

YOUR CRITICAL ILLNESS INSURANCE PLAN

For Employees of
Paul Hastings LLP

GROUP CRITICAL ILLNESS INSURANCE

CERTIFICATE OF COVERAGE

RELIASTAR LIFE INSURANCE COMPANY

250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

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

POLICYHOLDER: Paul Hastings LLP
GROUP POLICY NUMBER: 70543-8CCI2
POLICY EFFECTIVE DATE: January 1, 2026
GOVERNING JURISDICTION: California

Benefits are paid for Critical Illnesses and Covered Cancer Conditions as defined in the Certificate. This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law. Benefits are paid under the Policy for Critical Illnesses and Covered Cancer Conditions 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. If you are covered by this Certificate, a copy of this Certificate with an incorporated outline of coverage is provided to you.

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.

A Please read your Certificate carefully.

RIGHT TO EXAMINE CERTIFICATE

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

PLEASE REFER TO THE NOTICE SECTION WHICH FOLLOWS THIS PAGE FOR IMPORTANT INFORMATION REGARDING THE CANCER BENEFITS IN THIS CERTIFICATE AND A CONSUMER NOTICE. WE ARE REQUIRED BY STATE LAW TO INCLUDE THIS NOTICE SECTION. PLEASE READ THESE NOTICES CAREFULLY.

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



Amelia (Amy) J. Vaillancourt
President



Melissa A. O'Donnell
Secretary

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

IMPORTANT NOTICE INFORMATION

CANCER BENEFITS

This certificate provides benefits for Covered Cancer Conditions. This Certificate pays reduced benefits for the diagnosis of Non-Invasive Cancer. **Non-Invasive Cancer includes breast cancer, prostate cancer and other cancers that are confined to the site of origin and do not have the ability to spread to other parts of the body or invade adjacent normal tissue.** If a breast cancer, prostate cancer or other cancer has spread into other body parts and is not confined to the site of origin, such cancer will be considered under the Invasive Cancer definition. This Certificate pays reduced benefits for the diagnosis of Limited Skin Cancer.

No benefits are payable for premalignant conditions or polyps or any other histologically benign or nonmalignant condition.

The definitions of Invasive Cancer and Non-Invasive Cancer and Limited Skin Cancer are located in the ADDITIONAL DEFINITIONS THAT APPLY TO CANCER section. The differences in these definitions are primarily related to the growth and/or spread of abnormal cells or their potential to spread beyond their original site, as determined by a Doctor. The benefit amount payable for Non-Invasive Cancer and Limited Skin Cancer may be substantially less than the benefit amount payable for Invasive Cancer due to these differences.

Refer to the SCHEDULE OF BENEFITS for benefit amounts.

CONSUMER NOTICE

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

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

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

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

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

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

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RELIASTAR LIFE INSURANCE COMPANY

OUTLINE OF COVERAGE

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

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

Benefits: See the **SCHEDULE OF BENEFITS, CRITICAL ILLNESS BENEFITS** and **COVERED CANCER CONDITIONS BENEFITS** sections of the Certificate.

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

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

SCHEDULE OF BENEFITS

EMPLOYER: Paul Hastings LLP

GROUP POLICY NUMBER: 70543-8CC12

INSURED PERSON:

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

ELIGIBLE CLASS(ES)

All 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.

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

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

All Employees deemed to be scheduled to work 30+ hours per week

ELIGIBILITY WAITING PERIOD

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

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

WAIVER OF ELIGIBILITY WAITING PERIOD

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

CREDIT FOR PRIOR SERVICE

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

WHO PAYS FOR THE COVERAGE

You pay the cost of your coverage.

BENEFIT AMOUNT

Choice of \$10,000 or \$20,000 or \$30,000

CRITICAL ILLNESS BENEFITS

Base module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Heart Attack	100%	No maximum benefit amount
Stroke	100%	No maximum benefit amount
Sudden Cardiac Arrest	100%	No maximum benefit amount
Major Organ Transplant	100%	No maximum benefit amount
Coronary Artery Bypass	25%	No maximum benefit amount

Major organ module

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

Quality of life module

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

COVERED CANCER CONDITION BENEFITS**Covered Cancer Conditions Module**

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Invasive Cancer	100%	No maximum benefit amount
Non-Invasive Cancer	25%	No maximum benefit amount
Limited Skin Cancer	10%	Once per calendar year with a total maximum benefit amount of 10 times the BENEFIT AMOUNT

DEFINITIONS

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

Your work site must be one of the following:

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

Normal vacation is considered Active Employment.

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.

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

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

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

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

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

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

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

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

Critical Illness means any of the following as defined:

- Abdominal Aortic Aneurysm; or
- Addison’s Disease; or
- Advanced Dementia; or
- Amyotrophic Lateral Sclerosis (ALS); or
- Benign Brain Tumor; or
- Bone Marrow Transplant; 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 Requiring Hospitalization; or
- Loss of Hearing; or
- Loss of Sight; or
- Loss of Speech; or
- Major Organ Transplant; or
- Multiple Sclerosis; or
- Muscular Dystrophy; or
- Myasthenia Gravis; or
- Open Heart Surgery For Valve Replacement or Repair; or
- Pacemaker Placement; or
- Parkinson’s Disease; or
- Permanent Paralysis; or
- Ruptured or Dissecting Aneurysm; or
- Severe Burns; or

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

Different Diagnosis For A Critical Illness 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 is for the same illness/condition as a Critical Illness for which benefits were payable under the Policy.

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

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

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 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 Requiring Hospitalization 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
- COVID-19.

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

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

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

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

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

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

Major Organ Transplant means the irreversible failure of your heart, lung, pancreas, an entire kidney or the entire liver, or any combination of these conditions, as determined by a Doctor using established diagnostic criteria. 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.

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 Stage 4 or greater on the Modified Hoehn and Yahr scale (or similar scale equivalent), which is a chronic, progressive neurodegenerative disorder characterized by any combination of four cardinal signs: rest tremor; rigidity; bradykinesia (abnormal slowness of 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 For A Critical Illness means:

- A second or confirmatory medical opinion of a diagnosis for an illness/condition.

Exception: A subsequent diagnosis of the same illness/condition under the quality of life module, other than Coma and Infectious Disease Requiring Hospitalization, is considered the Same Diagnosis For A Critical Illness 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.

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

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

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

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

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

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

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

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

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

ADDITIONAL DEFINITIONS THAT APPLY TO CANCER BENEFITS

Covered Cancer Condition means any of the following as defined:

- Invasive Cancer; or
- Non-Invasive Cancer or
- Limited Skin Cancer.

Different Diagnosis For A Covered Cancer Condition means any of the following:

- A diagnosis of a Covered Cancer Condition 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 Covered Cancer Condition 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 Covered Cancer Condition for which we previously paid benefits if:
 - The subsequent diagnosis of a Covered Cancer Condition 1) is for the same illness/condition as a Covered Cancer Condition for which benefits were payable under the Policy, and 2) occurs more than 3 months after the date of the previous diagnosis.

Important Notes:

- A second or confirmatory medical opinion is not a Different Diagnosis For A Covered Cancer Condition.
- A diagnosis of a Critical Illness is considered a different diagnosis from a Covered Cancer Condition.
- A diagnosis of Non-Invasive Cancer is considered a Different Diagnosis For A Covered Cancer Condition from Invasive Cancer.
- A diagnosis of Limited Skin Cancer is considered a Different Diagnosis For A Covered Cancer Condition from Invasive Cancer or Non-Invasive Cancer.

Invasive Cancer means the diagnosis of one of a group of diseases characterized by the uncontrolled growth and/or spread of abnormal cells into normal tissue, either locally or distantly (metastatic cancer). Cancer can be a malignancy of any solid tissue, or blood/bone marrow or lymphoid tissue.

The diagnosis of Invasive Cancer must be pursuant to a pathological or clinical diagnosis, as long as such diagnosis is consistent with professional medical standards.

Breast cancer and prostate cancer where the cancer has spread into other body parts and is not confined to the site of origin will be considered Invasive Cancer.

Malignant melanoma that has a Breslow thickness that is more than .8 mm is considered Invasive Cancer.

For the purposes of the Policy, Invasive Cancer does not include:

- Limited Skin Cancer
- Pre-malignant conditions or polyps; or
- Any other histologically benign or nonmalignant condition.

Limited Skin Cancer means any malignant growth that arises on the surface of the skin that is any of the following:

- basal cell carcinoma; or
- squamous cell carcinoma; or
- malignant melanoma that has a Breslow thickness that is less than 0.8 mm.

Non-Invasive Cancer means the presence of a malignant tumor typically classified as in situ (stage 0), that is characterized by the abnormal growth of cells which are confined to the site of origin without invasion of the adjacent normal tissue (e.g. malignant cells confined to the epithelium without penetration of the basement membrane), or do not have the ability to spread to other parts of the body beyond the site from which they originate.

The diagnosis of Non-Invasive Cancer must be pursuant to a pathological or clinical diagnosis, as long as such diagnosis is consistent with professional medical standards.

Breast cancer and prostate cancer where the cancer is confined to the site of origin without spread to lymph nodes or a body part outside the breast or prostate will be considered Non-Invasive Cancer.

For purposes of the Policy, Non-Invasive Cancer does not include:

- Limited Skin Cancer; or
- Pre-malignant conditions or polyps; or
- Any other histologically benign or nonmalignant condition.

Same Diagnosis For A Covered Cancer Condition 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 Covered Cancer Condition for which we previously paid benefits if:
 - The subsequent diagnosis of a Covered Cancer Condition 1) is for the same illness/condition as a Covered Cancer Condition for which benefits were payable under the Policy, and 2) occurs within 3 months of the date of the previous diagnosis.

GENERAL PROVISIONS

ELIGIBILITY

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

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

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 date you enroll for coverage.
- The date you return to Active Employment, if you are not in Active Employment when your coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved non-medical leave of absence 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 is cancelled. 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 end of the grace period after a premium due date, if the premium is not paid.
- 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 and Covered Cancer Conditions.

POLICY CANCELLATION

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

PORTABILITY

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

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 cancels 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 Policy is canceled and coverage for all Insured Persons under the Policy terminates, upon 60 days Written notice of cancellation.

GRACE PERIOD

A grace period of 60 days will be granted for the payment of premium accruing after the first premium payment. During the Policyholder's grace period, the Policy will remain in force, but the Policyholder shall be liable to us for the payment of the premium accruing for the period the Policy continues in force.

If you are 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, but you shall be liable to us for the payment of the premium accruing for the 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.

TIME LIMIT ON CERTAIN DEFENSES

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

CLERICAL ERROR

Clerical error or omission by 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.

NOTICE OF CLAIM

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

PROOF OF LOSS

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

TIME OF PAYMENT OF CLAIMS

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

PHYSICAL EXAMINATION

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

BENEFIT PAYMENTS

Benefits are payable to you unless otherwise specified. Any accrued benefits that are payable at your death will be paid to the first survivor(s) who is/are living on the date of your death, in the following order:

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

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

"Spouse" in this provision means your lawful spouse. It includes your registered domestic partner who is recognized as equivalent to a spouse by California law. It also includes your domestic partner as defined by the Employer if you have completed and Signed an affidavit of domestic partnership on a form acceptable to the Employer.

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

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

LEGAL ACTION

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

MISSTATEMENT OF AGE

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

AGENCY

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

CONFORMITY WITH STATE STATUTES

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

CHANGES TO POLICY OR CERTIFICATE

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

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

CRITICAL ILLNESS BENEFITS

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

To be eligible for a benefit payment, a diagnosis meeting established diagnostic criteria must be made by a Doctor. The diagnosis must be a Different Diagnosis For A Critical Illness 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 For A Critical Illness as defined.

A Critical Illness that meets the definition of a Same Diagnosis For A Critical Illness 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 may include multiple payments for Different Diagnoses For A Critical Illness. 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 and Covered Cancer Conditions, no further benefits are payable and your coverage (including all riders) terminates.

BASE MODULE

Benefits for Heart Attack, Sudden Cardiac Arrest, Stroke, Major Organ Transplant and Coronary Artery Bypass 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, Sudden Cardiac Arrest, Coronary Artery Bypass or Stroke meeting established diagnostic criteria must be made by a Doctor, or as indicated by an autopsy report or a death certificate.

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

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

MAJOR ORGAN MODULE

Benefits for Type 1 Diabetes, Severe Burns, Transient Ischemic Attacks (TIA), Ruptured or Dissecting Aneurysm, Abdominal Aortic Aneurysm, Thoracic Aortic Aneurysm, Open Heart Surgery for Valve Replacement or Repair, Transcatheter Heart Valve Replacement or Repair, Coronary Angioplasty, Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement, Pacemaker Placement, Benign Brain Tumor, 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).

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 Requiring Hospitalization, 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 Requiring Hospitalization, Addison's Disease, Myasthenia Gravis, Systemic Lupus Erythematosus (SLE) and Systemic Sclerosis (Scleroderma) and 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).

Genetic testing does not qualify as a diagnosis of Muscular Dystrophy, or Myasthenia Gravis, or Multiple Sclerosis or Huntington's Disease (Huntington's Chorea). Only one benefit for Infectious Disease Requiring Hospitalization 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.

COVERED CANCER CONDITIONS BENEFITS

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

To be eligible for a benefit payment, a diagnosis meeting established diagnostic criteria must be made by a Doctor. The diagnosis must be a Different Diagnosis For A Covered Cancer Condition as defined in the ADDITIONAL DEFINITIONS THAT APPLY TO CANCER section of this Certificate. A subsequent diagnosis of a Covered Cancer Condition that is for the same illness/condition as a Covered Cancer Condition for which benefits were payable under the Policy may be eligible as a Different Diagnosis For A Covered Cancer Condition as defined.

A Covered Cancer Condition that meets the definition of a Same Diagnosis For A Covered Cancer Condition is not eligible for benefits.

Benefits for Covered Cancer Conditions are based on diagnosis and not on treatment or expenses. As an example: A group policy has a \$20,000 benefit amount. The percentage of the benefit amount payable for Invasive Cancer is 100% and the percentage for Non-Invasive Cancer is 25%. Under this example, benefits would be calculated as follows:

- An Employee has a lump in her breast and she is diagnosed with stage III breast cancer. This diagnosis meets the Policy definition of Invasive Cancer. $\$20,000 \text{ benefit amount} \times 100\% = \$20,000$.
- Another Employee has a lump in her breast and she is diagnosed with breast ductal carcinoma in situ (DCIS). This diagnosis meets the Policy definition of Non-Invasive Cancer. $\$20,000 \text{ benefit amount} \times 25\% = \$5,000$.
- Another Employee has a lump in her breast and she is diagnosed with atypical ductal hyperplasia (ADH). This diagnosis does not meet the Policy definition of Invasive Cancer or Non-Invasive Cancer and therefore no benefit is payable.

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

Benefits are payable up to the total maximum benefit amount shown on the SCHEDULE OF BENEFITS for each Covered Cancer Condition. This may include multiple payments for Different Diagnoses For A Covered Cancer Condition. The total maximum benefit amount is the maximum amount payable to you for each Covered Cancer Condition in the Certificate during your lifetime.

Any partial benefits paid will reduce the total maximum benefit amount for that Covered Cancer Condition.

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

COVERED CANCER CONDITIONS MODULE

Benefits for Invasive Cancer and Non-Invasive Cancer and Limited Skin Cancer 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).

SPOUSE CRITICAL ILLNESS RIDER

RELIASTAR LIFE INSURANCE COMPANY

250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: Paul Hastings LLP

GROUP POLICY NUMBER: 70543-8CC12

INSURED PERSON:

SPOUSE:

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

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

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SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE

You pay the cost of coverage under this rider.

SPOUSE BENEFIT AMOUNT

50% of Employee BENEFIT AMOUNT

SPOUSE CRITICAL ILLNESS BENEFITS

Base module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Heart Attack	100%	No maximum benefit amount
Stroke	100%	No maximum benefit amount
Sudden Cardiac Arrest	100%	No maximum benefit amount
Major Organ Transplant	100%	No maximum benefit amount
Coronary Artery Bypass	25%	No maximum benefit amount

Major organ module

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

Quality of life module

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

SPOUSE CRITICAL ILLNESS BENEFITS

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

SPOUSE COVERED CANCER CONDITION BENEFITS

Covered Cancer Conditions Module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Invasive Cancer	100%	No maximum benefit amount
Non-Invasive Cancer	25%	No maximum benefit amount
Limited Skin Cancer	10%	Once per calendar year with a total maximum benefit amount of 10 times the BENEFIT AMOUNT

SPOUSE COVERED CANCER CONDITION BENEFITS

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

DEFINITIONS

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

Spouse means your lawful spouse. It includes your registered domestic partner who is recognized as equivalent to a spouse by California law. 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.
- The effective date of your coverage under the Critical Illness Certificate.
- 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 date you enroll for Spouse coverage.
- The date you return to Active Employment, if you are not in Active Employment when your Spouse's coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved 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 coverage under the Critical Illness Certificate 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.

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 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, but you shall be liable to us for the premium payment of the premium accruing for the 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 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.

PHYSICAL EXAMINATION

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

BENEFIT PAYMENTS

Benefits under this rider are payable to you. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For PORTABILITY FOLLOWING DEATH OR DIVORCE any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment.

CRITICAL ILLNESS BENEFITS

We will pay the BENEFIT AMOUNT as shown on this rider's SCHEDULE OF BENEFITS if your Spouse is diagnosed with a Critical Illness 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, a diagnosis meeting established diagnostic criteria must be made by a Doctor. The diagnosis must be a Different Diagnosis For A Critical Illness 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 For A Critical Illness as defined.

A Critical Illness that meets the definition of a Same Diagnosis For A Critical Illness 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 may include multiple payments for Different Diagnoses For A Critical Illness. 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 and Covered Cancer Conditions, 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.

COVERED CANCER CONDITIONS BENEFITS

We will pay the BENEFIT AMOUNT as shown on this rider's SCHEDULE OF BENEFITS if your Spouse is diagnosed with a Covered Cancer Condition 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 Covered Cancer Condition on this rider's SCHEDULE OF BENEFITS.

The benefits for your Spouse are the same as the benefits for you as shown in the COVERED CANCER CONDITIONS BENEFITS section of the Certificate.

To be eligible for a benefit payment, a diagnosis meeting established diagnostic criteria must be made by a Doctor. The diagnosis must be a Different Diagnosis For A Covered Cancer Condition as defined in the ADDITIONAL DEFINITIONS THAT APPLY TO CANCER section of the Certificate. A subsequent diagnosis of a Covered Cancer Condition that is for the same illness/condition as a Covered Cancer Condition for which benefits were payable under the Policy may be eligible as a Different Diagnosis For A Covered Cancer Condition as defined.

A Covered Cancer Condition that meets the definition of a Same Diagnosis For A Covered Cancer Condition is not eligible for benefits.

Benefits for Covered Cancer Conditions are based on diagnosis and not on treatment or expenses. As an example: A group policy has a \$20,000 benefit amount. The percentage of the benefit amount payable for Invasive Cancer is 100% and the percentage for Non-Invasive Cancer is 25%. Under this example, benefits would be calculated as follows:

- A Spouse has a lump in her breast and she is diagnosed with stage III breast cancer. This diagnosis meets the Policy definition of Invasive Cancer. \$20,000 benefit amount x 100% = \$20,000.
- Another Spouse has a lump in her breast and she is diagnosed with breast ductal carcinoma in situ (DCIS). This diagnosis meets the Policy definition of Non-Invasive Cancer. \$20,000 benefit amount x 25% = \$5,000.
- Another Spouse has a lump in her breast and she is diagnosed with atypical ductal hyperplasia (ADH). This diagnosis does not meet the Policy definition of Invasive Cancer or Non-Invasive Cancer and therefore no benefit is payable.

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

Benefits are payable up to the total maximum benefit amount shown on this rider's SCHEDULE OF BENEFITS for each Covered Cancer Condition. This may include multiple payments for Different Diagnoses For A Covered Cancer Condition. The total maximum benefit amount is the maximum amount payable for each Covered Cancer Condition in this rider during your Spouse's lifetime.

Any partial benefits paid will reduce the total maximum benefit amount for that Covered Cancer Condition.

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

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

Executed at our home office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401



Amelia (Amy) J. Vaillancourt
President



Melissa A. O'Donnell
Secretary

CHILDREN'S CRITICAL ILLNESS RIDER

RELIASTAR LIFE INSURANCE COMPANY

250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: Paul Hastings LLP

GROUP POLICY NUMBER: 70543-8CCI2

INSURED PERSON:

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

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

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SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE

You pay the cost of coverage under this rider.

CHILDREN'S BENEFIT AMOUNT

50% of Employee BENEFIT AMOUNT

CHILDREN'S CRITICAL ILLNESS BENEFITS

Base module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Heart Attack	100%	No maximum benefit amount
Stroke	100%	No maximum benefit amount
Sudden Cardiac Arrest	100%	No maximum benefit amount
Major Organ Transplant	100%	No maximum benefit amount
Coronary Artery Bypass	25%	No maximum benefit amount

Major organ module

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

Quality of life module

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

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
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

CHILDREN'S COVERED CANCER CONDITION BENEFITS**Covered Cancer Conditions Module**

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Invasive Cancer	100%	No maximum benefit amount
Non-Invasive Cancer	25%	No maximum benefit amount
Limited Skin Cancer	10%	Once per calendar year with a total maximum benefit amount of 10 times the BENEFIT AMOUNT

CHILDREN'S COVERED CANCER CONDITION BENEFITS

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

DEFINITIONS

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

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 biological or adopted child (including a child placed for adoption).
- Your stepchild.
- A child of your registered domestic partner who is recognized as equivalent to a spouse by California law.
- A child of your domestic partner as defined by the Employer if you have completed and Signed an affidavit of domestic partnership on a form acceptable to the Employer.

The child must also meet all of the following conditions:

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

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

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

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

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

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

Congenital Birth Defects does not include prematurity.

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

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

Down Syndrome means diagnosis of down syndrome through a study of the 21st chromosome.

Down Syndrome includes:

- Trisomy 21 - an individual has three instead of two #21 chromosomes.
- Translocation - an extra part of the 21st chromosome is attached to another chromosome.
- Mosaicism - the individual has an extra 21st chromosome in only some of the cells but not all of them. The other cells have the usual pair of 21st 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. It includes your registered domestic partner who is recognized as equivalent to a spouse by California law. 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.
- The effective date of your coverage under the Critical Illness Certificate.
- 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.

ENROLLMENT

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

EFFECTIVE DATE

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

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

If you have coverage on yourself, your eligible newborn Child is automatically covered for the first 30 days after birth. This includes an adopted newborn Child who is placed with you within 30 days of birth. The coverage amount(s) will be the same as for your other eligible Children. If you do not already have Children's coverage under this rider, then coverage for the newborn will be at the lowest level available. If you do not already have Children's coverage under this rider, then Child coverage beyond the 30th day is subject to the conditions regarding application and Active Employment.

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

EFFECTIVE DATE OF CHANGES TO COVERAGE

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

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

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

TERMINATION

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

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

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

- The date your coverage under Critical Illness Certificate 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 and Covered Cancer Conditions.
- 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, but you shall be liable to us for the payment of the premium accruing for the 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 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.

PHYSICAL EXAMINATION

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

BENEFIT PAYMENTS

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

Any payment we make in good faith will discharge our liability as to the extent of such payment.

CRITICAL ILLNESS BENEFITS

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, a diagnosis meeting established diagnostic criteria must be made by a Doctor. The diagnosis must be a Different Diagnosis For A Critical Illness 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 For A Critical Illness as defined.

A Critical Illness that meets the definition of a Same Diagnosis For A Critical Illness 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 may include multiple payments for Different Diagnoses For A Critical Illness. 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 and Covered Cancer Conditions, 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 and Covered Cancer Conditions, 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, 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.

COVERED CANCER CONDITIONS BENEFITS

We will pay the BENEFIT AMOUNT as shown on this rider's SCHEDULE OF BENEFITS if your Child is diagnosed with a Covered Cancer Condition 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 Covered Cancer Condition on this rider's SCHEDULE OF BENEFITS.

The benefits for your Children are the same as the benefits for you as shown in the COVERED CANCER CONDITIONS BENEFITS section of the Certificate.

To be eligible for a benefit payment, a diagnosis meeting established diagnostic criteria must be made by a Doctor. The diagnosis must be a Different Diagnosis For A Covered Cancer Condition as defined in the ADDITIONAL DEFINITIONS THAT APPLY TO CANCER section of the Certificate. A subsequent diagnosis of a Covered Cancer Condition that is for the same illness/condition as a Covered Cancer Condition for which benefits were payable under the Policy may be eligible as a Different Diagnosis For A Covered Cancer Condition as defined.

A Covered Cancer Condition that meets the definition of a Same Diagnosis For A Covered Cancer Condition is not eligible for benefits.

Benefits for Covered Cancer Conditions are based on diagnosis and not on treatment or expenses. As an example: A group policy has a \$10,000 benefit amount for Children. The percentage of the benefit amount payable for Invasive Cancer is 100% and the percentage for Non-Invasive Cancer is 25%. Under this example, benefits would be calculated as follows:

- A Child has a lump in her breast and she is diagnosed with stage I breast cancer. This diagnosis meets the Policy definition of Invasive Cancer. $\$10,000 \text{ benefit amount} \times 100\% = \$10,000$.
- Another Child has a lump in her breast and she is diagnosed with breast ductal carcinoma in situ (DCIS). This diagnosis meets the Policy definition of Non-Invasive Cancer. $\$10,000 \text{ benefit amount} \times 25\% = \$2,500$.
- Another Child has a lump in her breast and she is diagnosed with atypical ductal hyperplasia (ADH). This diagnosis does not meet the Policy definition of Invasive Cancer or Non-Invasive Cancer and therefore no benefit is payable.

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

Benefits are payable up to the total maximum benefit amount shown on this rider's SCHEDULE OF BENEFITS for each Covered Cancer Condition. This may include multiple payments for Different Diagnoses For A Covered Cancer Condition. The total maximum benefit amount is the maximum amount payable for each Covered Cancer Condition in this rider during your Child's lifetime.

Any partial benefits paid will reduce the total maximum benefit amount for that Covered Cancer Condition.

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

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

Executed at our home office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401



Amelia (Amy) J. Vaillancourt
President



Melissa A. O'Donnell
Secretary

CONTINUATION OF INSURANCE RIDER

RELIASTAR LIFE INSURANCE COMPANY

250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: Paul Hastings LLP

GROUP POLICY NUMBER: 70543-8CC12

INSURED PERSON:

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

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

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DEFINITIONS

Covered Person means:

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

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.

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:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401

A handwritten signature in blue ink, appearing to read 'Amy J. Vaillancourt', with a long horizontal flourish extending to the right.

Amelia (Amy) J. Vaillancourt
President

A handwritten signature in blue ink, appearing to read 'Melissa A. O'Donnell', with a long horizontal flourish extending to the right.

Melissa A. O'Donnell
Secretary

WELLNESS BENEFIT RIDER

RELIASTAR LIFE INSURANCE COMPANY

250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: Paul Hastings LLP

GROUP POLICY NUMBER: 70543-8CC12

INSURED PERSON:

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

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

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SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE

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

WELLNESS BENEFIT

You:	\$50
Your Spouse:	\$50
Your Children:	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.

BENEFIT PAYMENTS

Benefits under this rider are payable to you unless otherwise specified. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For Portability Following Death or Divorce, any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment.

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

BENEFITS

We will pay you a wellness benefit (shown on the SCHEDULE OF BENEFITS) if a Covered Person has a health screening test 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
- Any cervical cancer screening test approved by the FDA
- Generally medically accepted cancer screening tests
- Routine eye exam
- Routine dental exam
- Well child/preventive exams for ages 1 through 18
- Biometric screenings
- Molecular or antigen test (Coronavirus)

Executed at our home office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401



Amelia (Amy) J. Vaillancourt
President



Melissa A. O'Donnell
Secretary

INFECTIOUS CONDITION ADDITIONAL BENEFIT RIDER

RELIASTAR LIFE INSURANCE COMPANY

250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: Paul Hastings LLP

GROUP POLICY NUMBER: 70543-8CCI2

INSURED PERSON:

COVERED PERSON:

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

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

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SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE

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

INFECTIOUS CONDITION BENEFITS

Infectious Condition Diagnosis Benefit

You: \$100
Your Spouse: \$100
Your Children: \$100

Infectious Condition Hospital Confinement Benefit

You: \$1,000
Your Spouse: \$1,000
Your Children: \$1,000

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.

Diagnose/Diagnosis means a diagnosis by a Doctor based on generally accepted procedures and criteria.

Diagnosis includes a lab report certified by a Doctor in the United States of a positive result of a test approved by the FDA such as a Nucleic Acid Amplification Test (including reverse-transcription polymerase chain reaction assays), antigen test, or serology test for COVID-19.

Infectious Condition means an infectious disease caused by germs (such as bacteria, viruses, and fungi) that enter the body, multiply, and can cause an infection. Infectious Conditions are limited to:

- Methicillin-resistant Staphylococcus aureus (MRSA);
- Sepsis;
- Bacterial pneumonia;
- Legionnaire's Disease;
- COVID-19.

Confined 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 also includes assignment to an observation unit in a Hospital, if you stay for at least 20 consecutive hours.

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.
- The effective date of your coverage under the Critical Illness Certificate.

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 coverage under the Critical Illness Certificate 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.
- 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.

BENEFIT PAYMENTS

Benefits under this rider are payable to you unless otherwise specified. Once a claim has been approved, we will make payment immediately upon receipt of due written proof of loss. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For PORTABILITY FOLLOWING DEATH OR DIVORCE, benefits are payable to your Spouse, and any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

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

BENEFITS

We will pay you an Infectious Condition Diagnosis Benefit if a Covered Person is Diagnosed with an Infectious Condition on or after the Covered Person's coverage effective date. The benefit amounts are shown on this rider's SCHEDULE OF BENEFITS. A benefit is payable up to a maximum of three times per Covered Person per calendar year.

If a Covered Person is Diagnosed with an Infectious Condition that results in them being Confined to a Hospital, we will also pay you an Infectious Condition Hospital Confinement Benefit. We will pay you an Infectious Condition Hospital Confinement Benefit if a Covered Person is Diagnosed with an Infectious Condition on or after the Covered Person's coverage effective date that results in them being Confined to a Hospital. The benefit amounts are shown on this rider's SCHEDULE OF BENEFITS. A benefit is payable up to a maximum of three times per Covered Person per calendar year.

Executed at our home office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401



Amelia (Amy) J. Vaillancourt
President



Melissa A. O'Donnell
Secretary

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

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

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

COVERAGE

- **Persons Covered**

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

- **Amounts of Coverage**

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

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

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

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

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

- **Health Insurance**

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

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

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

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

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

NOTICES

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

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

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

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

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

TEXAS CERTIFICATE ENDORSEMENT
for Group Critical Illness Insurance

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

I. DEFINITIONS

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

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

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

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

II. EFFECTIVE DATE

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

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



Melissa A. O'Donnell
Secretary

Texas Residents: Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

ReliaStar Life Insurance Company

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

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

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

Email: LifeClaims@voya.com

Mail: 250 Marquette Avenue, Suite 900, Minneapolis, MN 55401

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

Tiene una queja o necesita ayuda?

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

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

ReliaStar Life Insurance Company

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

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

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

Correo electronico: LifeClaims@voya.com

Direccion postal: 250 Marquette Avenue, Suite 900, Minneapolis, MN 55401

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacion ada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electronico: ConsumerProtection@tdi.texas.gov

Direccion postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

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:

Paul Hastings LLP Master Welfare Benefits Plan
70543-8CCI2
Paul Hastings LLP
515 South Flower Street, Floor 25
Los Angeles, CA, 90071

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

Paul Hastings LLP
515 South Flower Street, Floor 25
Los Angeles, CA, 90071
213-683-6000

Identification Numbers

IRS Employer Identification Number: 95-2209675
Plan Number: 501

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

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.