheter Heart Valve Replacement or Repair	10%	2 times the BENEFIT AMOUNT
Coronary Angioplasty	10%	2 times the BENEFIT AMOUNT
Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement	25%	2 times the BENEFIT AMOUNT
Pacemaker Placement	10%	2 times the BENEFIT AMOUNT

Enhanced cancer module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Benign Brain Tumor	100%	2 times the BENEFIT AMOUNT
Skin Cancer	10%	2 times the BENEFIT AMOUNT
Bone Marrow Transplant	25%	2 times the BENEFIT AMOUNT
Stem Cell Transplant	25%	2 times the BENEFIT AMOUNT

Quality of life module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Permanent Paralysis	50%	1 times the BENEFIT AMOUNT
Loss of Sight	50%	1 times the BENEFIT AMOUNT
Loss of Hearing	50%	1 times the BENEFIT AMOUNT
Loss of Speech	50%	1 times the BENEFIT AMOUNT
Coma	50%	2 times the BENEFIT AMOUNT
Multiple Sclerosis	25%	1 times the BENEFIT AMOUNT
Amyotrophic Lateral Sclerosis (ALS)	25%	1 times the BENEFIT AMOUNT
Parkinson's Disease	25%	1 times the BENEFIT AMOUNT
Advanced Dementia, including Alzheimer's Disease	50%	1 times the BENEFIT AMOUNT
Infectious Disease	25%	2 times the BENEFIT AMOUNT

CHILDREN'S CRITICAL ILLNESS BENEFITS

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

DEFINITIONS

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

Child or Children means a child from live birth to the end of the month in which the Child reaches 26 years of age, and who is one of the following:

- Your natural or adopted child (including a child placed for adoption).
- Your stepchild.
- A child for whom you are required to provide critical illness/specified disease coverage under a court or administrative order.

The child must also meet all of the following conditions:

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

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

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

Spouse means your lawful spouse.

GENERAL PROVISIONS

ELIGIBILITY

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

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

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

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

Once a claim for Employee benefits under the Policy has been approved, you are not eligible for any new, increased or additional Children's coverage. Once a claim for Child benefits under this rider has been approved, you are not eligible for any new, increased or additional Children's coverage.

ENROLLMENT

If you have a Child or Children eligible for coverage, you must enroll for any coverage before it will become effective. You may enroll for Children's coverage when you become newly eligible, or following a qualifying life event as allowed by the Employer, or during an enrollment period chosen by the Employer and approved by us. The Employer or we will provide you with the forms or information needed to complete your enrollment.

EFFECTIVE DATE

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

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

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

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

EFFECTIVE DATE OF CHANGES TO COVERAGE

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

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

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

TERMINATION

Coverage for each of your Children under this rider ends on the earliest of the following:

- The last day of the month during which the Child is no longer an eligible Child as defined by this rider. Eligibility of a Child who is incapable of self-sustaining employment due to physical or intellectual disability ends when there is no longer evidence satisfactory to us that the incapacity is continuing.
- The date coverage for all your Children ends as described below. The date your Child's total maximum benefit amount has been paid for all Critical Illnesses.

Coverage for all your Children under this rider ends on the earliest of the following:

- The date your Critical Illness insurance terminates. See the PORTABILITY FOLLOWING DEATH provision below if termination is due to death.
- The date coverage under this rider is terminated for all Active Employees under the Policy. See the PORTABILITY provisions below regarding Children's coverage previously continued by you or your Spouse.
- The date coverage under this rider is terminated for the eligible class of Active Employees to which you belong. See the PORTABILITY provisions below regarding Children's coverage previously continued by you or your Spouse.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates.
- The last day of the month during which you voluntarily cancel coverage under this rider.
- The last day of the month during which you no longer have any eligible Children as defined by this rider.
- The end of the period for which premiums for this rider are paid, if the next premium is not paid by its due date, subject to the GRACE PERIOD provision.

We will pay benefits for a loss that occurs while your Child is insured under this rider even if this rider has since terminated.

PORTABILITY

If you continue your coverage under the Certificate's PORTABILITY provision, then your Children's coverage under this rider may also be continued at the same time. Continued premium payment is required to keep your Children's coverage under this rider in force. You may not increase the continued Children's coverage amount. Continued Children's coverage under this provision is subject to all the terms of this rider.

PORTABILITY FOLLOWING DEATH

If you die and your Spouse continues coverage under the PORTABILITY FOLLOWING DEATH OR DIVORCE provision of the Spouse Critical Illness Rider, then Children's coverage under this rider may be continued at the same time under your Spouse's coverage. Following portability of this rider, Children may be covered only if they would have been eligible for coverage under the eligibility rules in force prior to the death of the Employee.

If your Spouse continues coverage under this provision, your Spouse will become the owner of the Children's coverage under this rider. Your Spouse may not increase the continued Children's coverage amount. Coverage continued under this provision is subject to all the terms of this rider.

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

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

- The end of the period for which premiums for this rider are paid, if the next premium is not paid by its due date, subject to the GRACE PERIOD provision.
- The date your Spouse voluntarily cancels coverage under this rider.
- The date your Spouse's coverage under the Spouse Critical Illness Rider terminates.
- The last day of the month during which there are no longer any eligible Children as defined by this rider.
- For each Child, the date your Child's total maximum benefit amount has been paid for all Critical Illnesses.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days Written notice of termination.

GRACE PERIOD

Refer to the GRACE PERIOD provision in the Certificate if you are continuing coverage under the Certificate's PORTABILITY provision.

If your Spouse is continuing Children's coverage under the PORTABILITY FOLLOWING DEATH provision, your Spouse has a grace period of 31 days for the payment of any premium due. During this grace period, your Children's coverage will remain in force. If the full premium payment is not received by us by the due date, we will give Written notification to your Spouse that if the premium is not paid by the end of the grace period, then all coverage under this rider will terminate on the last day of the grace period. If we fail to give such Written notice, coverage will continue in effect until the date such notice is given. We may extend the grace period by giving Written notice of such intent to your Spouse, and such notice will specify that all coverage will terminate on that date if the premium remains unpaid. A pro rata premium payment is required for any period your Children's coverage was in force during the grace period.

CRITICAL ILLNESS BENEFITS

We will pay the BENEFIT AMOUNT as shown on this rider's SCHEDULE OF BENEFITS if your Child is diagnosed with a Critical Illness on or after your Child's coverage effective date. The percentage of BENEFIT AMOUNT payable and any applicable maximum benefit amounts are listed for the Critical Illness on this rider's SCHEDULE OF BENEFITS. Benefits are payable for each covered Child.

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

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

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

Benefits are payable up to the total maximum benefit amount shown on this rider's SCHEDULE OF BENEFITS for each Critical Illness. This includes multiple payments for Different Diagnoses. The total maximum benefit amount is the maximum amount payable for each Critical Illness in this rider during your Child's lifetime.

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

When the total maximum benefit amount for a Child has been paid for a Critical Illness, no further benefits are payable for that Child for that Critical Illness. When the total maximum benefit amount for a Child has been paid for all Critical Illnesses, no further benefits are payable for that Child. When the total maximum benefit has been paid for all Children for all Critical Illnesses, no further benefits are payable and your Children's coverage under this rider terminates.

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

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

CLAIMS

NOTICE OF CLAIM

Written notice of your claim should be given to us within 30 days after the date of loss (date of diagnosis). The notice may be given to us at our home office or to our authorized administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible. If we do not accept your late notice and you believe we were not prejudiced by the failure, please refer to the LEGAL ACTION provision.

CLAIM FORM

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

FILING A CLAIM

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

PROOF OF CLAIM

You must send us Written proof of your claim within 90 days after the date of loss. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. If we do not accept your late notice and you believe we were not prejudiced by the failure, please refer to the LEGAL ACTION provision.

PHYSICAL EXAMINATION

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

BENEFIT PAYMENTS

Benefits under this rider are payable to you. Once a claim has been approved, we will make payment as soon as possible but no more than 30 days after receipt of proof of claim. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For PORTABILITY FOLLOWING DEATH, benefits are payable to your Spouse, and any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

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

LEGAL ACTION

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

Executed at our home office:
20 Washington Avenue South
Minneapolis, MN 55401



Robert L. Grubka
President



Melissa A. O'Donnell
Secretary

CONTINUATION OF INSURANCE RIDER

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Washington County School District

GROUP POLICY NUMBER: 72849-7CC12

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

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DEFINITIONS

Covered Person means:

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

Furlough means you remain an Employee of the Employer; however, the Employer requires or requests your absence from Active Employment for a limited period of time and for which continuation of insurance is available under the Employer's formal policy for furloughs. A Furlough is not intended to be permanent. Furlough also includes suspension of Active Employment caused by unanticipated plant closings that are not expected to be permanent. Furlough does not include a reduction in hours worked or a Temporary Layoff.

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

Labor Strike means you are absent from Active Employment for a period of time for which continuation of insurance is available under the Employer's Written plan for labor strikes.

Material Change to Work Schedule means the Employer has reduced your normal working hours by imposing mandatory unpaid time, and as a result you no longer meet the required minimum hours for Active Employment for your eligible class under the Policy. A Material Change to Work Schedule must be for a limited period of time, it must not be intended to be permanent, and continuation of insurance must be available under the Employer's formal policy for such changes.

Quarantine means you are absent from Active Employment for a period of time during which you are placed in enforced isolation as recommended by public health authority guidance or ordered by a Doctor in connection with carrying or having been exposed to an infectious and contagious disease or condition. Any absence from Active Employment due to Quarantine is subject to approval in Writing by the Employer.

Severance means your Active Employment is terminated and continuation of insurance is available under a severance plan provided by the Employer.

Temporary Layoff means you are absent from Active Employment and no longer an Employee of the Employer for a limited period of time and the layoff is not intended to be permanent.

Total Disability or Totally Disabled means that due to an injury or sickness you are unable to perform the material duties of your regular occupation, and you are unable to perform any other occupation for which you are fit by education, training or experience.

GENERAL PROVISIONS

ELIGIBILITY

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

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

EFFECTIVE DATE

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

CHANGE OF INSURANCE CARRIERS

The CHANGE OF INSURANCE CARRIERS provision in the Certificate is revised to include an Employee whose coverage was being continued under a similar continuation provision in the Employer's prior group policy of critical illness or specified disease insurance at the time the Employer's coverage under our Policy became effective.

TERMINATION

Coverage under this rider terminates on the earliest of the following:

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

PORTABILITY

If you continue your coverage under the Certificate's PORTABILITY provision, that continuation will not include this rider.

CONTINUATION OF INSURANCE

If you stop Active Employment due to:

- Employer-approved Leave of Absence, or
- Total Disability, or
- Furlough, or
- Quarantine, or
- Labor Strike, or
- Severance,

or you have a Material Change to Work Schedule, then coverage may be continued under the Policy beyond the date you are no longer in Active Employment or your hours were reduced, limited to the time period(s) described below.

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

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

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

EMPLOYER-APPROVED LEAVE(S) OF ABSENCE

Family and Medical Leave

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

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

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

Sickness or Injury

If you are on a Leave of Absence due to your sickness or injury, including Total Disability, then insurance coverage for all Covered Persons may be continued under this rider until the earliest of the following:

- The last day of the month which is on or next follows the date your approved Leave of Absence ends.
- The last day of the month which is on or next follows the date which is 9 months after the date you stopped Active Employment.

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

Military Leave

If you are on a Leave of Absence for active military service as described under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") and applicable state law, then insurance coverage for all Covered Persons may be continued under this rider until the earliest of the following:

- The last day of the month which is on or next follows the date your approved Leave of Absence ends.
- The last day of the month which is on or next follows the date which is 3 months after the date you stopped Active Employment.

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

Sabbatical

If you are on a Leave of Absence for an Employer-approved sabbatical, then insurance coverage for all Covered Persons may be continued under this rider until the earliest of the following:

- The last day of the month which is on or next follows the date your approved Leave of Absence ends.
- The last day of the month which is on or next follows the date which is 12 months after the date you stopped Active Employment.

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

FURLOUGH

If you stop Active Employment due to a Furlough, then insurance coverage for all Covered Persons may be continued under this rider until the earliest of the following:

- The last day of the month which is on or next follows the date your Furlough ends.
- The last day of the month which is on or next follows the date which is 3 months after the date you stopped Active Employment.

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

QUARANTINE

If you stop Active Employment due to a Quarantine, then insurance coverage for all Covered Persons may be continued under this rider until the earliest of the following:

- The last day of the month which is on or next follows the last day of the Quarantine period.
- The last day of the month which is on or next follows the date which is 3 months after the date you stopped Active Employment.

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

LABOR STRIKE

If you stop Active Employment due to a Labor Strike, then insurance coverage for all Covered Persons may be continued under this rider until the earliest of the following:

- The last day of the month which is on or next follows the end of the Labor Strike period.
- The last day of the month which is on or next follows the date which is 6 months after the date you stopped Active Employment.

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

SEVERANCE

If your Active Employment terminates and Severance is available, then insurance coverage for all Covered Persons may be continued under this rider until the earliest of the following:

- The last day of the month which is on or next follows the end of the Severance continuation period.
- The last day of the month which is on or next follows the date which is 3 months after the date you stopped Active Employment.

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

CONCURRENT LEAVES OF ABSENCE

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

MATERIAL CHANGE TO WORK SCHEDULE

If you experience a Material Change to Work Schedule, then coverage for all Covered Persons may be continued under this rider until the last day of the month which is on or next follows the date which is 3 months after the date your hours were reduced.

TERMINATION OF CONTINUATION

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

- The end of the continuation period as indicated above.
- The date coverage under this rider is terminated for all Active Employees under the Policy.
- The date coverage under this rider is terminated for the eligible class of Active Employees to which you belong.
- The end of the period for which premiums are paid, if the next premium is not paid by its due date, subject to the GRACE PERIOD provision.
- The date you are eligible under the Policy as an Active Employee.
- The date of your death.

- The date you become covered under another group critical illness or specified disease insurance policy as an employee or member.

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

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

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

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

RETURN TO ACTIVE EMPLOYMENT

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

PORTABILITY FOLLOWING TERMINATION OF CONTINUATION

When continuation under this rider ends, continued premium payment will be required to keep coverage in force. If you are not eligible as an Active Employee on that date, then your coverage can be continued under the Certificate's PORTABILITY provision. See the PORTABILITY provisions of the Spouse Critical Illness Rider and Children's Critical Illness Rider for information about continuing coverage after your death or divorce.

Executed at our home office:
20 Washington Avenue South
Minneapolis, MN 55401



Robert L. Grubka
President



Melissa A. O'Donnell
Secretary

WELLNESS BENEFIT RIDER

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

POLICYHOLDER: Washington County School District

GROUP POLICY NUMBER: 72849-7CC12

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

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SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE

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

WELLNESS BENEFIT

You: \$50
Your Spouse: \$50
Your Children: 50% of your wellness benefit amount per Child

A wellness benefit is payable up to a maximum of one time per Covered Person per calendar year. There is a maximum of \$100 in wellness benefits payable for all Children per calendar year.

DEFINITIONS

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

Covered Person means:

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

GENERAL PROVISIONS

ELIGIBILITY

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

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

Your Spouse is eligible for coverage under this rider on the later of the date above or the date your Spouse is eligible for coverage under the Spouse Critical Illness Rider.

Your Children are eligible for coverage under this rider on the later of the date above or the date each Child is eligible for coverage under the Children's Critical Illness Rider.

EFFECTIVE DATE

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

TERMINATION

Coverage under this rider will terminate on the earliest of the following:

- The date your Critical Illness insurance terminates. See the PORTABILITY FOLLOWING DEATH OR DIVORCE provision below and in the riders if termination is due to death or regarding coverage previously continued by your Spouse.
- The date coverage under this rider is terminated for all Active Employees under the Policy. See the PORTABILITY provisions below.
- The date coverage under this rider is terminated for the eligible class of Active Employees to which you belong. See the PORTABILITY provisions below.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates.
- For your Spouse's coverage, the date your Spouse's coverage under the Spouse Critical Illness Rider terminates.
- For each Child's coverage, the date your Child's coverage under the Children's Critical Illness Rider terminates.

PORTABILITY

If you continue your coverage under the Certificate's PORTABILITY provision, then coverage under this rider will also be continued during portability. Continued coverage under this provision is subject to all the terms of this rider.

PORTABILITY FOLLOWING DEATH OR DIVORCE

If you die or divorce and your Spouse continues coverage under the PORTABILITY FOLLOWING DEATH OR DIVORCE provision of the Spouse Critical Illness Rider, then coverage under this rider will also be continued under your Spouse's coverage. Continued coverage under this provision is subject to all the terms of this rider.

ASSIGNMENT

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

BENEFITS

We will pay you a wellness benefit (shown on the SCHEDULE OF BENEFITS) if a Covered Person has a health screening test on or after the Covered Person's coverage effective date. A benefit is payable up to a maximum of one time per Covered Person per calendar year. The amounts are shown on the SCHEDULE OF BENEFITS.

Health screening tests include, but are not limited to:

- Blood test for triglycerides
- Pap smear or thin prep pap test
- Flexible sigmoidoscopy
- CEA (blood test for colon cancer)
- Bone marrow testing
- Serum cholesterol test for HDL & LDL levels
- Hemoccult stool analysis
- Serum Protein Electrophoresis (myeloma)
- Breast ultrasound, sonogram, MRI
- Chest x-ray
- Mammography
- Colonoscopy
- CA 15-3 (breast cancer)
- Stress test on bicycle or treadmill
- Fasting blood glucose test
- Thermography
- PSA (prostate cancer)
- Electrocardiogram (EKG)
- Endoscopy
- Carotid Doppler
- Routine eye exam
- Routine dental exam
- Well child/preventive exams for ages 1 through 18
- Biometric screenings
- Molecular or antigen test (Coronavirus)

CLAIMS

The PHYSICAL EXAMINATION provision does not apply to this rider.

NOTICE OF CLAIM

Written notice of your claim must be given to us during the same calendar year the health screening test occurs or within 30 days of the end of the calendar year, whichever is later. The notice may be given to us at our home office or to our authorized administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible. If we do not accept your late notice and you believe we were not prejudiced by the failure, please refer to the LEGAL ACTION provision.

CLAIM FORM

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

FILING A CLAIM

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

PROOF OF CLAIM

You must send us Written proof of your claim within 90 days after the date of the health screening test. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. If we do not accept your late proof of claim and you believe we were not prejudiced by the failure, please refer to the LEGAL ACTION provision.

BENEFIT PAYMENTS

Benefits under this rider are payable to you unless otherwise specified. Once a claim has been approved, we will make payment as soon as possible but no more than 30 days after receipt of proof of claim. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For PORTABILITY FOLLOWING DEATH OR DIVORCE, benefits are payable to your Spouse, and any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

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

LEGAL ACTION

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

Executed at our home office:
20 Washington Avenue South
Minneapolis, MN 55401



Robert L. Grubka
President



Melissa A. O'Donnell
Secretary

ReliaStar Life Insurance Company
20 Washington Avenue South, Minneapolis, MN 55401

NOTICE TO CALIFORNIA POLICYHOLDERS/CERTIFICATEHOLDERS
KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

If you have a question about your policy, if you need assistance with a problem, or if you have questions about a claim, you may write to us at the above address or call 1-800-955-7736.

You will need to provide your policy number with any communication.

If you do not reach a satisfactory resolution after having discussions with us, or our agent or representative, or both, you may contact the following unit within the Department of Insurance that deals with consumer affairs:

**California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, California 90013**

**Outside Los Angeles: 1-800-927-HELP (1-800-927-4357)
Los Angeles: (213) 897-8921**

Web Site: www.insurance.ca.gov/01-consumers/101-help

**NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION**

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association (“the Association”). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers’ care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone’s rights or obligations or the rights or obligations of the Association.

COVERAGE

• **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

• **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

• **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- **Life Insurance**
 - 80% of death benefits but not to exceed \$300,000
 - 80% of cash surrender or withdrawal values but not to exceed \$100,000
- **Annuities and Structured Settlement Annuities**
 - 80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed \$250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is \$300,000, regardless of the number of policies or contracts covering the individual.

• **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is \$546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association’s website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state.
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P.O. Box 16860,
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927-4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

IDAHO CERTIFICATE ENDORSEMENT
for Group Critical Illness Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. CERTIFICATE COVER

The following statements are added to the cover page of your Certificate:

Notice to Buyer: This is a specified disease Certificate. This Certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your Certificate carefully with the outline of coverage.

RENEWABILITY

The group Policy is conditionally renewable for an additional year on each Policy anniversary according to the TERMINATION OF COVERAGE and POLICY TERMINATION provisions.

II. SCHEDULE OF BENEFITS

Every benefit amount and total maximum benefit amount (if any) in your Certificate and any riders is a multiple of \$1,000. If any amount does not equal a multiple of \$1,000, then that amount is rounded to the nearest \$1,000.

If your Certificate or any riders include a BENEFIT REDUCTIONS provision or reductions due to age, then the reduced benefit amount is rounded to the nearest \$1,000.

If your Certificate or any riders includes a benefit for Bone Marrow Transplant, then all references to "Bone Marrow Transplant" are changed to: "Bone Marrow Disease, Infection or Damage."

If your Certificate or any riders includes a benefit for Coronary Artery Bypass, then all references to "Coronary Artery Bypass" are changed to: "Critical Coronary Artery Disease."

If your Certificate or any riders includes a benefit for Major Organ Transplant, then all references to "Major Organ Transplant" are changed to "Major Organ Failure."

III. DEFINITIONS

If your Certificate includes a definition of **Abdominal Aortic Aneurysm**, then that definition is revised to remove any reference to surgical repair being advised.

If your Certificate includes a definition of **Bone Marrow Transplant**, then that definition is replaced by the following:

Bone Marrow Disease, Infection or Damage means the clinical diagnosis of bone marrow disease, infection or damage from chemotherapy that has resulted in irreversible bone marrow failure.

If your Certificate contains a definition of **Carcinoma in Situ (CIS)**, then the following is added to the definition:

A clinical diagnosis of Carcinoma in Situ will be accepted as evidence that Carcinoma in Situ exists when a pathological diagnosis cannot be made, provided the medical evidence substantially documents the diagnosis of Carcinoma in Situ.

If your Certificate includes a definition of **Coronary Artery Bypass**, then that definition is replaced by the following:

Critical Coronary Artery Disease means the diagnosis of severe left main or severe multi-vessel coronary artery disease with a SYNTAX score of ≥ 22 .

If the definition of **Hospital** in your Certificate excludes a hospice unit, including any bed designated as a hospice or swing bed, then that exclusion does not apply.

If your Certificate includes a definition of **Major Organ Transplant**, then that definition is replaced by the following:

Major Organ Failure means the diagnosis by a Doctor of irreversible failure of your heart, lung, pancreas, an entire kidney or the entire liver, or any combination of these conditions.

If your Certificate contains a definition of **Pre-Existing Condition**, and the time period in that definition is more than 6 months, then the time period in that definition is limited to 6 months.

If your Certificate contains a definition of **Skin Cancer**, then the following is added to the definition:

A clinical diagnosis of Skin Cancer will be accepted as evidence that Skin Cancer exists when a pathological diagnosis cannot be made, provided the medical evidence substantially documents the diagnosis of Skin Cancer.

If your Certificate includes a definition of **Thoracic Aortic Aneurysm**, then that definition is revised to remove any reference to surgical repair being advised.

IV. GENERAL PROVISIONS

The following provision is added to your Certificate:

CONSUMER NOTICE

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer, you may contact the Department of Insurance:

Idaho Department of Insurance
Consumer Affairs
700 W. State Street, 3rd Floor
P.O. Box 83720
Boise, Idaho 83720-0043

(800) 721-3272
www.DOI.Idaho.gov

V. CRITICAL ILLNESS BENEFITS

If your Certificate includes benefits for Major Organ Transplant (or Major Organ Failure), with reference to the UNOS (United Network Organ Sharing) list, then all references to the UNOS list do not apply.

If your Certificate includes benefits for Parkinson's Disease, then any references to clinical manifestations or activities of daily living are replaced by:

...unable to care for yourself and will continue to decline even with the best medical therapy.

If your Certificate includes benefits for Occupational HIV or Hepatitis B or C, then the following is added:

This benefit does not in any way alter or replace the Employer's obligations under the Workers' Compensation Law.

If your Certificate includes a Child Care Benefit, then the reference to "child" or "children" includes a child placed for adoption.

VI. EXCLUSIONS AND LIMITATIONS

If your Certificate and any riders contain an exclusion for felony or illegal activity, then that exclusion is replaced by the following:

- Participation in a felony.

If your Certificate and any riders contain an exclusion for alcoholism, drug abuse, or misuse of alcohol or taking of drugs, then that exclusion is replaced by the following:

- Alcoholism or drug addiction.

VII. CLAIMS

If the BENEFIT PAYMENTS provision in your Certificate and any riders indicates that there is a time limit on when we will make payment, then that statement is replaced by the following:

Once a claim has been approved, we will make payment immediately upon receipt of due written proof of claim.

VIII. CHILDREN'S CRITICAL ILLNESS RIDER

If your Certificate includes a Children's Critical Illness Rider, then in addition to any changes noted above, this rider is changed as follows:

If the rider includes a benefit for Congenital Birth Defects, then all references to "Congenital Birth Defects" are changed to: "Congenital Anomaly."

In the **DEFINITIONS** section:

If the definition of **Child** or **Children** includes a maximum Child age of less than 25 years, then this maximum is changed to 25 years.

The reference to an adopted child in the definition of **Child** or **Children** is changed to add the following: "Placed" means physical placement in your care, except when physical placement is prevented due to the medical needs of the child, in which case 'placed' means the date you sign an agreement for adoption of the child and assume financial responsibility for the child.

If the definition of **Child** or **Children** includes a requirement that the child be eligible to be claimed by you or your Spouse for federal income tax purposes, then that requirement does not apply to your natural or adopted child.

If the definition of **Child** or **Children** includes any requirements for full-time students over a certain age, then these requirements do not apply.

If the rider contains a definition of **Congenital Birth Defects**, that definition is replaced by the following (if the rider contains no such definition, the following definition is added):

Congenital Anomaly means a condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. The term significant deviation is defined to be a deviation which impairs the function of the body, and includes but is not limited to the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be congenital anomalies.

Examples includes, but are not limited to, the following:

- Heart defects.
- Lung defects.
- Spina Bifida.
- Cleft lip or palate.
- Limb malformations.

Congenital Anomaly includes being born blind without the recommendation of surgery. Congenital Anomaly does not include prematurity.

In the **GENERAL PROVISIONS** section:

If the ELIGIBILITY provision includes a time period following one parent's termination of Employee coverage during which the other parent may enroll for Child coverage, then this time period does not apply.

The following replaces any language in the EFFECTIVE DATE provision specific to a newborn Child (if there is no language specific to a newborn Child, then this is added):

If you have coverage on yourself, your eligible newborn Child is automatically covered for the first 60 days after birth. This includes an adopted newborn Child who is placed with you within 60 days of birth. The coverage amount(s) will be the same as for your other eligible Children. If you do not already have Children's coverage under this rider, then Child coverage beyond the 60th day is subject to the conditions regarding application and Active Employment.

If you pay any part of the cost of coverage under this rider, the Employer will notify you of the premium required for this rider and the date that either payroll deductions will begin or your first premium payment is due, which will not be less than 31 days following your receipt of the notification.

If you have coverage under this rider and you acquire a new eligible Child due to birth, marriage or adoption, then the newly eligible Child will be covered automatically from the date of the event. If an adopted newborn Child is placed with you within 60 days of birth, the "event" will be the date of birth. If an adopted Child is placed with you more than 60 days after birth, the "event" will be the date of placement. No additional premium is required.

In the **CRITICAL ILLNESS BENEFITS** section:

If the rider includes benefits for Additional Child Diseases, then this statement is added:

If any Additional Child Disease is also considered a Congenital Anomaly, only one benefit is payable.

In the **EXCLUSIONS (or EXCLUSIONS AND LIMITATIONS)** section, if any:

If the rider contains a PRE-EXISTING CONDITION EXCLUSION (or LIMITATION) provision, then the following statement is added to that provision:

A Congenital Anomaly is not considered a Pre-Existing Condition.

IX. ABSENCE FROM EMPLOYMENT PREMIUM WAIVER RIDER

If your Certificate includes an Absence from Employment Premium Waiver Rider, then this rider is changed as follows:

In the **DEFINITIONS** section:

If the rider includes a definition of **Waiting Period** and the time period in that definition is more than 30 days (or more than 1 month if shown in months), then this time period is limited to 30 days (or 1 month).

X. OUTLINE OF COVERAGE FOR IDAHO RESIDENTS

See the next page for the Outline of Coverage for Idaho Residents.

XI. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.



Melissa A. O'Donnell
Secretary

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

SPECIFIED DISEASE COVERAGE

**THE CERTIFICATE PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER MEDICAL EXPENSES**

OUTLINE OF COVERAGE FOR IDAHO RESIDENTS

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the "Guide to Health Insurance for People With Medicare" available from the company.

This coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. Persons covered under Medicaid should not purchase it.

Read Your Certificate Carefully. This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR CERTIFICATE CAREFULLY!

Specified disease coverage is designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of specified diseases. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

The policy provides a lump-sum benefit if a covered person is diagnosed with any of the covered illnesses/conditions listed on the Schedule of Benefits. Commonly covered conditions include: **heart attack, cancer, stroke, major organ failure, coronary artery disease, and carcinoma in situ (CIS)**. Please consult your certificate and riders for specific information about the conditions covered, how terms are used, any requirements that describe qualifying for a particular loss, and the benefit amounts. If you pay all or part of the cost of coverage, then the enrollment materials you received also contain a description of benefits available under the Policy.

In order for a benefit to be payable, the specified disease must be diagnosed after the covered person's coverage effective date. **A pre-existing condition exclusion or limitation may apply to a specified disease diagnosed during the first year that coverage (or an increase in coverage) is in force. Coverage may reduce based on age.** Benefit payment is contingent on proof of loss which may require additional information be provided prior to claim determination. The Policyholder may choose to have an eligibility waiting period, during which time no coverage is in force.

The exclusions that apply to all provisions for specified disease coverage are provided in the "Exclusions" section of the certificate and any riders. The "Schedule of Benefits," the Benefits section(s) and the "Exclusions" section of the certificate and any riders provide specific information about the conditions for receiving benefits and any limitations. If you pay all or part of the cost of coverage, then the enrollment materials you received also contain a description of the exclusions and limitations under the policy.

The eligibility requirements for a spouse and children may include age limitations, as provided in the riders. If you pay all or part of the cost of coverage, then the enrollment materials you received also contain a description of any age limitations under the policy.

Your coverage will continue under the policy, while the policy remains in force, as long as you continue to meet the eligibility requirements and all premiums due are paid. You may have the option to continue your coverage by direct payment of premiums to ReliaStar Life Insurance Company after you no longer meet the eligibility requirements.

The Policyholder may change the terms of the policy at any time with ReliaStar Life Insurance Company's agreement. The Policyholder or ReliaStar Life Insurance Company may terminate the policy at any time. ReliaStar Life Insurance Company reserves the right to change premiums at any time according to the terms of the policy.

ReliaStar Life Insurance Company

20 Washington Avenue South
Minneapolis, Minnesota 55401
(612) 372-5432

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

If the insurer or health maintenance organization that issued your life, annuity or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy or contract from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer or the health maintenance organization.

In addition, residents of Minnesota who purchase life insurance, annuities, health insurance, or health maintenance coverage from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer or health maintenance organization becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations.

Minnesota Life and Health Insurance Guaranty Association
3300 Wells Fargo Center
90 South Seventh Street
Minneapolis, Minnesota 55402
Telephone: (612) 322-8713

The maximum amount the Guaranty Association will pay for all policies or contracts issued on one life by the same insurer or health maintenance organization is limited to \$500,000. Subject to this \$500,000 limit, the Guaranty Association will pay up to \$500,000 in life insurance death benefits, \$130,000 in net cash surrender and net cash withdrawal values for life insurance, \$500,000 in health insurance, health maintenance organization, and long-term care benefits, including any net cash surrender and net cash withdrawal values, \$500,000 in disability income insurance, \$250,000 in annuity net cash surrender and net cash withdrawal values, \$410,000 in the present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be \$500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue code of 1986, as amended through December 31, 1992, are covered up to \$250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than \$10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed \$10,000,000, the \$10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the Guaranty Association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the Guaranty Association's limits you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The Guaranty Association assesses insurers and health maintenance organizations licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY CONTRACT OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, HEALTH INSURANCE, OR HEALTH MAINTENANCE ORGANIZATION POLICIES AND CONTRACTS OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY IMPAIRED OR INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, HEALTH INSURANCE, AND HEALTH MAINTENANCE ORGANIZATION POLICIES AND CONTRACTS ARE REQUIRED TO PROVIDE THIS NOTICE.

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

TEXAS CERTIFICATE ENDORSEMENT
for Group Critical Illness Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. DEFINITIONS

If your Certificate includes a Children's Critical Illness Rider, then the definition of **Child** or **Children** is changed as follows:

If the definition includes a maximum Child age of less than 25 years, then this maximum is changed to 25 years.

The definition includes your unmarried grandchild who is your dependent for federal income tax purposes on the date the grandchild is first eligible under this rider. The definition also includes a child for whom you must provide medical support under a court order.

If the definition includes any requirements for full-time students over a certain age, then these requirements do not apply.

II. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.



Melissa A. O'Donnell
Secretary

Texas Residents: 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.

ReliaStar Life Insurance Company

To get information or file a complaint with your insurance company:

Call: Customer Contact Center Manager at 1-800-955-7736

Toll-free: 1-888-238-4840 for Life Insurance and 1-877-236-7564 for Supplemental Benefits Insurance

Email: LifeClaims@voya.com

Mail: 20 Washington Avenue South, Minneapolis, MN 55401

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 149091, Austin, TX 78714-9091

Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamacion o con su prima de seguro, llame primero a su compania de seguros. Si no puedo resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, pro su nombre en ingles) pueda ayudar.

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

ReliaStar Life Insurance Company

Para obtener informacion o para presentar una queja ante su compania de seguros:

Llame a: Customer Contact Center Manager at 1-800-955-7736

Telefono gratuito: 1-888-238-4840 for Life Insurance and 1-877-236-7564 for Supplemental Benefits Insurance

Correo electronico: LifeClaims@voya.com

Direccion postal: 20 Washington Avenue South, Minneapolis, MN 55401

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacion ada 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 electronico: ConsumerProtection@tdi.texas.gov

Direccion postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

Notice of Protection Provided by Utah Life and Health Insurance Guaranty Association

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies. (For the purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs) and limited health plans.)

The basic protections provided by the Association are:

- Life Insurance
 - o \$500,000 in death benefits
 - o \$200,000 in cash surrender or withdrawal values
- Health Insurance
 - o \$500,000 in hospital, medical and surgical insurance benefits
 - o \$500,000 in long-term care insurance benefits
 - o \$500,000 for disability income insurance benefits
 - o \$500,000 in other types of health insurance benefits
- Annuities
 - o \$250,000 in the present value of annuity benefits in aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$500,000. Special rules may apply with regard to hospital, medical, and surgical insurance benefits.

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Utah law.

To learn more about the above protections, please visit the Association's website at www.utlifega.org, or contact:

Utah Life and Health Insurance Guaranty Assoc.
32 West 200 South #150
Salt Lake City, UT 84101
(801)320-9955

Utah Insurance Department
State Office Bldg., Rm. 3110
Salt Lake City, UT 84114
(801) 538-3800

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