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GROUP BOOKLET-CERTIFICATE FOR MEMBERS:

LOYOLA UNIVERSITY MARYLAND

ALL MEMBERS
Group Voluntary Term Life

Print Date: 09/26/2018

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BOOKLET-CERTIFICATE RIDER SETTLEMENT OF PROCEEDS

Effective as of February 1, 2015, the Booklet-Certificate to which this Rider is attached is hereby amended with respect to and to the extent provided below.

Death Benefit

Booklet-certificate form GH 203 (VTL), Description of Benefits, Member Life Insurance, Death Benefit is revised as follows:

If you die while insured for Member Life Insurance, We will pay your beneficiary the Scheduled Benefit (or approved amount, if applicable) in force on the date of your death, less any unpaid premium and less any Accelerated Benefit payment as discussed later in this section. Any benefit due a beneficiary who does not survive you will be paid in equal shares to your surviving beneficiaries. If a beneficiary dies at the same time or within 15 days of you, but before We receive Written proof of your death, payment will be made as if you survived the beneficiary. If no beneficiary survives you or if no beneficiary is named, We will make your payment in the following order of precedence:

- to your spouse;
- to your children born to or legally adopted by you;
- to your parents;
- to your brothers and sisters; or
- if none of the above, to the executor or administrator of your estate or other persons as provided in the Group Policy.

However, if a beneficiary is suspected or charged with your death, the Death Benefit may be withheld until additional information has been received or the trial has been held. If a beneficiary is found guilty of your death, such beneficiary may be disqualified from receiving any benefit due. Payment may then be made to any contingent beneficiary or to the executor or administrator of your estate.

No payment will be made before We receive Written proof of your death.

Upon your death, the Scheduled Benefit (or approved amount, if applicable) in force on the date of your death, less any unpaid premium and less any Accelerated Benefit payment as discussed later in this section will be paid in a single lump sum. Upon request, We may consider other payment options.

If you die by suicide within 24 months after the initial coverage effective date of your Member Life Insurance, We will pay your beneficiary the amount of any premium paid by you to Us during the period of time your insurance was in force in lieu of the Scheduled Benefit (or approved amount, if applicable) in force on the date of your death. If you were insured for at least 24 months after the initial coverage effective date and die by suicide within 24 months after an increase in the Scheduled Benefit amount (or approved amount, if applicable), We will pay your beneficiary the Scheduled Benefit amount in force immediately prior to the increase plus the amount of any premium paid by you to Us on such increase in lieu of the Scheduled Benefit (or approved amount, if applicable), in force on the date of your death. Any such payment will discharge Us to the full extent of such payment.

However, the 24 months may be reduced by any time satisfied under the Prior Policy, provided you were insured under the Prior Policy and coverage was in force for you on the date the Group Policy became effective.

Coverage During Disability

Booklet-certificate form GH 203 (VTL), Description of Benefits, Member Life Insurance, Continuation (Member Life Insurance - Coverage During Disability) is revised by adding the following provision:

We have the right to require you to undergo medical evaluations, functional capacity evaluations, vocational evaluations, and/or psychiatric evaluations during the course of a claim. The examinations or evaluations will be performed by a Physician or evaluator We choose as appropriate for the condition and will be conducted at the time, place and frequency We reasonably require.

We will pay for these examinations and evaluations and will choose the Physician or evaluator to perform them. Failure to attend a medical examination or cooperate with the Physician may be cause for denial of your benefits. Failure to attend an evaluation or to cooperate with the evaluator may also be cause for denial of your benefits. If you fail to attend an examination or an evaluation, any charges incurred for not attending an appointment as scheduled may be your responsibility.

All other benefits and provisions of the Booklet-Certificate remain in effect.

PRINCIPAL LIFE INSURANCE COMPANY
711 High Street
Des Moines, Iowa 50392-0002



Executive Vice President,
General Counsel and Secretary



Chairman, President and
Chief Executive Officer

Summary Plan Description for Purposes of Employee Retirement Income Security Act (ERISA):

This booklet-certificate (including any supplement) may be utilized in part in meeting the Summary Plan Description requirements under ERISA for insured employees (or those listed on the front cover) of the Policyholder who are eligible for Group Voluntary Life insurance.

A separate booklet-certificate will be issued if necessary to cover one or more separate classes of the Policyholder who are eligible for Group coverage. For further information, contact your plan administrator.

Your insurance has been designed to provide financial help for you when a covered loss occurs. Your employer has chosen benefits provided by a Group Policy issued by Us, Principal Life Insurance Company. To the extent that benefits are provided by that Group Policy, the administration and payment of claims will be done by Us as an insurer.

The provisions of the Group Policy determine Members' rights and benefits. This booklet briefly describes those rights and benefits. It outlines what you must do to be insured. It explains how to file claims. It is your certificate while you are insured.

NOTE: If this insurance replaces prior group life insurance provided through the Policyholder, the beneficiary named under the prior group life insurance and recorded by the Policyholder will be the beneficiary under the Group Policy unless you have named a new beneficiary. If you wish to change your beneficiary designation, you must complete a new beneficiary designation form - see the Policyholder for the necessary form.

THIS BOOKLET REPLACES ANY PRIOR BOOKLET THAT YOU MAY HAVE RECEIVED. If you have any questions about this new booklet, please contact your employer. In the event of future changes to your insurance, you will be provided with a new Scheduled Benefits Summary, booklet-certificate, or a booklet-certificate rider.

If you have an electronic booklet, paper copies of this booklet-certificate are also available. Please contact your employer if you would like to request a paper copy.

PLEASE READ YOUR BOOKLET CAREFULLY. We suggest that you start with a review of the terms listed in the DEFINITIONS Section (at the back of the booklet). The meanings of these terms will help you understand the insurance.

This booklet describes all the benefits available under the Group Policy underwritten by Us. However, if you have elected to not accept any available benefits, those benefits described in this booklet will not apply to you.

The group insurance policy and your insurance under the Group Policy may be discontinued or altered by the Policyholder or Us at any time without your consent.

We reserve complete discretion to construe or interpret the provisions of this group insurance, to determine eligibility for benefits, and to determine the type and extent of benefits, if any, to be provided. Our decisions in such matters will be as between Us and persons insured by the Group Policy, subject to the Claim Procedures shown on GH 113 of this booklet.

ACCELERATED BENEFITS - Benefits paid as shown in this booklet-certificate for Accelerated Benefits are an advance of a portion of your Life Insurance benefit. This provision:

- accelerates and reduces your benefit;
- is not intended to be used as long-term care insurance.

Effect on Government Benefits. If you receive payment of Accelerated Benefits, you may lose your right to receive certain public funds, such as Medicare, Medicaid, Social Security, Supplemental Security, Supplemental Security Income (SSI), and possibly others.

Tax Consequences. Receiving Accelerated Benefits from the Group Policy may have tax consequences for you. We cannot give you advice about this. You may wish to obtain advice from a tax professional or an attorney before you decide to receive Accelerated Benefits from the Group Policy.

War Restrictions Included.

The insurance provided in this booklet is subject to the laws of the state of MARYLAND.

For additional information about your individual purchase rights (conversion) or portability, please go to the following website: www.principal.com/loyolauniversitymaryland.

PRINCIPAL LIFE INSURANCE COMPANY
Des Moines, IA 50392-0002

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SUMMARY OF BENEFITS
(effective July 1, 2018)

This section highlights the benefits provided under this insurance. The purpose is to give you quick access to the information you will most often want to review. **Please read the other sections of this booklet for a more detailed explanation of benefits and any limitations or restrictions that might apply.**

MEMBER LIFE INSURANCE

If you die, your beneficiary will be paid the Scheduled Benefit then in force for you (however, see the exception noted below). Your specific Scheduled Benefit is shown on your Scheduled Benefits Summary and is based on your class:

Class	*Scheduled Benefit
ALL MEMBERS	An amount in increments of \$25,000 as applied for by you and approved by Us. The Maximum Scheduled Benefit amount will be \$150,000 and the Minimum Scheduled Benefit amount will be \$25,000.

Member Life Insurance benefits are subject to all reductions provided in the Group Policy including reductions due to salary changes, and age changes, and receipt of an Accelerated Benefit payment.

*The Scheduled Benefit is subject to the Evidence of Insurability requirements as described in the booklet on GH 110. If, because of these Evidence of Insurability requirements, We approve an amount of insurance that is different than the Scheduled Benefit, the approved amount will be paid.

*If you are insured on the date the Group Policy is effective and this insurance replaces insurance in force on the day immediately before the effective date of the Group Policy, your initial Scheduled Benefit will only be for the amount of insurance for which you were insured under the Prior Policy.

HOW TO BE INSURED - MEMBERS

MEMBER LIFE INSURANCE

Eligibility

To be eligible for insurance you must be a Member.

If you had insurance under the Prior Policy for which the Group Policy is a replacement and you are a Member on July 1, 2018 you will be eligible on that date.

If you are not a Member until later, you will be eligible on the first of the Insurance Month coinciding with or next following the date you become a Member as defined on GH 114.

In no circumstance will you be eligible for Member Life Insurance under the Group Policy if you are eligible under any other Group Voluntary Term Life Insurance policy underwritten by Us.

Effective Dates - Actively at Work

If you are not Actively at Work on the date your insurance would otherwise be effective, your insurance will not be in force until the day you return to Active Work.

This Actively at Work requirement will be waived for you if:

- you are absent from Active Work because of a regularly scheduled day off, holiday, or vacation day; and
- you were Actively at Work on your last scheduled work day before the date of your absence; and
- you were capable of Active Work on the day before the scheduled effective date of your insurance or change in your insurance, whichever is applicable.

This Actively at Work requirement may also be waived as described below.

When insurance under the Group Policy replaces coverage under a Prior Policy, the Active Work requirement may be waived for those Members who:

- are eligible and enrolled under the Group Policy on the date the Group Policy is effective; and
- were covered under the Prior Policy on the date of its termination.

In no event will the Active Work requirement be waived for those Members who, on the date of termination of the Prior Policy, either:

- had the option, under the terms of the Prior Policy, to convert their coverage under the Prior Policy to an individual policy; or
- were eligible under the terms of the Prior Policy to have their premiums waived due to Total Disability.

NOTE: When insurance under the Group Policy replaces coverage under a Prior Policy and the Active Work requirement is waived, any benefits payable will be the lesser of the Scheduled Benefit of the Group Policy or the amount that would have been paid by the Prior Policy had it remained in force.

Individual Incontestability

All statements made by any insured person will be representations and not warranties. In the absence of fraud, these statements may not be used to contest an insured person's insurance unless:

- the insurance has been in force for less than two years during the insured person's lifetime; and
- the statement is in Written form Signed by the insured person; and
- a copy of the form, which contains the statement, is given to the insured person or the insured person's beneficiary at the time insurance is contested.

However, the above will not preclude the assertion at any time of defenses based upon the person not being eligible for insurance under the Group Policy or upon other provisions of the Group Policy.

In addition, if a person's age is misstated, We may, at any time, adjust premium and benefits to reflect the correct age.

Assignments

Only assignments of Member Life Insurance will be allowed under the Group Policy and only if:

- they are not collateral assignments or assignments for consideration; and
- they are in Written form and recorded at Our home office in Des Moines, Iowa.

We will assume no responsibility for the validity of effect of any assignment.

Evidence of Insurability

In some instances, Evidence of Insurability will be required to place your insurance in force. We will determine the type and form of required proof. You will need to file Evidence of Insurability:

- If you request insurance more than 31 days after the date you are eligible including any insurance you refuse and later request.
- If you request insurance under the Group Policy and you were eligible under the Prior Policy, but elected to waive coverage under the Prior Policy.
- If you have failed to provide required Evidence of Insurability or you have been refused insurance under the Group Policy at any prior time.
- If you elect to terminate insurance and, more than 31 days later, you request to be insured again.
- *To make effective any Scheduled Benefit amounts for you that are, initially or through later increases, in excess of:
 - \$150,000 if you are under age 70; and
 - \$10,000 if you are age 70 or over.

No Evidence of Insurability is required for the initial excess amounts for Members insured on July 1, 2018.

*If you are insured on the date the Group Policy is effective and this insurance replaces insurance in force on the day immediately before the effective date of the Group Policy: the lesser of the amount shown above or the amount for which you were insured under the replaced insurance.

- To make effective any request for a Scheduled Benefit amount increase.
- To make effective any Scheduled Benefit amount increase if any previous Scheduled Benefit increase has been declined.

**Effective Date for Initial Insurance
(Evidence of Insurability Not Required)**

You must request initial insurance in a form provided by Us.

Your insurance will normally be in force on:

- the date you are eligible, if you make your request on or before that date; or
- the first of the Insurance Month coinciding with or next following the date of your request, if you make your request within 31 days after the date you are eligible.

However, if you are not Actively at Work on the date insurance would otherwise be effective, your insurance will not be in force until the day you return to Active Work.

**Effective Date for Initial Insurance
(Evidence of Insurability Required)**

If Evidence of Insurability is required, your insurance will normally be in force on the later of:

- the date insurance would have been effective had Evidence of Insurability not been required; or
- the date Evidence of Insurability is approved by Us.

However, if you are not Actively at Work on the date insurance would otherwise be effective, your insurance will not be in force until the day you return to Active Work.

Effective Date for Benefit Changes Due to Change in Insurance Class

A change in your Scheduled Benefit amount because of a change in your insurance class for which Evidence of Insurability is not required (see above) will normally be effective on the first of the Insurance Month coinciding with or next following the date of the change. However, if you are not Actively at Work on the date the Scheduled Benefit change would otherwise be effective, the Scheduled Benefit change will not be in force until the day you return to Active Work. Exception: Any decrease in Scheduled Benefit amounts due to a change in your insurance class will be effective on the date of the change, whether or not you are Actively at Work.

Any termination of Scheduled Benefit amounts due to a change in your insurance class will be effective on the date of the change, whether or not you are Actively at Work.

A change in your Scheduled Benefit amount due to a change in your insurance class for which Evidence of Insurability is required (see above), will be effective on the later of:

- the date the change would otherwise be effective if Evidence of Insurability had not been required; or

- the date Evidence of Insurability is approved by Us.

Effective Date for Benefit Changes Due to Changes by Policy Amendment

A change in your Scheduled Benefit amount because of a change in the Schedule of Insurance (as described on GH 109) by amendment to the Group Policy for which Evidence of Insurability is not required (see above) will be effective on the date of change. However, if you are not Actively at Work on the date an increase in the Scheduled Benefit would otherwise be effective, the Scheduled Benefit in force will continue to apply to you until the day you return to Active Work. When you return to Active Work, the Scheduled Benefit increase will then be in force for you. Exception: Any decrease in Scheduled Benefit amounts due to a change by amendment to the Group Policy will be effective on the date of change, whether or not you are Actively at Work.

A change in your Scheduled Benefit amount because of a change in the Schedule of Insurance (as described on GH 109) by amendment to the Group Policy for which Evidence of Insurability is required (see above) will be effective on the later of:

- the date the change would otherwise be effective if Evidence of Insurability had not been required; or
- the date Evidence of Insurability is approved by Us.

Effective Date for Benefit Changes Due to Changes Requested by the Member

A change in your Scheduled Benefit amount due to your request for which Evidence of Insurability is not required (see above), will be effective on the date of the request. However, if you are not Actively at Work on the date the Scheduled Benefit change would otherwise be effective, the Scheduled Benefit change will not be in force until the day you return to Active Work. Exception: Any decrease in Scheduled Benefit amounts will be effective on the date of the change, whether or not you are Actively at Work.

A change in your Scheduled Benefit amount due to your request for which Evidence of Insurability is required (see above), will be effective on the later of:

- the date the change would otherwise be effective if Evidence of Insurability had not been required; or
- the date Evidence of Insurability is approved by Us.

Effective Date for Benefit Changes Due to a Change in the Member's Family Status

You may request an increase in Scheduled Benefits, a decrease in Scheduled Benefits, or the addition of Scheduled Benefits for which you were not previously insured if a change in your family status as described below has occurred, provided a request for such increase, decrease, or addition is made in Writing within 31 days after the date of the change in family status:

- marriage or divorce;
- death of your spouse or child;
- birth or adoption of a child;
- termination of employment by your spouse or a change in your spouse's employment that causes loss of group insurance;
- your employment or your spouse's employment changes from part-time to full-time or from full-time to part-time;

- you or your spouse takes an unpaid leave of absence.

A change in the Scheduled Benefits because of a request by you when a change in family status has occurred for which Evidence of Insurability is not required (see above) will normally be effective on the date of the request. However, if you are not Actively at Work on the date the Scheduled Benefit change would otherwise be effective, the Scheduled Benefit change will not be in force until the day you return to Active Work. Exception: Any decrease in Scheduled Benefit amounts due to your request, will be effective on the date of the change, whether or not you are Actively at Work.

A change in the Scheduled Benefits because of a request by you when a change in family status has occurred for which Evidence of Insurability is required (see above) will be effective on the later of:

- the date the change would otherwise be effective if Evidence of Insurability had not been required; or
- the date Evidence of Insurability is approved by Us.

Termination

Your insurance under the Group Policy will cease on the earliest of:

- the date the Group Policy terminates; or
- the end of the Insurance Month for which the last premium is paid for your insurance; or
- the end of any Insurance Month, if requested by you before that date; or
- the end of the Insurance Month in which you cease to be a Member; or
- the end of the Insurance Month in which you cease to belong to a class for which insurance is provided; or
- the date you retire; or
- the end of the Insurance Month in which you cease Active Work.

Insurance While Outside of the United States

If you are temporarily outside the United States, you may choose to continue insurance, subject to premium payment for a period of six months or less for one of the following reasons:

- travel; or
- a business assignment; or
- full-time student status, provided you are either:
 - enrolled and attending an accredited school in a foreign country; or
 - participating in an academic program in a foreign country, for which the institution of higher learning at which you are enrolled in the U.S. grants academic credit.

The six-month period will not be reduced for any time covered under a Prior Policy.

If you are outside the United States for any other reason than those listed above, insurance for the person concerned will automatically terminate.

Continuation

If you cease Active Work because of sickness or injury, you may be eligible for limited continuation of insurance.

If you cease Active Work because of layoff, leave of absence, or sabbatical, insurance may be continued on a limited basis.

Your insurance may also be continued under the continuation provisions described on GH 118 and subject to the provisions of the Group Policy.

Your insurance may also be continued under the Portability option described under GH 307 and subject to the provisions of the Group Life Portability Policy.

If you are interested in continuing your insurance beyond the date it would normally terminate, you should consult with the Policyholder before your insurance terminates.

CONTINUATION

FMLA and Other Continuation Provisions

If you cease Active Work due to an approved leave of absence under the Federal Family and Medical Leave Act (FMLA), the Policyholder may choose to continue your insurance, subject to premium payment.

If the continuation portion of the FMLA applies to your insurance, these FMLA continuation provisions:

- are in addition to any other continuation provisions of the Group Policy, if any; and
- will run concurrently with any other continuation provisions of the Group Policy for sickness, injury, layoff, or approved leave of absence, if any.

If continuation qualifies for both state and FMLA continuation, the continuation period will be counted concurrently toward satisfaction of the continuation period under both the state and FMLA continuation periods.

Reinstatement

An Eligible Employee's terminated insurance may be reinstated in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA), subject to the Actively at Work requirements of the Group Policy.

Reinstatement of Insurance for you When Insurance Ends due to Living Outside of the United States

If insurance for you terminates because you are outside of the United States, you may become eligible again for insurance under the Group Policy, but only if:

- you return to the United States within six months of the date on which insurance terminated because the person is outside of the United States; and
- in your case, you return to Active Work in the United States for the Policyholder for a period of at least 30 consecutive days. You will be eligible for insurance on the day immediately following completion of the 30 consecutive days of Active Work.

The reinstated insurance will be on the same basis as that being provided on the date insurance is reinstated. However, any restrictions on this insurance, which were in effect before reinstatement, will continue to apply. If you do not complete the 30 consecutive days of residence, the insurance for such person concerned will not be reinstated.

See your employer for details on this reinstatement provision.

DESCRIPTION OF BENEFITS

MEMBER LIFE INSURANCE

Death Benefit

If you die while insured for Member Life Insurance, We will pay your beneficiary the Scheduled Benefit (or approved amount, if applicable) in force on the date of your death, less any unpaid premium and less any Accelerated Benefit payment as discussed later in this section. If your beneficiary does not survive you, We will make payment in the following order of precedence:

- to your spouse;
- to your children born to or legally adopted by you;
- to your parents;
- to your brothers and sisters; or
- if none of the above, to the executor or administrator of your estate or other persons as provided in the Group Policy.

However, if a beneficiary is suspected or charged with your death, the Death Benefit may be withheld until additional information has been received or the trial has been held. If a beneficiary is found guilty of your death, such beneficiary may be disqualified from receiving any benefit due. Payment may then be made to any contingent beneficiary or to the executor or administrator of your estate.

No payment will be made before We receive Written Proof of your death.

Interest will be payable on the Scheduled Benefit in force on the date of your death from the date of death to the payment of proceeds unless settlement is made within 30 days after the date of your death. If Written proof of death is submitted more than 180 days after the date of your death, interest will be payable on the Scheduled Benefit in force on the date of your death from the date Written proof of your death has been received to the payment of proceeds. The interest rate will be determined by Us, but not less than that which is payable on deposits with Us.

You or beneficiary may elect to have the payment of proceeds paid in a lump sum payment, interest-bearing draft account or paid according to other settlement options if agreed to, in Writing, by Us.

Upon your death, when the interest-bearing draft account is elected, the Scheduled Benefit (or approved amount, if applicable) in force on the date of your death, less any unpaid premium and less any Accelerated Benefit payment as discussed later in this section will be placed in an interest-bearing draft account at an interest rate determined by Us, unless a lump sum or other settlement option has been elected. With the interest-bearing draft account, the balance will be available to your beneficiary at any time, in total or in part, as provided in the Group Policy.

See the Policyholder if you would like more information on the Interest Draft Account or on any of the other settlement options that are available to your beneficiary upon your death.

In the event the Interest Draft Account is not available or otherwise does not apply, We reserve the right to make payment of proceeds according to other settlement options if agreed to, in Writing, by Us.

If you die by suicide within 24 months after the effective date of your Member Life Insurance, We will pay your beneficiary the amount of any premium paid by you to Us during the period of time your insurance was in force in lieu of

the Scheduled Benefit (or approved amount, if applicable) in force on the date of your death. Any such payment will discharge Us to the full extent of such payment.

However, the 24 months may be reduced by any time satisfied under the Prior Policy, provided you were insured under the Prior Policy and coverage was in force for you on the date the Group Policy became effective.

Beneficiary

You should name a beneficiary at the time you enroll for insurance. You may name or later change your beneficiary by sending a Written request to the Policyholder. See the Policyholder for change request forms. A change in your beneficiary will not be in force until the Policyholder record(s) the change. Once recorded, the change will apply as of the date the request was Signed. If We properly pay any benefit before a change request is received, that payment may not be contested.

Continuation (Member Life Insurance - Coverage During Disability)

If you cease Active Work for any reason, your insurance will normally terminate. However, if you cease Active Work because you are Totally Disabled, you might qualify to continue your Member Life Insurance. This continuation is called Coverage During Disability. This Coverage During Disability provision does not apply to you if you have continued coverage under the Portability provision, as described on GH 307.

To be qualified for Coverage During Disability, you must:

- become Totally Disabled while insured for Member Life Insurance; and
- become Totally Disabled before attainment of age 60; and
- remain Totally Disabled continuously; and
- be under the regular care and attendance of a Physician; and
- send proof of Total Disability to Us within one year of the date Total Disability starts and as often thereafter as We may require; and
- return, without claim, any individual policy issued under your purchase rights as described below. Upon return of such policy, We will refund premiums paid, less dividends and less any outstanding policy loan balance; and
- submit to examinations by a Physician or evaluations by an evaluator when We require (We will pay for these examinations and will choose the Physician).

We have the right to require you to undergo medical evaluations, functional capacity evaluations, vocational evaluations, and/or psychiatric evaluations during the course of a claim. The examinations or evaluations will be performed by a Physician or evaluator We choose as appropriate for the condition and will be conducted at the time, place and frequency We reasonably require.

We will pay for these examinations and evaluations and will choose the Physician or evaluator to perform them. Failure to attend a medical examination or cooperate with the Physician may be cause for denial of your benefits. Failure to attend an evaluation or to cooperate with the evaluator may also be cause for denial of your benefits. If you fail to attend an examination or an evaluation, any charges incurred for not attending an appointment as scheduled may be your responsibility.

If you qualify, Coverage During Disability will be in force on the earlier of:

- the day six months after the date your Total Disability began; or
- the date of your death.

Premium will not be charged for Member Life Insurance while your Coverage During Disability is in force.

Coverage During Disability will cease on the earliest of:

- the date your Total Disability ends; or
- the date you fail to send Us any required proof of Total Disability; or
- the date you cease to be under the regular care and attendance of a Physician; or
- the date you fail to submit to a required Physician's examination or evaluation by an evaluator; or
- the date you are age 65.

If you die while Coverage During Disability is in force, We will pay your beneficiary the Member Life Insurance benefit, if any, that would have been paid had you remained insured under the Schedule of Insurance in force on the date your Total Disability began. Member Life Insurance benefits are subject to all reductions provided in the Group Policy including reductions due to salary changes, and age changes, and receipt of an Accelerated Benefit payment.

Note that Coverage During Disability will not be in force and NO BENEFIT WILL BE PAID if Written proof of Total Disability is not sent to Us within ONE YEAR of the date Total Disability starts. However, failure to give Written proof within the time specified will not invalidate or reduce any claim if Written proof is given as soon as reasonably possible.

No benefits will be paid for any disability that:

- results from willful self-injury or self-destruction, while sane or insane; or
- results from war or act of war; or
- results from voluntary participation in an assault, felony, criminal activity, insurrection, or riot.

Accelerated Benefit

An Accelerated Benefit is an advance (before death) payment of a part of your Member Life Insurance benefit. To qualify for an Accelerated Benefit, you must:

- be insured for a Member Life Insurance benefit of at least \$10,000; and
- be Terminally Ill (expected to die within 12 months); and
- send a request for Accelerated Benefit payment to Us; and
- send proof, satisfactory to Us, of your Terminal Illness; and
- provide a release from the assignee, if your Member Life Insurance benefit has been assigned.

Proof of Terminal Illness will consist of a statement from your Physician, and any other medical information that We believe is needed to confirm your status.

If you qualify, We will pay you any amount you request, except that:

- only one Accelerated Benefit payment will be made during your lifetime; and
- you must request a payment of at least \$5,000; and
- We will not pay you more than the lesser of: (1) 75% of your Member Life Insurance benefit; or (2) \$150,000.

We will pay you the Accelerated Benefit payment in a lump sum.

If an Accelerated Benefit is paid, the Member Life Insurance benefit otherwise payable to your beneficiary upon your death will be reduced by any Accelerated Benefit payment.

Following is an EXAMPLE of how this benefit affects the final death benefit.

BENEFIT EXAMPLE	
Member Life Insurance Benefit Amount	\$ 100,000
Accelerated Benefit Amount Requested (Member would receive \$75,000)	\$ 75,000
 Payment to Member's Beneficiary ($\$100,000 - \$75,000$)	 \$ 25,000

During the two-year period following payment of an Accelerated Benefit:

- termination of Active Work because of your Terminal Illness will not result in termination of your Member Life Insurance; and
- your Member Life Insurance will be provided without premium charge.

Individual Purchase Rights

You will have the right to buy an individual life insurance policy without submitting Evidence of Insurability:

- If your total Member Life Insurance, or any portion of it, terminates because you end Active Work or cease to be in a class eligible for insurance. In these instances, the maximum amount you may buy will be your Member Life Insurance amount in force on the date of termination or the portion of your Member Life Insurance that has terminated, less any individual amount purchased earlier under these rights, and less any Accelerated Benefit as discussed earlier in this Section.
- If the Group Policy terminates or is amended to exclude your insurance class after you have been insured for at least five years. In these instances, the maximum amount you may buy will be the smaller of: (1) \$10,000;

or (2) your Member Life Insurance amount in force on the date of termination, less any Accelerated Benefit as discussed earlier in this Section and less any amount for which you become eligible under any group policy within 31 days.

- If your Coverage During Disability ceases because Total Disability ends and you do not then become insured under the Group Policy within 31 days. In this instance, the maximum amount you may buy will be the Coverage During Disability benefit amount in force on the date Total Disability ends, less any individual amount purchased earlier under these rights, and less any Accelerated Benefit as discussed earlier in this Section.
- If your Accelerated Benefit Premium Waiver Period ceases and you do not qualify for Coverage During Disability. In this instance, the maximum amount you may buy will be the Member Life Insurance benefit amount in force on the date you cease Active Work, less any individual amount purchased earlier under these rights, and less any Accelerated Benefit as discussed earlier in this Section.

You must apply for individual purchase and pay the first premium to Us within 31 days after your insurance or Coverage During Disability under the Group Policy ceases. the Group Policy ceases.

The Policyholder must give you notice of the individual purchase right within 15 days after your insurance under the Group Policy terminates. If notice is not given within the 15-day period, you will have an additional 15 days after the date of notice to apply for individual purchase. However, if notice is not given within 91 days after the date of termination of group insurance, the time allowed to exercise the individual purchase right will expire at the end of that 91-day period.

See the Policyholder for the proper forms. Any individual policy issued will be effective on the 32nd day.

The individual policy will be for life insurance only (other than term insurance). No Disability or other benefits will be included. The premium you pay will be at Our normal rate for your age and for the risk class to which you belong on the individual policy's date of issue.

If you die within the 31-day purchase period, your beneficiary will be paid the life insurance amount, if any, you had the right to buy. This payment will be made whether or not you have applied for an individual policy.

DESCRIPTION OF BENEFITS

PORTABILITY

When insurance would otherwise end under the Group Policy as described below, you may be eligible to continue insurance under a Group Life Portability Insurance Policy underwritten by Us. The Group Life Portability Insurance Policy will contain provisions that differ from the Group Policy. If you elect to continue insurance under this option, you will receive a certificate outlining the Group Life Portability Insurance Policy provisions.

NOTE: You may elect to purchase an individual policy of life insurance (see Individual Purchase Rights as described on GH 203) in place of this portability option.

Member Life Insurance

Eligibility

If Member Life Insurance under the Group Policy ends because you cease to meet the definition of a Member, you may be eligible to continue such insurance under the Group Life Portability Insurance Policy without submitting Evidence of Insurability.

In order to continue insurance under the Group Life Portability Insurance Policy:

- for Member Life Insurance, you must be less than age 70.

Insurance may not be continued under the Group Life Portability Insurance Policy if:

- your insurance has been continued under Coverage During Disability provisions described on GH 203; or
- you have received a benefit under Accelerated Benefits provisions described on GH 203; or
- your insurance under the Group Policy ends because the Group Policy terminates, and is replaced by another group voluntary policy; or
- you have exercised your Individual Purchase Rights described on GH 203; or
- you die.

Amount of Insurance

The insurance amount that is available for continuation will be the Member Life Insurance Scheduled Benefit amount (or approved amount, if applicable) in force on the date insurance terminates under the Group Policy.

Termination of Ported Insurance

Ported insurance under the Group Life Portability Insurance Policy will terminate on the earliest of:

- the date ending the period for which the last premium is paid; or
- for Member insurance, the May 1 next following your 70th birthday.

Note: When insurance under the Group Life Portability Insurance ends, you may qualify and elect to purchase an individual policy of life insurance.

Application/Effective Date

Notice of the Portability option must be given to you by the Policyholder before insurance under the Group Policy terminates, or as soon as reasonably possible thereafter.

When notice of eligibility to continue insurance under the Group Life Portability Insurance Policy is not provided to Us following the termination of insurance under the Group Policy, you must apply for insurance and pay the first premium within 60 days of your termination date. Any continued insurance under the Portability option will be in force on the day following termination of insurance under the Group Policy.

Payment of premium constitutes your consent to port your insurance.

If you die(s) within the 60-day portability option period, We will pay the named beneficiary the Scheduled Benefit amount (or approved amount, if applicable) in force, if any, you had the right to continue. This payment will be made whether or not you have applied for the portability option.

CLAIM PROCEDURES

Notice of Claim

Written notice of claim must be given to Us within 20 days after the date of occurrence or commencement of the loss. Failure to give notice within the time specified will not invalidate or reduce any claim if notice is given as soon as reasonably possible.

Claim Forms

Claim forms and other information needed to prove loss must be filed with Us in order to obtain payment of benefits. The Policyholder will provide forms to assist you in filing claims. If the forms are not provided within 15 days after We receive such notice, you will be considered to have complied with the requirements of the Group Policy upon submitting, within the time specified below for filing proof of loss, Written proof covering the occurrence, character and extent of the loss.

Proof of Loss

Completed claim forms and other information needed to prove loss should be filed promptly. Written proof of loss should be sent to Us within 90 days after the date of loss. Proof required includes the date, nature, and extent of the loss. We may request additional information to substantiate your loss or require a Signed unaltered authorization to obtain that information from the provider. Your failure to comply with such request could result in declination of the claim. For purposes of satisfying the claims processing timing requirements of the Employee Retirement Income Security Act (ERISA), receipt of claim will be considered to be met when the appropriate claim form is received by Us.

Failure to furnish proof of loss within the time required will not invalidate or reduce a claim if it was not reasonably possible to submit the proof within the time required, if the proof is furnished as soon as reasonably possible and, except in the absence of legal capacity of the claimant, not later than one year from the time proof of loss is otherwise required.

Payment, Denial, and Review

ERISA permits up to 45 days from receipt of claim for processing the claim. If a claim cannot be processed due to incomplete information, We will send a Written explanation prior to the expiration of the 45 days. A claimant is then allowed up to 45 days to provide all additional information requested. We are permitted two 30-day extensions for processing an incomplete claim. Written notification will be sent to a claimant regarding the extension.

In actual practice, benefits under the Group Policy will be payable sooner, provided We receive complete and proper proof of loss. Further, if a claim is not payable or cannot be processed, We will submit a detailed explanation of the basis for Our denial.

A claimant may request an appeal of a claim denial by Written request to Us within 180 days of the receipt of notice of the denial. We will make a full and fair review of the claim. We may require additional information to make the review. We will notify the claimant in Writing of the appeal decision within 45 days after receipt of the appeal request. If the appeal cannot be processed within the 45-day period because We did not receive the requested additional information, We are permitted a 45-day extension for the review. Written notification will be sent to the claimant regarding the extension. After exhaustion of the formal appeal process, the claimant may request an additional appeal. However, this appeal is voluntary and does not need to be filed before asserting rights to legal action.

For purposes of this section, "claimant" means you, your Dependent, or Beneficiary.

State Time Limits: Unless otherwise preempted by the Employee Retirement Income Security Act (ERISA), state time limits will apply. State law requires that benefits payable under the Group Policy will be payable not more than 30 days after receipt of proof and subject to the proof of loss.

Medical Examinations

We may have you, whose loss is the basis for claim, examined by a Physician during the course of a claim. We will pay for these examinations and will choose the Physician to perform them.

Autopsy

If payment for loss of life is claimed, We may require an autopsy. We will pay for any such autopsy.

Legal Action

Legal action to recover benefits under the Group Policy may not be started earlier than 60 days after proof of loss is filed. Further, no legal action may be started later than three years after that proof is required to be filed.

Time Limits

All time limits listed in this section will be adjusted as required by law.

STATEMENT OF RIGHTS

Federal law requires that this section be included in your booklet:

As a participant in this 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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare 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 Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

SUPPLEMENT TO YOUR BOOKLET-CERTIFICATE

The Employee Retirement Income Security Act (ERISA) requires that certain information be furnished to each participant in an employee benefit plan. Policyholders may use this booklet-certificate in part in meeting Summary Plan Description requirements under ERISA.

1. **Employer Plan Identification Number:**

EIN: 52-0591623
PN: 510

2. **Type of Administration:**

Life: Insurance Contract.

3. **Plan Administrator:**

LOYOLA UNIVERSITY MARYLAND
4501 NORTH CHARLES ST
BALTIMORE MD 21210

See your employer for the business telephone number of the Plan Administrator.

4. **Plan Sponsor:**

LOYOLA UNIVERSITY MARYLAND
4501 NORTH CHARLES ST
BALTIMORE MD 21210

5. **Agent for Service of Legal Process:**

LOYOLA UNIVERSITY MARYLAND
4501 NORTH CHARLES ST
BALTIMORE MD 21210
(410) 617-1366

Legal process may also be served upon the plan administrator.

6. **Type of Participants Insured Under the Plan:**

All active full-time employees of LOYOLA UNIVERSITY MARYLAND, and provided you are a Member as defined in the DEFINITIONS Section of this booklet (page GH 114).

7. **Sources and Methods of Contributions to the Plan:**

Employee pays all of employee's contribution.

8. **Ending Date of Plan's Fiscal Year:**

June 30

DEFINITIONS

Several words and phrases used to describe your insurance are capitalized whenever they are used in this booklet. These words and phrases have special meanings as explained in this section.

Active Work; Actively at Work means you will be considered Actively at Work if you are able and available for active performance of all your regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered Active Work provided you are able and available for active performance of all of your regular duties and were working the day immediately prior to the date of your absence.

Evidence of Insurability means Written evidence that a person is insurable under Our underwriting standards. This proof must be provided in a form satisfactory to Us.

Group Policy means the policy of group insurance issued to the Policyholder by Us which describes benefits and provisions for insured Members.

Insurance Month

Calendar month.

Member means any PERSON (other than a person who is affiliated with a religious order who has taken a vow of poverty) who is a full-time employee of the Policyholder and who regularly works at least 22.5 hours per week. The employee must be compensated by the Policyholder and either the employer or employee must be able to show taxable income on federal or state tax forms. Work must be at the Policyholder's usual place or places of business, at an alternative worksite at the direction of the Policyholder, or at another place to which the employee must travel to perform his or her regular duties. This excludes any person who is scheduled to work for the Policyholder on a seasonal, temporary, contracted, or part-time basis.

An owner, proprietor, or partner of the Policyholder's business will be deemed to be an eligible employee for purposes of the Group Policy, provided he or she is regularly scheduled to work for the Policyholder at least 22.5 hours per week and otherwise meets the definition of a Member.

Physician means:

- a licensed Doctor of Medicine (M.D.) or Osteopathy (D.O.); or
- any other licensed health care practitioner that state law requires be recognized as a Physician under the Group Policy.

The term Physician does not include you, one of your employees, your business or professional partner or associate, any person who has a financial affiliation or business interest with you, anyone related to you by blood or marriage, or anyone living in your household.

Policyholder means LOYOLA UNIVERSITY MARYLAND.

Prior Policy means the Group Voluntary Term Life coverage of either:

- the Policyholder; or
- a business entity which has been obtained by the Policyholder through a merger or acquisition;

for which the Group Policy is a replacement.

Qualifying Event means, for Accelerated Benefits, a medical condition, which would, in the absence of extensive or extraordinary medical treatment, result in a drastically limited life span. Such conditions may include, BUT ARE NOT LIMITED TO, one or more of the following:

- coronary artery disease resulting in an acute infarction or requiring surgery;
- permanent neurological deficit resulting from cerebral vascular accident;
- end stage renal failure; or
- acquired immune deficiency syndrome (AIDS).

Scheduled Benefits Summary means the page, which is issued as part of your certificate that contains benefit and other information pertaining to your insurance under the Group Policy.

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

Terminally Ill means, for Accelerated Benefits, you have experienced a Qualifying Event and you are expected to die within 12 months of the date you request payment of Accelerated Benefits.

Total Disability; Totally Disabled means for you, your inability, as determined by Us, due to sickness or injury, to perform the majority of the material duties of any occupation for which you are or may reasonably become qualified based on education, training or experience.

We, Us, and Our means Principal Life Insurance Company, Des Moines, Iowa.

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

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Plan Arranged By

PSA FINANCIAL INC
11311 MCCORMICK RD
HUNT VALLEY MD
21031-8622



Principal Life Insurance Company
Des Moines, Iowa 50392-0002