YOUR CRITICAL ILLNESS INSURANCE PLAN

For Employees of
Sierra View Medical Center

D9105 (12/22)

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:	Sierra View Medical Center
GROUP POLICY NUMBER:	70789-9CCI2
POLICY EFFECTIVE DATE:	January 1, 2023
GOVERNING JURISDICTION:	California

Benefits are paid for Critical Illnesses as defined in the Certificate. This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law. Benefits are paid under the Policy for Critical Illnesses as indemnity insurance and are not intended to cover medical expenses.

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

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

This certificate provides benefits for Cancer. The benefit amount payable is the different for a diagnosis of Cancer (Invasive) or Cancer (Non-Invasive) or Skin Cancer. No benefits are payable for a diagnosis of premalignant conditions or polyps. Refer to the SCHEDULE OF BENEFITS for benefit amounts. The definitions of Cancer (Invasive) and Cancer (Non-Invasive) and Skin Cancer are located in the DEFINITIONS section. The differences in these definitions are primarily related to the growth and/or spread of abnormal cells or their potential to spread beyond their original site, as determined by a Doctor. The benefit amount payable for Cancer (Non-Invasive) and Skin Cancer may be substantially less than the benefit amount payable for Cancer (Invasive) due to these differences.

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 are age 65 or older on the effective date of any coverage under the Policy for which you are required to pay all or part of the premium, then you have 30 days from the date you receive your initial Certificate to cancel your coverage and have your full premium contribution refunded, by returning the Certificate to the Policyholder for cancellation without claim.

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

RELIASTAR LIFE INSURANCE COMPANY
P.O. Box 20, Minneapolis, Minnesota 55440

CONSUMER NOTICE

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 1-888-238-4840.

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

TABLE OF CONTENTS

Section	Page
Cover Page	1
Consumer Notice	2
Table of Contents	3
Outline of Coverage	4
Schedule of Benefits	5
Definitions	8
General Provisions	15
Critical Illness Benefits	19

RELIASTAR LIFE INSURANCE COMPANY

OUTLINE OF COVERAGE

This outline is only a summary of certain provisions in your Certificate. You must consult the Policy and Certificate for contract provisions regarding coverage.

Category of Coverage: Specified Disease. This category of coverage is designed to provide, to persons insured, benefits ONLY when certain losses occur as a result of specified diseases. Benefits are not provided for basic hospital, basic medical-surgical, or major-medical expenses.

Benefits: See the SCHEDULE OF BENEFITS and CRITICAL ILLNESS BENEFITS sections of the Certificate.

Exceptions, Reductions and Limitations: See the SCHEDULE OF BENEFITS, CRITICAL ILLNESS BENEFITS, and if applicable, the EXCLUSIONS sections of the Certificate.

Continuation of Coverage: See the GENERAL PROVISIONS section of the Certificate.

Premiums: Information about your premium contribution for coverage may be obtained from the Policyholder.

SCHEDULE OF BENEFITS

EMPLOYER: Sierra View Medical Center

GROUP POLICY NUMBER: 70789-9CCI2

INSURED PERSON:

You must write your name in the space provided so that it becomes your Certificate. The date you are eligible for coverage is described in the GENERAL PROVISIONS section.

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.

Employees who are not citizens or legal residents of the United States are excluded from coverage.

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.

REHIRE

If your employment with the Employer ends and you are rehired within 12 months, your previous Active Employment while in an eligible class will apply toward the Eligibility Waiting Period. All other Policy provisions apply.

CREDIT FOR PRIOR SERVICE

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

WHO PAYS FOR THE COVERAGE

You pay the cost of your coverage.

BENEFIT AMOUNT

Choice of $10,000 or $20,000

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 (Invasive)	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
Cancer (Non-Invasive)	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	100%	1 times the BENEFIT AMOUNT
Loss of Sight, Hearing or Speech	100%	3 times the BENEFIT AMOUNT
Coma	100%	2 times the BENEFIT AMOUNT
Multiple Sclerosis	50%	1 times the BENEFIT AMOUNT
Amyotrophic Lateral Sclerosis (ALS)	50%	1 times the BENEFIT AMOUNT
Parkinson’s Disease	50%	1 times the BENEFIT AMOUNT
Advanced Dementia, including Alzheimer’s Disease	50%	1 times the BENEFIT AMOUNT
Huntington’s Disease (Huntington’s Chorea)	50%	1 times the BENEFIT AMOUNT
Muscular Dystrophy	50%	1 times the BENEFIT AMOUNT
Infectious Disease	25%	2 times the BENEFIT AMOUNT
Addison’s Disease	10%	1 times the BENEFIT AMOUNT
Myasthenia Gravis	25%	1 times the BENEFIT AMOUNT
Systemic Lupus Erythematosus (SLE)	25%	1 times the BENEFIT AMOUNT
Systemic Sclerosis (Scleroderma)	10%	1 times the BENEFIT AMOUNT

DEFINITIONS

Active Employment means you are working for the Employer for earnings that are paid regularly. You must be working at least the minimum number of hours as described under the MINIMUM HOURS REQUIREMENT shown in the SCHEDULE OF BENEFITS.

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

Normal vacation is considered Active Employment.
Temporary and seasonal workers are excluded from coverage.

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.

Addison's Disease means the diagnosis of a long-term endocrine disorder that occurs when your body produces insufficient amounts of steroid hormones produced by your adrenal glands, confirmed via blood tests, urine tests, or medical imaging.

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

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

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

For purposes of the Policy, the following are not considered Benign Brain Tumors:
- Tumors of the skull;
- Pituitary adenomas; and
- Germinomas.

Benign Brain Tumor does not include diagnosis of any of the following conditions prior to your coverage effective date:
- Neurofibromatosis I;
- Neurofibromatosis II;
- Von Hippel Lindau;
- Tuberous Sclerosis;
- Li Fraumani Syndrome;
- Cowden Disease; and
- Turcot Syndrome.

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

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

Cancer (Invasive) 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 (Invasive) must be established according to the criteria of the American Board of Pathology or the American Joint Committee on Cancer. This includes a clinical diagnosis whenever such diagnosis is consistent with professional medical standards

For the purposes of the Policy, the following are not considered Cancer (Invasive):
- Cancer (Non-Invasive);
- Skin Cancer;
- Pre-malignant conditions or polyps; and
- Any other histologically benign or nonmalignant condition.

Cancer (Non-Invasive) (also known as carcinoma in situ) means the diagnosis of tumor cells tending toward malignancy but that do not invade the underlying tissue or have the ability to spread beyond the site from which they originate (e.g. malignant cells confined to the epithelium without penetration of the basement membrane). The diagnosis of Cancer (Non-Invasive) must be established according to the criteria of the American Board of Pathology or the American Joint Committee on Cancer. This includes a clinical diagnosis whenever such diagnosis is consistent with professional medical standards.

For purposes of the Policy, the following are not considered Cancer (Non-Invasive):
- Cancer (Invasive);
- Skin Cancer;
- Pre-malignant conditions or polyps; and
- Any other histologically benign or nonmalignant condition.

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

Coma means the diagnosis of a continuous state of profound unconsciousness, characterized by having a Glasgow scale of 3; defined as the absence of:
- Eye opening;
- Verbal response; and
- Motor response.

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

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

Coronary 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 $\geq$23) for which is advised an open heart coronary artery bypass surgery - a surgical procedure that requires an incision through the chest and an incision in the heart and/or attached blood vessels.

Critical Illness means any of the following as defined:

- Abdominal Aortic Aneurysm; or
- Addison's Disease; or
- Advanced Dementia; or
- Amyotrophic Lateral Sclerosis (ALS); or
- Benign Brain Tumor; or
- Bone Marrow Transplant; or
- Cancer (Invasive); or
- Cancer (Non-Invasive); or
- Coma; or
- Coronary Angioplasty; or
- Coronary Artery Bypass; or
- Heart Attack; or
- Huntington's Disease (Huntington's Chorea); 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
- Muscular Dystrophy; or
- Myasthenia Gravis; 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
- Systemic Lupus Erythematosus (SLE); or
- Systemic Sclerosis (Scleroderma); 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. Note: A Cancer (Invasive) that has spread to a different area of the body is not a different illness/condition than the previously diagnosed Cancer (Invasive).
- A subsequent diagnosis of a Critical Illness that is for the same illness/condition (including a Cancer (Invasive) that has spread to a different area of the body) as a Critical Illness for which benefits were payable under the Policy, and that occurs more than 12 months after the date of the previous diagnosis.
- A subsequent diagnosis of a Critical Illness that is for the same illness/condition (including a Cancer (Invasive) that has spread to a different area of the body) as an illness/condition diagnosed prior to your coverage effective date under the Policy, and that occurs more than 30 days after the date of the previous diagnosis.

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

- A diagnosis of Skin Cancer is considered a Different Diagnosis from Cancer (Invasive) or Cancer (Non-Invasive).
- A diagnosis of Cancer (Non-Invasive) is considered a Different Diagnosis from Cancer (Invasive).

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

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

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

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

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

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

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

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

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

Huntington's Disease (Huntington’s Chorea) means the diagnosis of an inherited disease that causes the progressive degeneration of nerve cells in the brain. The Huntington’s Disease (Huntington’s Chorea) diagnosis must be based on symptoms and laboratory testing.

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 a severe infectious disease that results in you being confined to a Hospital for five (5) or more consecutive days or confined to a transitional care facility for fourteen (14) or more consecutive days.

Examples include, but are not limited to:

- Polio;
- Rabies;
- Meningitis;
- Lyme’s Disease;

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

Insured Person means an Employee covered under the Policy and whose coverage remains in effect according to the terms of the Policy.

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

Loss of Sight means the diagnosis of clinically proven irreversible reduction of sight in both eyes with:
- Sight in the better eye reduced to a best corrected visual acuity of less than 6/60 (metric acuity) or 20/200 (Snellen or E-Chart Acuity); or
- Visual field restriction to 20 degrees or less in both eyes.

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

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

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

Muscular Dystrophy means the diagnosis of a group of muscle diseases that weaken the musculoskeletal system and are characterized by progressive skeletal muscle weakness, defects in muscle proteins, and the death of muscle cells and tissue.

Myasthenia Gravis means the diagnosis of a neuromuscular disease characterized by weakness and rapid fatigue of any of the muscles under your voluntary control.

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

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.

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

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

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

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.

For purposes of the Policy, aneurysms of the arm or leg are not considered a Ruptured or Dissecting Aneurysm.

Same Diagnosis means either of the following:

- A subsequent diagnosis of a Critical Illness that is for the same illness/condition (including a Cancer (Invasive) that has spread to a different area of the body) as a Critical Illness for which benefits were payable under the Policy, and that occurs within 12 months of the date of the previous diagnosis.
- A subsequent diagnosis of a Critical Illness that is for the same illness/condition (including a Cancer (Invasive) that has spread to a different area of the body) as an illness/condition diagnosed prior to your coverage effective date under the Policy, and that occurs within 30 days 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.

Skin Cancer means the diagnosis of tumor cells tending toward malignancy and which invade the underlying tissue or are present in situ. The diagnosis of Skin Cancer must be established according to the criteria of the American Board of Pathology or the American Joint Committee on Cancer. This includes a clinical diagnosis whenever such diagnosis is consistent with professional medical standards.

Skin Cancer includes:

- Basal cell carcinoma and squamous cell carcinoma of the skin including squamous cell carcinoma in situ; and
- Melanoma that is diagnosed as Breslow's classification less than 0.75mm or which is considered melanoma in situ. Melanoma that is deeper than 0.75mm is considered to be Cancer (Invasive) instead of Skin Cancer.

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

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

Stroke does not include:

- Transient ischemic attacks (TIA)
- Temporary neurological deficits lasting less than 24 hours that result from a variety of causes; can be a precursor to stroke; but, does not result in infarction/death of brain tissue.
- Ischemic disorders of the vestibular system;
- Brain injury related to trauma or infection; or
- Brain injury associated with hypoxia/anoxia or hypotension.

Systemic Lupus Erythematosus (SLE) means the diagnosis of an autoimmune disease that occurs when your body's immune system attacks your own tissues and organs.

Systemic Sclerosis (Scleroderma) means the diagnosis of an autoimmune disease that involves the hardening and tightening of the skin and connective tissues.

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 is advised a procedure, performed through the blood vessels, to repair or replacement of one or more of the heart valves.

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.

GENERAL PROVISIONS

ELIGIBILITY

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

- The Policy effective date.
- The day after you complete your Eligibility Waiting Period, unless waived. **Exception:** If your Eligibility Waiting Period ends on the first day of the month, this eligibility date is the day you complete your Eligibility Waiting Period.

EFFECTIVE DATE OF COVERAGE

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

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

EFFECTIVE DATE OF CHANGES TO COVERAGE

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

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

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

TERMINATION OF COVERAGE

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

- The date the Policy is canceled.
- The date you are no longer in an eligible class.
- The date your eligible class is no longer covered.
- The date you voluntarily cancel your coverage.
- The end of the period for which you paid premiums, if you stop making a required premium contribution, subject to the grace period.
- The end of the grace period after a premium due date, if the premium is not paid.
- The last day you are in Active Employment.
- The date the total maximum benefit amount has been paid for all Critical Illnesses.

Termination of your coverage will be without prejudice to any claim originating prior to the effective date of such termination.

POLICY CANCELLATION

We may cancel this Policy at any time by written notice delivered to the Policyholder, or mailed to the Policyholder's last address as shown on our records, stating when, not less than 31 days thereafter, such cancellation shall be effective. The Policyholder may cancel this Policy at any time by written notice delivered or mailed to us at our home office, effective on receipt or on such later date as may be specified in the notice. In the event of such cancellation by either us or by the Policyholder, we shall promptly return on a prorata basis the unearned premium paid, if any, and the Policyholder shall promptly pay on a prorata basis the earned premium which has not been paid. (In computing the prorata premium to be returned by us or to be paid by the Policyholder, any discounts in premium or premium rate actually allowed to the Policyholder because of the longer periods for which premiums, at the time of the cancellation, had been paid or agreed to be paid shall be disregarded, and the prorata return or payment of premium will be computed upon the basis of our regular and customary premium or premium rate for the coverage of this Policy.) Such cancellation shall be without prejudice to any claim originating prior to the effective date of such cancellation.

PORTABILITY

Portability means you have the option to continue your coverage after it would otherwise terminate if certain conditions are met. You must elect portability before you reach age 70.

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

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

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

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

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

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

GRACE PERIOD

A grace period of 60 days will be granted for the payment of premiums accruing after the first premium during which grace period the Policy shall continue in force, but the Policyholder shall be liable to us for the payment of the premium accruing for the period the Policy continues in force.

If you are on portability, you also have a grace period of 31 days for the payment of any premium due. During the grace period your coverage will remain in force, but you shall be liable to us for the payment of the premium accruing for the period your coverage remains in force.

TIME LIMIT ON CERTAIN DEFENSES

After three years from the date of issue of the Policy, no misstatement of the Policyholder, except a fraudulent misstatement, made in the application shall be used to void the Policy. After three years from your effective date of coverage under the Policy, no misstatements, except fraudulent misstatements, made by you in your application for coverage shall be used to deny a claim for loss incurred after the expiration of the three-year period.

CLERICAL ERROR

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

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

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

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

NOTICE OF CLAIM

Written notice of claim must be given to us within 30 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of you to us at P.O. Box 20, Minneapolis, MN 55440 or to our authorized agent, with information sufficient to identify you, shall be deemed notice to us.

PROOF OF LOSS
Written proof of loss must be furnished to us within 90 days after the date of such loss. Failure to submit such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of your legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS
Indemnities payable under the Policy will be paid to you as they accrue immediately upon receipt of due written proof of such loss.

PHYSICAL EXAMINATION
At our expense, we shall have the right and opportunity to require you (your Person) to be examined as it relates to the Critical Illness that is the basis of the claim. We can require such examination when and as often as we may reasonably require during the pendency of a claim.

BENEFIT PAYMENTS
Benefits are payable to you unless otherwise specified. 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 biological 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. It includes your registered domestic partner who is recognized as equivalent to a spouse by California law. It also includes your domestic partner as defined by the Employer if you have completed and signed an affidavit of domestic partnership on a form acceptable to the Employer.

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
No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

MISSTATEMENT OF AGE
If your age has been misstated, all amounts payable to you under the Policy shall be such as the premium paid would have purchased at the correct age.

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

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

CHANGES TO POLICY OR CERTIFICATE

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

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

CRITICAL ILLNESS BENEFITS

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

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

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

Critical Illness benefits, including benefits for Cancer (Invasive) and Cancer (Non-Invasive) and Skin Cancer and Benign Brain Tumor, are based on diagnosis and not on treatment or expenses. As an example: A group policy has a $20,000 critical illness benefit amount. The percentage of the benefit amount payable for Cancer (Invasive) is 100% and the percentage for Cancer (Non-Invasive) is 25%. Under this example, benefits would be calculated as follows:

- **An Employee has a lump in her breast and she is diagnosed with stage III breast cancer. This diagnosis meets the Policy definition of Cancer (Invasive). $20,000 benefit amount x 100% = $20,000.**
- **Another Employee has a lump in her breast and she is diagnosed with breast ductal carcinoma in situ (DCIS). This diagnosis meets the Policy definition of Cancer (Non-Invasive). $20,000 benefit amount x 25% = $5,000.**

These examples are for illustrative purposes only. Refer to the SCHEDULE OF BENEFITS for coverage amounts and covered conditions. All benefits are subject to the terms of this Certificate.

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 (Invasive), Stroke, Major Organ Transplant, Coronary Artery Bypass and Cancer (Non-Invasive) are payable when we receive due proof of such condition which is diagnosed after your coverage effective date (including the effective date of any changes to coverage).

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

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.

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 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, or 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, Huntington's Disease (Huntington's Chorea), Muscular Dystrophy, Infectious Disease, Addison's Disease, Myasthenia Gravis, Systemic Lupus Erythematosus (SLE) and Systemic Sclerosis (Scleroderma) are payable when we receive due proof of such condition which is diagnosed after your coverage effective date (including the effective date of any changes to coverage).

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

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

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

A diagnosis of Muscular Dystrophy, Myasthenia Gravis, Multiple Sclerosis or Huntington's Disease (Huntington's Chorea) 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.

A diagnosis of Systemic Lupus Erythematosus (SLE) or Systemic Sclerosis (Scleroderma) must be confirmed by a rheumatologist or a Doctor familiar with the diagnosis of the specific condition.

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

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

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

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

ENHANCED CANCER MODULE

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

A diagnosis of Benign Brain Tumor or Skin Cancer must be made by a Doctor familiar with the specific condition.

SPOUSE CRITICAL ILLNESS RIDER

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Sierra View Medical Center

GROUP POLICY NUMBER: 70789-9CCI2

INSURED PERSON:

SPOUSE:

You must write your name and your Spouse's name in the spaces provided so that it becomes your rider. The date your Spouse is eligible for coverage is described in the GENERAL PROVISIONS section of this rider.

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

CONTENTS

Section	Page
Schedule of Benefits	1
Definitions	4
General Provisions	4
Critical Illness Benefits	5

SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE

You pay the cost of coverage under this rider.

SPOUSE BENEFIT AMOUNT

Choice of $5,000 or $10,000

The BENEFIT AMOUNT for your Spouse will not exceed 100% 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 (Invasive)	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
Cancer (Non-Invasive)	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	100%	2 times the BENEFIT AMOUNT
Loss of Sight, Hearing or Speech	100%	2 times the BENEFIT AMOUNT
Coma	100%	2 times the BENEFIT AMOUNT
Multiple Sclerosis	50%	2 times the BENEFIT AMOUNT
Amyotrophic Lateral Sclerosis (ALS)	50%	2 times the BENEFIT AMOUNT
Parkinson's Disease	50%	2 times the BENEFIT AMOUNT
Advanced Dementia, including Alzheimer's Disease	50%	2 times the BENEFIT AMOUNT
Huntington's Disease (Huntington's Chorea)	50%	2 times the BENEFIT AMOUNT
Muscular Dystrophy	50%	2 times the BENEFIT AMOUNT
Infectious Disease	25%	2 times the BENEFIT AMOUNT
Addison's Disease	10%	2 times the BENEFIT AMOUNT
Myasthenia Gravis	25%	2 times the BENEFIT AMOUNT
Systemic Lupus Erythematosus (SLE)	25%	2 times the BENEFIT AMOUNT
Systemic Sclerosis (Scleroderma)	10%	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. It includes your registered domestic partner who is recognized as equivalent to a spouse by California law. It also includes your domestic partner as defined by the Employer if you have completed and signed an affidavit of domestic partnership on a form acceptable to the Employer. Any reference to marriage includes establishment of a domestic partnership. Any reference to divorce includes termination of a domestic partnership.

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

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

EFFECTIVE DATE

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

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

EFFECTIVE DATE OF CHANGES TO COVERAGE

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

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

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

TERMINATION

This rider terminates on the earliest of the following:

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

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

PORTABILITY FOLLOWING DEATH OR DIVORCE
If you die or divorce, your Spouse can apply to continue Spouse coverage if certain conditions are met. Your Spouse must have been insured under this rider on the date of your death or divorce, your Spouse must be under age 70 and your Spouse must apply for portability and pay the first premium within 31 days of the date of your death or divorce.

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

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

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

PHYSICAL EXAMINATION
At our expense, we shall have the right and opportunity to require your Spouse to be examined as it relates to the Critical Illness that is the basis of the claim. We can require such examination when and as often as we may reasonably require during the pendency of a claim.

BENEFIT PAYMENTS
Benefits under this rider are payable to you. 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, 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.

CRITICAL ILLNESS BENEFITS

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

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

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

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

Critical Illness benefits, including benefits for Cancer (Invasive) and Cancer (Non-Invasive) and Skin Cancer and Benign Brain Tumor, are based on diagnosis and not on treatment or expenses. As an example: A group policy has a $20,000 critical illness benefit amount. The percentage of the benefit amount payable for Cancer (Invasive) is 100% and the percentage for Cancer (Non-Invasive) is 25%. Under this example, benefits would be calculated as follows:

- **A Spouse has a lump in her breast and she is diagnosed with stage III breast cancer. This diagnosis meets the Policy definition of Cancer (Invasive). $20,000 benefit amount x 100% = $20,000.**
- **Another Spouse has a lump in her breast and she is diagnosed with breast ductal carcinoma in situ (DCIS). This diagnosis meets the Policy definition of Cancer (Non-Invasive). $20,000 benefit amount x 25% = $5,000.**

These examples are for illustrative purposes only. Refer to the SCHEDULE OF BENEFITS for coverage amounts and covered conditions. All benefits are subject to the terms of the Certificate and this rider.

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 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.

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: Sierra View Medical Center

GROUP POLICY NUMBER: 70789-9CCI2

INSURED PERSON:

You must write your name in the space provided so that it becomes your rider. The date your Child is eligible for coverage is described in the GENERAL PROVISIONS section of this rider.

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

CONTENTS

Section	Page
Schedule of Benefits	1
Definitions	4
General Provisions	4
Critical Illness Benefits	6

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 (Invasive)	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
Cancer (Non-Invasive)	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	100%	2 times the BENEFIT AMOUNT
Loss of Sight, Hearing or Speech	100%	2 times the BENEFIT AMOUNT
Coma	100%	2 times the BENEFIT AMOUNT
Multiple Sclerosis	50%	2 times the BENEFIT AMOUNT
Amyotrophic Lateral Sclerosis (ALS)	50%	2 times the BENEFIT AMOUNT
Parkinson's Disease	50%	2 times the BENEFIT AMOUNT
Advanced Dementia, including Alzheimer's Disease	50%	2 times the BENEFIT AMOUNT
Huntington's Disease (Huntington's Chorea)	50%	2 times the BENEFIT AMOUNT
Muscular Dystrophy	50%	2 times the BENEFIT AMOUNT
Infectious Disease	25%	2 times the BENEFIT AMOUNT
Addison's Disease	10%	2 times the BENEFIT AMOUNT
Myasthenia Gravis	25%	2 times the BENEFIT AMOUNT
Systemic Lupus Erythematosus (SLE)	25%	2 times the BENEFIT AMOUNT
Systemic Sclerosis (Scleroderma)	10%	2 times the BENEFIT AMOUNT

CHILDREN'S CRITICAL ILLNESS BENEFITS

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

DEFINITIONS

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

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

- Your biological or adopted child (including a child placed for adoption).
- Your stepchild.
- A child of your registered domestic partner who is recognized as equivalent to a spouse by California law.
- A child of your domestic partner as defined by the Employer if you have completed and signed an affidavit of domestic partnership on a form acceptable to the Employer.
- Your foster child or a child or grandchild for whom you are a legal guardian.
- Your grandchild if the child's parent is insured as your Child under this rider.

The child must also meet all of the following conditions:

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

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

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

Spouse means your lawful spouse. It includes your registered domestic partner who is recognized as equivalent to a spouse by California law. It also includes your domestic partner as defined by the Employer if you have completed and signed an affidavit of domestic partnership on a form acceptable to the Employer. Any reference to marriage includes establishment of a domestic partnership. Any reference to divorce includes termination of a domestic partnership.

GENERAL PROVISIONS

ELIGIBILITY

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

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

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

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

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.

EFFECTIVE DATE

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

- The date your Children are eligible for coverage, if you apply for Children's coverage on or before that date.
- The date you apply for Children's coverage.
- The date you return to Active Employment, if you are not in Active Employment when your Children'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 nonmedical leave of absence and paid time off for nonmedical-related absences.

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 Child ends on the earliest of the following:

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

This rider terminates on the earliest of the following:

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

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

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

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

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

PHYSICAL EXAMINATION
At our expense, we shall have the right and opportunity to require your Child to be examined as it relates to the Critical Illness that is the basis of the claim. We can require such examination when and as often as we may reasonably require during the pendency of a claim.

BENEFIT PAYMENTS
Benefits under this rider are payable to you. 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, 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.

CRITICAL ILLNESS BENEFITS

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

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

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

Critical Illness benefits, including benefits for Cancer (Invasive) and Cancer (Non-Invasive) and Skin Cancer and Benign Brain Tumor, are based on diagnosis and not on treatment or expenses. As an example: A group policy has a $10,000 critical illness benefit amount for Children. The percentage of the benefit amount payable for Cancer (Invasive) is 100% and the percentage for Cancer (Non-Invasive) is 25%. Under this example, benefits would be calculated as follows:

- **A Child has a lump in her breast and she is diagnosed with stage I breast cancer. This diagnosis meets the Policy definition of Cancer (Invasive). $10,000 benefit amount x 100% = $10,000.**
- **Another Child has a lump in her breast and she is diagnosed with breast ductal carcinoma in situ (DCIS). This diagnosis meets the Policy definition of Cancer (Non-Invasive). $10,000 benefit amount x 25% = $2,500.**

These examples are for illustrative purposes only. Refer to the SCHEDULE OF BENEFITS for coverage amounts and covered conditions. All benefits are subject to the terms of the Certificate and this rider.

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 this rider terminates.

Payment of any benefits for your Child's Critical Illness will not impact the available BENEFIT AMOUNT for your Critical Illness. Payment of any benefits for your Critical Illness will not impact the available BENEFIT AMOUNT for your Child's Critical Illness or Additional Child Disease 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.

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: Sierra View Medical Center

GROUP POLICY NUMBER: 70789-9CCI2

INSURED PERSON:

You must write your name in the space provided so that it becomes your rider. The date you are eligible for coverage is described in the GENERAL PROVISIONS section of this rider.

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

CONTENTS

Section	Page
Definitions	1
General Provisions	1
Continuation of Insurance	2

DEFINITIONS

Covered Person means:

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

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

GENERAL PROVISIONS

ELIGIBILITY

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

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

EFFECTIVE DATE

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

TERMINATION

This rider terminates on the earliest of the following:

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

CONTINUATION OF INSURANCE

If you stop Active Employment due to:

- Employer-approved Leave of Absence,

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

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

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

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

EMPLOYER-APPROVED LEAVE(S) OF ABSENCE

Family and Medical Leave

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

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

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

Sickness or Injury

If you are on a Leave of Absence due to your sickness or injury, then insurance coverage for all Covered Persons may be continued until the last day of the month which next follows the date which is 4 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 until the last day of the month which next follows the date which is 6 months after the date you stopped Active Employment.

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

Other Leave of Absence
If you are on a Leave of Absence for any other reason, then insurance coverage for all Covered Persons may be continued until the last day of the month which next follows the date which is 1 month after the date you stopped Active Employment.

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

CONCURRENT LEAVES OF ABSENCE

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

TERMINATION OF CONTINUATION

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

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

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

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

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

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

RETURN TO ACTIVE EMPLOYMENT

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

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

Robert L. Grubka
President

Melissa A. O'Donnell
Secretary

WELLNESS BENEFIT RIDER

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Sierra View Medical Center

GROUP POLICY NUMBER: 70789-9CCI2

INSURED PERSON:

You must write your name in the space provided so that it becomes your rider. The date you are eligible for coverage is described in the GENERAL PROVISIONS section of this rider.

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

CONTENTS

Section	Page
Schedule of Benefits	1
Definitions	2
General Provisions	2
Benefits	3

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:	$75
Your Spouse:	$75
Your Children:	50% of your wellness benefit amount, to a maximum of $150 for all Children in one calendar year

DEFINITIONS

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

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

GENERAL PROVISIONS

ELIGIBILITY
If you are working for the Employer in an eligible class (shown in the Certificate's SCHEDULE OF BENEFITS), you are eligible for this rider on the latest of the following dates:
- The Policy effective date.
- The date this rider is available to the eligible class of Insured Persons to which you belong.
- Your Critical Illness coverage effective date.

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

TERMINATION
This rider will terminate on the earliest of the following:
- The date your Certificate terminates.
- The date this rider is terminated for all Insured Persons under the Policy.
- For your Spouse's coverage, the date the Spouse Critical Illness Rider terminates.
- For each Child's coverage, the date your Child's coverage under the Children's Critical Illness Rider terminates.

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

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

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

BENEFIT PAYMENTS
Benefits under this rider are payable to you unless otherwise specified. 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, 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.

The PHYSICAL EXAMINATION provision in the Certificate and riders does not apply to this rider.

BENEFITS

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

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

Health screening tests include, but are not limited to:

- Blood test for triglycerides
- 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)
- Routine eye exam
- Routine dental exam
- Well child/preventive exams for ages 1 through 18
- Biometric screenings

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

Robert L. Grubka
President

Melissa A. O'Donnell
Secretary

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.

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