GROUP LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PROGRAM

Lewis University

RELIANCE STANDARD LIFE INSURANCE COMPANY

Home Office: Chicago, Illinois
Administrative Office: Philadelphia, Pennsylvania

CERTIFICATE OF INSURANCE

We certify that you (provided you belong to a class described on the Schedule of Benefits) are insured, for the benefits which apply ttyPic eie rifeiii pwhij0 -11.4 TD 0.31776 Tc (W) Tj0.10224 Tc en1.5512.87c (i) Tj1.5510 Tc (wh) T benefSfj1544(b) TjT0.04332 Tc whrc efenefSrw h rr r S eSr orw h nceSrr i whnr pfr

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(1) hand or foot, means the complete severance through or above the wrist or ankle joint;

(2) the eye, speech or hearing, means total and irrecoverable loss thereof.

"Injury" means accidental bodily injury which is caused directly by accidental means and which occurs while your coverage under the Policy is in force.

INCONTESTABILITY

EFFECTIVE DATE AND TERMINATION

EFFECTIVE DATE OF INDIVIDUAL INSURANCE: If the Policyholder pays the entire premium, your insurance will go into effect on the date stated on the Schedule of Benefits. If you pay a part of the premium, you must apply in writing for the insurance to go into effect. You will become insured on the later of:

(1) the Individual Effective Date stated on the Schedule of Benefits, if you apply on or before that date; or

(2) the date you apply, if you apply within thirty-one (31) days from the date you first met the eligibility requirements; or

(3) the date we approve any required proof of good health. We require proof of good health if you apply:

   (a) after thirty-one (31) days from the date you first become eligible; or
   (b) after you terminated this insurance but you remained in a class eligible for this insurance; or
   (c) for an Amount of Insurance greater than the Amount of Insurance shown on the Schedule of Benefits as not subject to our approval of a person's good health; or
   (d) for an Amount of Insurance greater than you were insured for under the prior group life insurance plan carrier, if applicable; or
   (e) after being eligible for coverage under a prior group life insurance plan for more than thirr re Insuranuover prthe F 0 T (I n)
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TERMINATION OF INSURANCE: Your insurance will terminate on the first of the following to occur:

(1) the date the Policy terminates; or

(2) the date you cease to be in a class eligible for this insurance; or

(3) the end of the period for which premium has been paid for you; or

(4) the date you enter military service (not including Reserve or National Guard).

CONTINUATION OF INSURANCE: Your insurance may be continued, by payment of premium, beyond the date you cease to be eligible for this insurance, but not longer than:

(1) twelve (12) months, if due to illness or injury; or
(2) one (1) month, if due to temporary lay-off or approved leave of absence.

CONVERSION PRIVILEGE

You can use this privilege when your insurance is no longer in force. It has several parts. They are:

A. If the insurance ceases due to termination of employment or membership in any of the Policy's classes, an individual Life Insurance Policy may be issued. You are entitled to a policy without disability or supplemental benefits. You must make written application for the policy within thirty-one (31) days after you

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BENEFICIARY AND FACILITY OF PAYMENT

BENEFICIARY: The beneficiary will be as named in writing by you to receive benefits at your death. This beneficiary designation must be on file with us or the Plan Administrator and will be effective on the date you sign it. Any payment made by us before receiving the designation shall fully discharge us to the extent of that payment.

If you name more than one beneficiary to share the benefit, you must state the percentage of the benefit that is to be paid to each beneficiary. Otherwise, they0.47112 Tc2ot0.04332 Tc (r) Tj0 Tc (e) Tj(s) Tj0 Tc (e,) Tj0.11at

The balance of the benefit, if any, will be held by us, until an individual or representative:

(1) is validly named; or
(2) is appointed to receive the proceeds; and
(3) can give valid release to us.

The benefit will be held with interest at a rate set by us.

We will not be liable for any payment we have made in good faith.

will not be payable under the Waiver of Premium in Event of Total Disability provision unless the converted policy is surrendered to us.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Nothing in this section will change or affect any of the terms of the Policy other than as specifically set out in this section. All the Policy provisions not in conflict with these provisions shall apply to this section.

If you suffer any one of the losses listed below, as a result of an injury, we will pay the benefit shown. The loss must be caused solely by an accident which occurs while you are insured, and must occur within 365 days of the accident. Only one benefit (the larger) will be paid for more than one loss resulting from any one accident. The Amount of Insurance can be found on the Schedule of Benefits.

LOSS OF:	**AMOUNT OF INSURANCE:**
Life	The Full Amount
Both Hands	The Full Amount
Both Feet	The Full Amount
The Sight of Both Eyes	The Full Amount
Speech and Hearing	The Full Amount
One Hand and One Foot	The Full Amount
One Hand and the Sight of One Eye	The Full Amount
One Foot and the Sight of One Eye	The Full Amount
One Hand	One-Half of the Amount
One Foot	One-Half of the Amount
Speech or Hearing	One-Half of the Amount
The Sight of One Eye	One-Half of the Amount

EXCLUSIONS (1) caused by or icalaualctintedcicinar

A benefit will not be payable for a loss:

(1) caused by suicide or intentionally self-inflicted injuries; or

(2) caused by or resulting from war, or any act of war, declared or undeclared;

Maximum Benefit Payable – The total combined maximum benefit payable under the Seat Belt and Air Bag Benefit is $25,000.

EXCLUSIONS

No benefit is payable for any loss sustained by you:

(1) if you were driving or riding in any private passenger Four-Wheel Vehicle which was being used in a race, speed or endurance test, or for acrobatic or stunt driving at the time of the accident;

(2) if you were not wearing a Seat Belt for any reason;

(3) while you were sharing a Seat Belt.

CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice must be given to us within 31 days after the Loss occurs, or as soon as reasonably possible. The notice should be sent to us at our Administrative Offices or to our authorized agent. The notice should include your name and the Policy Number.

CLAIM FORMS: When we receive written notice of a claim, we will send claim forms to the claimant within 15 days. If we do not, the claimant will satisfy the requirements of written proof of loss by sending us written proof as shown below. The proof must describe the occurrence, extent and nature of the loss.

PROOF OF LOSS: For any covered Loss, written proof must be sent to us within 90 days. If it is not reasonably possible to give proof within 90 days, the claim is not affected if the proof is sent as soon as reasonably possible. In any event, proof must be given within 1 year, unless the claimant is legally incapable of doing so.

PAYMENT OF CLAIMS: Payment will be made as soon as proper proof is received. All benefits will be paid to you, if living. Any benefits unpaid at the time of death, or due to death, will be paid to the beneficiary.

PHYSICAL EXAMINATION: At our own expense, we will have the right to have you examined as reasonably necessary when a claim is pending. We can have an autopsy made unless prohibited by law.

LEGAL ACTION: No legal action may be brought against us to recover on the Policy within 60 days after written proof of loss has been given as required by the Policy. No action may be brought after three (3) years (Kansas, five (5) years; South Carolina and Michigan, six (6) years) from the time written proof of loss is required to be submitted.

EXTENSION OF COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT AND UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Family and Medical Leave of Absence:

We will continue your coverage and that of any Insured Dependent, if applicable, in accordance with the Policyholder's policies regarding leave under the Family and Medical Leave Act of 1993, as amended, or any similar state law, as amended, if:

(1) the premium for you and your Insured Dependents, if applicable, continues to be paid during the leave; and
(2) the Policyholder has approved your leave in writing and provides a copy of such approval within thirty-one (31) days of our request.

As long as the above requirements are satisfied, we will continue coverage until the later of:

(1) the end of the leave period required by the Family and Medical Leave Act of 1993, as amended; or
(2) the end of the leave period required by any similar state law, as amended.

Military Services Leave of Absence:

We will continue your coverage and that of any Insured Dependents, if applicable, in accordance with the Policyholder's policies regarding Military SeA

applicable, will apply during the leave except that increases in the amount of insurance, whether automatic or subject to election, will not be effective if you are not considered Actively at Work until you have returned to Active Work for one (1) full day.

A leave of absence taken in accordance with the Family and Medical Leave Act of 1993 or USERRA will run concurrently with any other applicable continuation of insurance provision in the Policy.

Your coverage and that of any Insured Dependents, if applicable, will cease under this extension on the earliest of:

(1) the date the Policy terminates; or
(2) the end of the period for which premium has been paid for you; or
(3) the date such leave should end in accordance with the Policyholder's policies regarding Family and Medical Leave of Absence and Military Services Leave of Absence in compliance with the Family and Medical Leave Act of 1993, as amended and USERRA.

Should the Policyholder choose not to continue your coverage during a Family and Medical Leave of Absence and/or Military Services Leave of Absence, your coverage as well as any dependent coverage, if applicable, will be reinstated.

PORTABILITY

You may continue insurance coverage under the Policy if coverage would otherwise terminate because you cease to be an Eligible Person, for reasons other than the termination of the Policy, or your retirement, provided you:

(1) notify us in writing within thirty-one (31) days from the date you cease to be eligible; and
(2) remit the necessary premiums when due; and
(3) are not approved for extension of coverage under the Waiver of Premium in Event of Total Disability provision, if applicable; and
(4) have not been terminated under the Waiver of Premium in Event of Total Disability provision, if applicable; and
(5) have been covered for twelve (12) months under the Policy and/or the prior group life insurance policy.

Such coverage may be continued for a period of two (2) years beginning on the date you are no longer an Eligible Person.

The amount of coverage available under the Portability provision will be the current amount of coverage you are insured for under the Policy on the last day you were Actively at Work. However, the amount of coverage will never be more than:

(1) the highest amount of life insurance available to Eligible Persons; or
(2) a total of $500,000 from all RSL group life and accidental death and dismemberment insurance combined,

whichever is less.

The premium charged to continue coverage will be based on the prevailing rate charged to Insureds who choose to continue coverage under the Portability provision. Such premium will be billed directly to you on a quarterly, semi-annual or annual basis.

If your coverage under the Policy includes Accidental Death and Dismemberment, then such benefits may be continued under the Policy.

Insurance coverage continued under this provision for you will terminate on the first of the following to occur:

(1) the date the Policy terminates; or
(2) the end of the period for which premium has been paid; or
(3) the date you are covered under another group term life insurance policy; or
(4) at the end of the two (2) year period; or

(5) at any time coverage would normally terminate according to the terms of the Policy had you continued to be an Eligible Person.

In addition, coverage will reduce at any time it would normally red (r) Tj0 Tc (e

GROUP TERM LIFE INSURANCE ACCELERATED BENEFIT RIDER

THIS RIDER ADDS AN ACCELERATED BENEFIT PROVISION. RECEIPT OF THIS ACCELERATED BENEFIT WILL REDUCE THE DEATH BENEFIT AND MAY BE TAXABLE. IN ADDITION, RECEIPT OF THIS BENEFIT MAY AFFECT THE INSURED'S ELIGIBILITY FOR MEDICAID OR OTHER GOVERNMENT BENEFITS OR ENTITLEMENTS. INSUREDS SHOULD SEEK ASSISTANCE FROM THEIR PERSONAL TAX ADVISOR.

Attached to Group Policy Number: GL 154709
Issued to Group Policyholder: Lewis University

This Rider is attached to and made a part of the Policy indicated above. Your Certificate is hereby amended, in consideration of the application for this coverage, by the addition of the following benefit. In this Rider, Reliance Standard Life Insurance Company will be referred to as “we", “us", “our".

DEFINITIONS: This section gives the meaning of terms used in this Rider. The Definitions of the Policy and Certificate also apply unless they conflict with Definitions given here.

"Certified" or "Certification" refers to a written statement, made by a Physician on a form provided by us, as to the Insured’s Terminal Illness.

"Certificate" means the document, issued to each Insured, which explains the terms of his coverage under the Group Life Insurance Policy.

"Death Benefit" means the insurance amount payable under the Certificate at death of the Insured. It does not include any amount that is only payable in the event of Accidental Death.

"Insured" means the primary Insured and hisnt7112 Tc ( )4j0.10224 Tc (ntn) Tj0 ananenty ycc.P.10224 Tcp12 0 Tc (In) Tj0.06 Tc (s) Tj0 Tc (u) Tj083Tj0.0433 the pri

expected to result in death in less than 24 months.

"Written Request" means a request made, in writing, by the Insured to us.

All pronouns include either gender unless the context indicates otherwise.

DESCRIPTION OF COVERAGE: This benefit is payable to the Insured if the Insured's coverage is in force and the Insured is Certified as Terminally Ill: at any time for loss resulting from accidental injury; or after having been insured under this Rider for at least 30 days prior to a loss resulting from sickness. In order for this benefit to be paid:

(1) the Insured must make a Written Request; and

(2) we must receive from any assignee or irrevocable beneficiary their signed acknowledgment and agreement to payment of this benefit.

We may, at our option, confirm the terminal diagnosis with a second medical exam performed at our own expense.

AMOUNT OF THE ACCELERATED BENEFIT: The Accelerated Benefit will be an amount equal to 75% of the Death Benefit applicable to the Insured under the Policy on the date of the Certification of Terminal Illness, subject to a maximum benefit of $500,000. This benefit may be paid as a single lump sum or in installment payments mutually agreed to

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MISSTATEMENT OF AGE OR SEX: The Accelerated Benefit will be adjusted to reflect the amount of benefit that would have been purchased by the actual premium paid at the correct age athe8 Tc (t a) Tj0.10224 Tc (g) TS

ACCELERATED BENEFIT RIDER DISCLOSURE
FOR RIDER LRS-8596-001-0200 IL

The Accelerated Benefit option is an advance payment of life insurance proceeds under our group term life insurance program. This option allows the Insured to access the face amount of his insurance coverage prior to death if he is diagnosed as having less than 24 months to live. There are no restrictions placed on how the proceeds may be used.

ELIGIBILITY: The Insured is eligible to exercise the Accelerated Benefit option if, after having been covered under the Rider for at least thirty (30) days (this thirty (30) day elimination period does not apply with respect to a condition resulting from an accident), he has been diagnosed as having a medical condition which will result in a drastically limited life-span and his doctor certifies that death will occur within 24 months. We reserve the right to investigate further to verify eligibility.

THE BENEFIT: The Accelerated Benefit Option pays 75% of the death benefit, to a maximum of $500,000, in a single lump sum or in installment payments mutually agreed to by us and the Insured. The portion of the death benefit which is not accelerated is payable to his beneficiary at his death.

There is no additional premium charge for the Accelerated Benefit Rider. There is no reduction in the premium for the group term life insurance coverage if benefits become payable under this Rider.

If the group Policy and/or the Insured's life insurance benefits under the Group Policy terminate, all of the Insured's rights under the Accelerated Benefit Rider also terminate.

EFFECT OF BENEFIT: Receipt of the Accelerated Benefit may be taxable and could adversely affect the Insured's eligibility for Medicaid or other government benefits or entitlements. It is recommended that the Insured consult his personal tax advisor for clarification of the current tax law with respect to accelerated death benefits.

NOTICE OF
PROTECTION PROVIDED BY
ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

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

The Association was established to provide protection in the unlikely event that your member life, annuity or health insurance company becomes financially unable to meet its obligations and is placed into Receivership by the Insurance Department of the state in which the company is domiciled. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Illinois law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association per insolvency are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits*
  - $300,000 in disability insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

*The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except special rules apply to hospital, medical and surgical insurance benefits for which the maximum amount of protection is $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion 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 residency requirements and other limitations under Illinois law.

Claim Procedures and ERISA Statement of Rights

CLAIM PROCEDURES FOR CLAIMS FILED WITH RELIANCE STANDARD LIFE INSURA

Disability Benefit Claims
In the case of a claim for disabilityil

the claimant to perfect the claim and an explanation of why such material or information is necessary; and

4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an adverse benefit determination on review.

Disability Benefit Claims

A claimant shall be provided with written notification of any adverse benefit determination. The notification shall be set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Employee Retirement

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APPEALS OF ADVERSE BENEFIT DETERMINATIONS

Appeals of adverse benefit determinations may be submitted in accordance with the following procedures to:

Reliance Standard Life Insurance Company
Quality Review Unit
P.O. Box 8330
Philadelphia, PA 19101-8330

Non-Disability Benefit Claims

1. Claimants (or their authorized representatives) must appeal within 60 days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
5. No deference to the initial adverse benefit determination shall be afforded upon appeal;
6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and
7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant's adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination.

Disability Benefit Claims

1. Claimants (or their authorized representatives) must appeal within 180 days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and

other information relevant to the claimant's claim for benefits;

4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
5. No deference to the initial adverse benefit determination shall be afforded upon appeal;
6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant's adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination; and
8. In deciding the appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, the individual conducting the appeal shall consult with a health care professional:

   (a) who has appropriate training and experience in the field of medicine involved in the medical judgment; and
   (b) who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal; nor the subordinate of any such individual.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

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necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Disability Benefit Claims

The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 45 days after receipt of the claimant's timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days fcenono

3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and
4. A statement of the claimant's right to bring an action under section 502(a) of ERISA (where applicable).

Disability Benefit Claims

A claimant must be provided with written notification of the determination on review. In the case of adverse benefit determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
4. A statement of the claimant's right to bring an action under section 502(a) of ERISA (where applicable);
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; and
6. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency (where applicable)."

DEFINITIONS

The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan.

The term "us" or "our" refers to Reliance Standard Life Insurance Company.

The term "relevant" means:

A document, record, or other information shall be considered relevant to a claimant's claim if such document, record or other information:

- Was relied upon in making the benefit determination;
- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
- Demonstrates compliance with administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants; or
- In the case of a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit of the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Reliance Standard Life Insurance Company shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduns

Assistance with Your Questions

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

Home Office: Chicago, Illinois
Administrative