

# YOUR CRITICAL ILLNESS INSURANCE PLAN

For Employees of  
Horne LLP

# 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:** Horne LLP  
**GROUP POLICY NUMBER:** 73114-5CCI2  
**POLICY EFFECTIVE DATE:** January 1, 2023  
**GOVERNING JURISDICTION:** Mississippi

### 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

## TABLE OF CONTENTS

| Section                        | Page |
|--------------------------------|------|
| Cover Page.....                | 1    |
| Table of Contents.....         | 2    |
| Schedule of Benefits.....      | 3    |
| Definitions.....               | 6    |
| General Provisions.....        | 14   |
| Critical Illness Benefits..... | 18   |
| Claims.....                    | 21   |

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.**

Idaho residents:

**If you contribute to the cost of your coverage, you may cancel your coverage for any reason within 10 days after your receipt of your initial Certificate of coverage under the Policy, provided no benefits have been paid. Contact the Policyholder to cancel your coverage and receive any premium refund.**

Maryland residents:

**Notice: This Certificate of insurance may not provide all benefits required for a policy issued and delivered in Maryland.**

New Mexico residents:

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

West Virginia residents:

**Please read this Certificate carefully. If you are not satisfied with it for any reason, you may return it within 10 days after receipt for a refund of any premium you paid.**

## SCHEDULE OF BENEFITS

**EMPLOYER:** Horne LLP

**GROUP POLICY NUMBER:** 73114-5CCI2

### **ELIGIBLE CLASS(ES)**

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

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

Temporary and seasonal workers are excluded from coverage.

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

### **MINIMUM HOURS REQUIREMENT**

30 hours per week.

### **ELIGIBILITY WAITING PERIOD**

Persons in an eligible class on or before the Policy effective date: None

Persons entering an eligible class after the Policy effective date: None

### **WHO PAYS FOR THE COVERAGE**

You pay the cost of your coverage.

### **BENEFIT AMOUNT**

Choice of \$5,000 to \$30,000 in \$5,000 increments

### **CRITICAL ILLNESS BENEFITS**

#### **Base module**

| <b>Covered illness/condition</b> | <b>Percent of<br/>BENEFIT<br/>AMOUNT payable</b> | <b>Total maximum benefit<br/>amount for coverage</b> |
|----------------------------------|--|--|
| Heart Attack                     | 100%   | 5 times the BENEFIT<br>AMOUNT                        |
| Cancer                           | 100%   | 5 times the BENEFIT<br>AMOUNT                        |
| Stroke                           | 100%   | 5 times the BENEFIT<br>AMOUNT                        |
| Major Organ Transplant           | 100%   | 5 times the BENEFIT<br>AMOUNT                        |
| Coronary Artery Bypass           | 50%  | 5 times the BENEFIT<br>AMOUNT                        |
| Carcinoma in Situ (CIS)          | 50%  | 5 times the BENEFIT<br>AMOUNT                        |

**Major organ module**

| <b>Covered illness/condition</b>                                     | <b>Percent of BENEFIT AMOUNT payable</b> | <b>Total maximum benefit amount for coverage</b> |
|--|--|--|
| Severe Burns   | 100%                                     | 5 times the BENEFIT AMOUNT                       |
| Transient Ischemic Attacks (TIA)                                     | 10%                                      | 5 times the BENEFIT AMOUNT                       |
| Ruptured or Dissecting Aneurysm                                      | 10%                                      | 5 times the BENEFIT AMOUNT                       |
| Abdominal Aortic Aneurysm  | 10%                                      | 5 times the BENEFIT AMOUNT                       |
| Thoracic Aortic Aneurysm   | 10%                                      | 5 times the BENEFIT AMOUNT                       |
| Open Heart Surgery for Valve Replacement or Repair                   | 25%                                      | 5 times the BENEFIT AMOUNT                       |
| Transcatheter Heart Valve Replacement or Repair                      | 10%                                      | 5 times the BENEFIT AMOUNT                       |
| Coronary Angioplasty   | 10%                                      | 5 times the BENEFIT AMOUNT                       |
| Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement | 25%                                      | 5 times the BENEFIT AMOUNT                       |
| Pacemaker Placement  | 10%                                      | 5 times the 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%                                     | 5 times the BENEFIT AMOUNT   |
| Skin Cancer                      | 10%                                      | For Skin Cancer, the maximum is once per calendar year with a total maximum benefit amount of 5 times the BENEFIT AMOUNT |
| Bone Marrow Transplant           | 100%                                     | 5 times the BENEFIT AMOUNT   |
| Stem Cell Transplant             | 100%                                     | 5 times the 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%                                     | 5 times the 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%                                      | 5 times the BENEFIT AMOUNT                       |
| Addison's Disease                                | 10%                                      | 1 times the BENEFIT AMOUNT                       |
| Myasthenia Gravis                                | 50%                                      | 1 times the BENEFIT AMOUNT                       |
| Systemic Lupus Erythematosus (SLE)               | 50%                                      | 1 times the BENEFIT AMOUNT                       |
| Systemic Sclerosis (Scleroderma)                 | 10%                                      | 1 times the BENEFIT AMOUNT                       |
| Occupational HIV                                 | 100%                                     | 1 times the BENEFIT AMOUNT                       |
| Occupational Hepatitis B or C                    | 100%                                     | 1 times the BENEFIT AMOUNT                       |

## DEFINITIONS

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

Your work site must be one of the following:

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

Normal vacation is considered Active Employment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

**Critical Illness** means any of the following as defined:

- Abdominal Aortic Aneurysm; or
- 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
- Occupational HIV; or
- Occupational Hepatitis B or C; or
- Open Heart Surgery For Valve Replacement or Repair; or
- Pacemaker Placement; or
- Parkinson's Disease; or
- Permanent Paralysis; or
- Ruptured or Dissecting Aneurysm; or
- Severe Burns; or
- Skin Cancer; or
- Stem Cell Transplant; or
- Stroke; or
- Systemic Lupus Erythematosus (SLE); or
- Systemic Sclerosis (Scleroderma); or
- Thoracic Aortic Aneurysm; or
- Transcatheter Heart Valve Replacement or Repair; or
- Transient Ischemic Attacks (TIA).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Infectious Diseases include, but are not limited to:

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

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

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

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

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

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

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

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

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

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

**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.

**Occupational HIV** means the diagnosis of HIV (Human Immunodeficiency Virus) caused by an accidental needle stick, other accidental sharp injury, or accidental mucous membrane exposure to blood or bloodstained bodily fluid while at work and performing normal occupational duties. Such exposure must have occurred during the 12 months preceding the first diagnosis of HIV.

**Occupational Hepatitis B or C** means the diagnosis of Hepatitis B or C caused by an accidental needle stick, other accidental sharp injury, or accidental mucous membrane exposure to blood or bloodstained bodily fluid while at work and performing normal occupational duties. Such exposure must have occurred during the 12 months preceding the first diagnosis of Hepatitis B or C.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Skin Cancer includes:

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

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

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

Stroke does not include:

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

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

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

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

## GENERAL PROVISIONS

### ELIGIBILITY

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

- The Policy effective date.
- The date you enter an eligible class.

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

### ENROLLMENT

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

### EFFECTIVE DATE OF COVERAGE

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

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

### EFFECTIVE DATE OF CHANGES TO COVERAGE

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

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

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

### TERMINATION OF COVERAGE

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

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

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

## **POLICY TERMINATION**

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

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

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

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

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

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

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

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

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

## **PORTABILITY**

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

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

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

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

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



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

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

## **GRACE PERIOD**

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

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

## **REPRESENTATIONS NOT WARRANTIES**

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

## **INCONTESTABILITY**

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

## **CLERICAL ERROR**

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

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

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

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

## **MISSTATEMENT OF AGE**

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

**ASSIGNMENT**

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

**AGENCY**

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

**CONFORMITY WITH STATE STATUTES**

Any provision of the Policy which, on the Policy effective date, conflicts with any law of the governing jurisdiction where an Insured Person resides, is automatically amended to conform to the minimum requirements of such law with respect to that Insured Person.

**CHANGES TO POLICY OR CERTIFICATE**

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

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

## CRITICAL ILLNESS BENEFITS

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

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

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

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

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

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

### BASE MODULE

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

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

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

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

### MAJOR ORGAN MODULE

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

A diagnosis of 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 on or after your coverage effective date (including the effective date of any changes to coverage).

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

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

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

A diagnosis of 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 on or after your coverage effective date (including the effective date of any changes to coverage) or you become incapacitated, meaning:

- Exhibiting 2 or more of the following clinical manifestations:
  - Muscle rigidity;
  - Tremor; and
  - Bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses); **and**

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

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

**Benefits for Occupational HIV or Hepatitis B or C** are payable when we receive due proof of such condition which is diagnosed on or after your coverage effective date (including the effective date of any changes to coverage). The accident must be reported in accordance with the established occupational procedures for such accidents. You must have undergone a blood test within five days of the accident. Such blood test must indicate the absence of HIV or antibodies to such a virus, or Hepatitis B or C. The accident follow-up must include a subsequent blood test within 12 months following the accidental exposure indicating the presence of HIV or antibodies to such a virus, or Hepatitis B or C. The date of diagnosis is the date on which the follow-up blood test results are received.

#### **ENHANCED CANCER MODULE**

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

## **CLAIMS**

### **NOTICE OF CLAIM**

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

### **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**

All benefits payable under this Certificate for any loss will be paid within 25 days after receipt of due written proof of such loss in the form of a clean claim where claims are submitted electronically, and will be paid within 35 days after receipt of due written proof of such loss in the form of clean claim where claims are submitted in paper format.

Benefits due under the Certificate are overdue if not paid within 25 days or 35 days, whichever is applicable, after we receive a clean claim containing necessary medical information and other information essential for us to administer the preexisting condition, provision, if any. A "clean claim" means a claim received by us for adjudication and which requires no further information, adjustment or alteration by the provider of the services or us in order to be processed and paid by us. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected. Errors, such as system errors, attributable to us, do not change the clean claim status.

A clean claim does not include any of the following:

- a. A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within 30 days of the original claim;
- b. Claims which are submitted fraudulently or that are based upon material misrepresentations;
- c. Claims that require information essential for us to administer preexisting condition provision, if any; or
- d. Claims submitted more than 30 days after the date of billing by the provider to the insured.

Not later than 25 days after the date we actually receive an electronic claim, we shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify you of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Not later than 35 days after the date we actually receive a paper claim, we shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify you of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by us shall be paid within 20 days after receipt.

For purposes of this provision, the term "pay" means that we shall either send cash or a cash equivalent by United States mail, or send cash or a cash equivalent by other means such as electronic transfer, in full satisfaction of the appropriate benefit due. To calculate the extent to which any benefits are overdue, payment shall be treated as made on the date a draft or other valid instrument was placed in the United States mail to your last known address in a properly addressed, postpaid envelope, or, if not so posted, or not sent by United States mail, on the date of delivery of payment to you.

If the claim is not denied for valid and proper reasons by the end of the applicable time period noted above we must pay interest on accrued benefits at the rate of 3% per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated.

In the event we fail to pay benefits when due, you may bring action to recover such benefits, any interest which may accrue as provided above, and any other damages as may be allowable by law. If it is determined in such action that we acted in bad faith as evidenced by a repeated or deliberate pattern of failing to pay benefits and/or claims when due, you shall be entitled to recover damages in an amount up to 3 times the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated.

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.

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

"Spouse" in this provision means your lawful spouse. It also includes your domestic partner as defined by the Employer if you have completed and signed an affidavit of domestic partnership on a form acceptable to the Employer.

## **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:** Horne LLP

**GROUP POLICY NUMBER:** 73114-5CCI2

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

### **CONTENTS**

| <b>Section</b>                 | <b>Page</b> |
|--------------------------------|-------------|
| Schedule of Benefits.....      | 1           |
| Definitions.....               | 4           |
| General Provisions.....        | 4           |
| Critical Illness Benefits..... | 6           |
| Claims.....                    | 7           |

### **SCHEDULE OF BENEFITS**

#### **WHO PAYS FOR THE COVERAGE**

You pay the cost of coverage under this rider.

#### **SPOUSE BENEFIT AMOUNT**

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

The BENEFIT AMOUNT for your Spouse will not exceed 100% of your Employee BENEFIT AMOUNT.

## SPOUSE CRITICAL ILLNESS BENEFITS

### Base module

| Covered illness/condition | Percent of BENEFIT AMOUNT payable | Total maximum benefit amount for coverage |
|---------------------------|-----------------------------------|---|
| Heart Attack              | 100%                              | 5 times the BENEFIT AMOUNT                |
| Cancer                    | 100%                              | 5 times the BENEFIT AMOUNT                |
| Stroke                    | 100%                              | 5 times the BENEFIT AMOUNT                |
| Major Organ Transplant    | 100%                              | 5 times the BENEFIT AMOUNT                |
| Coronary Artery Bypass    | 50%                               | 5 times the BENEFIT AMOUNT                |
| Carcinoma in Situ (CIS)   | 50%                               | 5 times the BENEFIT AMOUNT                |

### Major organ module

| Covered illness/condition  | Percent of BENEFIT AMOUNT payable | Total maximum benefit amount for coverage |
|--|-----------------------------------|---|
| Severe Burns   | 100%                              | 5 times the BENEFIT AMOUNT                |
| Transient Ischemic Attacks (TIA)                                     | 10%                               | 5 times the BENEFIT AMOUNT                |
| Ruptured or Dissecting Aneurysm                                      | 10%                               | 5 times the BENEFIT AMOUNT                |
| Abdominal Aortic Aneurysm  | 10%                               | 5 times the BENEFIT AMOUNT                |
| Thoracic Aortic Aneurysm   | 10%                               | 5 times the BENEFIT AMOUNT                |
| Open Heart Surgery for Valve Replacement or Repair                   | 25%                               | 5 times the BENEFIT AMOUNT                |
| Transcatheter Heart Valve Replacement or Repair                      | 10%                               | 5 times the BENEFIT AMOUNT                |
| Coronary Angioplasty   | 10%                               | 5 times the BENEFIT AMOUNT                |
| Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement | 25%                               | 5 times the BENEFIT AMOUNT                |
| Pacemaker Placement  | 10%                               | 5 times the BENEFIT AMOUNT                |

**Enhanced cancer module**

| <b>Covered illness/condition</b> | <b>Percent of<br/>BENEFIT<br/>AMOUNT payable</b> | <b>Total maximum<br/>benefit amount for<br/>coverage</b>   |
|----------------------------------|--|--|
| Benign Brain Tumor               | 100%   | 5 times the BENEFIT AMOUNT   |
| Skin Cancer                      | 10%  | For Skin Cancer, the maximum is once per calendar year with a total maximum benefit amount of 5 times the BENEFIT AMOUNT |
| Bone Marrow Transplant           | 100%   | 5 times the BENEFIT AMOUNT   |
| Stem Cell Transplant             | 100%   | 5 times the BENEFIT AMOUNT   |

**Quality of life module**

| <b>Covered illness/condition</b>                 | <b>Percent of<br/>BENEFIT<br/>AMOUNT payable</b> | <b>Total maximum<br/>benefit amount for<br/>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%   | 5 times the 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%  | 5 times the BENEFIT AMOUNT                               |
| Addison's Disease                                | 10%  | 1 times the BENEFIT AMOUNT                               |
| Myasthenia Gravis                                | 50%  | 1 times the BENEFIT AMOUNT                               |
| Systemic Lupus Erythematosus (SLE)               | 50%  | 1 times the BENEFIT AMOUNT                               |

|                                     |      |                               |
|-------------------------------------|------|-------------------------------|
| Systemic Sclerosis<br>(Scleroderma) | 10%  | 1 times the BENEFIT<br>AMOUNT |
| Occupational HIV                    | 100% | 1 times the BENEFIT<br>AMOUNT |
| Occupational Hepatitis B or C       | 100% | 1 times the BENEFIT<br>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. The term includes your domestic partner as defined by the Employer if you have completed and Signed an affidavit of domestic partnership on a form acceptable to the Employer. Any reference to marriage includes establishment of a domestic partnership. Any reference to divorce includes termination of a domestic partnership.

## **GENERAL PROVISIONS**

### **ELIGIBILITY**

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

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

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

### **ENROLLMENT**

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

### **EFFECTIVE DATE OF COVERAGE**

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

- The date your Spouse is eligible for coverage, if you enroll for Spouse coverage on or before that date.
- The first day of the month that is on or next follows the date you enroll for Spouse coverage.
- The January 1st that is on or next follows the last day of an annual enrollment period, if you enroll for Spouse coverage during an annual enrollment period chosen by the Employer and approved by us.

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

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

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

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

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

## **TERMINATION**

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

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

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

## **PORTABILITY**

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

## **PORTABILITY FOLLOWING DEATH OR DIVORCE**

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

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

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

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

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

## **GRACE PERIOD**

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

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

## **CRITICAL ILLNESS BENEFITS**

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

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

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

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

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

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

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

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

## **CLAIMS**

### **NOTICE OF CLAIM**

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

### **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**

All benefits payable under this rider for any loss will be paid within 25 days after receipt of due written proof of such loss in the form of a clean claim where claims are submitted electronically, and will be paid within 35 days after receipt of due written proof of such loss in the form of clean claim where claims are submitted in paper format. Benefits due under the rider are overdue if not paid within 25 days or 35 days, whichever is applicable, after we receive a clean claim containing necessary medical information and other information essential for us to administer the preexisting condition, provision, if any. A "clean claim" means a claim received by us for adjudication and which requires no further information, adjustment or alteration by the provider of the services or us in order to be processed and paid by us. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected. Errors, such as system errors, attributable to us, do not change the clean claim status.

A clean claim does not include any of the following:

- a. A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within 30 days of the original claim;
- b. Claims which are submitted fraudulently or that are based upon material misrepresentations;
- c. Claims that require information essential for us to administer preexisting condition provision, if any; or
- d. Claims submitted more than 30 days after the date of billing by the provider to the insured.

Not later than 25 days after the date we actually receive an electronic claim, we shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify you of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Not later than 35 days after the date we actually receive a paper claim, we shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify you of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by us shall be paid within 20 days after receipt.

For purposes of this provision, the term "pay" means that we shall either send cash or a cash equivalent by United States mail, or send cash or a cash equivalent by other means such as electronic transfer, in full satisfaction of the appropriate benefit due. To calculate the extent to which any benefits are overdue, payment shall be treated as made on the date a draft or other valid instrument was placed in the United States mail to your last known address in a properly addressed, postpaid envelope, or, if not so posted, or not sent by United States mail, on the date of delivery of payment to you.

If the claim is not denied for valid and proper reasons by the end of the applicable time period noted above we must pay interest on accrued benefits at the rate of 3% per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated.

In the event we fail to pay benefits when due, you may bring action to recover such benefits, any interest which may accrue as provided above, and any other damages as may be allowable by law. If it is determined in such action that we acted in bad faith as evidenced by a repeated or deliberate pattern of failing to pay benefits and/or claims when due, you shall be entitled to recover damages in an amount up to 3 times the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated.

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.



## **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:** Horne LLP

**GROUP POLICY NUMBER:** 73114-5CCI2

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

### CONTENTS

| Section                        | Page |
|--------------------------------|------|
| Schedule of Benefits.....      | 1    |
| Definitions.....               | 5    |
| General Provisions.....        | 7    |
| Critical Illness Benefits..... | 9    |
| Claims.....                    | 10   |

### SCHEDULE OF BENEFITS

#### WHO PAYS FOR THE COVERAGE

You pay the cost of coverage under this rider.

#### CHILDREN'S BENEFIT AMOUNT

50% of Employee BENEFIT AMOUNT

## CHILDREN'S CRITICAL ILLNESS BENEFITS

### Base module

| Covered illness/condition | Percent of BENEFIT AMOUNT payable | Total maximum benefit amount for coverage |
|---------------------------|-----------------------------------|---|
| Heart Attack              | 100%                              | 5 times the BENEFIT AMOUNT                |
| Cancer                    | 100%                              | 5 times the BENEFIT AMOUNT                |
| Stroke                    | 100%                              | 5 times the BENEFIT AMOUNT                |
| Major Organ Transplant    | 100%                              | 5 times the BENEFIT AMOUNT                |
| Coronary Artery Bypass    | 50%                               | 5 times the BENEFIT AMOUNT                |
| Carcinoma in Situ (CIS)   | 50%                               | 5 times the BENEFIT AMOUNT                |

### Major organ module

| Covered illness/condition  | Percent of BENEFIT AMOUNT payable | Total maximum benefit amount for coverage |
|--|-----------------------------------|---|
| Severe Burns   | 100%                              | 5 times the BENEFIT AMOUNT                |
| Transient Ischemic Attacks (TIA)                                     | 10%                               | 5 times the BENEFIT AMOUNT                |
| Ruptured or Dissecting Aneurysm                                      | 10%                               | 5 times the BENEFIT AMOUNT                |
| Abdominal Aortic Aneurysm  | 10%                               | 5 times the BENEFIT AMOUNT                |
| Thoracic Aortic Aneurysm   | 10%                               | 5 times the BENEFIT AMOUNT                |
| Open Heart Surgery for Valve Replacement or Repair                   | 25%                               | 5 times the BENEFIT AMOUNT                |
| Transcatheter Heart Valve Replacement or Repair                      | 10%                               | 5 times the BENEFIT AMOUNT                |
| Coronary Angioplasty   | 10%                               | 5 times the BENEFIT AMOUNT                |
| Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement | 25%                               | 5 times the BENEFIT AMOUNT                |
| Pacemaker Placement  | 10%                               | 5 times the 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%                                     | 5 times the BENEFIT AMOUNT   |
| Skin Cancer                      | 10%                                      | For Skin Cancer, the maximum is once per calendar year with a total maximum benefit amount of 5 times the BENEFIT AMOUNT |
| Bone Marrow Transplant           | 100%                                     | 5 times the BENEFIT AMOUNT   |
| Stem Cell Transplant             | 100%                                     | 5 times the 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%                                     | 5 times the 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%                                      | 5 times the BENEFIT AMOUNT                       |
| Addison's Disease                                | 10%                                      | 1 times the BENEFIT AMOUNT                       |
| Myasthenia Gravis                                | 50%                                      | 1 times the BENEFIT AMOUNT                       |

|                                    |      |                            |
|------------------------------------|------|----------------------------|
| Systemic Lupus Erythematosus (SLE) | 50%  | 1 times the BENEFIT AMOUNT |
| Systemic Sclerosis (Scleroderma)   | 10%  | 1 times the BENEFIT AMOUNT |
| Occupational HIV                   | 100% | 1 times the BENEFIT AMOUNT |
| Occupational Hepatitis B or C      | 100% | 1 times the BENEFIT AMOUNT |

## CHILDREN'S CRITICAL ILLNESS BENEFITS

The benefit percentages and maximums for your Children are the same as the benefit percentages and maximums for you as shown in the SCHEDULE OF BENEFITS section of the Certificate. 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, and 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 as defined by the Employer if you have completed and Signed an affidavit of domestic partnership on a form acceptable to the Employer.
- Your foster child or a child or grandchild for whom you are a legal guardian.
- Your grandchild if the child's parent is insured as your Child under this rider.

The child must also meet all of the following conditions:

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

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

**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, which is confirmed via blood testing.

Sickle Cell Anemia does not include the sickle cell trait.

**Spouse** means your lawful spouse. The term includes your domestic partner as defined by the Employer if you have completed and Signed an affidavit of domestic partnership on a form acceptable to the Employer. Any reference to marriage includes establishment of a domestic partnership. Any reference to divorce includes termination of a domestic partnership.

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

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

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

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

### **ENROLLMENT**

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

### **EFFECTIVE DATE**

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

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

If you have coverage on yourself, your eligible newborn Child is automatically covered for the first 30 days after birth. This includes an adopted newborn Child who is placed with you within 30 days of birth. The coverage amount(s) will be the same as for your other eligible Children. If you do not already have Children's coverage under this rider, then coverage for the newborn will be at the lowest level available. If you do not already have Children's coverage under this rider, then Child coverage beyond the 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 of your Children under this rider ends on the earliest of the following:

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

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

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

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

## **PORTABILITY**

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

## **PORTABILITY FOLLOWING DEATH**

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

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

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

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

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

## **GRACE PERIOD**

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

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

## **CRITICAL ILLNESS BENEFITS**

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

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

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 or Additional Child Disease that is for the same illness/condition as a Critical Illness or Additional Child Disease 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 your Children's coverage under 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 coverage. Payment of any benefits for your Critical Illness will not impact the available BENEFIT AMOUNT for your Child's Critical Illness coverage as long as your coverage remains in force.

A diagnosis of any Critical Illness 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 on or 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 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**

All benefits payable under this rider for any loss will be paid within 25 days after receipt of due written proof of such loss in the form of a clean claim where claims are submitted electronically, and will be paid within 35 days after receipt of due written proof of such loss in the form of clean claim where claims are submitted in paper format. Benefits due under the rider are overdue if not paid within 25 days or 35 days, whichever is applicable, after we receive a clean claim containing necessary medical information and other information essential for us to administer the preexisting condition, provision, if any. A "clean claim" means a claim received by us for adjudication and which requires no further information, adjustment or alteration by the provider of the services or us in order to be processed and paid by us. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected. Errors, such as system errors, attributable to us, do not change the clean claim status.

A clean claim does not include any of the following:

- a. A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within 30 days of the original claim;
- b. Claims which are submitted fraudulently or that are based upon material misrepresentations;
- c. Claims that require information essential for us to administer preexisting condition provision, if any; or
- d. Claims submitted more than 30 days after the date of billing by the provider to the insured.

Not later than 25 days after the date we actually receive an electronic claim, we shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify you of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Not later than 35 days after the date we actually receive a paper claim, we shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify you of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by us shall be paid within 20 days after receipt.

For purposes of this provision, the term "pay" means that we shall either send cash or a cash equivalent by United States mail, or send cash or a cash equivalent by other means such as electronic transfer, in full satisfaction of the appropriate benefit due. To calculate the extent to which any benefits are overdue, payment shall be treated as made on the date a draft or other valid instrument was placed in the United States mail to your last known address in a properly addressed, postpaid envelope, or, if not so posted, or not sent by United States mail, on the date of delivery of payment to you.

If the claim is not denied for valid and proper reasons by the end of the applicable time period noted above we must pay interest on accrued benefits at the rate of 3% per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated.

In the event we fail to pay benefits when due, you may bring action to recover such benefits, any interest which may accrue as provided above, and any other damages as may be allowable by law. If it is determined in such action that we acted in bad faith as evidenced by a repeated or deliberate pattern of failing to pay benefits and/or claims when due, you shall be entitled to recover damages in an amount up to 3 times the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated.

Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For PORTABILITY FOLLOWING DEATH, benefits are payable to your Spouse, and any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

**LEGAL ACTION**

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

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



Robert L. Grubka  
President



Melissa A. O'Donnell  
Secretary

# CONTINUATION OF INSURANCE RIDER

## RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

**POLICYHOLDER:** Horne LLP

**GROUP POLICY NUMBER:** 73114-5CCI2

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

### CONTENTS

| Section                        | Page |
|--------------------------------|------|
| Definitions.....               | 1    |
| General Provisions.....        | 1    |
| Continuation of Insurance..... | 2    |

### DEFINITIONS

**Covered Person** means:

- You, if you are covered for Critical Illness insurance under the Policy.
- Your Spouse if covered under the Spouse Critical Illness Rider.
- Your Children if covered under the 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. Normal vacation time is not considered a Leave of Absence.

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

### GENERAL PROVISIONS

#### ELIGIBILITY

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

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

#### EFFECTIVE DATE

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

## **TERMINATION**

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

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

## **PORTABILITY**

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

## **CONTINUATION OF INSURANCE**

If you stop Active Employment due to:

- Employer-approved Leave of Absence, or
- Total Disability,

then 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 terminate according to the Certificate and riders in effect the day prior to the continuation period.

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

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

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

### **Family and Medical Leave**

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

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

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

### **Sickness or Injury**

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

- The last day of the month which is on or next follows the date your approved Leave of Absence ends.
- The last day of the month which is on or next follows the date which is 6 months after the date you stopped Active Employment.

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



**Military Leave**

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

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

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

**Sabbatical**

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

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

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

**Other Leave of Absence**

If you are on a Leave of Absence for any other reason, then insurance coverage for all Covered Persons may be continued under this rider until the earliest of the following:

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

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

**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 date coverage under this rider is terminated for all Active Employees under the Policy.
- The date coverage under this rider is terminated for the eligible class of Active Employees to which you belong.
- The end of the period for which premiums are paid, if the next premium is not paid by its due date, subject to the GRACE PERIOD provision.
- The date you are eligible under the Policy as an Active Employee.
- The date of your death.
- The date you become covered under another group critical illness or specified disease insurance policy as an employee or member.

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

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

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

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

**RETURN TO ACTIVE EMPLOYMENT**

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

**PORTABILITY FOLLOWING TERMINATION OF CONTINUATION**

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

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



Robert L. Grubka  
President



Melissa A. O'Donnell  
Secretary

# WAIVER OF PREMIUM RIDER

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

**POLICYHOLDER:** Horne LLP

**GROUP POLICY NUMBER:** 73114-5CC12

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

### CONTENTS

| Section                        | Page |
|--------------------------------|------|
| Definitions.....               | 1    |
| General Provisions.....        | 1    |
| Waiver of Premium Benefit..... | 2    |
| Claims.....                    | 3    |

### DEFINITIONS

**Doctor** means a person who is licensed to practice medicine in the state in which treatment is received and providing treatment or advice in accordance with the license. State law may require consideration of professional services of a practitioner other than a medical physician. 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. This definition does not include you or your spouse, or your or your spouse's children, parents, grandparents, grandchildren, siblings and their spouses.

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

**Waiting Period** means the 3 months period immediately following the date you stop Active Employment during which you are continuously Totally Disabled. If you return to work for a total of 30 days or less during the Waiting Period and then stop work again due to the same Total Disability, your Waiting Period will not be interrupted.

### GENERAL PROVISIONS

#### ELIGIBILITY

If you are working for the Employer in an eligible class (shown in the Certificate's SCHEDULE OF BENEFITS), 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 Insured Persons to which you belong.
- Your Critical Illness coverage effective date.

## **EFFECTIVE DATE**

You will be covered at 12:01 a.m. standard time at the Policyholder's address on the date you are eligible for 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.
- The date Critical Illness coverage is being continued under the Certificate's PORTABILITY provision.

This rider will not terminate while premiums are being waived under the terms of this rider.

## **TERMINATION OF COVERAGE**

The TERMINATION OF COVERAGE provision in your Certificate is revised to add this item to the terms under which your coverage ends:

- The date premiums are no longer being waived under the Waiver of Premium Rider, if you are not in an eligible class on that date.

The TERMINATION provision in your Spouse Critical Illness Insurance Rider is revised to add this item to the terms under which your Spouse coverage ends:

- The date we approve a claim under the Waiver of Premium Rider.

The TERMINATION provision in your Children's Critical Illness Insurance Rider is revised to add this item to the terms under which your Children's coverage ends:

- The date we approve a claim under the Waiver of Premium Rider.

## **WAIVER OF PREMIUM BENEFIT**

If you become Totally Disabled while covered under this rider and meet the other conditions below, we will waive premiums due under the Policy and continue insurance during your Total Disability, according to the terms of this rider. When we waive premiums, the amount of continued Critical Illness insurance equals the amount that would have been provided if you had not become Totally Disabled. That amount will reduce or stop according to the Certificate and riders in effect on the date Total Disability began. Premiums that are waived are not deducted from any proceeds that may become payable.

Continued Critical Illness insurance includes the following if effective on the date before your Total Disability began:

- Critical Illness insurance.

Continued Critical Illness insurance does not include:

- coverage under the Spouse Critical Illness Insurance Rider.
- coverage under the Children's Critical Illness Insurance Rider.
- the Wellness Benefit Rider.
- any continuation rider(s).

Any rider or coverage that is not eligible for waiver of premium under this rider will terminate on the date that coverage would otherwise end due to your termination of Active Employment.

Continued insurance is subject to all other terms of the Policy.

## **CONDITIONS FOR WAIVER OF PREMIUM**

All of the following conditions must be met in order to waive premiums:

- Total Disability begins before your 60<sup>th</sup> birthday.
- You are covered under this rider on the date your Total Disability begins.
- You are continuously Totally Disabled for the entire Waiting Period. Premiums due during the Waiting Period are subject to the continuation provision(s) of any riders.
- All premiums due for Critical Illness insurance and this rider are paid to us through the date we approve your claim for waiver of premium or the date the continuation period under any rider ends, whichever is earlier. Premiums due are payable by the Policyholder or you as applicable.
- You provide notice of claim and proof of Total Disability to us as described below.

## **NOTICE OF CLAIM AND PROOF OF TOTAL DISABILITY**

You must send us written notice of claim while you are living, while you are Totally Disabled, and within 12 months of the date your Total Disability begins. Failure to give notice within 12 months will not invalidate or reduce any claim if it is shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

Notice of claim includes proof of your Total Disability. Proof of your Total Disability includes information from your Doctor, at your expense, regarding your condition and your inability to work. We may require additional information from the Employer in order to verify eligibility. We may also require you to be interviewed by our authorized representative. Proof of your Total Disability, including any attachments indicated on the claim form(s) as required, should be sent directly to us at the address indicated on the form(s). Claim forms are available from the Employer or us.

We have the right to request a second or third medical opinion, at our expense, in order to determine if you are Totally Disabled. Any second medical opinion may include a physical examination by a Doctor or other medical practitioner of our choice. In the case of conflicting medical opinions, Total Disability will be determined by a third medical opinion that is provided by a Doctor who is mutually acceptable to you and us.

## **EFFECTIVE DATE OF WAIVER OF PREMIUM**

When we approve your claim, premiums are waived as of the date after the Waiting Period ends. We will refund any unearned premiums we receive to the Policyholder or to you, as appropriate. We will notify you in writing when your claim is approved.

We will notify you and the Employer if we deny your claim.

If we approve a claim for which notice of claim was provided to us more than 12 months after the date your Total Disability began, then any refund of unearned premiums will not exceed 12 months of premiums dating back from the date the notice of claim was received by us.

After your claim is approved, we may periodically request additional proof of your continuing Total Disability, but not more frequently than once every six months.

## **TERMINATION OF WAIVER OF PREMIUM**

We will stop waiving premiums on the earliest of the following dates:

- The date you are no longer Totally Disabled.
- The date you do not give us proof of Total Disability as requested.
- The end of the 24 month period during which your premiums are waived.

If premiums are no longer waived, insurance under the Policy will stay in force only if all of the following conditions are met:

- Critical Illness insurance is in force for Insured Persons 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.

You will not be eligible for portability under the Certificate's PORTABILITY provision on the date we stop waiving your premiums.

## CLAIMS

Except for the LEGAL ACTION provision, the CLAIMS section of the Certificate does not apply to this rider.

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



Robert L. Grubka  
President



Melissa A. O'Donnell  
Secretary

# WELLNESS BENEFIT RIDER

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

**POLICYHOLDER:** Horne LLP

**GROUP POLICY NUMBER:** 73114-5CCI2

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

### CONTENTS

| Section                   | Page |
|---------------------------|------|
| Schedule of Benefits..... | 1    |
| Definitions.....          | 1    |
| General Provisions.....   | 2    |
| Benefits.....             | 3    |
| Claims.....               | 3    |

### SCHEDULE OF BENEFITS

#### WHO PAYS FOR THE COVERAGE

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

#### WELLNESS BENEFIT

You: \$50  
Your Spouse: \$50  
Your Children: 100% of your wellness benefit  
amount per Child

**A wellness benefit is payable up to a maximum of one time per Covered Person per calendar year.**

### DEFINITIONS

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

#### **Covered Person** means:

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



## **GENERAL PROVISIONS**

### **ELIGIBILITY**

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

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

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

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

### **EFFECTIVE DATE**

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

### **TERMINATION**

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

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

### **PORTABILITY**

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

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

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

### **ASSIGNMENT**

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

## **BENEFITS**

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

Health screening tests include, but are not limited to:

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

## **CLAIMS**

The PHYSICAL EXAMINATION provision does not apply to this rider.

### **NOTICE OF CLAIM**

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

### **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**

All benefits payable under this rider for any loss will be paid within 25 days after receipt of due written proof of such loss in the form of a clean claim where claims are submitted electronically, and will be paid within 35 days after receipt of due written proof of such loss in the form of clean claim where claims are submitted in paper format. Benefits due under the rider are overdue if not paid within 25 days or 35 days, whichever is applicable, after we receive a clean claim containing necessary medical information and other information essential for us to administer the preexisting condition, provision, if any. A "clean claim" means a claim received by us for adjudication and which requires no further information, adjustment or alteration by the provider of the services or us in order to be processed and paid by us. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected. Errors, such as system errors, attributable to us, do not change the clean claim status.

A clean claim does not include any of the following:

- a. A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within 30 days of the original claim;
- b. Claims which are submitted fraudulently or that are based upon material misrepresentations;
- c. Claims that require information essential for us to administer preexisting condition provision, if any; or
- d. Claims submitted more than 30 days after the date of billing by the provider to the insured.

Not later than 25 days after the date we actually receive an electronic claim, we shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify you of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Not later than 35 days after the date we actually receive a paper claim, we shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify you of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by us shall be paid within 20 days after receipt.

For purposes of this provision, the term "pay" means that we shall either send cash or a cash equivalent by United States mail, or send cash or a cash equivalent by other means such as electronic transfer, in full satisfaction of the appropriate benefit due. To calculate the extent to which any benefits are overdue, payment shall be treated as made on the date a draft or other valid instrument was placed in the United States mail to your last known address in a properly addressed, postpaid envelope, or, if not so posted, or not sent by United States mail, on the date of delivery of payment to you.

If the claim is not denied for valid and proper reasons by the end of the applicable time period noted above we must pay interest on accrued benefits at the rate of 3% per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated.

In the event we fail to pay benefits when due, you may bring action to recover such benefits, any interest which may accrue as provided above, and any other damages as may be allowable by law. If it is determined in such action that we acted in bad faith as evidenced by a repeated or deliberate pattern of failing to pay benefits and/or claims when due, you shall be entitled to recover damages in an amount up to 3 times the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated.

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.

### **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

The Summary Plan Description on the following pages is provided to you at the request of the Policyholder. It is not part of the insurance certificate.

## SUMMARY PLAN DESCRIPTION

For a Plan of Insurance Underwritten by  
ReliaStar Life Insurance Company  
P.O. Box 122  
Minneapolis, Minnesota 55440-0122

**Plan Name, Number and Name and Address of Plan Sponsor:**

Horne LLP Cafeteria Compensation Plan  
73114-5CCI2  
Horne LLP  
661 Sunnybrook Rd Suite 100  
Ridgeland, MS 39157

**Name, Address, and Telephone Number of the Plan Administrator:**

Terry Traylor, Director of Finance  
661 Sunnybrook Rd Suite 100  
Ridgeland, MS 39157  
601-326-1132

**Identification Numbers**

IRS Employer Identification Number: 20-1941244  
Plan Number: 505

**Agent for Legal Process:** Plan Administrator

**Trustees:** None

**Collective Bargaining or Multiple-Employer Agreements under which Plan is Established:** None

**Type of Administration:** Records maintained by Policyholder.

**Premium Payments:** Premiums are 100% Employee paid.

**Plan Year:** January 1 through December 31

**Claim Procedures:** Please refer to CLAIM PROCEDURES section(s).

**Statement of ERISA Rights:** Please refer to STATEMENT OF ERISA RIGHTS section.

**Eligibility and Circumstances Limiting Eligibility:** As described in the Certificate of insurance.

**Type of Plan:** As described in the Certificate of insurance.

**Benefits in Plan:** As described in the Certificate of insurance.

**Amendment or Termination of Plan:** The Plan Sponsor makes no promise to continue these benefits in the future and rights to future benefits will never vest. The Plan Sponsor reserves the right to amend, modify, revoke or terminate the plan, in whole or part, at any time. ReliaStar Life Insurance Company's policy may be amended or terminated as set forth in the Policy.

**Benefits, Rights, and Obligations after Termination:** As described in the Certificate of insurance.

## SUMMARY PLAN DESCRIPTION

### CLAIM PROCEDURES FOR CRITICAL ILLNESS INSURANCE

- 1) Information regarding claim submission may be obtained from the Plan Administrator or Human Resource Department.
- 2) ReliaStar Life Insurance Company (ReliaStar Life) will process the claim and make payment or issue a denial notice.
- 3) Written notice of denial of a claim will be furnished to the claimant within 90 days after receipt of the claim. An extension of 90 days will be allowed for processing the claim if special circumstances are involved. The claimant will be given notice of any such extension. The notice will state the special circumstances involved and the date a decision is expected.
- 4) The notice of denial will be written in an understandable manner and include the following:
  - a. The specific reason(s) for the denial.
  - b. Specific reference to the provision which forms the basis of the denial.
  - c. A description of additional information, if any, which would enable a claimant to receive the benefits sought and an explanation of why it is needed.
  - d. An explanation of the claim review procedure, including the time limits applicable to such procedures and notice of the claimant's right to bring a civil action pursuant to Section 502(a) of ERISA following an adverse decision on appeal.
- 5) The claimant may request an appeal at any time during the 60-day period following receipt of the notice of denial of the claim.
- 6) ReliaStar Life will consider requests for an appeal of a denied claim upon written application of the claimant or his or her duly authorized representative. As part of the appeal, the claimant has the right, upon request and free of charge, to access or obtain copies of all documents, records and other information that is relevant to the claim for benefits. The claimant may, in the course of this appeal, submit to ReliaStar Life written comments, documents, records, and other information relating to the claim. ReliaStar Life will provide a full and fair review that takes into account all comments, documents, records and other information submitted by the claimant without regard to whether such information was submitted or considered in the initial benefit determination. Review of claim denials and final decisions on appeal are the responsibility of ReliaStar Life.
- 7) ReliaStar Life will provide the claimant with a written decision of the final determination of the claim. This decision will be written in an understandable way, state the specific reason(s) for the decision, and make specific reference to the provision(s) on which the decision is based. This decision will be issued as soon as practicable from the date of appeal, but not longer than 60 days unless an extension is needed. An extension of 60 days will be allowed for making this decision if special circumstances are present. The claimant will be given notice if this extension is necessary. If the decision on review is not received within these time limits, the claim may be considered denied. If the claimant receives an adverse benefit determination, the claimant will then have the right to bring a civil action pursuant to Section 502(a) of ERISA.
- 8) ReliaStar Life has final discretionary authority to determine all questions of eligibility and status, to interpret and construe the terms of this policy(ies) of insurance, and to make claim determinations.

## SUMMARY PLAN DESCRIPTION

### CLAIM PROCEDURES FOR WAIVER OF PREMIUM RIDER

- 1) Information regarding claim submission may be obtained from the Plan Administrator or Human Resource Department.
- 2) ReliaStar Life Insurance Company (ReliaStar Life) will process the claim and make payment or issue a denial notice.
- 3) Written notice of denial of a claim will be furnished to the claimant within 45 days after receipt of the claim. Up to two extensions of 30 days each will be allowed for processing the claim for matters beyond the Plan's control or if additional information is needed from the claimant. The claimant will be given notice of any such extension. The notice will state the standards on which the entitlement to the benefit is based, the unresolved issues that prevent a decision on the claim, the additional information needed to resolve those issues, if any, and the date a decision is expected.
- 4) The notice of denial will be written in an understandable manner and include the following:
  - a. The specific reason(s) for the denial.
  - b. Specific reference to the provision, internal rule, guideline or protocol which forms the basis of the denial.
  - c. A description of additional information, if any, which would enable a claimant to receive the benefits sought and an explanation of why it is needed.
  - d. An explanation of the claim review procedure, including the time limits applicable to such procedures and notice of the claimant's right to bring a civil action pursuant to Section 502(a) of ERISA following an adverse decision on appeal.
- 5) The claimant may request an appeal at any time during the 180-day period following receipt of the notice of denial of the claim.
- 6) ReliaStar Life will consider requests for an appeal of a denied claim upon written application of the claimant or his or her duly authorized representative. As part of the appeal, the claimant has the right, upon request and free of charge, to access or obtain copies of all documents, records and other information that is relevant to the claim for benefits. The claimant may, in the course of this appeal, submit to ReliaStar Life written comments, documents, records, and other information relating to the claim. ReliaStar Life will provide a full and fair review that takes into account all comments, documents, records and other information submitted by the claimant without regard to whether such information was submitted or considered in the initial benefit determination. Review of claim denials and final decisions on appeal are the responsibility of ReliaStar Life.
- 7) Prior to rendering an adverse decision on appeal, ReliaStar Life will provide notice to the claimant of any new or additional evidence considered, relied upon, or generated by the plan, insurers or other persons making the benefit determination. ReliaStar Life Insurance Company of New York will also notify the claimant if it has new or additional rationale for an adverse appeal determination. ReliaStar Life Insurance Company of New York will then provide the claimant with a reasonable opportunity to review and respond to this new information before making its decision. The time period ReliaStar Life Insurance Company of New York has to make its determination will be tolled while it is waiting for the claimant's response.
- 8) ReliaStar Life will provide the claimant with a written decision of the final determination of the claim. If ReliaStar Life Insurance Company of New York sends an adverse benefit determination following its review of the appeal, the notice of the determination will be written in an understandable manner and include the following:
  - a. The specific reason(s) for the adverse benefit determination.
  - b. Reference to the specific provision on which the determination is based.
  - c. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim.
  - d. A statement of the claimant's right to bring a civil action and any contractual statute of limitations period, including the specific calendar date on which such limitations period will expire.
  - e. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, then a copy of any such rule, guideline, protocol or other criterion will be provided free of



charge.

- f. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

This decision will be issued as soon as practicable from the date of appeal, but not longer than 45 days unless an extension is needed. An extension of 45 days will be allowed for making the decision for matters beyond the Plan's control or if additional information is needed from the claimant. The claimant will be given notice if this extension is necessary, stating the reason for the extension, the date a decision is expected, and the additional information needed from the claimant, if any. If the decision on review is not received within these time limits, the claim may be considered denied. If the claimant receives an adverse benefit determination, the claimant will then have the right to bring a civil action pursuant to Section 502(a) of ERISA.

- 9) ReliaStar Life has final discretionary authority to determine all questions of eligibility and status, to interpret and construe the terms of this policy(ies) of insurance, and to make claim determinations.

# SUMMARY PLAN DESCRIPTION

## STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

### **Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

### **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

### **Enforce Your Rights**

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Office of Participant Assistance, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.