RELIANCE STANDARD
LIFE INSURANCE COMPANY

Home Office: Schaumburg, Illinois • Administrative Office: Philadelphia, Pennsylvania

WHERE TO FIND **Page**

CERTIFICATE OF INSURANCE

We certify that you (provided you belong to a class described on the Schedule of Benefits) are insured for the benefits which apply to your class, under Group Policy No. VAI 857945 issued to Silver Birch Services LLC (DBA Silver Birch Living), the Policyholder.

This Certificate is not a contract of insurance. It contains only the major terms of insurance coverage and payment of benefits under the Policy. Coverage is subject to the terms and conditions of the Policy. In the event of a conflict between the Policy and this Certificate, the terms of the Policy control.

Secretary

President

READ THIS CERTIFICATE CAREFULLY. THE POLICY PROVIDES LIMITED BENEFITS. THE POLICY IS NOT A MEDICAL INSURANCE POLICY

GROUP ACCIDENT CERTIFICATE

SCHEDULE OF BENEFITS

EFFECTIVE DATE: August 1, 2021

ELIGIBLE CLASSES: Each Active Full-time employee, except any person employed on a temporary or seasonal basis.

INDIVIDUAL EFFECTIVE DATE: The first day of the month coinciding with or next following the date you complete your enrollment form.

INDIVIDUAL REINSTATEMENT: 6 months

COVERAGE TYPE: On and off-the-Job (24 hour) coverage

EMPLOYEE AND SPOUSE ELIGIBLE AGE:

You must be under age 70 to enroll for insurance coverage.

Your spouse must be under age 70 to enroll for insurance coverage.

CHANGES IN BENEFIT AMOUNTS: Increases in the Benefit Amounts for any reason are effective on the August 1st coinciding with or next following the date of the change, provided you are Actively at Work on the effective date of the change. If you are not Actively at Work when the change would otherwise take effect, the change will take effect on the day after you have returned to Active Work in an Eligible Class for one full day.

Decreases in the Benefit Amounts are effective on the August 1st coinciding with or next following the date of the change.

CONTRIBUTIONS: You are required to contribute toward the cost of your insurance coverage. You are required to contribute toward the cost of the Dependent Insurance coverage.

Receipt of benefits under the Policy may be taxable. It is recommended that you contact your personal tax advisor.

BENEFIT AMOUNTS: Eligible for Plan C

PLAN C

Type of Benefit	Benefit Amount
Ambulance	
Air Ambulance Transportation	$1,500
Ground Ambulance Transportation	$300
Blood, Plasma and Platelets	$1,000
Burns	
2nd Degree Burns	
Covering less than 10% of the body	$235
Covering 10% but less than 25% of the body	$470
Covering 25% but less than 35% of the body	$940
Covering 35% or greater of the body	$1,880
3rd Degree Burns	
Covering less than 10% of the body	$1,880
Covering 10% but less than 25% of the body	$3,760
Covering 25% but less than 35% of the body	$7,520
Covering 35% or greater of the body	$15,040
Skin Grafts due to Burns	25% of the benefit payable for Burns
Chiropractic Services	$50 per visit
Coma	$10,000
Concussion	$500
Dental Injury	
Extraction	$150
Crown	$450
Diagnostic Examination	$200

Type of Benefit	Benefit Amount	
Dislocations	**Surgical**	**Non-Surgical**
Ankle	$4,020	$2,010
Collarbone	$4,020	$2,010
Elbow	$2,010	$1,005
Finger	$670	$335
Foot	$4,020	$2,010
Hand	$2,010	$1,005
Hip	$10,720	$5,360
Knee	$6,700	$3,350
Lower Jaw	$2,010	$1,005
Shoulder	$2,010	$1,005
Toe	$670	$335
Wrist	$2,010	$1,005
Partial Dislocation	25% of benefit for non-surgical dislocation	
Multiple Dislocations	100% of the highest benefit for any one dislocation among all dislocations sustained	
Emergency Treatment	$201	
Epidural Anesthesia Injection	$100 per injection	
Eye Injury		
Removal of Foreign Object	$200	
Surgical Repair	$400	

Type of Benefit	Benefit Amount	
Fractures:	**Surgical**	**Non-Surgical**
Ankle	$1,500	$750
Arm	$1,500	$750
Bones of Face	$750	$375
Coccyx	$750	$375
Collarbone	$1,500	$750
Elbow	$1,500	$750
Finger	$250	$125
Foot	$1,500	$750
Hand	$1,500	$750
Hip	$8,000	$4,000
Jaw	$1,500	$750
Kneecap	$1,500	$750
Leg	$4,000	$2,000
Nose	$750	$375
Pelvis	$4,000	$2,000
Rib	$750	$375
Shoulder Blade	$1,500	$750
Skull (Except bones of face or nose – Depressed)	$12,500	$6,250
Skull (Simple)	$3,750	$1,875
Sternum	$1,500	$750
Toe	$250	$125
Vertebrae	$1,500	$750
Vertebral Column	$4,000	$2,000
Wrist	$1,500	$750
Chip Fractures	25% of benefit for non-surgical fracture	
Multiple Fractures	100% of the highest benefit for any one fracture among all fractures sustained	
Hospitalization		
Initial Hospital Admission	$1,500	
Initial Intensive Care Unit (ICU) Hospital Admission	$1,500	
Hospital Confinement	$300 per day	
Intensive Care Unit (ICU) Confinement	$600 per day	
Lacerations		
No Sutures Required	$ 43.75	
Sutures Required (Total length of all sutured Lacerations)		
Less than 2” long	$88	
2” but less than 6” long	$350	
6” long or greater	$700	
Medical Appliance	$200	
Organized Youth Sports	25% of Benefit Amount(s)	
Paralysis		
Paraplegia or Hemiplegia	$20,000	
Quadriplegia	$40,000	
Physical Therapy	$50 per session	

Type of Benefit	**Benefit Amount**
Physician Visit	
Initial Physician Office Visit	$100
Follow-up Physician Office Visit	$100
Prosthesis	
One	$1,000
Two or more	$2,000
Rehabilitation Facility Confinement	$150 per day
Surgery	
Abdominal or Thoracic Surgery (Surgically Repaired)	$3,000
Exploratory Surgery (No Repair)	$300
Knee Cartilage (Surgically Repaired)	$900
Ruptured Disc (Surgically Repaired)	$1,500
Tendon, Ligament or Rotator Cuff (**Surgically Repaired**)	
One Repair	$900
Two or more Repairs	$1,800
Transportation	$402
X-Ray	$125
Wellness Benefit:	$75

DEFINITIONS

"We", "us", and "our" means Reliance Standard Life Insurance Company.

"You", "your", and "yours" means a person who meets the eligibility requirements of the Policy and is enrolled for this insurance.

"Actively at Work" and "Active Work" means you are actually performing on a Full-time basis each and every duty pertaining to your job working for the Policyholder in the place where and the manner in which the job is normally performed. This includes approved time off for vacation, jury duty and funeral leave, but does not include time off as a result of injury or sickness.

"Burns" means:

(1) 2nd degree burns, which are those that have burned through the first layer of skin as well as the second layer of skin (dermis); and
(2) 3rd degree burns, which are those that have burned through all layers of the skin and causes permanent tissue damage; and

cover a specific percentage of the body as shown on the Schedule of Benefits.

"Coma" means a state of profound unconsciousness, from which one cannot be aroused, that lasts continuously for at least a period of 168 hours requiring confinement in a Hospital under the care of a Physician, board certified as a neurologist. The Physician's diagnosis must be supported by a Glasgow Coma Scale score of no greater than 7 or a score of Level V or less on the Rancho Los Amigos Scale throughout the 168 hour period and an abnormal Electroencephalogram (EEG).

"Concussion" means a blow to the head that results in loss of consciousness, confusion, loss of memory or generally being dazed.

"Covered Accident" means an accident or event that:

(1) could not have been foreseen, anticipated or expected;
(2) occurs while your or your Insured Dependents coverage is in force under the Policy;
(3) occurs on or off the job;
(4) results in Injury for which benefits may be payable; and
(5) is not excluded under the terms of the Policy.

"Dentist" means a licensed doctor of dentistry, operating within the scope of his or her license, in the jurisdiction in which such license was issued. The Dentist may not be you or a member of your Immediate Family.

"Dependents" means:

(1) your legal spouse; and
(2) your child(ren), from birth to 26 years, including natural children, legally adopted children, children who are dependent on you during the waiting period before adoption, stepchildren, foster children and children under legal guardianship of you; and
(3) your child(ren) beyond the limiting age who is incapable of self-sustaining employment by reason of intellectual disability or physical handicap and who is chiefly dependent on you for support and maintenance.

"Dislocation" means complete displacement of a bone from its normal articulation with a joint, also called luxation. Partial Dislocation is an incomplete displacement of a bone from its normal articulation with a joint, also called subluxation.

"Eligible Person" means a person who meets the Eligibility Requirements of the Policy.

"Epidural Anesthesia Injection" means injection of drugs through a catheter placed into the epidural space.

"Fracture" means a bone that is broken which is diagnosed by a Physician. A Chip Fracture means that a fragment of bone has been broken off.

"Full-time" means working for the Policyholder for a minimum of 30 hours during your regularly scheduled work week.

"Glasgow Coma Scale" means a system for assessing the severity of brain impairment in an individual with a brain injury that uses the sum of scores given for eye-opening, verbal, and motor responses.

"Hospital" means a legally operated, accredited facility licensed to provide full-time care and treatment for the condition for which benefits are payable under the Policy. It is operated with a full-time staff of Physicians and registered nurses. It does not include facilities that primarily provide custodial or rehabilitative care, education, or long-term institutional care on a residential basis.

"Hospital Confinement/Confined" means that you or your Insured Dependent have been formally admitted to or placed under observation in a Hospital and remains in the Hospital more than 23 hours.

"Immediate Family" means your or your Dependent's parents, siblings, spouse or children.

"Injury" means bodily injury to you or your Insured Dependent resulting directly from an accident independent of all other causes, which occurs while your or your Insured Dependent's coverage under the Policy is in force.

"Inpatient" means that you or your Insured Dependent have been Hospital confined.

"Insured Dependent" means a "Dependent", as defined, whose insurance under the Policy is in effect.

"Insured Person" means a person employed by the Policyholder who meets the Eligibility Requirements of the Policy and is enrolled for this insurance.

"Intensive Care Unit (ICU)" means a specific area of the Hospital, set apart from the surgical recovery room and other rooms used for confinement of patients, providing:

(1) intensive medical care and treatment to only those patients who are in critical condition;
(2) continuous observation of and care to patients by a specially trained nursing staff that is dedicated exclusively to the ICU on a 24 hour basis;
(3) a Physician assigned exclusively to the ICU on a full-time basis; and
(4) life-saving equipment required to treat patients in critical condition which is permanently located in the ICU.

"Medical Appliance" means an appliance that assists you or your Insured Dependent with mobility such as crutches, wheel chairs, or walkers.

"Medical Professional" means a person, other than a Physician or Dentist, that provides medical care and services within the scope of his or her license such as chiropractors, physical therapists, occupational therapists, physician's assistants, nurse practitioners and registered nurses. The Medical Professional may not be you or a member of your Immediate Family.

"Organized Youth Sports" means a sport activity that is governed by an organization and requires formal registration to participate.

"Outpatient" means you or your Insured Dependent who receive medical care, treatment and services when not Hospital Confined.

"Paralysis" means Paraplegia, Quadriplegia or Hemiplegia diagnosed by a Physician and as defined below:

(1) "Paraplegia" means complete and permanent loss of motor function of both lower limbs.
(2) "Quadriplegia" means complete and permanent loss of motor function of both the upper and lower limbs.
(3) "Hemiplegia" means complete and permanent loss of motor function of the upper and lower limbs of the same side of the body.

"Physician" means a duly licensed medical or osteopathic doctor who is recognized by the law of the jurisdiction in which

treatment is provided as qualified to treat the type of Injury for which claim is made. The Physician may not be you or a member of your Immediate Family.

"Ranchos Los Amigos Scale" means a system used by the medical profession for measuring levels of awareness, cognition, behavior and interaction with the environment

"Rehabilitation Facility" means any facility or Hospital that is licensed in the jurisdiction in which it is operating to provide rehabilitation services, therapy or retraining to you or your Insured Dependent to enable you or your Insured Dependent to walk, communicate, and/or function as a member of society.

GENERAL PROVISIONS

INCONTESTABILITY: Any statements made by you or any Insured Dependent or on your behalf or any Insured Dependent's to persuade us to provide coverage, will be deemed a representation, not a warranty. This provision limits our use of these statements in contesting the Benefit Amount for which you or your Insured Dependent are covered. The following rules apply to each statement:

(1) No statement will be used in a contest unless:

   (a) it is in a written form signed by you or any Insured Dependent, or on your behalf or any Insured Dependent's behalf; and
   (b) a copy of such written instrument is or has been furnished to you or any Insured Dependent or your or any Insured Dependent's beneficiary, or legal representative.

(2) If the statement relates to your or any Insured Dependent's insurability, it will not be used to contest the validity of insurance which has been in force, before the contest, for at least 2 years during your or your Insured Dependent's lifetime. Also, we will not use such statements to contest a benefit increase after such benefit increase has been in force for 2 years during your or your Insured Dependent's lifetime.

ASSIGNMENT: The benefits under the Policy may not be assigned, except as required by law.

CLERICAL ERROR: Clerical errors in connection with the Policy or delays in keeping records for the Policy, whether by the Policyholder, us, or the Plan Administrator:

(1) will not terminate insurance that would otherwise have been effective; and
(2) will not continue insurance that would otherwise have ceased or should not have been in effect.

Clerical Errors include (but are not limited to) the payment of premium for coverage not provided by the Policy. If appropriate, a fair adjustment of premium will be made to correct a clerical error. Such adjustments will be limited to the 12 month period preceding the date we receive proof from the Policyholder that an adjustment due to overpayment of premium should be made or the date we discover that premium has been underpaid.

MISSTATEMENT OF FACTS: If relevant facts about you or any Insured Dependent were misstated:

(1) an adjustment of the premium will be made; and
(2) the true facts will decide what amount of insurance is valid under the Policy.

If any misstated facts impacts the amount of premium that should have been paid, any benefit payable shall be in the amount the paid premium would have purchased based on the correct fact(s).

NOT IN LIEU OF WORKERS' COMPENSATION: The Policy is not a Workers' Compensation Policy. It does not provide Workers' Compensation benefits.

INDIVIDUAL ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

ELIGIBLE CLASSES: The eligible classes will be those persons described on the Schedule of Benefits.

ELIGIBILITY REQUIREMENTS: You are eligible for insurance under the Policy if you are a member of an Eligible Class, as shown on the Schedule of Benefits page.

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

(1) the Individual Effective Date as shown on the Schedule of Benefits; or
(2) the first day of the month coinciding with or next following the date you apply; or
(3) the date premium is remitted.

Changes in your Benefit Amount are effective as shown on the Schedule of Benefits.

If you, as an Eligible Person, are not Actively At Work on the day your insurance is to go into effect, the insurance will go into effect on the day you return to Active Work in an Eligible Class for one full day.

TERMINATION OF INDIVIDUAL INSURANCE: Your coverage will terminate on the first of the following to occur:

(1) the date the Policy terminates;
(2) the last day of the Policy month in which you cease to be in a class eligible for this insurance;
(3) the end of the period for which premium has been paid; or
(4) the date you enter military service on active duty (not including Reserves or National Guard).

Any Loss which occurs prior to the termination of this insurance coverage will not be affected.

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

(1) 12 months, if due to sickness or Injury; or
(2) 1 month, if due to temporary lay-off or approved leave of absence.

INDIVIDUAL REINSTATEMENT: Insurance may be reinstated if you, as a former Insured Person have been:
(1) on an approved leave of absence; or
(2) on temporary lay-off.

You, as the former Insured Person, must return to Active Work with the Policyholder within the period of time shown on the Schedule of Benefits. You must also be a member of a class eligible for this insurance.

You, as the former Insured Person, will not be required to fulfill the Service Waiting Period of the Policy again. The insurance will go into effect on the date you return to Active Work for one full day. However, if you return after having resigned or having been discharged, you will be required to fulfill the eligibility requirements of the Policy again.

DEPENDENT INSURANCE

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

When an Insured Dependent sustains an Injury due to a Covered Accident we will pay the applicable benefit shown on the Schedule of Benefits. Only dependents that meet the definition of Dependent can be insured for this benefit.

A person may not have coverage under the Policy both as an Insured Person and as an Insured Dependent. Only one eligible spouse may cover the eligible children as Insured Dependents. Dependents may be covered as Insured Dependents if not covered as an Insured. If insurance is in force for an Insured Dependent child, any newly eligible Dependent child(ren) will be automatically covered.

ELIGIBILITY: You, as an Eligible Person are eligible to enroll your eligible Dependents on the date you become an Insured Person.

EFFECTIVE DATE OF DEPENDENT INSURANCE: If the Policyholder pays the entire premium for Dependents, a Dependent's insurance will become effective on the later of:

(1) the first day of the month coinciding with or next following the date you become eligible for Dependent Insurance; or
(2) the first day of the month coinciding with or next following the date the dependent meets the definition of Dependent.

If you are required to pay a portion of the Dependent premium for Dependent insurance, you may insure your Dependents by making written application. In this case, the insurance for Dependents will take effect on the later of:

(1) the first day of the month coinciding with or next following the date you become eligible for Dependent insurance; or
(2) the first day of the month coinciding with or next following the date the dependent meets the definition of Dependent, if application is made on or before that date; or
(3) the first day of the month coinciding with or next following the date of application; or
(4) the date the premium applicable to the coverage selected is remitted.

Changes in the Insured Dependent's Benefit Amount are effective as shown on the Schedule of Benefits.

TERMINATION OF DEPENDENT INSURANCE: The insurance for an Insured Dependent will terminate on the first of the following dates:

(1) the date this Section terminates;
(2) the end of the period for which premium for Dependent insurance has been paid;
(3) the date your insurance terminates; or
(4) the date the dependent is no longer a Dependent as defined.

NEWLYWED PROVISION: At your marriage, if you did not previously elect Dependent spouse coverage, your new spouse shall automatically become an Insured Dependent spouse.

Such spouse shall be an Insured Dependent spouse for 31 days. He/she shall then cease to be an Insured Dependent spouse unless:

(1) you request continuation of such Dependent spouse coverage within such 31 day period; and
(2) the additional premium is paid for such coverage.

NEWBORN CHILDREN: If a child is born to you and you have not elected Dependent child(ren) coverage, such child shall be an Insured Dependent child from the moment of birth.

The newborn child shall be an Insured Dependent child for 31 days. He/she shall then cease to be an Insured Dependent child unless:

(1) you request continuation of such Dependent child(ren) coverage within such 31 day period, and
(2) the additional premium is paid for such coverage.

The above coverage will also be extended to newly adoptive children from the earlier of: 1) the date of placement for the purpose of adoption; or 2) the date of the entry of an order granting the adoptive parent custody of the child for the purposes of adoption. Such coverage shall continue unless the placement is disrupted prior to legal adoption and the child is removed from placement, provided notice and payment of any required premium is paid within 31 days from the date in (1) or (2) above. The above coverage will be extended to foster or stepchildren, as of the date they become financially dependent on you for support, provided they otherwise meet the definition of a Dependent.

PORTABILITY

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

(1) notify us in writing within 31 days from the date you cease to be eligible; and
(2) remit the necessary premiums when due.

The Benefit Amount available under the Portability provision will be the current Benefit Amount you and your Insured Dependents are insured for under the Policy on the last day you were Actively at Work.

The premium charged to continue coverage will be based on the prevailing rate charged to Insured Persons who choose to continue coverage under the Portability provision. Such premium will be billed directly to you on a quarterly basis.

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

(1) the end of the period for which premium has been paid; or
(2) the date you reach age 70; or
(3) at any time coverage would normally terminate according to the terms of the Policy had you continued to be eligible.

In addition, coverage will reduce at any time it would normally reduce according to the terms of the Policy had you and your Insured Dependent spouse continued to be eligible.

If the Policy terminates subsequent to your election to continue your coverage, and that of your Insured Dependentsin accordance with the Portability provision, such coverage will be continued in accordance with the provisions of your certificate.

BENEFIT PROVISIONS

Please refer to the Schedule of Benefits for benefit amounts payable.

AMBULANCE BENEFITS:

Air Ambulance Transportation: An Air Ambulance Transportation benefit will be payable if you or your Insured Dependent sustain an Injury as a result of a Covered Accident and:

(1) a licensed ambulance company provides air transport:
    (a) to or from a Hospital; or
    (b) between medical facilities; and
(2) the air ambulance transportation is provided within 48 hours of the Covered Accident.

Only one benefit will be paid for each person insured per Covered Accident. This benefit may be payable in addition to an Ambulance Transportation benefit.

Ground Ambulance Transportation: An Ambulance Transportation benefit will be payable if you or your Insured Dependent sustain an Injury as a result of a Covered Accident and:

(1) a licensed ambulance company provides ground transport:
    (a) to or from a Hospital; or
    (b) between medical facilities; and
(2) ground transportation is provided within 90 days of the Covered Accident.

Only one benefit will be paid for each person insured per Covered Accident. This benefit may be payable in addition to an Air Ambulance Transportation benefit.

BLOOD, PLASMA AND PLATELETS: A Blood, Plasma and Platelet benefit will be payable if you or your Insured Dependent sustain an Injury as a result of a Covered Accident requiring a transfusion of blood, plasma or platelets provided such transfusion is administered within 90 days of the Covered Accident.

Only one benefit will be paid for each person insured per Covered Accident.

BURNS: A Burn benefit will be payable if you or your Insured Dependent sustain a 2nd or 3rd degree burn as a result of a Covered Accident provided treatment is received from a Physician within 72 hours of the Covered Accident.

If you or your Insured Dependent sustain Burns in more than one 1 classification as shown on the Schedule of Benefits, only one Burn benefit, which is the highest, will be paid for each person insured per Covered Accident.

Skin Graft (due to Burns): A Skin Graft benefit will be payable if you or your Insured Dependent require skin grafting as a result of a Burn sustained in a Covered Accident and were paid a benefit under the Burn benefit.

Only one benefit will be paid for each person insured per Covered Accident.

CHIROPRACTIC SERVICES: A Chiropractic Services benefit will be payable if you or your Insured Dependent suffer a structural imbalance as a result of a Covered Accident and receives spinal manipulation by a Medical Professional in their office. Treatment must begin within 6 months of the Covered Accident. Benefits are not payable for services for massage therapy or treatment of chronic conditions or other injuries not related to structural imbalance.

This benefit is payable for up to 6 visits for each person insured per Covered Accident, but no more than 12 visits per calendar year.

COMA: A Coma benefit will be payable if you or your Insured Dependent are in a Coma, as diagnosed by a Physician, for 168 hours as a result of a Covered Accident. However, benefits will not be paid when a Coma has been medically induced.

Only one benefit will be paid for each person insured per Covered Accident.

CONCUSSION: A Concussion benefit will be payable if you or your Insured Dependent sustain a Concussion as a result of a Covered Accident provided it is diagnosed by a Physician within 72 hours of the Covered Accident.

Only one benefit will be paid for each person insured per Covered Accident.

DENTAL INJURY: A Dental Injury benefit will be payable if you or your Insured Dependent sustain an Injury as a result of a Covered Accident to your or your Insured Dependent's natural teeth which requires:

(1) extraction; or
(2) repair by insertion of a crown.

Initial treatment must be provided by a Dentist within 6 months of the Covered Accident.

Only one benefit for extraction and one benefit for a crown will be paid for each person insured per Covered Accident.

DIAGNOSTIC EXAMINATION: A Diagnostic Examination benefit will be payable if you or your Insured Dependent must undergo one of the following diagnostic examinations as prescribed by a Physician due to Injury sustained as a result of a Covered Accident:

(1) Computed Tomography (CT or CAT) scan;
(2) Magnetic Resonance Imaging (MRI);
(3) Positron Emission Tomography (PET) scan; or
(4) Single Photon Emission Computed Tomography (SPECT) scan.

Such examination must be performed within 6 months of the Covered Accident.

Only one benefit will be paid for each person insured per Covered Accident.

DISLOCATION: A Dislocation benefit will be payable if you or your Insured Dependent sustain a dislocation or partial dislocation as a result of a Covered Accident provided it is diagnosed by a Physician within 90 days of the Covered Accident.

If you or your Insured Dependent sustain more than one dislocation as a result of such Covered Accident, we will pay one benefit which is the highest.

EMERGENCY TREATMENT: Emergency Treatment will be payable if you or your Insured Dependent sustain an Injury as a result of a Covered Accident and:

(1) you or your Insured Dependent is examined or treated in a Hospital emergency room, urgent care facility, Physician's office or Dentist's office; and
(2) emergency treatment is received within 72 hours of the Covered Accident.

Only one benefit will be paid for each person insured per Covered Accident.

EPIDURAL ANESTHESIA INJECTION: An Epidural Anesthesia Injection benefit will be payable if you or your Insured Dependent receive an epidural injection administered for pain management for an Injury as a result of a Covered Accident. The epidural must be:

(1) prescribed by a Physician;
(2) administered in a Physician's office or Hospital; and
(3) received within 6 months of the Covered Accident.

A benefit will not be paid for:

(1) an epidural injection administered during a surgical procedure;
(2) epidural steroid injections; or
(3) an epidural administered during labor and delivery.

Only 2 benefits will be paid for each person insured per Covered Accident.

EYE INJURY: An Eye Injury benefit will be payable if you or your Insured Dependent sustain an Injury to the eye or eyes as a result of a Covered Accident provided a Physician:

(1) performs surgical repair on the eye or eyes within 90 days of a Covered Accident; or
(2) removes a foreign object from the eye or eyes within 90 days of the Covered Accident.

Only one benefit will be paid for each eye for each person insured per Covered Accident.

FRACTURE: A Fracture benefit will be payable if you or your Insured Dependent sustain a Fracture or Chip Fracture as a result of a Covered Accident provided it is diagnosed by a Physician within 6 months of the Covered Accident.

If you or your Insured Dependent sustain more than one fracture as a result of such Covered Accident, we will pay one benefit which is the highest.

HOSPITALIZATION:

Initial Hospital Admission: An Initial Hospital Admission lump sum benefit will be payable if you or your Insured Dependent sustain an Injury due to a Covered Accident and require Hospital Confinement and:

(1) Hospital Confinement occurs with 180 days of the Covered Accident; and
(2) it is the first Hospital Confinement for such Covered Accident.

Only one benefit will be paid for each person insured per Covered Accident.

This benefit will not be payable if treatment is provided:

(1) in the emergency room; or
(2) on an Outpatient basis.

If a benefit is payable under the Initial Hospital Admission benefit as well as under the Initial Intensive Care Unit (ICU) Hospital Admission benefit, only one benefit will be paid which is the highest.

You or your Insured Dependent may also be eligible for a Hospital Confinement benefit.

Initial Intensive Care Unit (ICU) Hospital Admission: An Initial ICU Hospital Admission lump sum benefit will be payable if you or your Insured Dependent sustain an Injury due to a Covered Accident and require admission to the ICU of a Hospital and:

(1) admission occurs within 180 days of the Covered Accident;
(2) the ICU stay is more than 23 hours; and
(3) it is the first ICU admission for such Covered Accident.

Only one benefit will be paid for each person insured per Covered Accident.

If a benefit is payable under the Initial Intensive Care Unit (ICU) Hospital Admission benefit as well as under the Initial Hospital Admission benefit, only one benefit will be paid which is the highest.

You or your Insured Dependent may also be eligible for an Intensive Care Unit (ICU) Confinement benefit.

Hospital Confinement: A Hospital Confinement benefit will be payable for each day you or your Insured Dependent are Hospital Confined because an Injury is sustained due to a Covered Accident if the initial confinement begins within 180 days of the Covered Accident.

This benefit is payable per day for up to three hundred sixty-five (365) days for each person insured per Covered Accident over the course of 365 days from the date of Initial Hospital Confinement.

Only one Hospital Confinement benefit is payable regardless of whether more than one Covered Accident caused such confinement.

If a Hospital Confinement benefit and an Intensive Care Unit (ICU) Confinement benefit are both payable on the same day, only the ICU Confinement benefit will be paid for that day. A Hospital Confinement benefit and an Intensive Care Unit (ICU) Confinement benefit may both be payable for one Hospital stay but are payable based on where you or your Insured Dependent are on any given day.

Intensive Care Unit (ICU) Confinement: An ICU Confinement benefit will be payable for each day you or your Insured Dependent are confined in the ICU of a Hospital because of an Injury sustained due to a Covered Accident if confinement begins within 30 days of the Covered Accident.

This benefit will be payable for up to thirty (30) days for each person insured per Covered Accident over the course of 365 days from the date of initial ICU confinement.

Only one ICU Confinement benefit is payable regardless of whether more than one Covered Accident caused such confinement.

If an ICU Confinement benefit and a Hospital Confinement benefit are both payable on the same day, only the ICU Confinement benefit will be paid for that day. An ICU Confinement benefit and a Hospital Confinement benefit may both be payable for one Hospital stay but are payable based on where you or your Insured Dependent are on any given day. If you or your Insured Dependent exhaust the ICU Confinement benefit before such confinement is over, a Hospital Confinement benefit may be payable.

LACERATIONS: A Laceration benefit will be payable if you or your Insured Dependent are Injured as a result of a Covered Accident and sustain a laceration (cut), provided it is treated by a Physician or Medical Professional within 72 hours of the Covered Accident.

This benefit is payable:
(1) once for the total number of lacerations received not requiring sutures (stitches); and
(2) once for the total length of all lacerations received requiring sutures,

for each person insured as a result of any one Covered Accident.

If a laceration would normally require sutures but the Physician or Medical Professional chooses to repair the laceration by some other medically accepted method, the benefit will still be payable as if the repair was made with sutures.

MEDICAL APPLIANCE: A Medical Appliance benefit will be payable if you or your Insured Dependent sustain an Injury as a result of a Covered Accident which requires a Medical Appliance to assist with mobility provided such appliance is prescribed by a Physician or Medical Professional and received by you or your Insured Dependent within 365 days of the Covered Accident.

Only one benefit is payable for each person insured per Covered Accident.

ORGANIZED YOUTH SPORTS: An additional benefit will be payable if your Insured Dependent child sustains an Injury as a result of a Covered Accident while participating in an Organized Youth Sport. Your Insured Dependent child must be age 18 or younger on the date of the Covered Accident. Proof of registration may be required.

PARALYSIS: A Paralysis benefit will be payable if you or your Insured Dependent sustain an Injury due to a Covered Accident that results in Paralysis and:

(1) you or your Insured Dependent lose the function of 2 or more limbs for an uninterrupted period of 60 days; and
(2) such Paralysis is confirmed by a Physician.

The uninterrupted 60 day period of Paralysis is waived if clinical and radiological evidence shows that the spinal cord has been transected with no possibility of returned functionality.

PHYSICAL THERAPY: A Physical Therapy benefit will be payable if you or your Insured Dependent sustain an Injury as a result of a Covered Accident which requires therapy if it:

(1) is prescribed by a Physician;
(2) is provided by a Medical Professional;
(3) is performed in an office, Hospital or Rehabilitation Facility;
(4) begins within 6 months of the Covered Accident; and
(5) is completed within 365 days of the Covered Accident.

This benefit is payable for up to six (6) therapy sessions for each person insured per Covered Accident.

PHYSICIAN VISIT:

Initial Physician Office Visit: An Initial Physician Office Visit benefit will be payable if you or your Insured Dependent sustain an Injury as a result of a Covered Accident and are examined or treated by a Physician or Medical Professional in such individual's office. Examination or treatment must be provided within 6 months of the Covered Accident.

This benefit is not payable if you or your Insured Dependent are eligible to receive a benefit under Emergency Treatment.

Only one benefit will be paid for each person insured per Covered Accident.

Follow-up Physician Office Visit: A Follow-up Physician Office Visit benefit will be payable for follow-up examination or treatment by a Physician or Medical Professional in such individual's office if you or your Insured Dependent have sustained an Injury as a result of a Covered Accident. Examination or treatment must be provided within 60 days of the Covered Accident.

This benefit is not payable while you or your Insured Dependent are confined in a Hospital, ICU or Rehabilitative Facility.

Only six (6) benefit will be paid for each person insured per Covered Accident.

PROSTHESIS: A Prosthesis benefit will be payable if you or your Insured Dependent require a prosthetic limb as a result of Injury sustained due to a Covered Accident if such prosthesis is prescribed by a Physician and received by you or your Insured Dependent within 365 days of the Covered Accident.

Only one benefit is payable per limb, up to 2 limbs for each person insured per Covered Accident.

REHABILITATION FACILITY CONFINEMENT: A Rehabilitation Facility Confinement benefit will be payable for each day you or your Insured Dependent are confined in a Rehabilitation Facility because of Injury sustained due to a Covered Accident if confinement begins within 180 days of the Covered Accident.

This benefit is payable per day for up to thirty (30) days for each person insured per Covered Accident over the course of 365 days from the date of initial Rehabilitation Facility Confinement.

Only one Rehabilitation Facility Confinement benefit is payable regardless of whether more than one Covered Accident caused such confinement.

The Rehabilitation Facility Confinement benefit is not payable for any day that you or your Insured Dependent receive benefits under the Hospital Confinement or ICU Confinement benefits.

SURGERY:

Abdominal or Thoracic Surgery: An Abdominal or Thoracic Surgery benefit will be payable if you or your Insured Dependent sustain an Injury as a result of a Covered Accident that is diagnosed as requiring abdominal or thoracic surgery and has surgical treatment by a Physician within 72 hours of the Covered Accident.

Only one benefit will be payable for each person insured per Covered Accident.

Exploratory Surgery: An Exploratory Surgery benefit will be payable for exploratory surgery for the procedures listed under Surgery Benefits if such surgery is performed and no repair is done.

Only one benefit will be payable for each person insured per Covered Accident.

Knee Cartilage: A Knee Cartilage benefit will be payable if you or your Insured Dependent sustain torn cartilage in the knee due to a Covered Accident and the Injury is:

(1) treated by a Physician within 6 months of the Covered Accident; and
(2) repaired or removed through surgery by a Physician within 365 days of the Covered Accident.

Only one benefit will be payable per knee for each person insured per Covered Accident.

Ruptured Disc: A Ruptured Disc benefit will be payable if you or your Insured Dependent sustain a ruptured disc in the spine as a result of a Covered Accident requiring surgical repair if the Injury is:

(1) treated by a Physician within 6 months of the Covered Accident; and
(2) repaired surgically by a Physician within 365 days of the Covered Accident.

Only one benefit will be payable for each person insured per Covered Accident.

Tendon, Ligament, Rotator Cuff: A Tendon, Ligament, Rotator Cuff benefit will be payable if you or your Insured Dependent sustain an Injury to tendons, ligaments or rotator cuffs as a result of a Covered Accident requiring surgical repair and the Injury is:

(1) treated by a Physician within 6 months of the Covered Accident; and
(2) repaired surgically by a Physician within 180 days of the Covered Accident.

This benefit will be payable for up to 2 surgically repaired tendons, ligaments or rotator cuffs, or any combination thereof, for each person insured per Covered Accident.

TRANSPORTATION: A Transportation benefit will be payable if you or your Insured Dependent sustain an Injury due to a Covered Accident and:

(1) you or your Insured Dependent must travel more than one hundred (100) miles one way for treatment at a Hospital or other medical facility;
(2) the treatment is prescribed by a Physician;
(3) the treatment is not available locally; and

(4) transportation is by bus, train, airplane or medical transportation vehicle.

This benefit is payable for up to three (3) round trips for treatment for each person insured per Covered Accident.

The Transportation benefit is not payable if transport is provided by ambulance or air ambulance.

X-RAY: Benefits will be paid for an x-ray if you or your Insured Dependent sustain an Injury due to a Covered Accident. The x-ray must be:

(1) prescribed by a Physician or Dentist; and
(2) performed within 6 months of the Covered Accident.

Only one benefit will be payable for each person insured per Covered Accident.

WELLNESS BENEFIT

We will pay the amount shown on the Schedule of Benefits for one health screening test performed during a 12 month period for you and your Insured Dependents, up to a maximum of 4 benefits per family, provided you:

(1) supply proof satisfactory to us that such a health screening test has been performed; and
(2) were covered under the Policy at the time the test was performed; and
(3) have not already had one of the following health screening tests performed at any time during the same twelve (12) month period.

Health screening tests covered under the Policy are:

(1) ALT/AST (liver function test);
(2) Biopsy for cancer;
(3) Blood test for triglycerides;
(4) Bone density testing (DEXA scan);
(5) Bone marrow testing;
(6) CA 15-3 (blood test for breast cancer);
(7) CA 125 (blood test for ovarian cancer);
(8) CEA (blood test for colon cancer);
(9) Chest X-ray;
(10) Colonoscopy;
(11) Echocardiogram;
(12) Electrocardiogram;
(13) Fasting blood glucose test;
(14) Flexible sigmoidoscopy;
(15) Genetic tests;
(16) Hemoccult stool analysis;
(17) Hepatitis screening;
(18) Human Immunodeficiency Virus (HIV) screening;
(19) Mammography;
(20) Pap test;
(21) PSA (blood test for prostate cancer);
(22) Serum cholesterol test to determine level of HDL and LDL;
(23) Serum Protein Electrophoresis (blood test for myeloma).
(24) Skin cancer screening;
(25) Stress test; and
(26) Ultrasound screening (of the breast, of the abdominal aorta for abdominal aortic aneurysms, of carotid arteries (carotid doppler), or for cancer detection).

The Wellness Benefit is paid in addition to any other benefits you or your Insured Dependents may receive under the Policy.

BENEFICIARY AND FACILITY OF PAYMENT

BENEFICIARY: If you die, any death benefit payable and any other accrued benefits will be paid to the beneficiary named in records maintained by the Policyholder. A beneficiary designation will be effective as of the date you signed it. Any payment made by us before receiving the designation shall fully discharge us to the extent of that payment.

You will be the beneficiary of any benefit payable at the death of an Insured Dependent, unless another beneficiary has been named and placed on file as required.

You can change the beneficiary by telling us in writing on our form. The consent of a revocable beneficiary is not needed. The change will take effect only when it is received and approved by us or an authorized Plan Administrator. We cannot attest to the validity of such a change.

If your beneficiary dies at the same time as you, or within 15 days after your death but before we receive written proof of your death, payment will be made as if you survived the beneficiary, unless noted otherwise in another provision of the Policy.

If you have not named a beneficiary, or your named beneficiary is not surviving at your death, any benefits due shall be paid to the first of the following classes to survive you:

(1) your legal spouse;
(2) your surviving children (including legally adopted children), in equal shares;
(3) your surviving parents, in equal shares;
(4) your surviving siblings, in equal shares; or, if none of the above,
(5) your estate.

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

FACILITY OF PAYMENT: If a beneficiary, in our opinion, cannot give a valid release (and no guardian has been appointed), we may pay the benefit to the person who has custody or is the main support of the beneficiary. Payment to a minor shall not exceed $1,000.

If you have not named a beneficiary or the beneficiary is not surviving at your death, we may pay up to $2,500 of the benefit to the person(s) who, in our opinion, has incurred expenses in connection with your last illness, death or burial. Payment may also be made to the executor or administrator of your estate, or to any relative of yours by blood or marriage.

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

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

With respect to the Facility of Payment provision, the benefit will be held with interest at a rate set by us.

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

CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice must be given to us within 31 days after the service or event occurs for which claim may be made, or as soon as reasonably possible. The notice should be sent to us at our Administrative Offices or to our authorized agent. The notice should include the Policyholder's name, your or your Insured Dependent's name and the Policy Number.

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

PROOF OF CLAIM: We must be given written proof of claim within 90 days after the date of services or the occurrence of an event, or as soon as reasonably possible thereafter. In any event, proof must be given within one year , unless the claimant is legally incapable of doing so.

Proof of claim for any Covered Accident must include:

(1) the nature and date of the claim and reason claim is being made;
(2) a description of the event and/or services provided; and
(3) proof that the services or event occurred. Such proof may take the form of a receipt for services or some other official documentation supporting the claim and which is acceptable to us.

Within 15 days after receiving the first proof of claim, we may send a written acknowledgment. Such acknowledgment may request any missing information or other items we need in order to adjudicate your or your Insured Dependent's claim. Such information or items we may request may include, but are not limited to:

(1) copies of x-rays or any other diagnostic tests performed;
(2) copies of medical records or charts; or
(3) any other information we may reasonably require.

TIME OF PAYMENT OF CLAIMS: When we receive satisfactory written proof of loss, we will pay any benefits due. Benefits that provide for periodic payment will be paid accordingly.

Simple interest will accrue on claims that are not processed promptly. The rate will be as required by Indiana law.

Under a clean claim, interest will accrue from:
(1) the 46th day after we receive the first proof of claim in writing; or
(2) the 31st day after we receive the first proof of claim by electronic means.

A claim is considered "clean" when the first proof of claim is complete; no part of the claim is contested; and no other defect prevents prompt payment. A claim will also be considered "clean" when we fail to promptly request more information or to resolve it, within 45 days after receiving a written claim or 30 days after receiving an electronic claim.

Under a defective claim, interest will accrue from:
(1) the 46th day after we receive enough proof to confirm liability, if the claim is filed in writing and we request more information within 45 days; or
(2) the 31st day after we receive enough proof to confirm liability, if the claim is filed by electronic means and we request more information within 30 days.

A claim is considered "defective" when the first proof of claim is incomplete; any part of the claim is contested; or some other defect prevents prompt payment.

PAYMENT OF CLAIMS: If you die, we will pay any death benefit and any other accrued benefits in accordance with the Beneficiary and Facility of Payment provisions. All other benefits will be paid to you.

Reliance Standard Life Insurance Company shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.

PHYSICAL EXAMINATION AND AUTOPSY: At our own expense, we have the right to have you or your Insured Dependent examined as often as reasonably necessary when a claim is pending. We can also have an autopsy performed unless prohibited by law.

LEGAL ACTION: No legal action may be brought against us to recover on the Policy within 60 days after written proof of claim has been given as required by the Policy. No action may be brought after 3 years from the time written proof of claim is required to be submitted.

PREMIUMS

PREMIUM RATE: The premium for this insurance is based on the plan and coverage selected.

We reserve the right to adjust the premium rates. We will notify the Policyholder in writing at least 31 days before a premium change is made.

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

Family and Medical Leave of Absence:

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

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

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

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

Military Services Leave of Absence:

We will continue your coverage and that of any Insured Dependents, if applicable, in accordance with the Policyholder's policies regarding Military Services Leave of Absence under USERRA if the premium for you and your Dependents, if applicable, continues to be paid during the leave.

As long as the above requirement is satisfied, we will continue coverage until the end of the period required by USERRA.

The Policy, while coverage is being continued under the Military Services Leave of Absence extension, does not cover any loss which occurs while on active duty in the military if such loss is caused by or arises out of such military service, including but not limited to war or any act of war, whether declared or undeclared.

While you are on a Family and Medical Leave of Absence for any reason other than your own illness or injury, or Military Services Leave of Absence, you will be considered Actively at Work. Any changes such as revisions to coverage due to change in class will apply during the leave except that increases in the Benefit Amount, whether automatic or subject to election, will not be effective for you if you are not considered Actively at Work until you have returned to Active Work in an Eligible Class for one full day.

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

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

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

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

EXCLUSIONS

The Policy does not cover any loss:

(1) caused by committing or attempting to commit suicide, while sane or insane or intentionally self-inflicted injuries; or

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

(3) caused by or resulting from riding in, getting into or out of any aircraft, unless:

  (a) you or your Insured Dependent is a passenger (not a pilot or crew member) in a tested and approved civilian aircraft being operated as passenger transport in compliance with the then current rules of the authority having jurisdiction over its operation; and
  (b) the aircraft is not owned, leased or operated by or on behalf of the Policyholder, you or your Insured Dependents, or any other employer of the Insured or your Insured Dependent unless a specific written agreement has been obtained from us; or

(4) sustained during your or your Insured Dependent's commission or attempted commission of an assault or felony; or

(5) to which your or your Insured Dependent's acute or chronic alcoholic intoxication is a contributing factor; or

(6) to which your or your Insured Dependent's voluntary consumption of an illegal or controlled substance or a non-prescribed narcotic or drug is a contributing factor.

Claim Procedures and
ERISA Statement of Rights

CLAIM PROCEDURES FOR CLAIMS FILED WITH
RELIANCE STANDARD LIFE INSURANCE COMPANY
ON OR AFTER APRIL 1, 2018

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed form along with any requested information to:

Reliance Standard Life Insurance Company
Claims Department
P.O. Box 8330
Philadelphia, PA 19101-8330

Claim forms are available from your benefits representative or may be requested by writing to the above address or by calling 1-800-644-1103.

In the event of any *Adverse Benefit Determination* (defined below), the claimant (or their authorized representative) may appeal that *Adverse Benefit Determination* in accordance with the following procedures. This opportunity to appeal exists without regard to the applicability of the Employee Retirement Income Security Act of 1974 as amended ("ERISA"), 29 U.S.C. 1001 *et seq.*

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION

Non-Disability Benefit Claims
If a non-disability claim is wholly or partially denied, the claimant shall be notified of the Adverse Benefit Determination within a reasonable period of time, but not later than 90 days after our receipt of the claim, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the benefit determination is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing.

Disability Benefit Claims
In the case of a claim for disability benefits, the claimant shall be notified of the Adverse Benefit Determination within a reasonable period of time, but not later than 45 days after our receipt of the claim. This period may be extended for up to 30 days, provided that it is determined that such an extension is necessary due to matters beyond our control and that notification is provided to the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If, prior to the end of the first 30-day extension period, it is determined that, due to matters beyond our control, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the claimant is notified, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which a decision is expected to be rendered. In the case of any such extension, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

Non-Disability Benefit Claims
A Claimant shall be provided with written notification of any Adverse Benefit Determination. The notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and
4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an Adverse Benefit Determination on Review.

Disability Benefit Claims
A claimant shall be provided with written notification of any Adverse Benefit Determination. The notification shall be set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an Adverse Benefit Determination on Review; and
5. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
   a) The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
   b) The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination; and
   c) A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;
6. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist;
7. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant (defined below) to a claim for benefits; and
8. The notification shall be provided in a Culturally and Linguistically Appropriate (defined below) manner.

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

Appeals of Adverse Benefit Determinations may be submitted in accordance with the following procedures to:

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

Non-Disability Benefit Claims
1. Claimants (or their authorized representatives) must appeal within 60 days following their receipt of a notification of an Adverse Benefit Determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
5. No deference to the initial Adverse Benefit Determination shall be afforded upon appeal;

6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual; and
7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant's Adverse Benefit Determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination.

Disability Benefit Claims

1. Claimants (or their authorized representatives) must appeal within 180 days following their receipt of a notification of an Adverse Benefit Determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant (defined below) to the claimant's claim for benefits;
4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
5. No deference to the initial Adverse Benefit Determination shall be afforded upon appeal;
6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant's Adverse Benefit Determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination;
8. In deciding the appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, the individual conducting the appeal shall consult with a health care professional:

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

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

Non-Disability Benefit Claims

The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Disability Benefit Claims

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

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on

review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

Non-Disability Benefit Claims

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

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant (defined below) to the claimant's claim for benefits; and
4. A statement of the claimant's right to bring an action under section 502(a) of ERISA (where applicable).

Disability Benefit Claims

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

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant (defined below) to the claimant's claim for benefits;
4. A statement of the claimant's right to bring an action under section 502(a) of ERISA (where applicable) as well as a description of any applicable contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim;
5. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
   a) The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
   b) The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination; and
   c) A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;
6. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist;
7. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant (defined below) to a claim for benefits; and
8. The notification shall be provided in a Culturally and Linguistically Appropriate (defined below) manner.

REQUESTS CONCERNING ALLEGED VIOLATION OF THESE PROCEDURES

In the event that a claimant requests a written explanation of any alleged violation of these procedures, such explanation should be provided within 10 days, including a specific description of any basis for asserting that any violation should not cause any administrative remedies available under the plan to be exhausted (where applicable).

DEFINITIONS

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

The term "Culturally and Linguistically Appropriate Manner" means:

- Oral language services (such as telephone customer assistance hotline) that includes answering questions in any Applicable Non-English Language and providing assistance with filing claims and appeals in any Applicable Non-English Language must be provided;
- A notice in any Applicable Non-English Language must be provided upon request; and
- A statement prominently displayed in any Applicable Non-English Language clearly indicating how to access the language services provided must be included in the English versions of all notices.

The term "Applicable Non-English Language" means:
With respect to an address in any United States county to which a notice is sent, a non-English language is an Applicable Non-English Language if ten percent or more of the population residing in the county is literate only in the same non-English language as determined in guidance published by the United States Secretary of Health and Human Services.

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

The term "Relevant" means:

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

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

The term "Reliance Standard Life Insurance Company" means Reliance Standard Life Insurance Company and/or its authorized claim administrators.

ERISA STATEMENT OF RIGHTS

As a participant in the Group Insurance Plan, you may be entitled to certain rights and protections in the event that the Employee Retirement Income Security Act of 1974 (ERISA) applies. 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 benefits plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interests 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.

Reliance Standard Life Insurance Company shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.

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 the 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 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.