

# YOUR CRITICAL ILLNESS INSURANCE PLAN

For Employees of  
Archdiocese of Seattle

# 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:** Archdiocese of Seattle  
**GROUP POLICY NUMBER:** 68879-7CCI2  
**POLICY EFFECTIVE DATE:** July 1, 2022  
**GOVERNING JURISDICTION:** Washington

### THIS IS LIMITED BENEFIT INDEMNITY COVERAGE

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

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

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

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

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

**Please read your Certificate carefully.**

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



Robert L. Grubka  
President



Melissa A. O'Donnell  
Secretary

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Arizona Residents:

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

California residents:

**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.**

Florida residents:

**The benefits of the Policy providing your coverage are governed primarily by the law of a state other than Florida.**

## SCHEDULE OF BENEFITS

**EMPLOYER:** Archdiocese of Seattle

**GROUP POLICY NUMBER:** 68879-7CC12

### ELIGIBLE CLASS(ES)

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

You must be an Employee of the Employer and in an eligible class.  
Temporary and seasonal workers are excluded from coverage.

### 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.

### WHO PAYS FOR THE COVERAGE

You pay the cost of your coverage.

### BENEFIT AMOUNT

Choice of \$5,000 or \$10,000 or \$15,000 or \$20,000 or \$25,000 or \$30,000

### CRITICAL ILLNESS BENEFITS

#### Base module

<b>Covered illness/condition</b>	<b>Percent of BENEFIT AMOUNT payable</b>	<b>Total maximum benefit amount for coverage</b>
Heart Attack	100%	No maximum benefit amount
Sudden Cardiac Arrest	50%	No maximum benefit amount
Cancer	100%	No maximum benefit amount
Stroke	100%	No maximum benefit amount
Major Organ Transplant	100%	No maximum benefit amount
Coronary Artery Bypass	25%	No maximum benefit amount
Carcinoma in Situ (CIS)	25%	No maximum benefit amount

**Major organ module**

<b>Covered illness/condition</b>	<b>Percent of BENEFIT AMOUNT payable</b>	<b>Total maximum benefit amount for coverage</b>
Type 1 Diabetes	100%	No maximum benefit amount
Transient Ischemic Attacks (TIA)	10%	No maximum benefit amount
Ruptured or Dissecting Aneurysm	10%	No maximum benefit amount
Abdominal Aortic Aneurysm	10%	No maximum benefit amount
Thoracic Aortic Aneurysm	10%	No maximum benefit amount
Open Heart Surgery for Valve Replacement or Repair	25%	No maximum benefit amount
Transcatheter Heart Valve Replacement or Repair	10%	No maximum benefit amount
Coronary Angioplasty	10%	No maximum benefit amount
Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement	25%	No maximum benefit amount
Pacemaker Placement	10%	No maximum benefit amount

**Enhanced cancer module**

<b>Covered illness/condition</b>	<b>Percent of BENEFIT AMOUNT payable</b>	<b>Total maximum benefit amount for coverage</b>
Benign Brain Tumor	100%	No maximum benefit amount
Skin Cancer	10%	For Skin Cancer, the maximum is once per calendar year with a TOTAL MAXIMUM BENEFIT amount of 2 times the BENEFIT AMOUNT
Bone Marrow Transplant	100%	No maximum benefit amount
Stem Cell Transplant	100%	No maximum benefit amount

**Quality of life module**

<b>Covered illness/condition</b>	<b>Percent of BENEFIT AMOUNT payable</b>	<b>Total maximum benefit amount for coverage</b>
Permanent Paralysis	100%	1 times the BENEFIT AMOUNT
Loss of Sight	100%	1 times the BENEFIT AMOUNT
Loss of Hearing	100%	1 times the BENEFIT AMOUNT
Loss of Speech	100%	1 times the BENEFIT AMOUNT
Coma	100%	No maximum benefit amount
Multiple Sclerosis	100%	1 times the BENEFIT AMOUNT
Amyotrophic Lateral Sclerosis (ALS)	100%	1 times the BENEFIT AMOUNT
Parkinson's Disease	100%	1 times the BENEFIT AMOUNT
Advanced Dementia, including Alzheimer's Disease	100%	1 times the BENEFIT AMOUNT
Huntington's Disease (Huntington's Chorea)	100%	1 times the BENEFIT AMOUNT
Muscular Dystrophy	100%	1 times the BENEFIT AMOUNT
Infectious Disease	25%	No maximum benefit amount
Addison's Disease	10%	1 times the BENEFIT AMOUNT
Myasthenia Gravis	50%	1 times the BENEFIT AMOUNT
Systemic Lupus Erythematosus (SLE)	100%	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 and you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under the MINIMUM HOURS REQUIREMENT shown in the SCHEDULE OF BENEFITS.

Your work site must be one of the following:

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

Normal vacation is considered Active Employment.

Temporary and seasonal workers are excluded from coverage.

**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.

**Attained Age** means that the rates will go up based on your age each policy year.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"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; or
- Carcinoma in Situ; 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
- Skin Cancer; or
- Stem Cell Transplant; or
- Stroke; or
- Systemic Lupus Erythematosus (SLE); or
- Systemic Sclerosis (Scleroderma); or
- Sudden Cardiac Arrest; or
- Thoracic Aortic Aneurysm; or
- Transcatheter Heart Valve Replacement or Repair; or
- Transient Ischemic Attacks (TIA); or
- Type 1 Diabetes.

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

- A diagnosis of a Critical Illness that is for a different illness/condition than a previously diagnosed illness/condition.
- A diagnosis that is related to an illness/condition that existed prior to your coverage effective date if:
  - The subsequent diagnosis of the Critical Illness is for the same illness/condition as an illness/condition diagnosed prior to your coverage effective date under the Policy. Note: A second or confirmatory medical opinion is not a Different Diagnosis.
- A diagnosis that is related to a Critical Illness for which we previously paid benefits if:
  - The subsequent diagnosis of the Critical Illness 1) is for the same illness/condition as a Critical Illness for which benefits were payable under the Policy, and 2) occurs more than 6 months after the date of the previous diagnosis.

**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 Carcinoma in Situ is considered a Different Diagnosis from Cancer.

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

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

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

**Employee** means a person who is a citizen or legal resident of the United States 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.

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

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

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

- It is operated in accordance with the laws pertaining to hospitals in the jurisdiction in which it is located;
- It is under the supervision of a medical staff and has one or more Doctors available at all times;
- It provides 24 hours a day service by registered graduate nurses (RNs); and

- It is not an institution or any part of an institution used as: a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a free-standing surgical center; a rehabilitative facility; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care, or care or treatment for persons suffering from mental diseases or disorders, or care for the aged, or drug or alcohol addiction.

**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 five (5) or more consecutive days.

Infectious Diseases include:

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

"Confined/confinement" means that on the advice of a Doctor, your assignment to a bed as a resident inpatient in a Hospital or transitional care facility. There must be a charge for room and board, other than in any government, military or veterans' facility for which there is no charge for room and board. "Transitional care facility" means a facility which provides a bridge between the Hospital and home for restorative and rehabilitation care. It must provide skilled nursing care and must be either located in a community nursing home or a Hospital. Confined/confinement also includes assignment to an observation unit in a Hospital, if you stay for at least 20 consecutive hours.

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

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

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

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

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

**Major Organ Transplant** means the irreversible failure of your heart, lung, pancreas, an entire kidney, the entire liver, or any combination of these conditions, 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, except for kidney failure. If you receive the transplant prior to placement on the network, the network requirement will be waived. If your physician determines you are not healthy enough to be placed on the UNOS list or you are rejected from the list, the network requirement will be waived. "Kidney failure" means chronic, irreversible failure of one or both kidneys for which a Doctor recommends either of the following:

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

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

**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.

**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.

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

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

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

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

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

Skin Cancer includes:

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

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

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

Stroke does not include:

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

**Sudden Cardiac Arrest** means the sudden, unexpected loss of heart function, breathing and consciousness resulting when the heart suddenly and unexpectedly stops beating because of an internal electrical disturbance of the heart. In the event of death, an autopsy report and/or death certificate may be used to confirm Sudden Cardiac Arrest.

**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. **Exception:** If your Eligibility Waiting Period ends on the first day of the month, the eligibility date is the day you complete your Eligibility Waiting Period.

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

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

### EFFECTIVE DATE OF CHANGES TO COVERAGE

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

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

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

### TERMINATION OF COVERAGE

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

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

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

### POLICY TERMINATION

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

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

- There is less than 15% participation of those eligible persons who pay all or part of their premium for the Policy.
- The Policyholder does not promptly provide us with information that is reasonably required.
- Fewer than 25 persons are insured under the Policy.

- The premium is not paid in accordance with the provisions of the Policy.
- We determine that there is a significant change in the size, occupation or age of the eligible class(es) as a result of a corporate transaction such as a merger, divestiture, acquisition, sale or reorganization of the Policyholder and/or its persons.
- We stop providing the type of coverage under this Policy to all groups in the Policy issue state.

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

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

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

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

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

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

## **PORTABILITY**

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

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

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

Ported coverage is subject to all the terms of the Policy and this Certificate.

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

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

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

## **GRACE PERIOD**

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

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

## **REPRESENTATIONS NOT WARRANTIES**

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

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

## **INCONTESTABILITY**

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

## **CLERICAL ERROR**

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

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

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

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

## **MISSTATEMENT OF AGE**

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

## **ASSIGNMENT**

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

## **AGENCY**

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

## **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/producer, 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 Certificate or rider 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, and any applicable maximum benefit amounts payable, is listed for the Critical Illness on the SCHEDULE OF BENEFITS.

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

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

Benefits are payable up to the total maximum benefit amount shown on the SCHEDULE OF BENEFITS for each 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, Sudden Cardiac Arrest, Cancer, Stroke, Major Organ Transplant, Coronary Artery Bypass and Carcinoma in Situ (CIS)** are payable when we receive due proof of such condition which is diagnosed after your coverage effective date (including the effective date of any changes to coverage).

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

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

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

### MAJOR ORGAN MODULE

**Benefits for Type 1 Diabetes, 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 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, or Myasthenia Gravis, or 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
  - Bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses); **and**

- Resulting in the inability to perform independently 2 or more of the following activities of daily living:
  - Eating;
  - Bathing;
  - Dressing;
  - Toileting;
  - Transferring; and
  - Maintaining continence.

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

### **ENHANCED CANCER MODULE**

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

# CLAIMS

## NOTICE OF CLAIM

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

## CLAIM FORM

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

## FILING A CLAIM

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

## PROOF OF CLAIM

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

## PHYSICAL EXAMINATION

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

## BENEFIT PAYMENTS

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

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

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

"Spouse" in this provision means your lawful spouse. It includes your domestic partner who is recognized as equivalent to a spouse by Washington law.

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

**LEGAL ACTION**

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

# SPOUSE CRITICAL ILLNESS RIDER

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

**POLICYHOLDER:** Archdiocese of Seattle

**GROUP POLICY NUMBER:** 68879-7CCI2

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

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### SCHEDULE OF BENEFITS

#### WHO PAYS FOR THE COVERAGE

You pay the cost of coverage under this rider.

#### SPOUSE BENEFIT AMOUNT

Choice of \$5,000 or \$10,000 or \$15,000

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%	No maximum benefit amount
Sudden Cardiac Arrest	50%	No maximum benefit amount
Cancer	100%	No maximum benefit amount
Stroke	100%	No maximum benefit amount
Major Organ Transplant	100%	No maximum benefit amount
Coronary Artery Bypass	25%	No maximum benefit amount
Carcinoma in Situ (CIS)	25%	No maximum benefit amount

### Major organ module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Type 1 Diabetes	100%	No maximum benefit amount
Transient Ischemic Attacks (TIA)	10%	No maximum benefit amount
Ruptured or Dissecting Aneurysm	10%	No maximum benefit amount
Abdominal Aortic Aneurysm	10%	No maximum benefit amount
Thoracic Aortic Aneurysm	10%	No maximum benefit amount
Open Heart Surgery for Valve Replacement or Repair	25%	No maximum benefit amount
Transcatheter Heart Valve Replacement or Repair	10%	No maximum benefit amount
Coronary Angioplasty	10%	No maximum benefit amount
Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement	25%	No maximum benefit amount
Pacemaker Placement	10%	No maximum benefit amount

**Enhanced cancer module**

<b>Covered illness/condition</b>	<b>Percent of BENEFIT AMOUNT payable</b>	<b>Total maximum benefit amount for coverage</b>
Benign Brain Tumor	100%	No maximum benefit amount
Skin Cancer	10%	For Skin Cancer, the maximum is once per calendar year with a TOTAL MAXIMUM BENEFIT amount of 2 times the BENEFIT AMOUNT
Bone Marrow Transplant	100%	No maximum benefit amount
Stem Cell Transplant	100%	No maximum benefit amount

**Quality of life module**

<b>Covered illness/condition</b>	<b>Percent of BENEFIT AMOUNT payable</b>	<b>Total maximum benefit amount for coverage</b>
Permanent Paralysis	100%	1 times the BENEFIT AMOUNT
Loss of Sight	100%	1 times the BENEFIT AMOUNT
Loss of Hearing	100%	1 times the BENEFIT AMOUNT
Loss of Speech	100%	1 times the BENEFIT AMOUNT
Coma	100%	No maximum benefit amount
Multiple Sclerosis	100%	1 times the BENEFIT AMOUNT
Amyotrophic Lateral Sclerosis (ALS)	100%	1 times the BENEFIT AMOUNT
Parkinson's Disease	100%	1 times the BENEFIT AMOUNT
Advanced Dementia, including Alzheimer's Disease	100%	1 times the BENEFIT AMOUNT
Huntington's Disease (Huntington's Chorea)	100%	1 times the BENEFIT AMOUNT
Muscular Dystrophy	100%	1 times the BENEFIT AMOUNT
Infectious Disease	25%	No maximum benefit amount
Addison's Disease	10%	1 times the BENEFIT AMOUNT
Myasthenia Gravis	50%	1 times the BENEFIT AMOUNT
Systemic Lupus Erythematosus (SLE)	100%	1 times the BENEFIT AMOUNT
Systemic Sclerosis (Scleroderma)	10%	1 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 domestic partner who is recognized as equivalent to a spouse by Washington law.

## 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 first day of the month following the date you apply for Spouse coverage.
- The first day of the month following 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 last day of the month during which you voluntarily cancel this rider.
- The last day of the month during which your Spouse is no longer an eligible Spouse as defined by this rider. See the PORTABILITY FOLLOWING DEATH OR DIVORCE provision below.
- The end of the period for which premiums 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**

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

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

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

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

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

## **CRITICAL ILLNESS BENEFITS**

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

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

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

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

Benefits are payable up to the total maximum benefit amount shown on this rider's SCHEDULE OF BENEFITS for each 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.

## **CLAIMS**

### **NOTICE OF CLAIM**

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

### **CLAIM FORM**

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

### **FILING A CLAIM**

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

### **PROOF OF CLAIM**

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

### **PHYSICAL EXAMINATION**

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

### **BENEFIT PAYMENTS**

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

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

**LEGAL ACTION**

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

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



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:** Archdiocese of Seattle

**GROUP POLICY NUMBER:** 68879-7CCI2

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

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### SCHEDULE OF BENEFITS

#### WHO PAYS FOR THE COVERAGE

You pay the cost of coverage under this rider.

#### CHILDREN'S BENEFIT AMOUNT

Choice of: \$5,000.00 or \$10,000.00

The BENEFIT AMOUNT for your Children will not exceed 100% of your 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%	No maximum benefit amount
Sudden Cardiac Arrest	50%	No maximum benefit amount
Cancer	100%	No maximum benefit amount
Stroke	100%	No maximum benefit amount
Major Organ Transplant	100%	No maximum benefit amount
Coronary Artery Bypass	25%	No maximum benefit amount
Carcinoma in Situ (CIS)	25%	No maximum benefit amount

### Major organ module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Type 1 Diabetes	100%	No maximum benefit amount
Transient Ischemic Attacks (TIA)	10%	No maximum benefit amount
Ruptured or Dissecting Aneurysm	10%	No maximum benefit amount
Abdominal Aortic Aneurysm	10%	No maximum benefit amount
Thoracic Aortic Aneurysm	10%	No maximum benefit amount
Open Heart Surgery for Valve Replacement or Repair	25%	No maximum benefit amount
Transcatheter Heart Valve Replacement or Repair	10%	No maximum benefit amount
Coronary Angioplasty	10%	No maximum benefit amount
Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement	25%	No maximum benefit amount
Pacemaker Placement	10%	No maximum benefit amount

**Enhanced cancer module**

<b>Covered illness/condition</b>	<b>Percent of BENEFIT AMOUNT payable</b>	<b>Total maximum benefit amount for coverage</b>
Benign Brain Tumor	100%	No maximum benefit amount
Skin Cancer	10%	For Skin Cancer, the maximum is once per calendar year with a TOTAL MAXIMUM BENEFIT amount of 2 times the BENEFIT AMOUNT
Bone Marrow Transplant	100%	No maximum benefit amount
Stem Cell Transplant	100%	No maximum benefit amount

**Quality of life module**

<b>Covered illness/condition</b>	<b>Percent of BENEFIT AMOUNT payable</b>	<b>Total maximum benefit amount for coverage</b>
Permanent Paralysis	100%	1 times the BENEFIT AMOUNT
Loss of Sight	100%	1 times the BENEFIT AMOUNT
Loss of Hearing	100%	1 times the BENEFIT AMOUNT
Loss of Speech	100%	1 times the BENEFIT AMOUNT
Coma	100%	No maximum benefit amount
Multiple Sclerosis	100%	1 times the BENEFIT AMOUNT
Amyotrophic Lateral Sclerosis (ALS)	100%	1 times the BENEFIT AMOUNT
Parkinson's Disease	100%	1 times the BENEFIT AMOUNT
Advanced Dementia, including Alzheimer's Disease	100%	1 times the BENEFIT AMOUNT
Huntington's Disease (Huntington's Chorea)	100%	1 times the BENEFIT AMOUNT
Muscular Dystrophy	100%	1 times the BENEFIT AMOUNT
Infectious Disease	25%	No maximum benefit amount
Addison's Disease	10%	1 times the BENEFIT AMOUNT
Myasthenia Gravis	50%	1 times the BENEFIT AMOUNT
Systemic Lupus Erythematosus (SLE)	100%	1 times the BENEFIT AMOUNT
Systemic Sclerosis (Scleroderma)	10%	1 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. Benefit percentages for the Additional Child Diseases are shown below.

**Additional Child Diseases module**

<b>Covered illness/condition</b>	<b>Percent of BENEFIT AMOUNT payable</b>	<b>Total maximum benefit amount for coverage</b>
Cerebral Palsy	100%	1 times the BENEFIT AMOUNT
Congenital Birth Defects	100%	1 times the BENEFIT AMOUNT
Cystic Fibrosis	100%	1 times the BENEFIT AMOUNT
Down Syndrome	100%	1 times the BENEFIT AMOUNT
Gaucher Disease, Type II or III	100%	1 times the BENEFIT AMOUNT
Infantile Tay Sachs	100%	1 times the BENEFIT AMOUNT
Niemann-Pick Disease	100%	1 times the BENEFIT AMOUNT
Pompe Disease	100%	1 times the BENEFIT AMOUNT
Sickle Cell Anemia	100%	1 times the BENEFIT AMOUNT
Type 1 Diabetes	100%	1 times the BENEFIT AMOUNT
Type IV Glycogen Storage Disease	100%	1 times the BENEFIT AMOUNT
Zellweger Syndrome	100%	1 times the BENEFIT AMOUNT

## DEFINITIONS

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

**Additional Child Diseases** means in addition to the benefits provided for Critical Illnesses as defined in the Certificate, this rider also covers the following child diseases:

- Cerebral Palsy.
- Congenital Birth Defects.
- Cystic Fibrosis.
- Down Syndrome.
- Gaucher Disease, Type II or III.
- Infantile Tay Sachs.
- Niemann-Pick Disease.
- Pompe Disease.
- Sickle Cell Anemia.
- Type 1 Diabetes.
- Type IV Glycogen Storage Disease.
- Zellweger Syndrome.

This definition does not include premature birth or stillbirth caused or contributed to by a Critical Illness or Additional Child Disease.

**Cerebral Palsy** means a group of disorders of the development of movement and posture causing activity limitation that are attributed to progressive disturbances that occurred in the developing fetal or infant brain. The motor disorders of Cerebral Palsy are often accompanied by disturbances of sensation, cognition, communication, perception and/or behavior and/or by a seizure disorder.

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

- Your natural or adopted child (including a child placed for adoption).
- Your stepchild.
- A child of your domestic partner who is recognized as equivalent to a spouse by Washington law.
- Your foster child or a child or grandchild for whom you are a legal guardian.

The child must also meet all of the following conditions:

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

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

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

**Congenital Birth Defects** means the malformation of an organ or organ system that results in the recommendation of surgery.

Examples include but are not limited to the following:

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

Congenital Birth Defects includes developmental disorders of the brain or being born blind without the recommendation of surgery.

Congenital Birth Defects does not include prematurity.

**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 or Additional Child Disease.

**Cystic Fibrosis** means a definite diagnosis of cystic fibrosis by a licensed family practitioner, pediatrician or pulmonologist where the Child has chronic lung disease and pancreatic insufficiency. The diagnosis made via a sweat test should be based upon sweat chloride concentrations greater than 60 mmol/L on two independent tests.

**Down Syndrome** means diagnosis of down syndrome through a study of the 21<sup>st</sup> chromosome.

Down Syndrome includes:

- Trisomy 21 - an individual has three instead of two #21 chromosomes.
- Translocation - an extra part of the 21<sup>st</sup> chromosome is attached to another chromosome.
- Mosaicism - the individual has an extra 21<sup>st</sup> chromosome in only some of the cells but not all of them. The other cells have the usual pair of 21<sup>st</sup> chromosomes.

**Gaucher Disease, Type II or III** means a definitive diagnosis of Gaucher Disease, Type II or III through a blood test reviewing beta-glucosidase leukocyte (BGL).

**Infantile Tay Sachs** means a definitive diagnosis of Infantile Tay Sachs through a blood test reviewing Hexosaminidase A levels.

**Niemann-Pick Disease** means a definitive diagnosis of Niemann-Pick, Type A, B, or C, through blood test or genetic test.

**Pompe Disease (Type II Glycogen Storage Disease)** means a definitive diagnosis of Pompe Disease (Type II Glycogen Storage Disease) through enzyme testing or genetic testing.

**Sickle Cell Anemia** means the diagnosis of a blood disorder that results in an abnormality in the oxygen-carrying protein hemoglobin found in red blood cells, that is confirmed via blood testing.

Sickle Cell Anemia does not include the sickle cell trait.

**Spouse** means your lawful spouse. It includes your domestic partner who is recognized as equivalent to a spouse by Washington law.

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

**Type IV Glycogen Storage Disease** means a definitive diagnosis of Type IV Glycogen Storage Disease through testing of glycogen branching enzyme deficiency in the liver, muscle, or skin, or through genetic testing.

**Zellweger Syndrome** means a definitive diagnosis of Zellweger Syndrome through genetic testing.

## 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 first day of the month following the date you apply for Children's coverage.
- The first day of the month following 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 30<sup>th</sup> day is subject to the conditions regarding application and Active Employment and having no approved Employee claims under the Policy.

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

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

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

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

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

## **TERMINATION**

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

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

## **PORTABILITY**

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

## **PORTABILITY FOLLOWING DEATH**

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

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

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

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

## **CRITICAL ILLNESS BENEFITS**

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

The benefits for your Children are the same as the benefits for you as shown in the CRITICAL ILLNESS BENEFITS section of the Certificate. Benefits for the Additional Child Diseases module are shown below.

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

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

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

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

When the total maximum benefit amount for a Child has been paid for a Critical Illness or Additional Child Disease, no further benefits are payable for that Child for that Critical Illness or Additional Child Disease. When the total maximum benefit amount for a Child has been paid for all Critical Illnesses and Additional Child Diseases, no further benefits are payable for that Child. When the total maximum benefit has been paid for all Children for all Critical Illnesses and Additional Child Diseases, no further benefits are payable and this rider terminates.

Payment of any benefits for your Child's Critical Illness or Additional Child Disease 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 or Additional Child Disease must be made after your Child's live birth and by a Doctor familiar with the diagnosis of the specific condition.

### **ADDITIONAL CHILD DISEASES MODULE**

Benefits for Cerebral Palsy, Congenital Birth Defects, Cystic Fibrosis, Down Syndrome, Gaucher Disease, Type II or III, Infantile Tay Sachs, Niemann-Pick Disease, Pompe Disease, Sickle Cell Anemia, Type 1 Diabetes, and Type IV Glycogen Storage Disease and Zellweger Syndrome are payable when we receive due proof of such condition which is diagnosed after your Child's 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.

If Type 1 Diabetes is included in the Major Organ Module as well as this rider, only one benefit is payable.

## **CLAIMS**

### **NOTICE OF CLAIM**

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

### **CLAIM FORM**

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

### **FILING A CLAIM**

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

### **PROOF OF CLAIM**

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

### **PHYSICAL EXAMINATION**

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

### **BENEFIT PAYMENTS**

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

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

**LEGAL ACTION**

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

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



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:** Archdiocese of Seattle

**GROUP POLICY NUMBER:** 68879-7CCI2

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

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**DEFINITIONS**

**Covered Person** means:

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

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

**GENERAL PROVISIONS**

**ELIGIBILITY**

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

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

**EFFECTIVE DATE**

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

## **TERMINATION**

This rider terminates on the earliest of the following:

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

## **CONTINUATION OF INSURANCE**

If you stop Active Employment due to:

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

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

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

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

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

### **Family and Medical Leave**

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

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

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

### **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 9 months after the date you stopped Active Employment.

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

## **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 your Leave of Absence for active military service, and you return to Active Employment while coverage is in force for Employees under the Policy, then coverage for all Covered Persons may be reinstated in accordance with USERRA and applicable state law.

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

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



Robert L. Grubka  
President



Melissa A. O'Donnell  
Secretary

# HEALTH SCREENING BENEFIT RIDER

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

**POLICYHOLDER:** Archdiocese of Seattle

**GROUP POLICY NUMBER:** 68879-7CCI2

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

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### SCHEDULE OF BENEFITS

#### WHO PAYS FOR THE COVERAGE

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

#### HEALTH SCREENING BENEFIT

You: \$100  
Your Spouse: \$100  
Your Children: 50% of your health screening benefit amount

**The health screening benefit is payable up to a maximum of one day per Covered Person per calendar year. There is a maximum of 4 health screening benefits payable for all Children per calendar year.**

### DEFINITIONS

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

**Covered Person** means:

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

## **GENERAL PROVISIONS**

### **ELIGIBILITY**

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

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

### **EFFECTIVE DATE**

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

### **TERMINATION**

This rider will terminate on the earliest of the following:

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

### **PORTABILITY**

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

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

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

### **ASSIGNMENT**

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

## BENEFITS

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

A health screening benefit is limited to once per calendar 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)
- Covid-19 test
- Stress test on bicycle or treadmill
- Fasting blood glucose test
- Thermography
- PSA (prostate cancer)
- Electrocardiogram (EKG)
- Endoscopy
- Carotid Doppler
- Routine eye exam
- Routine dental exam
- Well child/preventive exams for ages 1 through 18
- Health Screening fairs
- Biometric screenings

## CLAIMS

The PHYSICAL EXAMINATION provision does not apply to this rider.

### NOTICE OF CLAIM

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

### CLAIM FORM

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

### FILING A CLAIM

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

**PROOF OF CLAIM**

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

**BENEFIT PAYMENTS**

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

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

**LEGAL ACTION**

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

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



Robert L. Grubka  
President



Melissa A. O'Donnell  
Secretary

## Consumer Notice for Arkansas Residents

The nearest servicing office is the Minneapolis, Minnesota office of Voya Employee Benefits, a division of ReliaStar Life Insurance Company and ReliaStar Life Insurance Company of New York.

The mailing address is:

PO Box 20  
Minneapolis, Minnesota 55440-0122  
Telephone: (800) 537-5024

If you are not provided with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department  
Consumer Services Division  
1200 West Third Street  
(Corner of Third and Cross Street)  
Little Rock, Arkansas 72201-1904

Telephone: (501) 371-2640  
Toll Free in AR: (800) 852-5494

This consumer notice is for information only and does not become a part or condition of this certificate or policy. Please insert this notice in your certificate or policy.

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

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

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

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

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

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

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

**Web Site: [www.insurance.ca.gov/01-consumers/101-help](http://www.insurance.ca.gov/01-consumers/101-help)**

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

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

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

**COVERAGE**

• **Persons Covered**

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

• **Amounts of Coverage**

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

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

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

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

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

• **Health Insurance**

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

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## **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](http://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.**

**NOTICE OF PROTECTION PROVIDED BY  
PENNSYLVANIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION**

This notice provides a **brief summary** regarding the protections provided to the policyholders by the Pennsylvania Life and Health Insurance Guaranty Association (“the Association”). This protection was created under Pennsylvania law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity, or health insurance company, RANLI PPO, hospital plan corporation, professional health services plan corporation or health maintenance organization (member insurer) becomes financially unable to meet its obligations. If this should happen, the Association will typically arrange to provide coverage, pay claims, or otherwise provide protection in accordance with Pennsylvania law. The protection provided by the Association is not unlimited and is not a substitute for consumers’ care in selecting companies that are well managed and financially stable.

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, individuals will be protected by the Association if the member insurer was a member of the Association and the individual lives in Pennsylvania at the time the member insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees of such individuals.

**Amounts of Coverage**

The basic coverage protections provided by the Association per insured in each insolvency are limited in the aggregate to \$300,000 (or \$500,000 in the case of health benefit plans), including specific limits for the following types of coverage but not in excess of the contractual obligations of the member insurer;

**Life insurance:**

- Up to \$300,000 in death benefits including up to \$100,000 in net cash surrender or withdrawal value.

**Accident, accident and health, or health insurance (including HMOs):**

- Up to \$500,000 for health benefit plans, with some exceptions.
- Up to \$300,000 for disability income benefits.
- Up to \$300,000 for long-term care insurance benefits.
- Up to \$100,000 for all other types of health insurance.

**Individual Annuities**

- Up to \$250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

**LIMITATIONS AND EXCLUSIONS FROM COVERAGE**

The Association also does not provide coverage for:

- any policy or contract or portion of a policy or contract which is not guaranteed by the member insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

- claims based on marketing materials or other documents which are not approved policy or contract forms, claims based on misrepresentations of policy or contract benefits, and other extra-contractual claims;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields or increases based on an index that exceed an average rate specified by statute;
- dividends, experience rating credits, or credits given in connection with the administration of a policy or contract by a group contract holder;
- employers' plans that are self-funded (that is, not insured by member insurer, even if member insurer administers them);
- unallocated annuity contracts (which give rights to group contract holders, not individuals) other than in limited circumstances and amounts;
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the member insurer; or
- policies providing health care benefits for Medicare Parts C or D coverage, for Medicaid or under the Pennsylvania program for Comprehensive Health Care for Uninsured Children.

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 Pennsylvania when it issued the policy or contract.
- If the person is provided coverage by the guaranty association of another state.
- A policy issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

### **NOTICES**

Member insurers or their agents are required by law to give or send you this notice, and are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance or other coverage. Policyholders with additional questions should first contact their member insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at [www.palifega.org](http://www.palifega.org). You can obtain additional information from the Association by contacting it at the address below. You may also contact the Pennsylvania Insurance Department to file a complaint with the Pennsylvania Insurance Commissioner to allege a violation of any provisions of Pennsylvania laws and regulations relating to insurance including the law establishing the Association:

Pennsylvania Life and Health Insurance  
 Guaranty Association  
 290 King of Prussia Road  
 Radnor Station Building 2, Suite 218  
 Radnor, PA 19087  
 (610) 975-0572

Pennsylvania Insurance Department  
 1209 Strawberry Square  
 Harrisburg, PA 17120  
 1-877-881-6388  
[www.insurance.pa.gov](http://www.insurance.pa.gov)

The summary provided by this notice and on the Association's website do not limit or alter the more comprehensive and detailed provisions of the law and are subject to change without notice. The statements made herein are for information purposes only. The Association has not reviewed any specific policy, or verified the information provided regarding residency or other relevant factors. Moreover, whether coverage will be provided to any specific policyholder can only be determined by reference to the statute in effect, at the earliest, at the time that the member insurer is declared insolvent. No final determination of coverage can be made until a member insurer is declared insolvent and the specific factual and legal circumstances can be reviewed. Nothing contained herein is intended to guarantee coverage for any insured, or to bind the Association in any way. Finally, this summary and the Association's website are for general information purposes and should not be relied upon as legal advice.