Group Critical Illness Certificate of Insurance

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

Effective July 1, 2022

Applies to Residents of Arizona

POLICYHOLDER: Pima County

POLICY NUMBER: 76212

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

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

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

Reading Your Certificate Carefully

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

Legal Actions

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

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GROUP CRITICAL ILLNESS CERTIFICATE OF INSURANCE
GENERAL INFORMATION

POLICYHOLDER: Pima County

POLICY NUMBER: 76212

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

POLICY SITUS: The policy was issued and delivered in Arizona.

POLICY EFFECTIVE DATE: July 1, 2022

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

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

Class 1: A regular full-time, part-time, temporary, or variable-time employee scheduled to work twenty (20) or more hours per week in a benefits eligible employment classification.

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

NO DOUBLE COVERAGE: A person cannot be covered under more than one class. Any person who is eligible as an employee under the policy, or insured under the portability provisions, is not eligible as a dependent. Only one person can insure an eligible dependent child.

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

MINIMUM HOURS PER WEEK REQUIREMENT: 20 hours per week

EMPLOYMENT WAITING PERIOD: For Elected Officials: None

For all employees excluding Elected Officials: The period commencing with the employee’s date of employment and ending with the first day of the month next following 30 days from the employee’s date of hire.

BENEFIT WAITING PERIOD: None

BENEFIT SEPARATION PERIOD: 6 months
EMPLOYEE BENEFIT SCHEDULE

EMPLOYEE GROUP CRITICAL ILLNESS INSURANCE:

Supplemental Group Critical Illness Insurance

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Employee Supplemental Group Critical Illness Insurance Benefit Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>$10,000, as elected by the employee</td>
</tr>
</tbody>
</table>

Health and Wellness Benefit

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Employee Health and Wellness Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>$50</td>
</tr>
</tbody>
</table>

You can only receive one health and wellness benefit per year. A year is defined as beginning on July 1 of each year and renewing on July 1 of each following year.

GENERAL PROVISIONS FOR EMPLOYEE INSURANCE

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

CONTRIBUTORY/NONCONTRIBUTORY: Supplemental insurance is contributory insurance.

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

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

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

For employees who first become eligible after the effective date of this certificate:
$10,000

PORTABILITY AMOUNT: $10,000

DEPENDENT BENEFIT SCHEDULE

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

SPOUSE CRITICAL ILLNESS INSURANCE

Supplemental Group Critical Illness Insurance

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Spouse Supplemental Group Critical Illness Insurance Benefit Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>50% of the employee’s amount of supplemental Group Critical Illness insurance.</td>
</tr>
</tbody>
</table>
Health and Wellness Benefit

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Spouse Health and Wellness Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>$50</td>
</tr>
</tbody>
</table>

A spouse can only receive one health and wellness benefit per year. A year is defined as beginning on July 1 of each year and renewing on July 1 of each following year.

CHILD GROUP CRITICAL ILLNESS INSURANCE

Supplemental Group Critical Illness Insurance

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Child Supplemental Group Critical Illness Insurance Benefit Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>50% of the employee’s amount of supplemental Group Critical Illness insurance.</td>
</tr>
</tbody>
</table>

Health and Wellness Benefit

<table>
<thead>
<tr>
<th>Eligible Class</th>
<th>Child Health and Wellness Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>$50</td>
</tr>
</tbody>
</table>

A child can only receive one health and wellness benefit per year. A year is defined as beginning on July 1 of each year and renewing on July 1 of each following year.

GENERAL PROVISIONS FOR DEPENDENT INSURANCE

RETIREMENT REDUCTIONS:

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

CONTRIBUTORY/NONCONTRIBUTORY:

Supplemental insurance is contributory insurance.

GUARANTEED ISSUE AMOUNT:

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

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

Supplemental Insurance

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

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

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>$5,000</td>
</tr>
<tr>
<td>Child</td>
<td>$5,000</td>
</tr>
</tbody>
</table>

PORTABILITY AMOUNT: $5,000
BENEFITS FOR COVERED CONDITIONS  -- The benefits for covered conditions applicable to an insured is based on the employee’s state of residence at the time a claim is submitted.

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

<table>
<thead>
<tr>
<th>Covered Condition</th>
<th>Initial Occurrence Benefit</th>
<th>Recurrence Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alzheimer’s disease*</td>
<td>100%</td>
<td>None</td>
</tr>
<tr>
<td>amyotrophic lateral sclerosis (ALS) and other motor neuron disease*</td>
<td>100%</td>
<td>None</td>
</tr>
<tr>
<td>bacterial meningitis</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>benign brain tumor</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>blindness*</td>
<td>100%</td>
<td>None</td>
</tr>
<tr>
<td>cerebral palsy*</td>
<td>50%</td>
<td>None</td>
</tr>
<tr>
<td>coma</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>coronary artery disease needing surgery or angioplasty</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>cystic fibrosis*</td>
<td>50%</td>
<td>None</td>
</tr>
<tr>
<td>full benefit cancer</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>heart attack</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>infectious encephalitis</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>kidney failure*</td>
<td>100%</td>
<td>None</td>
</tr>
<tr>
<td>loss of hearing*</td>
<td>100%</td>
<td>None</td>
</tr>
<tr>
<td>loss of speech*</td>
<td>100%</td>
<td>None</td>
</tr>
<tr>
<td>major organ failure</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>multiple sclerosis*</td>
<td>100%</td>
<td>None</td>
</tr>
<tr>
<td>muscular dystrophy*</td>
<td>50%</td>
<td>None</td>
</tr>
<tr>
<td>necrotizing fasciitis</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>osteomyelitis</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>paralysis*</td>
<td>100%</td>
<td>None</td>
</tr>
<tr>
<td>Parkinson’s disease*</td>
<td>100%</td>
<td>None</td>
</tr>
<tr>
<td>partial benefit cancer</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>poliomyelitis (polio)*</td>
<td>50%</td>
<td>None</td>
</tr>
<tr>
<td>rabies*</td>
<td>50%</td>
<td>None</td>
</tr>
<tr>
<td>sickle cell anemia*</td>
<td>50%</td>
<td>None</td>
</tr>
<tr>
<td>skin cancer (non-melanoma and carcinoma-in-situ of the skin)</td>
<td>$250</td>
<td>None</td>
</tr>
<tr>
<td>spina bifida*</td>
<td>50%</td>
<td>None</td>
</tr>
<tr>
<td>Stroke</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>sudden cardiac arrest</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>systemic lupus erythematosus (nephritis cerebritis)*</td>
<td>50%</td>
<td>None</td>
</tr>
<tr>
<td>type 1 diabetes*</td>
<td>100%</td>
<td>None</td>
</tr>
</tbody>
</table>

*Not all benefits are medically able to meet the definition of recurrence, including Alzheimer’s disease, amyotrophic lateral sclerosis (ALS) and other motor neuron disease, blindness, cerebral palsy, cystic fibrosis, kidney failure, loss of hearing, loss of speech, multiple sclerosis, muscular dystrophy, paralysis, Parkinson’s disease, poliomyelitis (polio), rabies, sickle cell anemia, spina bifida, systemic lupus erythematosus (nephritis & cerebritis), type 1 diabetes.
ADDITIONAL INFORMATION

WAIVER OF PREMIUM APPLICATION: Applies to contributory employee insurance.

ANNUAL OPEN ENROLLMENTS: During the policyholder’s annual open enrollment an employee may elect insurance without providing evidence of insurability. In addition, an employee may elect spouse and/or child coverage without evidence of insurability.

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

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

QUALIFIED STATUS CHANGES: An employee who experiences one of the qualified status change events listed below may elect insurance without providing evidence of insurability, provided enrollment is made within 30 days of the status change. In addition, an employee may also elect spouse and/or child coverage without evidence of insurability.

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

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

SUPPLEMENTS TO THE CERTIFICATE

COVID-19
Health and Wellness
Portability
Trauma
Waiver of Premium
General Definitions

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

application
Your application or enrollment for insurance under the group policy.

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

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

child/children
Your or your spouse’s:

(1) natural child;
(2) adopted child;
(3) stepchild;
(4) foster child;
(5) grandchild;
(6) legal ward;
(7) a child in your or your spouse’s court-appointed guardianship; or
(8) a child in your or your spouse’s court-ordered custody or administrative order.

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

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

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

Grandchild means a grandchild:

(1) who is financially dependent on you;
(2) for whom you have legal custody; and
(3) who resides with you.

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

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

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

dependent
Your children or spouse.

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

employee
An individual who is employed by the policyholder or by an associated company. A sole proprietor will be considered the employee of the proprietorship. A partner in a partnership will be considered an employee so long as the partner’s principal work is the conduct of the partnership’s business. The term employee does not include corporate directors who are not otherwise employees.

employer
The policyholder or any designated associated companies.

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

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

guaranteed issue amount

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

initial occurrence

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

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

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

insured

An employee or dependent covered for insurance under this certificate.

legal partner

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

non-contributory insurance

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

non-work day

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

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

permanent neurological deficit with persisting clinical signs and symptoms

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

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

The following are not covered under this definition:

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

physician

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

A physician cannot be a person who:

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

policyholder

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

separate and unrelated

A full benefit cancer or partial benefit cancer that is:

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

specialist

A person who:

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

A specialist cannot be a person who:

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

specifications page

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

spouse

Your legally married spouse.

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

we, our, us

Securian Life Insurance Company.

you, your, certificate holder

An insured employee.

Critical Illness Definitions

Alzheimer's disease

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

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

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

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

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

amyotrophic lateral sclerosis (ALS) and other motor neuron disease

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

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

bacterial meningitis

A bacterial infection of the meninges of the brain causing brain dysfunction. There must be a definite diagnosis by a specialist of bacterial meningitis that must be proven on analysis of the cerebrospinal fluid. There must also be permanent neurological deficit with persisting clinical signs and symptoms that is present on physical examination at least 90 days after the diagnosis of the meningitis infection.

The date of diagnosis is the date the diagnosis of bacterial meningitis is made by a specialist satisfying the policy definition above.

benign brain tumor

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

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

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

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

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

cerebral palsy

A non-progressive neurological disorder affecting the developing brain. A specialist must make the definite diagnosis of cerebral palsy before the insured reaches the age of 5. The disease must have caused permanent motor deficits with muscle dysfunction and activity limitation.

The date of diagnosis is the date the diagnosis of cerebral palsy is made by a specialist satisfying the policy definition above.
coronary artery disease needing surgery or angioplasty

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

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

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

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

cystic fibrosis

A genetic disorder characterized by abnormal transport of chloride and sodium causing organ dysfunction. A specialist must make the definite diagnosis of cystic fibrosis based on clinically accepted tests at the time of claim. The disease must cause ongoing symptoms indicating involvement of the lungs, pancreas, liver, or intestines.

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

full benefit cancer

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

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

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

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

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

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

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

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

heart attack

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

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

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

Heart attack does not mean sudden cardiac arrest and in the event that both heart attack and sudden cardiac arrest occur within 48 hours of each other, the greater of the two benefits will be paid. If the benefit amount for both
covered conditions is the same, you can choose the covered condition benefit to be paid.

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

**infectious encephalitis**

An acute infectious (viral, bacterial, or fungal) inflammation of the brain. A specialist must make the diagnosis of infectious encephalitis. This diagnosis must be supported by abnormalities of the cerebral spinal fluid or brain imaging consistent with the diagnosis. The encephalitis must have caused permanent objective neurological deficit that is evident on physical examination and present for more than 30 days.

The date of diagnosis is the date the diagnosis of encephalitis is made by a specialist that satisfies the policy definition above.

**kidney failure**

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

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

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

**major organ failure**

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

For the above definition, the following is not covered:

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

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

**multiple sclerosis (MS)**

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

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

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

**muscular dystrophy**

A genetic muscle disorder causing motor dysfunction. A specialist must make the definite diagnosis of muscular dystrophy based on clinically accepted tests at the time of claim. The disease must cause permanent muscle weakness evident on physical examination.

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

**necrotizing fasciitis**

A progressive, rapidly spreading infection located in the deep fascia causing necrosis of the subcutaneous tissues and muscle, requiring surgical debridement. A definite diagnosis of necrotizing fasciitis must be made by a specialist and the diagnosis must be supported with laboratory evidence of the presence of bacteria that is a known cause of necrotizing fasciitis.

The date of diagnosis is the date the diagnosis of necrotizing fasciitis is made by a specialist satisfying the policy definition above.

**osteomyelitis**

An infection (bacterial or fungal) within the bone of sufficient severity that results in a recommendation of prolonged intravenous antibiotics, surgery, or both. A specialist must make the diagnosis of osteomyelitis.

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

**Parkinson’s disease**

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

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

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

**partial benefit cancer**

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

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

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

The following cancers are excluded:

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

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

**poliomyelitis (polio)**

An acute infection caused by the polio virus that must result in paralysis that is evident by physical examination. A diagnosis of poliomyelitis must be made by a specialist and there must be laboratory confirmation of the polio virus as the cause for symptoms. Post-polio syndrome which is the recurrence of paralysis years after the original infection has resolved is not covered under this definition.

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

**rabies**

An infectious disease caused by the rabies virus, transmitted by animal saliva, that results in multiple neurologic and other physical abnormalities. There must be a diagnosis by a specialist of rabies with diagnostic laboratory evidence of the rabies virus.

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

**sickle cell anemia**

An inherited blood disorder of hemoglobin production that results in abnormally shaped (sickled) red blood cells, leading to multiple symptoms such as pain, fatigue, frequent infections, and delayed growth. A specialist must make the diagnosis of sickle cell anemia. Sickle cell anemia does not mean sickle cell trait (asymptomatic carriers of a single abnormal hemoglobin gene) and any other disorder of hemoglobin production is not covered under this definition.

The date of diagnosis is the date the diagnosis of sickle cell anemia is first confirmed by a specialist after live birth satisfying the policy definition above.

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

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

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

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

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

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

**spina bifida**

A congenital malformation resulting in a protrusion of the meninges through an opening in the spinal canal (meningocele) or the protrusion of the spinal cord and nerves through an opening in the bones of the spinal cord (myelomeningocele). A specialist must make a diagnosis
of spina bifida. Spina bifida occulta, which is a simple opening in the backbone covered by skin and without neurologic impairment, is not covered under this definition.

The date of diagnosis is the date the diagnosis of spina bifida is first confirmed by a specialist after live birth satisfying the policy definition above.

**stroke**

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

The following are excluded:

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

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

**sudden cardiac arrest**

The sudden loss of heart pumping function due to malfunction of the electrical system of the heart. There must be a diagnosis by a specialist of sudden cardiac arrest that must be evidenced by a disturbance in heart rhythm (arrhythmia) leading to absence of pulse, abnormal breathing and loss of consciousness. Sudden cardiac arrest does not mean heart attack (myocardial infarction) and in the event that both heart attack and sudden cardiac arrest occur within 48 hours of each other, the greater of the two benefits will be paid. If the benefit amount for both covered conditions is the same, you can choose the covered condition benefit to be paid.

The date of diagnosis is the date of the sudden cardiac arrest that satisfies the policy definition above.

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

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

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

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

Discoid lupus and medication induced lupus are excluded.

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

**type 1 diabetes**

A chronic autoimmune condition that develops primarily in children in which the cells of the pancreas are destroyed, resulting in the daily requirement of insulin treatment from the time of diagnosis. There must be a diagnosis by a specialist of type 1 diabetes. Type 1 diabetes does not mean type 2 diabetes, which later goes on to require insulin treatment in its management.

The date of diagnosis is the date the diagnosis of type 1 diabetes is made by a specialist satisfying the policy definition above.

### General Information

**What is your agreement with us?**

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

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

This certificate is issued in consideration of your application and the payment of any required premium.
Can this certificate be amended?

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

Who is eligible for insurance?

You are eligible for group critical illness insurance if you:

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

Are your dependents eligible for insurance?

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

What is the actively at work requirement?

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

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

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

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

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

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

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

Are retired employees eligible for insurance?

No. A retired employee is not eligible for insurance under the group policy.

What is the dependent non-confinement requirement?

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

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

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

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

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

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

When can you elect or make changes to your insurance?

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

When will we require evidence of insurability?

Evidence of insurability is never required.

When does your insurance become effective?

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

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

When does insurance for a dependent become effective?

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

1. Your insurance becomes effective;
2. The dependent meets all eligibility requirements; and
3. For contributory insurance, you apply for dependent coverage on forms which are approved by us.

When will changes in your coverage amount be effective?

Requested increases in the amount of your contributory insurance, if approved, are effective on the date we approve the increase. Requested decreases in the amount of your contributory insurance are effective on the first day of the month following receipt of your request for a decrease.

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

Premiums

When and how often are your premium contributions due?

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

How is the premium determined?

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

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

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

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

Covered Condition Benefits

What is the benefit amount for a covered condition?

The benefit amount for a covered condition will be a percentage of the insured’s amount of insurance shown on the specifications page.

What is the initial occurrence benefit?

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

Can more than one initial occurrence benefit be paid?

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

What is the recurrence benefit?

The recurrence benefit will be paid, as shown on the specifications page, if an initial occurrence benefit has been paid and an insured is diagnosed again for the same covered condition.
What are the requirements for a recurrence benefit?

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

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

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

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

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

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

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

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

Can an insured receive more than one recurrence benefit?

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

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

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

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

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

Exclusions and Limitations

Is there an overall maximum benefit amount?
No. There is no overall maximum benefit amount.

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

1. Self-inflicted injury, self-destruction, or autoeroticism, whether sane or insane;
2. Suicide or attempted suicide, whether sane or insane;
3. An insured’s participation in, or attempt to commit, a crime, assault, felony, or any illegal activity, regardless of any legal proceedings thereto;
4. The use of alcohol;
5. The use of prescription drugs, non-prescription drugs, illegal drugs, medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected;
6. Motor vehicle collision or accident where the insured is the operator of the motor vehicle and the insured’s blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or
7. War or any act of war, whether declared or undeclared.
Are there any additional limitations that apply?

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

Claims

What notice of claim must be provided?

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

Will claim forms be provided?

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

When is proof of a covered condition required?

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

When will the benefit be paid?

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

To whom will benefits be paid?

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

What are our physical examination rights?

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

Termination

When does your coverage terminate?

Coverage ends on the earliest of the following:

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

When does an insured dependent’s coverage terminate?

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

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

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

Can your coverage be reinstated?

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

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

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

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

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

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

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

Can this insurance be assigned?
No. Insurance coverage under the group policy cannot be assigned.

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

Securian Life has the exclusive right and authority, in its sole discretion, to interpret the group policy and decide all matters arising thereunder. Securian Life’s exercise of that authority shall be conclusive and binding on all persons unless it can be shown that the determination was arbitrary and capricious.
General Information
This certificate supplement is subject to every term, condition, exclusion, limitation, and provision of the certificate unless otherwise expressly provided for herein.

What does this supplement provide?
This supplement amends the Critical Illness Definitions section of the certificate to include COVID-19 disease of specified severity. It provides a benefit payment for the initial occurrence of COVID-19 disease if an insured is diagnosed with COVID-19 disease of specified severity as described herein.

What are the conditions to receive a benefit payment?
You are eligible to receive a COVID-19 benefit payment under this supplement if you or your insured dependent(s) are diagnosed with COVID-19 disease of specified severity.

What does COVID-19 disease of specified severity mean?
COVID-19 disease of specified severity means a definite diagnosis of COVID-19 as made by a specialist and supported by confirmatory testing. COVID-19 is a respiratory disease with potential multi-organ effects caused by the Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). The illness must be of sufficient severity as to have directly required inpatient hospitalization of at least 5 days.

In the event an insured is hospitalized due to COVID-19 but dies as a direct result of COVID-19 before the minimum period of hospitalization has been met, a benefit will be payable.

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

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

For the above definition, the following are not covered:

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

The date of diagnosis is the date of diagnosis of COVID-19.

What is the COVID-19 disease of specified severity benefit amount?
The COVID-19 disease of specified severity benefit amount will be a percentage of the insured’s amount of insurance shown below:

<table>
<thead>
<tr>
<th>Covered Condition</th>
<th>Initial Occurrence Benefit</th>
<th>Recurrence Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVID-19 disease of specified severity</td>
<td>25%</td>
<td>None</td>
</tr>
</tbody>
</table>

Termination
When does coverage under this supplement terminate?
This coverage ends on the earliest of the following:

1. the date an insured’s coverage under the certificate terminates; or
2. the date this supplement terminates.

Secretary
President
General Information

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

What does this supplement provide?

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

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

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

Payment of Benefit

What is the benefit amount?

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

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

No. There is no waiting period.

When will the health and wellness benefit be payable?

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

To whom do we pay the benefit?

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

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

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

When does your coverage under this supplement terminate?

Your coverage ends on the earliest of the following:

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

[Signatures]
Secretary                  President
Portability Certificate Supplement
Securian Life Insurance Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

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

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

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

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

1. the employee terminates employment, including retirement;
2. the employee's number of working hours are reduced;
3. the employee is no longer in a class eligible for insurance or is on a leave or layoff;
4. a class or group of employees insured under the policy are no longer considered eligible and there is no successor plan for that class or group. Successor plan means an insurance policy or policies provided by us or another insurer that replaces insurance provided under the policy;
5. legal separation or divorce;
6. the dependent ceases to be an eligible dependent; or
7. the employee's death.

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

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

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

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

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

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

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

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

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

**How will premiums be paid?**

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

**Can the premium rate change?**

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

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

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

**What happens to insurance provided under this supplement when the group policy terminates?**

Anything in the group policy notwithstanding, termination of the group policy by the policyholder or us will not terminate critical illness insurance for any person with coverage under the terms of this supplement. The group policy will remain in force solely for the purpose of continuing such insurance.

Any insurance continued under the terms of this supplement will remain in force until terminated by the provisions of the section entitled “When will insurance continued under this supplement terminate?”

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

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

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

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

Renee D. Montz
Secretary

Charles M. Jeffers
President
General Information

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

What does this supplement provide?

This supplement provides benefits for additional covered conditions. It provides a benefit payment for an initial occurrence for a traumatic event if an insured suffers a traumatic event while coverage is in force.

What is a traumatic event?

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

What is an accidental injury?

An accidental injury is a bodily injury which:

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

What is the trauma benefit amount?

The trauma benefit amount is shown on the specifications page.

Trauma Definitions

coma

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

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

blindness

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

1. sight in the better eye reduced to a best corrected visual acuity of less than 20/200; or
2. visual field restriction to 20 degrees or less in both eyes

must be clinically confirmed by a specialist.

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

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

loss of hearing

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

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

loss of speech

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

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

paralysis

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

**Termination**

*When does coverage under this supplement terminate?*

This coverage ends on the earliest of the following:

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

[Signatures]

Secretary

President
**General Information**

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

The specifications page indicates to what insurance this supplement applies. This supplement does not apply to an insured with portability status.

**What does this supplement provide?**

This supplement provides for waiver of premium if you become totally and permanently disabled, as defined herein, while under age 60. Upon approval of proof of such disability, your and your dependent’s insurance, including all supplements to your certificate which were in force on the date of the onset of your disability, will be continued in force without payment of premiums during the uninterrupted continuance of the total and permanent disability.

**What is total disability?**

Total disability is a disability which occurs while your insurance is in force and which results from an accidental injury or an illness that continuously prevents you from engaging in any occupation for which you are reasonably suited by education, training, or experience on a full or part time basis. You must be under the care of a licensed physician. The licensed physician cannot be you or a member of your immediate family. For purposes of this supplement, your immediate family consists of your spouse, children, parents, grandparents, grandchildren, brothers and sisters, and their spouses.

**What is permanent disability?**

Permanent disability is a total disability which has existed continuously for at least six months.

**Are there any limitations?**

Yes. Insurance will not be continued if your disability results from intentionally self-inflicted injury, participation in or any attempt to commit a crime, or war or any act of war, whether declared or undeclared.

**What will be considered due proof of total and permanent disability?**

You must furnish evidence satisfactory to us as to both substance and form that your disability:

1. commenced while your insurance under your certificate was in force;
2. meets the definition of total disability;
3. commenced before your 60th birthday; and
4. was continuous for six months or more.

We will, from time to time, also require additional proof satisfactory to us that you continue to be totally and permanently disabled. After you have provided at your expense the requested claim forms and records, we may also require that you submit to one or more medical examinations at our expense.

If you die within one year of the date of onset of your total disability, your beneficiary may claim benefits under this supplement even if your premium payments were discontinued and you had not submitted due proof satisfactory to us of your total disability or you were continuously disabled for less than six months. Your beneficiary must submit due proof satisfactory to us that your total disability, which began before premium payments on your behalf were discontinued and before your 60th birthday, continued without interruption until your death.

**When must we be notified of your disability or death?**

We must receive written notice at our home office of your total disability within one year of the date of onset of such disability. However, failure to give notice within the time provided will not invalidate the claim if it is shown that notice was given as soon as reasonably possible.

We must receive written notice at our home office within one year of death that you died during a period of continuance provided by this supplement. Proof must be furnished that you continued to be totally disabled during the entire period of continuance until death. If such notice and proof are not provided within the required time frame, there shall be no liability for any payment under this supplement. However, failure to give notice within the time provided will not invalidate the claim if it is shown that notice was given as soon as reasonably possible.

**What is the amount of insurance to be continued under this supplement?**

The amount of insurance continued without payment of premium shall be the amount of insurance that was in force on the date of onset of total disability.

If the group policy provides for reductions in amounts of insurance based on age or retirement, such reductions shall apply to your insurance while disabled.

**How long will insurance continue without payment of premium?**

If you become totally and permanently disabled, insurance will be continued, without payment of premium, until the earliest of:

1. your 65th birthday;
2. the date you retire;
(3) the date you recover so that you are no longer totally and permanently disabled; or
(4) the date you fail to furnish proof of continued disability when requested or you refuse to submit to a required medical examination.

What happens to your insurance when the waiver of premium benefit ends?

When the benefits under this supplement end according to the provisions of the section entitled “How long will insurance be continued without payment of premium?”, the following will apply:

(1) If you are then eligible for coverage under your certificate, your insurance may be continued provided premiums are paid. The first such premium payment must be made within 31 days of the date the waiver of premium benefit ends.

(2) If the group policy is no longer in force, or you do not meet the eligibility requirements of your certificate, coverage under the policy ends.

Your insurance will end unless, within 31 days of the date benefits under this supplement end, premium payments on your behalf are resumed.

Termination

When does your coverage under this supplement terminate?

Your waiver of premium coverage terminates on the earliest of:

(1) the date you are no longer insured for critical illness insurance covered by this supplement;
(2) the date requested by the policyholder to cancel the Waiver of Premium coverage for its plan; or
(3) the date the group policy is terminated.

Insurance being continued without further payment of premiums in accordance with the provisions of this supplement will not end due solely to the termination of the Waiver of Premium Certificate Supplement or of the group policy.

Secretary

President
Group Critical Illness Insurance
Certificate Endorsement
Securian Life Insurance Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

This Certificate Endorsement is a part of the certificate of insurance describing the benefits available to you under Group Policy No. 76212, issued by Securian Life Insurance Company to Pima County. This endorsement is subject to every term, condition, exclusion and provision of the certificate unless otherwise expressly provided for herein.

The following applies to Arizona residents:

1. The provision entitled Legal Actions on the face page of the Certificate is amended in its entirety and replaced with the following:

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

2. The provision entitled When will the benefit be paid? under the Claims section of the Certificate is amended in its entirety and replaced with the following:

   When will the benefit be paid?

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

Secretary

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

GROUP CRITICAL ILLNESS CERTIFICATE OF INSURANCE