

YOUR CRITICAL ILLNESS INSURANCE PLAN

For Employees of
St. Norbert College Inc.

All Eligible Employees Enrolled in the HDHP

GROUP CRITICAL ILLNESS INSURANCE CERTIFICATE OF COVERAGE

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

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

POLICYHOLDER: St. Norbert College Inc.
GROUP POLICY NUMBER: 73183-8CCI2
POLICY EFFECTIVE DATE: January 1, 2023
GOVERNING JURISDICTION: Wisconsin

THIS IS LIMITED BENEFIT INDEMNITY COVERAGE

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

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

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

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

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

Please read your Certificate carefully.

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



Robert L. Grubka
President



Melissa A. O'Donnell
Secretary

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Florida residents:

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

SCHEDULE OF BENEFITS

EMPLOYER: St. Norbert College Inc.

GROUP POLICY NUMBER: 73183-8CCI2

CLASS DESCRIPTION: All Eligible Employees Enrolled in the HDHP

ELIGIBLE CLASS(ES)

All eligible Employees enrolled in the HDHP in Active Employment with the Employer in the United States.

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

Temporary and seasonal workers are excluded from coverage.

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

MINIMUM HOURS REQUIREMENT

30 hours per week

ELIGIBILITY WAITING PERIOD

Persons in an eligible class on or before the Policy effective date: 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

The Employer pays the cost of your coverage.

BENEFIT AMOUNT

\$10,000

CRITICAL ILLNESS BENEFITS FOR All Eligible Employees Enrolled in the HDHP**Base module**

| Covered illness/condition | Percent of BENEFIT AMOUNT payable | Total maximum benefit amount for coverage |
|----------------------------------|--|--|
| Heart Attack | 100% | 2 times the BENEFIT AMOUNT |
| Cancer | 100% | 2 times the BENEFIT AMOUNT |
| Stroke | 100% | 2 times the BENEFIT AMOUNT |
| Sudden Cardiac Arrest | 25% | 2 times the BENEFIT AMOUNT |
| Major Organ Transplant | 100% | 2 times the BENEFIT AMOUNT |
| Coronary Artery Bypass | 25% | 2 times the BENEFIT AMOUNT |
| Carcinoma in Situ (CIS) | 25% | 2 times the BENEFIT AMOUNT |

Major organ module

| Covered illness/condition | Percent of BENEFIT AMOUNT payable | Total maximum benefit amount for coverage |
|--|--|--|
| Type 1 Diabetes | 100% | 2 times the BENEFIT AMOUNT |
| Severe Burns | 100% | 2 times the BENEFIT AMOUNT |
| Transient Ischemic Attacks (TIA) | 10% | 2 times the BENEFIT AMOUNT |
| Ruptured or Dissecting Aneurysm | 10% | 2 times the BENEFIT AMOUNT |
| Abdominal Aortic Aneurysm | 10% | 2 times the BENEFIT AMOUNT |
| Thoracic Aortic Aneurysm | 10% | 2 times the BENEFIT AMOUNT |
| Open Heart Surgery for Valve Replacement or Repair | 25% | 2 times the BENEFIT AMOUNT |
| Transcatheter Heart Valve Replacement or Repair | 10% | 2 times the BENEFIT AMOUNT |
| Coronary Angioplasty | 10% | 2 times the BENEFIT AMOUNT |
| Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement | 25% | 2 times the BENEFIT AMOUNT |
| Pacemaker Placement | 10% | 2 times the BENEFIT AMOUNT |

Enhanced cancer module

| Covered illness/condition | Percent of BENEFIT AMOUNT payable | Total maximum benefit amount for coverage |
|----------------------------------|--|--|
| Benign Brain Tumor | 100% | 2 times the BENEFIT AMOUNT |
| Skin Cancer | 10% | 2 times the BENEFIT AMOUNT |
| Bone Marrow Transplant | 25% | 2 times the BENEFIT AMOUNT |
| Stem Cell Transplant | 25% | 2 times the BENEFIT AMOUNT |

Quality of life module

| Covered illness/condition | Percent of BENEFIT AMOUNT payable | Total maximum benefit amount for coverage |
|--|--|--|
| Permanent Paralysis | 100% | 1 times the BENEFIT AMOUNT |
| Loss of Sight | 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% | 2 times the BENEFIT AMOUNT |
| Multiple Sclerosis | 25% | 1 times the BENEFIT AMOUNT |
| Amyotrophic Lateral Sclerosis (ALS) | 25% | 1 times the BENEFIT AMOUNT |
| Parkinson's Disease | 25% | 1 times the BENEFIT AMOUNT |
| Advanced Dementia, including Alzheimer's Disease | 25% | 1 times the BENEFIT AMOUNT |
| Huntington's Disease (Huntington's Chorea) | 25% | 1 times the BENEFIT AMOUNT |
| Muscular Dystrophy | 100% | 1 times the BENEFIT AMOUNT |
| Infectious Disease | 10% | 2 times the BENEFIT AMOUNT |

DEFINITIONS

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

Your work site must be one of the following:

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

Normal vacation is considered Active Employment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Coronary Artery Bypass means the diagnosis of severe left main or multi-vessel coronary artery disease (such as a SYNTAX score ≥ 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
- Advanced Dementia; or
- Amyotrophic Lateral Sclerosis (ALS); or
- Benign Brain Tumor; or
- Bone Marrow Transplant; or
- Cancer; or
- Carcinoma in Situ; or
- Coma; or
- Coronary Angioplasty; or
- Coronary Artery Bypass; or
- Heart Attack; or
- Huntington's Disease (Huntington's Chorea); or
- Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement; or
- Infectious Disease; or
- Loss of Hearing; or
- Loss of Sight; or
- Loss of Speech; or
- Major Organ Transplant; or
- Multiple Sclerosis; or
- Muscular Dystrophy; or
- Open Heart Surgery For Valve Replacement or Repair; or
- Pacemaker Placement; or
- Parkinson's Disease; or
- Permanent Paralysis; or
- Ruptured or Dissecting Aneurysm; or
- Severe Burns; or
- Skin Cancer; or
- Stem Cell Transplant; or
- Stroke; or
- Sudden Cardiac Arrest; or
- Thoracic Aortic Aneurysm; or
- Transcatheter Heart Valve Replacement or Repair; or
- Transient Ischemic Attacks (TIA); or
- Type 1 Diabetes.

Different Diagnosis means any of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement means the diagnosis of ventricular tachycardia or fibrillation, or deemed at high risk for cardiac arrest, for which the initial placement of an implantable cardioverter-defibrillator (ICD) has been advised.

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

Infectious Diseases include, but are not limited to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Same Diagnosis means any of the following:

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

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

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

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

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

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

Skin Cancer includes:

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

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

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

Stroke does not include:

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

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.

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.

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.

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

ENROLLMENT

You are not required to enroll for coverage before it becomes effective.

EFFECTIVE DATE OF COVERAGE

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

TERMINATION OF COVERAGE

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

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

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

POLICY TERMINATION

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

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

- There is less than 100% participation of those eligible persons for a Policyholder paid plan.
- The Policyholder does not promptly provide us with information that is reasonably required.
- Fewer than 25 persons are insured under the Policy.
- The premium is not paid in accordance with the provisions of the Policy.
- We determine that there is a significant change in the size, occupation or age of the eligible class(es) as a result of a corporate transaction such as a merger, divestiture, acquisition, sale or reorganization of the Policyholder and/or its persons.
- We stop providing the type of coverage under this Policy to all groups in the Policy issue state.

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

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

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

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

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

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

PORTABILITY

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

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

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

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

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

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

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

GRACE PERIOD

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

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

REPRESENTATIONS NOT WARRANTIES

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

INCONTESTABILITY

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

CLERICAL ERROR

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

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

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

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

MISSTATEMENT OF AGE

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

ASSIGNMENT

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

AGENCY

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

CONFORMITY WITH STATE STATUTES

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

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

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

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

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

BASE MODULE

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

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

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

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

MAJOR ORGAN MODULE

Benefits for Type 1 Diabetes, Severe Burns, Transient Ischemic Attacks (TIA), Ruptured or Dissecting Aneurysm, Abdominal Aortic Aneurysm, Thoracic Aortic Aneurysm, Open Heart Surgery for Valve Replacement or Repair, Transcatheter Heart Valve Replacement or Repair, Coronary Angioplasty, Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement and Pacemaker Placement are payable when we receive due proof of such condition which is diagnosed on or after your coverage effective date.

A diagnosis of Type 1 Diabetes must: 1) be made by a board-certified or board-eligible endocrinologist or other specialist in the treatment of diabetes, 2) be based on blood tests, and 3) require insulin administration for a continuous period of at least 3 months.

A diagnosis of Ruptured or Dissecting Aneurysm, or Transient Ischemic Attacks (TIA) must be confirmed by a neurologist or a Doctor familiar with the diagnosis of the specific condition.

A diagnosis of Abdominal Aortic Aneurysm, or Thoracic Aortic Aneurysm, or Open Heart Surgery for Valve Replacement or Repair, or Transcatheter Heart Valve Replacement or Repair, or Coronary Angioplasty, or Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement, or Pacemaker Placement must be made by a cardiologist or a Doctor familiar with the diagnosis of the specific condition.

One benefit for Open Heart Surgery for Valve Replacement or Repair is payable if the diagnosis is for replacement or repair of one or more valves.

One benefit for Transcatheter Heart Valve Replacement or Repair is payable if the diagnosis is for replacement or repair of one or more valves.

QUALITY OF LIFE MODULE

A Critical Illness under this module, other than Coma and Infectious Disease, is not eligible for multiple benefit payments.

Benefits for Permanent Paralysis, Loss of Sight, Loss of Hearing, Loss of Speech, Coma, Multiple Sclerosis, Amyotrophic Lateral Sclerosis (ALS), Advanced Dementia, including Alzheimer's Disease, Huntington's Disease (Huntington's Chorea), Muscular Dystrophy and Infectious Disease are payable when we receive due proof of such condition which is diagnosed on or after your coverage effective date.

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

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

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

A diagnosis of Muscular Dystrophy, or Multiple Sclerosis or Huntington's Disease (Huntington's Chorea) must be made by a neurologist or a Doctor familiar with the diagnosis of the specific condition. Genetic testing does not qualify as a diagnosis.

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

Benefits for Parkinson's Disease are payable when we receive due proof of such condition which is diagnosed on or after your coverage effective date or you become incapacitated, meaning:

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

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

ENHANCED CANCER MODULE

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

CLAIMS

NOTICE OF CLAIM

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

CLAIM FORM

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

FILING A CLAIM

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

PROOF OF CLAIM

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

PHYSICAL EXAMINATION

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

BENEFIT PAYMENTS

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

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

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

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

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

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

SPOUSE CRITICAL ILLNESS RIDER

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: St. Norbert College Inc.

GROUP POLICY NUMBER: 73183-8CCI2

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 Employer pays the cost of coverage under this rider.

SPOUSE BENEFIT AMOUNT

\$10,000

SPOUSE CRITICAL ILLNESS BENEFITS

Base module

| Covered illness/condition | Percent of BENEFIT AMOUNT payable | Total maximum benefit amount for coverage |
|----------------------------------|--|--|
| Heart Attack | 100% | 2 times the BENEFIT AMOUNT |
| Cancer | 100% | 2 times the BENEFIT AMOUNT |
| Stroke | 100% | 2 times the BENEFIT AMOUNT |
| Sudden Cardiac Arrest | 25% | 2 times the BENEFIT AMOUNT |
| Major Organ Transplant | 100% | 2 times the BENEFIT AMOUNT |
| Coronary Artery Bypass | 25% | 2 times the BENEFIT AMOUNT |
| Carcinoma in Situ (CIS) | 25% | 2 times the BENEFIT AMOUNT |

Major organ module

| Covered illness/condition | Percent of BENEFIT AMOUNT payable | Total maximum benefit amount for coverage |
|--|--|--|
| Type 1 Diabetes | 100% | 2 times the BENEFIT AMOUNT |
| Severe Burns | 100% | 2 times the BENEFIT AMOUNT |
| Transient Ischemic Attacks (TIA) | 10% | 2 times the BENEFIT AMOUNT |
| Ruptured or Dissecting Aneurysm | 10% | 2 times the BENEFIT AMOUNT |
| Abdominal Aortic Aneurysm | 10% | 2 times the BENEFIT AMOUNT |
| Thoracic Aortic Aneurysm | 10% | 2 times the BENEFIT AMOUNT |
| Open Heart Surgery for Valve Replacement or Repair | 25% | 2 times the BENEFIT AMOUNT |
| Transcatheter Heart Valve Replacement or Repair | 10% | 2 times the BENEFIT AMOUNT |
| Coronary Angioplasty | 10% | 2 times the BENEFIT AMOUNT |
| Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement | 25% | 2 times the BENEFIT AMOUNT |
| Pacemaker Placement | 10% | 2 times the BENEFIT AMOUNT |

Enhanced cancer module

| Covered illness/condition | Percent of BENEFIT AMOUNT payable | Total maximum benefit amount for coverage |
|----------------------------------|--|--|
| Benign Brain Tumor | 100% | 2 times the BENEFIT AMOUNT |
| Skin Cancer | 10% | 2 times the BENEFIT AMOUNT |
| Bone Marrow Transplant | 25% | 2 times the BENEFIT AMOUNT |
| Stem Cell Transplant | 25% | 2 times the BENEFIT AMOUNT |

Quality of life module

| Covered illness/condition | Percent of BENEFIT AMOUNT payable | Total maximum benefit amount for coverage |
|--|--|--|
| Permanent Paralysis | 100% | 1 times the BENEFIT AMOUNT |
| Loss of Sight | 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% | 2 times the BENEFIT AMOUNT |
| Multiple Sclerosis | 25% | 1 times the BENEFIT AMOUNT |
| Amyotrophic Lateral Sclerosis (ALS) | 25% | 1 times the BENEFIT AMOUNT |
| Parkinson's Disease | 25% | 1 times the BENEFIT AMOUNT |
| Advanced Dementia, including Alzheimer's Disease | 25% | 1 times the BENEFIT AMOUNT |
| Huntington's Disease (Huntington's Chorea) | 25% | 1 times the BENEFIT AMOUNT |
| Muscular Dystrophy | 100% | 1 times the BENEFIT AMOUNT |
| Infectious Disease | 10% | 2 times the BENEFIT AMOUNT |

SPOUSE CRITICAL ILLNESS BENEFITS

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

DEFINITIONS

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

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

GENERAL PROVISIONS

ELIGIBILITY

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

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

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

ENROLLMENT

You are not required to enroll for Spouse coverage before it becomes effective.

EFFECTIVE DATE OF COVERAGE

Your Spouse will be covered at 12:01 a.m. standard time at the Policyholder's address on the date your Spouse is eligible for coverage.

TERMINATION

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

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

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

PORTABILITY

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

PORTABILITY FOLLOWING DEATH OR DIVORCE

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

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

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

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

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

GRACE PERIOD

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

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

CRITICAL ILLNESS BENEFITS

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

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

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

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

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

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

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

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

CLAIMS

NOTICE OF CLAIM

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

CLAIM FORM

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

FILING A CLAIM

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

PROOF OF CLAIM

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

PHYSICAL EXAMINATION

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

BENEFIT PAYMENTS

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

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

LEGAL ACTION

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

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



Robert L. Grubka
President



Melissa A. O'Donnell
Secretary

CHILDREN'S CRITICAL ILLNESS RIDER

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: St. Norbert College Inc.

GROUP POLICY NUMBER: 73183-8CCI2

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 Employer pays the cost of coverage under this rider.

CHILDREN'S BENEFIT AMOUNT

\$10,000

CHILDREN'S CRITICAL ILLNESS BENEFITS

Base module

| Covered illness/condition | Percent of BENEFIT AMOUNT payable | Total maximum benefit amount for coverage |
|---------------------------|-----------------------------------|---|
| Heart Attack | 100% | 2 times the BENEFIT AMOUNT |
| Cancer | 100% | 2 times the BENEFIT AMOUNT |
| Stroke | 100% | 2 times the BENEFIT AMOUNT |
| Sudden Cardiac Arrest | 25% | 2 times the BENEFIT AMOUNT |
| Major Organ Transplant | 100% | 2 times the BENEFIT AMOUNT |
| Coronary Artery Bypass | 25% | 2 times the BENEFIT AMOUNT |
| Carcinoma in Situ (CIS) | 25% | 2 times the BENEFIT AMOUNT |

Major organ module

| Covered illness/condition | Percent of BENEFIT AMOUNT payable | Total maximum benefit amount for coverage |
|--|-----------------------------------|---|
| Type 1 Diabetes | 100% | 2 times the BENEFIT AMOUNT |
| Severe Burns | 100% | 2 times the BENEFIT AMOUNT |
| Transient Ischemic Attacks (TIA) | 10% | 2 times the BENEFIT AMOUNT |
| Ruptured or Dissecting Aneurysm | 10% | 2 times the BENEFIT AMOUNT |
| Abdominal Aortic Aneurysm | 10% | 2 times the BENEFIT AMOUNT |
| Thoracic Aortic Aneurysm | 10% | 2 times the BENEFIT AMOUNT |
| Open Heart Surgery for Valve Replacement or Repair | 25% | 2 times the BENEFIT AMOUNT |
| Transcatheter Heart Valve Replacement or Repair | 10% | 2 times the BENEFIT AMOUNT |
| Coronary Angioplasty | 10% | 2 times the BENEFIT AMOUNT |
| Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement | 25% | 2 times the BENEFIT AMOUNT |
| Pacemaker Placement | 10% | 2 times the BENEFIT AMOUNT |

Enhanced cancer module

| Covered illness/condition | Percent of BENEFIT AMOUNT payable | Total maximum benefit amount for coverage |
|----------------------------------|--|--|
| Benign Brain Tumor | 100% | 2 times the BENEFIT AMOUNT |
| Skin Cancer | 10% | 2 times the BENEFIT AMOUNT |
| Bone Marrow Transplant | 25% | 2 times the BENEFIT AMOUNT |
| Stem Cell Transplant | 25% | 2 times the BENEFIT AMOUNT |

Quality of life module

| Covered illness/condition | Percent of BENEFIT AMOUNT payable | Total maximum benefit amount for coverage |
|--|--|--|
| Permanent Paralysis | 100% | 1 times the BENEFIT AMOUNT |
| Loss of Sight | 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% | 2 times the BENEFIT AMOUNT |
| Multiple Sclerosis | 25% | 1 times the BENEFIT AMOUNT |
| Amyotrophic Lateral Sclerosis (ALS) | 25% | 1 times the BENEFIT AMOUNT |
| Parkinson's Disease | 25% | 1 times the BENEFIT AMOUNT |
| Advanced Dementia, including Alzheimer's Disease | 25% | 1 times the BENEFIT AMOUNT |
| Huntington's Disease (Huntington's Chorea) | 25% | 1 times the BENEFIT AMOUNT |
| Muscular Dystrophy | 100% | 1 times the BENEFIT AMOUNT |
| Infectious Disease | 10% | 2 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.

DEFINITIONS

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

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

- Your natural or adopted child (including a child placed for adoption).
- Your stepchild.
- A child of your domestic partner who is recognized as equivalent to a spouse by Wisconsin law.
- Your grandchild if the child's parent is insured as your Child under this rider.

The child must also meet all of the following conditions:

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

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

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

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

GENERAL PROVISIONS

ELIGIBILITY

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

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

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

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

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

ENROLLMENT

You are not required to enroll for Children's coverage before it becomes effective.

EFFECTIVE DATE

Your Children will be covered at 12:01 a.m. standard time at the Policyholder's address on 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 and having no approved Employee claims under the Policy.

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

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. The date your Child's total maximum benefit amount has been paid for all Critical Illnesses.

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

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

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

PORTABILITY

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

PORTABILITY FOLLOWING DEATH

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

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

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

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

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

GRACE PERIOD

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

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

CRITICAL ILLNESS BENEFITS

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

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

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

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

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

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

Payment of any benefits for your Child'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 Child's Critical Illness coverage as long as your coverage remains in force.

A diagnosis of any Critical Illness must be made after your Child's live birth and by a Doctor familiar with the diagnosis of the specific condition.

CLAIMS

NOTICE OF CLAIM

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

CLAIM FORM

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

FILING A CLAIM

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

PROOF OF CLAIM

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

PHYSICAL EXAMINATION

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

BENEFIT PAYMENTS

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

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

LEGAL ACTION

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

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



Robert L. Grubka
President



Melissa A. O'Donnell
Secretary

CONTINUATION OF INSURANCE RIDER

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

POLICYHOLDER: St. Norbert College Inc.

GROUP POLICY NUMBER: 73183-8CCI2

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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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' formal leave policies. Normal vacation time is not considered a Leave of Absence.

Severance means your Active Employment is terminated and continuation of insurance is available under a severance plan provided by the Employer.

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, or
- Severance,

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 60 days 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 12 months after the date you stopped Active Employment.

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

Other Leave of Absence

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

- The last day of the month which is on or next follows the date your approved Leave of Absence ends.
- The last day of the month which is on or next follows the date which is 60 days 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.

SEVERANCE

If your Active Employment terminates and Severance is available, 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 end of the Severance continuation period.
- The last day of the month which is on or next follows the date which is 60 days after the date you stopped Active Employment.

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

CONCURRENT LEAVES OF ABSENCE

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

TERMINATION OF CONTINUATION

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

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

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

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

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

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

RETURN TO ACTIVE EMPLOYMENT

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

PORTABILITY FOLLOWING TERMINATION OF CONTINUATION

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

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



Robert L. Grubka
President



Melissa A. O'Donnell
Secretary

Consumer Notice for Arkansas Residents

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

The mailing address is:

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

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

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

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

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

Notice of Protection Provided by Utah Life and Health Insurance Guaranty Association

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies. (For the purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs) and limited health plans.)

The basic protections provided by the Association are:

- Life Insurance
 - o \$500,000 in death benefits
 - o \$200,000 in cash surrender or withdrawal values
- Health Insurance
 - o \$500,000 in hospital, medical and surgical insurance benefits
 - o \$500,000 in long-term care insurance benefits
 - o \$500,000 for disability income insurance benefits
 - o \$500,000 in other types of health insurance benefits
- Annuities
 - o \$250,000 in the present value of annuity benefits in aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$500,000. Special rules may apply with regard to hospital, medical, and surgical insurance benefits.

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Utah law.

To learn more about the above protections, please visit the Association's website at www.utlifega.org, or contact:

Utah Life and Health Insurance Guaranty Assoc.
32 West 200 South #150
Salt Lake City, UT 84101
(801)320-9955

Utah Insurance Department
State Office Bldg., Rm. 3110
Salt Lake City, UT 84114
(801) 538-3800

Wisconsin Complaint Notice

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? – If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

**ReliaStar Life Insurance Company
Customer Service
P.O. Box 20
Minneapolis, MN 55440-0020
1-877-236-7564**

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can file a complaint electronically with the **OFFICE OF THE COMMISSIONER OF INSURANCE**

at its website at <http://oci.wi.gov/>,

or by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517
608-266-0103.

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