

YOUR CRITICAL ILLNESS INSURANCE PLAN

For Employees of
Saint Joseph's University

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: Saint Joseph's University
GROUP POLICY NUMBER: 71819-0CCI2
POLICY EFFECTIVE DATE: January 1, 2021
GOVERNING JURISDICTION: Pennsylvania

THIS IS A LIMITED CERTIFICATE - READ IT CAREFULLY

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. The Policy is conditionally renewable on each Policy anniversary, subject to the POLICY TERMINATION provision.

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.

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 the Certificate carefully.

RIGHT TO EXAMINE CERTIFICATE

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

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



William Bainbridge
President



Melissa A. O'Donnell
Secretary

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Arizona Residents:

Notice: This Certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read this Certificate carefully.

California residents:

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

Florida residents:

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

Maryland residents:

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

SCHEDULE OF BENEFITS

EMPLOYER: Saint Joseph's University

GROUP POLICY NUMBER: 71819-0CCI2

ELIGIBLE CLASS(ES)

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

You must be an Employee of the Employer and in an eligible class.
Temporary and seasonal workers are excluded from coverage.

MINIMUM HOURS REQUIREMENT

Employees: 20 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.

CREDIT FOR PRIOR SERVICE

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

WHO PAYS FOR THE COVERAGE

You pay the cost of your coverage.

BENEFIT AMOUNT

Choice of \$15,000 or \$30,000

CRITICAL ILLNESS BENEFITS

Base module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Heart Attack	100%	2 times the BENEFIT AMOUNT
Cancer	100%	2 times the BENEFIT AMOUNT
Stroke	100%	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
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
Coma	100%	2 times the BENEFIT AMOUNT
Amyotrophic Lateral Sclerosis (ALS)	100%	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)	100%	1 times the BENEFIT AMOUNT
Muscular Dystrophy	25%	1 times the BENEFIT AMOUNT
Infectious Disease	25%	2 times the BENEFIT AMOUNT
Addison's Disease	10%	1 times the BENEFIT AMOUNT
Myasthenia Gravis	25%	1 times the BENEFIT AMOUNT
Systemic Lupus Erythematosus (SLE)	10%	1 times the BENEFIT AMOUNT
Systemic Sclerosis (Scleroderma)	10%	1 times the BENEFIT AMOUNT

DEFINITIONS

Active Employment 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.

Temporary and seasonal workers are excluded from coverage.

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

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

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

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

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

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

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

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

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

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

Bone Marrow Transplant means the clinical diagnosis of the need for a surgical transplant when you have been added to the *Be The Match* registry for a bone marrow transplant.

Bone Marrow Transplant 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 the document that explains the parts of the Policy which apply to eligible Insured Persons. It may include riders, endorsements or amendments.

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.

"Continuous state of profound unconsciousness" means 14 consecutive days or longer.

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 is advised 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.

Critical Illness means any of the following as defined:

- Abdominal Aortic Aneurysm; or
- Addison's Disease; or
- Advanced Dementia; or
- Amyotrophic Lateral Sclerosis (ALS); or
- Benign Brain Tumor; or
- Bone Marrow Transplant; or
- Cancer; or
- Carcinoma in Situ; or
- Coma; or
- Coronary Angioplasty; or
- Coronary Artery Bypass; or
- Heart Attack; or
- Huntington's Disease (Huntington's Chorea); or
- Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement; or
- Infectious Disease; or
- Major Organ Transplant; or
- Muscular Dystrophy; or
- Myasthenia Gravis; or
- Open Heart Surgery For Valve Replacement or Repair; or
- Pacemaker Placement; or
- Parkinson's Disease; or
- Ruptured or Dissecting Aneurysm; or
- Severe Burns; or
- Skin Cancer; or
- Stem Cell Transplant; or
- Stroke; or
- Systemic Lupus Erythematosus (SLE); or
- Systemic Sclerosis (Scleroderma); or
- Thoracic Aortic Aneurysm; or
- Transcatheter Heart Valve Replacement or Repair; or
- Transient Ischemic Attacks (TIA).

Different Diagnosis means any of the following:

- A diagnosis of a Critical Illness that is for a different illness/condition than a previously diagnosed illness/condition. Note: A Cancer that has spread to a different area of the body is not a different illness/condition than the previously diagnosed Cancer.
- A subsequent diagnosis of a Critical Illness that is for the same illness/condition (including a Cancer that has spread to a different area of the body) as a Critical Illness for which benefits were payable under the Policy, and that occurs more than 12 months after the date of the previous diagnosis.
- A subsequent diagnosis of a Critical Illness that is for the same illness/condition (including a Cancer that has spread to a different area of the body) as an illness/condition diagnosed prior to your coverage effective date under the Policy, and that occurs more than 12 months after 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 not considered a Different Diagnosis regardless of the time period between diagnoses.

- A diagnosis of Skin Cancer is considered a Different Diagnosis from Cancer.
- A diagnosis of Carcinoma in Situ is considered a Different Diagnosis from Cancer.
- A diagnosis of Skin Cancer is considered a Different Diagnosis from 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 in Active Employment with the Employer in the United States.

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 or both of the following must confirm the acute myocardial infarction (Heart Attack):

- 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.

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 provides 24 hours a day service by or under the supervision of registered graduate nurses (RNs).

For purposes of the Policy, "hospital" does not include 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 a severe 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 fourteen (14) or more consecutive days.

Examples 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; and
- Ebola Virus Disease.

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.

Major Organ Transplant means the irreversible failure of your heart, lung, pancreas, entire kidney or liver, or any combination thereof, 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. If you receive the transplant prior to placement on the network, the network requirement will be waived.

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

Myasthenia Gravis means the diagnosis of a neuromuscular disease characterized by weakness and rapid fatigue of any of the muscles under your voluntary control.

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

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.

Policy means the written group insurance contract between us and the Policyholder.

Policyholder means the Employer to which the Policy is issued and who 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.

For purposes of the Policy, aneurysms of the arm or leg are not considered a Ruptured or Dissecting Aneurysm.

Same Diagnosis means either of the following:

- A subsequent diagnosis of a Critical Illness that is for the same illness/condition (including a Cancer that has spread to a different area of the body) as a Critical Illness for which benefits were payable under the Policy, and that occurs within 12 months of the date of the previous diagnosis.
- A subsequent diagnosis of a Critical Illness that is for the same illness/condition (including a Cancer that has spread to a different area of the body) as an illness/condition diagnosed prior to your coverage effective date under the Policy, and that occurs within 12 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.

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 studies and evidence of persistent neurological impairment confirmed at the time of discharge from a Hospital.

Stroke does not include:

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

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

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

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

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

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.

GENERAL PROVISIONS

ELIGIBILITY

If you are working for the Employer 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 day after you complete your Eligibility Waiting Period.

EFFECTIVE DATE OF COVERAGE

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

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

EFFECTIVE DATE OF CHANGES TO COVERAGE

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

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

Any decrease in coverage will take effect at the end of the month but will not affect a payable claim that occurs prior to the decrease.

TERMINATION OF COVERAGE

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

- The date the Policy terminates.
- The date you are no longer in an eligible class.
- The date your eligible class is no longer covered.
- The date you voluntarily cancel your coverage.
- The end of the period for which you paid premiums, if you stop making a required premium contribution, subject to the grace period.
- The end of the Policyholder's grace period, if the Policyholder does not remit premium to us by the end of such period.
- The last day you are in Active Employment.
- The date the total maximum benefit amount has been paid for all Critical Illnesses.

We will provide coverage for a payable claim that occurs while you are covered under the Policy.

POLICY TERMINATION

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

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

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

- We stop providing the type of coverage under this Policy to all groups in the Policy issue state.

We reserve the right to review and terminate all class(es) covered under the Policy if any class(es) cease(s) 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.

To continue your coverage, you must apply for portability and pay the first premium within 31 days of the date your coverage 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 Insured Persons.
- The Policyholder terminates coverage under the Policy for all Insured Persons, and does not replace it with a similar insurance plan.
- You are no longer eligible for coverage under the Policy.

You can decrease, but not increase, the ported coverage amount. Ported coverage is subject to all the terms of the Policy and this Certificate.

Premiums will be billed directly to you. 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 you apply for portability. 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 you paid premiums, if you stop making a required premium contribution, subject to the grace period.
- The date you die.
- 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 grace period the Policy will remain in force. If full 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. 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 on portability, you also have a grace period of 31 days for the payment of any premium due. During the grace period your coverage will remain in force. If full payment is not received by us by the end of the grace period, your coverage will automatically terminate at the end of the grace period.

TIME LIMIT ON CERTAIN DEFENSES

After three years from the Policy's effective date, no misstatements, except fraudulent misstatements, made by the Policyholder in the application for such Policy shall be used to void the Policy. After three years from your coverage effective date under the Policy, no misstatements, except fraudulent misstatements, made by you in an application for coverage shall be used to deny a claim for loss incurred or disability (as defined in the Policy) commencing after the expiration of such three year period.

No claim for loss incurred or disability (as defined in the Policy) commencing after 3 months from your coverage effective date shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to your coverage effective date.

CLERICAL ERROR

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

- Prevent you from receiving coverage, 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.

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 OR TOBACCO USE STATUS

If premiums are based on your age or tobacco use status and you have misstated your age or tobacco use status, we will make a fair adjustment of benefits to reflect the amount that the premium paid would have purchased at your true age or based upon your tobacco use status. 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 jurisdiction where the Policy is issued, is automatically amended to conform to the minimum requirements of such law.

CHANGES TO POLICY OR CERTIFICATE

No agent, representative or employee of ours or of any other entity may change or waive the terms of the Policy, or of any Certificate or rider issued under it, except in writing signed by one of our executive officers and endorsed or attached to the Policy.

If there is a conflict between the terms of this Certificate or any attached rider and the Policy, the Policy controls.

CRITICAL ILLNESS BENEFITS

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

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

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

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

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

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

BASE MODULE

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

A diagnosis of Heart Attack or Coronary Artery Bypass must be made by a cardiologist or a Doctor familiar with the specific condition. A diagnosis of Stroke must be made by a neurologist or a Doctor familiar with the diagnosis of Stroke.

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.

MAJOR ORGAN MODULE

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

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

A diagnosis of Abdominal Aortic Aneurysm, or Thoracic Aortic Aneurysm, or Open Heart Surgery for Valve Replacement or Repair, or Transcatheter Heart Valve Replacement or Repair, or Coronary Angioplasty, or Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement, or Pacemaker Placement, or 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 Coma, Amyotrophic Lateral Sclerosis (ALS), Advanced Dementia, including Alzheimer's Disease, Huntington's Disease (Huntington's Chorea), Muscular Dystrophy, Infectious Disease, Addison's Disease, Myasthenia Gravis, Systemic Lupus Erythematosus (SLE) and Systemic Sclerosis (Scleroderma) are payable when we receive due proof of such condition which is diagnosed after your coverage effective date (including the effective date of any changes to coverage).

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

A diagnosis of Systemic Lupus Erythematosus (SLE) or Systemic Sclerosis (Scleroderma) must be confirmed by a rheumatologist or a Doctor familiar with the diagnosis of the specific condition.

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

Benefits for Parkinson's Disease are payable when we receive due proof of such condition which is diagnosed after your coverage effective date (including the effective date of any changes to coverage) or you become incapacitated, meaning:

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

A diagnosis of Parkinson's Disease must be made by a psychiatrist or 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 after your coverage effective date (including the effective date of any changes to coverage).

CLAIMS

NOTICE OF CLAIM

Written notice of your claim should be given to us within 30 days after the date of loss (date of diagnosis). The notice may be given to us at our home office or to our authorized agent or 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. 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.

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

PROOF OF LOSS

You must send us written proof of loss within 90 days after the date of loss (date of diagnosis). 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 loss 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 immediately upon receipt of due written proof of loss. Any accrued benefits that are payable at your death will be paid to the first survivor(s) who is/are living on the date of your death, in the following order:

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

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

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

"Spouse" in this provision means your lawful spouse.

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 loss has been given to us, and no later than three years from the time proof of loss 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: Saint Joseph's University

GROUP POLICY NUMBER: 71819-0CCI2

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

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SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE

You pay the cost of coverage under this rider.

SPOUSE BENEFIT AMOUNT

50% of Employee BENEFIT AMOUNT

SPOUSE CRITICAL ILLNESS BENEFITS

Base module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Heart Attack	100%	2 times the BENEFIT AMOUNT
Cancer	100%	2 times the BENEFIT AMOUNT
Stroke	100%	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
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
Coma	100%	2 times the BENEFIT AMOUNT
Amyotrophic Lateral Sclerosis (ALS)	100%	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)	100%	1 times the BENEFIT AMOUNT
Muscular Dystrophy	25%	1 times the BENEFIT AMOUNT
Infectious Disease	25%	2 times the BENEFIT AMOUNT
Addison's Disease	10%	1 times the BENEFIT AMOUNT
Myasthenia Gravis	25%	1 times the BENEFIT AMOUNT
Systemic Lupus Erythematosus (SLE)	10%	1 times the BENEFIT AMOUNT
Systemic Sclerosis (Scleroderma)	10%	1 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.

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 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.

EFFECTIVE DATE

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

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

EFFECTIVE DATE OF CHANGES TO COVERAGE

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

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

Any decrease in coverage will take effect at the end of the month but will not affect a payable claim that occurs prior to the decrease.

TERMINATION

This rider terminates on the earliest of the following:

- The date your Certificate terminates.
- The date this rider is terminated for all Insured Persons under the Policy.
- The date you voluntarily cancel this rider.
- The date 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 are paid, if the next required premium contribution is not paid, subject to the grace period.
- The date your Spouse's total maximum benefit amount has been paid for all Critical Illnesses.

PORTABILITY

If you are approved by us to continue your coverage under the Certificate's PORTABILITY provision, then this rider can also be continued during portability.

PORTABILITY FOLLOWING DEATH OR DIVORCE

If you die or divorce, your Spouse can apply to continue Spouse coverage 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 apply for portability and pay the first premium within 31 days of the date of your death or divorce.

If your Spouse is approved by us for portability, your Spouse will become the owner of the Spouse coverage that was previously provided under this rider. Your Spouse can decrease, but not increase, the ported coverage amount. Ported coverage is subject to all the terms of the Policy and Certificate.

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 applies for 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 your Spouse paid premiums, if your Spouse stops making a required premium contribution, subject to the grace period.
- The date your Spouse dies.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

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 after your Spouse's coverage effective date. The percentage of BENEFIT AMOUNT payable is 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 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 agent or 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. 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.

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

PROOF OF LOSS

You must send us written proof of loss within 90 days after the date of loss (date of diagnosis). 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 loss 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 immediately upon receipt of due written proof of loss. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For PORTABILITY FOLLOWING DEATH OR DIVORCE, benefits are payable to your Spouse, and any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

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

LEGAL ACTION

You can start legal action regarding a claim no earlier than 60 days after written proof of loss has been given to us, and no later than three years from the time proof of loss 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



William Bainbridge
President



Melissa A. O'Donnell
Secretary

CHILDREN'S CRITICAL ILLNESS RIDER

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Saint Joseph's University

GROUP POLICY NUMBER: 71819-0CCI2

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

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SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE

You pay the cost of coverage under this rider.

CHILDREN'S BENEFIT AMOUNT

50% of Employee BENEFIT AMOUNT

CHILDREN'S CRITICAL ILLNESS BENEFITS

Base module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Heart Attack	100%	2 times the BENEFIT AMOUNT
Cancer	100%	2 times the BENEFIT AMOUNT
Stroke	100%	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
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
Coma	100%	2 times the BENEFIT AMOUNT
Amyotrophic Lateral Sclerosis (ALS)	100%	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)	100%	1 times the BENEFIT AMOUNT
Muscular Dystrophy	25%	1 times the BENEFIT AMOUNT
Infectious Disease	25%	2 times the BENEFIT AMOUNT
Addison's Disease	10%	1 times the BENEFIT AMOUNT
Myasthenia Gravis	25%	1 times the BENEFIT AMOUNT
Systemic Lupus Erythematosus (SLE)	10%	1 times the BENEFIT AMOUNT
Systemic Sclerosis (Scleroderma)	10%	1 times the BENEFIT AMOUNT

CHILDREN'S CRITICAL ILLNESS BENEFITS

The benefit percentages for your Children 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 Children.

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

- Your natural or adopted child (including a child placed for adoption).
- Your stepchild.

The child must also meet all of the following conditions:

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

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

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.

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 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 apply for Children's coverage under this rider within 60 days.

EFFECTIVE DATE

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

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

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.

EFFECTIVE DATE OF CHANGES TO COVERAGE

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

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

Any decrease in coverage will take effect at the end of the month but will not affect a payable claim that occurs prior to the decrease.

TERMINATION

Coverage for each Child ends on the earliest of the following:

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

This rider terminates on the earliest of the following:

- The date your Certificate terminates.
- The date this rider is terminated for all Insured Persons under the Policy.
- The date you voluntarily cancel this rider.
- The date you no longer have any eligible Children covered under this rider. See the PORTABILITY FOLLOWING DEATH provision below.
- The end of the period for which premiums are paid, if the next required premium contribution is not paid, subject to the grace period.

PORTABILITY

If you are approved by us to continue your coverage under the Certificate's PORTABILITY provision, then this rider can also be continued during portability.

PORTABILITY FOLLOWING DEATH

If you die and your Spouse is approved by us for portability under the Spouse Critical Illness Rider, then this rider can be continued 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.

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 applies for 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 your Spouse paid premiums, if your Spouse stops making a required premium contribution, subject to the grace period.
- The date your Spouse dies.
- The date there are no longer any eligible Children covered under this rider.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

CRITICAL ILLNESS BENEFITS

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 from any previously diagnosed Critical Illness. 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 this rider terminates.

Payment of any benefits for your Child's Critical Illness will not impact the available BENEFIT AMOUNT for your Critical Illness. Payment of any benefits for your Critical Illness will not impact the available BENEFIT AMOUNT for your Child's Critical Illness 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 agent or 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. 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.

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

PROOF OF LOSS

You must send us written proof of loss within 90 days after the date of loss (date of diagnosis). 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 immediately upon receipt of due written proof of loss. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For PORTABILITY FOLLOWING DEATH, benefits are payable to your Spouse, and any accrued benefits that are payable at the time of your Spouse's death are payable 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 loss has been given to us, and no later than three years from the time proof of loss is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your coverage.

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



William Bainbridge
President



Melissa A. O'Donnell
Secretary

CONTINUATION OF INSURANCE RIDER

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

POLICYHOLDER: Saint Joseph's University

GROUP POLICY NUMBER: 71819-0CC12

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

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DEFINITIONS

Covered Person means:

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

Leave of Absence means you are absent from Active Employment for a period of time under a leave granted in writing by the Employer that is in accordance with the Employer's formal leave policies. Your normal vacation time is not considered a Leave of Absence.

GENERAL PROVISIONS

ELIGIBILITY

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

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

EFFECTIVE DATE

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

TERMINATION

This rider terminates on the earliest of the following:

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

CONTINUATION OF INSURANCE

If you stop Active Employment due to:

- Employer-approved Leave of Absence,
- then insurance 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 stop 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 paid 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 an 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.

Sabbatical

If you are on a Leave of Absence for an Employer-approved sabbatical, then insurance coverage for all Covered Persons may be continued until 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.

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 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.
- The date you are eligible under the Policy due to Active Employment.
- 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.
- The date the Policy terminates.
- The date coverage for all Employees under the Policy terminates.

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 Employees under the Policy; and
- You are in an eligible class for coverage under the Policy; and
- Your premium payments are resumed.

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

RETURN TO ACTIVE EMPLOYMENT

If coverage is not continued during your Leave of Absence for active military service, and you return to Active Employment while coverage is in force for Employees under the Policy, then coverage for all Covered Persons may be reinstated in accordance with USERRA and applicable state law.

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

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



Robert L. Grubka
President



Melissa A. O'Donnell
Secretary

WELLNESS BENEFIT RIDER

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

POLICYHOLDER: Saint Joseph's University

GROUP POLICY NUMBER: 71819-0CC12

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

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SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE

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

WELLNESS BENEFIT

You:	\$50
Your Spouse:	\$50
Your Children:	50% of your wellness benefit amount, to a maximum of \$100 for all Children in one calendar year

DEFINITIONS

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

Covered Person means:

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

GENERAL PROVISIONS

ELIGIBILITY

If you are working for the Employer in an eligible class (shown in the Certificate's SCHEDULE OF BENEFITS), you are eligible for this rider on the latest of the following dates:

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

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

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

EFFECTIVE DATE

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

TERMINATION

This rider will terminate on the earliest of the following:

- The date your Certificate terminates.
- The date this rider is terminated for all Insured Persons under the Policy.
- For your Spouse's coverage, the date the Spouse Critical Illness Rider terminates.
- For each Child's coverage, the date your Child's coverage under the Children's Critical Illness Rider terminates.

PORTABILITY

If you are approved by us to continue your coverage under the Certificate's PORTABILITY provision, then this rider will also be continued during portability.

PORTABILITY FOLLOWING DEATH OR DIVORCE

If you die or divorce and your Spouse is approved by us for portability under the Spouse Critical Illness Rider, then this rider can also be continued under your Spouse's coverage.

ASSIGNMENT

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

BENEFITS

We will pay you a wellness benefit (shown on the SCHEDULE OF BENEFITS) if a Covered Person has a health screening test.

A wellness benefit is limited to one annual payment per Policy year per Covered Person.

Health screening tests include, but are not limited to:

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

CLAIMS

The PHYSICAL EXAMINATION provision does not apply to this rider.

NOTICE OF CLAIM

Written notice of your claim must be given to us during the same Policy year the health screening test occurs or within 30 days of the end of the Policy year, whichever is later. The notice may be given to us at our home office or to our authorized agent or 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. The claim form(s) may require completion by you and the Employer and the Covered Person's attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

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

PROOF OF LOSS

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

BENEFIT PAYMENTS

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

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

LEGAL ACTION

You can start legal action regarding a claim no earlier than 60 days after written proof of loss has been given to us, and no later than three years from the time proof of loss 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 the Covered Person's coverage.

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



William Bainbridge
President



Melissa A. O'Donnell
Secretary

ReliaStar Life Insurance Company
20 Washington Avenue South, Minneapolis, MN 55401

NOTICE TO CALIFORNIA POLICYHOLDERS/CERTIFICATEHOLDERS
KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

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

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

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

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

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

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

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

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

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

COVERAGE

- **Persons Covered**

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

- **Amounts of Coverage**

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

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

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

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

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

- **Health Insurance**

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

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

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

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

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

NOTICES

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

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

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

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

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

NEW HAMPSHIRE CERTIFICATE ENDORSEMENT
for Group Critical Illness Insurance

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

I. DEFINITIONS

If your Certificate contains a definition of **Pre-Existing Condition**, and the time period in that definition is more than 6 months, then the time period in that definition for you and any Covered Person is limited to 6 months. As it relates to your Children, congenital anomalies are not considered a Pre-Existing Condition.

II. EXCLUSIONS

If your Certificate and any riders contain a PRE-EXISTING CONDITION EXCLUSION, and the length of that exclusion is more than 6 months, then the length of that exclusion for you and any Covered Person is limited to 6 months.

III. CLAIMS

If the PROOF OF CLAIM provisions in your Certificate and any riders indicate that there is a one year limit for providing proof of claim, then this statement does not apply to you.

IV. CHILDREN'S CRITICAL ILLNESS RIDER

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

If the definition includes a maximum Child age of less than 26 years, then this maximum is changed to 26 years.

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

V. EFFECTIVE DATE

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

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



Melissa A. O'Donnell
Secretary

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

SPOUSE ENDORSEMENT FOR NEW HAMPSHIRE RESIDENTS

Your Certificate(s) and Spouse rider(s) have been changed as follows. Please keep this endorsement with your Certificate(s). This endorsement is subject to all other terms of the Policy.

If your Certificate contains definitions of "You and Your" and "We, Us and Our", then all references to "you" and "your" in this endorsement mean "You and Your" as defined in your Certificate, and all references to "we" and "us" and "our" in this endorsement mean "We, Us and Our" as defined in your Certificate.

I. CONTINUATION FOLLOWING DIVORCE OR LEGAL SEPARATION

If you divorce or legally separate, and the final decree of divorce or legal separation does not expressly prohibit continuation of coverage for your former Spouse, then your former Spouse can elect to continue Spouse coverage for a limited time. The former Spouse must have been insured under our Policy as your Spouse on the date before the date of divorce or legal separation. In order to continue coverage under this provision, the former Spouse has 30 days after the date of divorce or legal separation in which to make the election, pay the first premium, and provide us with the final decree of divorce or legal separation.

When we put the former Spouse on continuation under this provision, the former Spouse becomes the owner of that Spouse coverage under the Policy. All Spouse benefits are payable to the former Spouse. Premiums will be billed directly to the former Spouse. Continued premium payment is required to keep coverage in force. The benefits and premium rates for Spouse coverage continued under this provision will remain the same as though the former Spouse were still eligible as your lawful Spouse. Spouse coverage may not be increased.

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

- The 3-year anniversary of the final decree of divorce or legal separation.
- The date of the former Spouse's remarriage.
- The date of your remarriage.
- The date the former Spouse dies.
- The date you die.
- The end date of coverage, if any, as provided by the final decree of divorce or legal separation.
- The end of the period for which the former Spouse paid premiums, if the former Spouse stops making a required premium contribution, subject to the grace period.
- The date the Policy terminates.

If all of the following are true:

- the former Spouse's coverage was being continued under a similar provision of the Employer's prior group policy that provided the same type of coverage as our Policy,
- your coverage under the prior policy is replaced by coverage under our Policy, and
- the former Spouse's coverage under the prior policy stops due to the prior policy's termination,

then the former Spouse can elect to continue the Spouse coverage for the remainder of the time period described above while our Policy is in force. The benefits, premium rates and all other terms for continued Spouse coverage are subject to the terms of our Policy. In order to continue Spouse coverage, the former Spouse has 30 days after your coverage effective date under our Policy in which to make the election, pay the first premium, and provide us with proof of their eligibility for continuation under the prior policy.

II. EFFECTIVE DATE

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

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



Melissa A. O'Donnell
Secretary

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

SUMMARY PLAN DESCRIPTION

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

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

Saint Joseph's University Flexible Benefits Plan
71819-0CCI2
Saint Joseph's University
5600 City Avenue
Philadelphia, PA 19131

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

Zenobia Hargust, Chief Human Resources Officer
5600 City Avenue
Philadelphia, PA 19131
610-660-3336

Identification Numbers

IRS Employer Identification Number: 23-1352674
Plan Number: 501

Agent for Legal Process: Plan Administrator

Trustees: None

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

Type of Administration: Records maintained by Policyholder.

Premium Payments: Premiums are 100% Employee paid.

Plan Year: January 1 through December 31

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

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

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

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

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

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

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

SUMMARY PLAN DESCRIPTION

CLAIM PROCEDURES FOR CRITICAL ILLNESS INSURANCE

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

SUMMARY PLAN DESCRIPTION

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

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