RELIANCE STANDARD
LIFE INSURANCE COMPANY

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

POLICYHOLDER: Silver Birch Services LLC (DBA Silver Birch Living) **POLICY NUMBER:** VAI 857945

EFFECTIVE DATE: August 1, 2021

ANNIVERSARY DATES: August 1, 2022 and each August 1st thereafter.

PREMIUM DUE DATES: The first premium is due on the Effective Date. Further premiums are due monthly, in advance, on the first day of each month.

This Policy is delivered in Indiana and is governed by its laws and/or the Employee Retirement Income Security Act of 1974 ("ERISA") as amended, where applicable.

This insurance Policy is a contract between you, the Policyholder named above, and us, Reliance Standard Life Insurance Company. We agree to provide insurance to you in exchange for the payment of premium and the signed Application. This Policy insures against certain accidental losses as described herein. It will cover the Insureds for whom the proper premium has been paid for the Benefit Amounts shown on the Schedule of Benefits. Coverage is subject to the terms and conditions of this Policy. In the event of a conflict between this Policy and the Certificate, the terms of this Policy control.

The Effective Date of this Policy is shown above. Insurance starts and ends at 12:01 A.M., local time, at your address. It stays in force in accordance with the provisions set forth in this Policy. The "POLICY TERMINATION" section of the GENERAL PROVISIONS explains when this Policy can be ended.

This Policy is signed by our President and Secretary.

Secretary

President

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

GROUP ACCIDENT POLICY

APPLICATION FOR GROUP ACCIDENT POLICY

RELIANCE STANDARD LIFE INSURANCE COMPANY
PHILADELPHIA, PENNSYLVANIA

GROUP POLICY NUMBER:	VAI 857945	**POLICY EFFECTIVE DATE:**	August 1, 2021
POLICY DELIVERED IN:	Indiana	**ANNIVERSARY DATE:**	August 1st in each year

APPLICATION IS MADE TO US BY: Silver Birch Services LLC (DBA Silver Birch Living)

This Application is completed in duplicate, one copy is attached to your Policy and the other is to be returned to us.

It is agreed that this Application takes the place of any previous application for your Policy.

Signed at:_____ This:_____ Day of:_____

Policyholder: _____

Federal Employer Identification Number: 82-3479583

By: _____
(Signature)

_____
(Title)

Please sign and return.

*BC1COAPVAI 85794508/01/2021*RSL
*BC2COAPSilver Birch Services LLC (DBA Silver Birch Living)

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By: _____
(Signature)

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(Title)

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

NAME OF SUBSIDIARIES, DIVISIONS OR AFFILIATES TO BE COVERED: NONE

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 an Eligible Person completes his/her enrollment form.

INDIVIDUAL REINSTATEMENT: 6 months

MINIMUM PARTICIPATION REQUIREMENTS: Number of Insureds: 18

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

EMPLOYEE AND SPOUSE ELIGIBLE AGE:

The employee must be under age 70 to enroll for insurance coverage.

The 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 the Insured is Actively at Work on the effective date of the change. If the Insured is not Actively at Work when the change would otherwise take effect, the change will take effect on the day after the Insured has 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:	Each Eligible Person:	100%
	Each Eligible Person and Dependent spouse:	100%
	Each Eligible Person and Dependent child(ren):	100%
	Each Eligible Person and Dependents:	100%

Receipt of benefits under this Policy may be taxable. It is recommended that the Insured contact his/her 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 the Policyholder.

"Actively at Work" and "Active Work" means the Insured Person is actually performing on a Full-time basis each and every duty pertaining to his job working for you 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 the Insured's coverage is in force under this 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 this 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 the Insured Person or a member of his/her Immediate Family.

"Dependents" means:

(1) the Insured Person's legal spouse; and
(2) the Insured Person's child(ren), from birth to 26 years, including natural children, legally adopted children, children who are dependent on the Insured Person during the waiting period before adoption, stepchildren, foster children and children under legal guardianship of the Insured Person; and
(3) the Insured Person's 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 the Insured Person 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 this 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 you for a minimum of 30 hours during a person's 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 this 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 the Insured has been formally admitted or placed under observation in a Hospital and remains in the Hospital more than 23 hours.

"Immediate Family" means the parents, siblings, spouse or children of the Insured.

"Injury" means bodily injury to the Insured resulting directly from an accident independent of all other causes, which occurs while such Insured’s coverage under this Policy is in force.

"Inpatient" means that the Insured has been Hospital confined.

"Insured" means a person whose insurance under this Policy is in effect.

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

"Insured Person" means a person who meets the eligibility requirements of this Policy and is enrolled for this insurance, and whose insurance under this Policy is in effect.

"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 the Insured 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 the Insured Person or a member of his/her Immediate Family.

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

"Outpatient" means an Insured who receives 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 the Insured Person or a member of his/her 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 the Insured to enable him or her to walk, communicate, and/or function as a member of society.

CERTAIN RESPONSIBILITIES OF THE POLICYHOLDER

For the purposes of this Policy, you as the Policyholder, act on your behalf or as the employee's agent. Under no circumstances will you be deemed our agent.

Compliance With The Employee Retirement Income Security Act (ERISA)

It is your responsibility to establish and maintain procedures which comply with the employer and/or Plan Administrator responsibilities of ERISA and the accompanying regulations, where applicable.

Distribution Of Certificates Of Insurance

Certificates of Insurance will be provided to you for distribution to each Insured Person and you agree to distribute a certificate to each Insured Person. The Certificate will outline the insurance coverage and to whom benefits are payable.

Maintenance Of Records

It is your responsibility to maintain sufficient records of each Insured's insurance, including additions, terminations and changes. We reserve the right to examine these records at the place where they are kept during normal business hours or at a place mutually agreeable to you and us. Such records must be maintained by you for at least 3 years after this Policy terminates.

Premium Rate Changes

It is your responsibility to provide advance notice to Insured Persons in the event of any applicable rate change that would impact their premium contribution.

Reporting Of Eligibility And Coverage Amounts

It is your responsibility to notify us on a timely basis of all individuals eligible for coverage under this Policy, of all individuals whose eligibility for coverage ends and of all changes in individual coverage amounts.

It is your responsibility to provide accurate census information on all Insureds on or before each Anniversary Date, if we request such information.

Timely Payment Of Premiums

It is your responsibility to pay all premiums required under this Policy when due. Any change in the premium contribution basis must be approved by us.

GENERAL PROVISIONS

ENTIRE CONTRACT: The entire contract between you and us is this Policy, your signed application for this Policy (a copy of which is attached at issue), and any endorsements or amendments.

CHANGES: No agent has the authority to change or waive any part of this Policy. To be valid, any change or waiver must be in writing, signed by a President, Vice President or Secretary and attached to this Policy.

INCONTESTABILITY: Any statement made in your application will be deemed a representation, not a warranty. We cannot contest this Policy after it has been in force for 2 years from the date of issue, except for non-payment of premium.

Any statements made by you, any Insured or on behalf of any Insured 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 an Insured is 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 the Insured, or on behalf of any Insured; and

   (b) a copy of such written instrument is or has been furnished to the Insured, the Insured's beneficiary or legal representative.

(2) If the statement relates to an Insured'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 the lifetime of the Insured. Also, we will not use such statements to contest a benefit increase after such benefit increase has been in force for 2 years during the Insured's lifetime.

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

RECORDS MAINTAINED: You or an authorized Plan Administrator must maintain records of all Insureds. Such records must show the essential data of the insurance, including new persons, terminations, changes, etc. This information must be reported to us regularly. We reserve the right to examine the insurance records maintained at the place where they are kept. This review will only take place during normal business hours.

CLERICAL ERROR: Clerical errors in connection with the Policy or delays in keeping records for the Policy, whether by you, 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 this 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 you 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 any Insured 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 this Policy.

If any misstated fact 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: This Policy is not a Workers' Compensation Policy. It does not provide Workers' Compensation benefits.

CONFORMITY WITH STATE LAWS: Any provision in this Policy which, on its Effective Date, is in conflict with the laws in the state where it is issued or in a state that otherwise has jurisdiction over such provision, is amended to conform with the minimum requirements of such laws of that state.

CERTIFICATE OF INSURANCE: We will send to you a certificate of insurance for distribution to each Insured Person and you agree to distribute a certificate to each Insured Person. The certificate will outline the insurance coverage and to whom benefits are payable.

POLICY TERMINATION: You may cancel this Policy at any time by providing us with written notice. This Policy will be cancelled on the date we receive your letter or, if later, the date requested in your letter.

We may cancel this Policy:

(1) if the premium is not paid at the end of the grace period; or

(2) if the number of Insured Persons covered is less than the Minimum Participation Number on the Schedule of Benefits.

If we cancel because of (1) above, this Policy will be cancelled at the end of the grace period. If we cancel because of (2) above, we will give you 31 days written notice prior to the date of cancellation.

You will still owe us any premium that is not paid up to the date this Policy is cancelled. We will return any part of the premium paid beyond the date this Policy is cancelled.

INDIVIDUAL ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

GENERAL GROUP: The general group will be your employees and employees of any subsidiaries, divisions or affiliates named on the Schedule of Benefits.

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

ELIGIBILITY REQUIREMENTS: A person is eligible for insurance under this Policy if he/she is a member of an Eligible Class, as shown on the Schedule of Benefits page.

EFFECTIVE DATE OF INDIVIDUAL INSURANCE: If you pay the entire premium, the insurance of an Eligible Person will go into effect on the date stated on the Schedule of Benefits. If an Eligible Person pays a part of the premium, he/she must apply for the insurance to go into effect. He/she 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 he/she applies; or
(3) the date premium is remitted.

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

If an Eligible Person is not Actively At Work on the day his/her insurance is to go into effect, the insurance will go into effect on the day he/she returns to Active Work in an Eligible Class for one full day.

TERMINATION OF INDIVIDUAL INSURANCE: An Insured Person's coverage will terminate on the first of the following to occur:

(1) the date this Policy terminates;
(2) the last day of the Policy month in which the Insured Person ceases 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 the Insured Person enters 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 the Insured Person ceases 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 a former Insured Person has been:
(1) on an approved leave of absence; or
(2) on temporary lay-off.

The former Insured Person must return to Active Work with you within the period of time shown on the Schedule of Benefits. He/she must also be a member of a class eligible for this insurance.

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

DEPENDENT INSURANCE

Nothing in this section will change or affect any of the terms of this 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 this 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: An Eligible Person is eligible to enroll his/her eligible Dependents on the date he/she becomes an Insured Person.

EFFECTIVE DATE OF DEPENDENT INSURANCE: If you pay 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 the Insured Person becomes 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 require an Insured Person to pay a portion of the Dependent premium for Dependent insurance, he/she may insure his/her 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 the Insured Person becomes 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 the Insured Person's insurance terminates; or
(4) the date the dependent is no longer a Dependent as defined.

NEWLYWED PROVISION: At the marriage of an Insured Person who had not previously elected Dependent spouse coverage, his/her 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) the Insured Person requests, in writing and within such 31 day period, continuation of such Dependent spouse coverage; and
(2) the additional premium is paid for such coverage.

NEWBORN CHILDREN: If a child is born to an Insured Person who has 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) the Insured Person requests, in writing and within such 31 day period, continuation of such Dependent child(ren) coverage; 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 an Insured Person for support, provided they otherwise meet the definition of a Dependent.

PORTABILITY

The Insured Person may continue the Group Accident insurance coverage under this Policy and that of his/her Insured Dependents if coverage would otherwise terminate because he/she ceases to be an Eligible Person, for reasons other than the termination of this Policy or the Insured Person's retirement provided he/she:

(1) notifies us in writing within 31 days from the date he/she ceases to be eligible; and
(2) remits the necessary premiums when due.

The Benefit Amount available under the Portability provision will be the current Benefit Amount the Insured is insured for under this Policy on the last day the Insured Person was 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 the Insured Person on a quarterly basis.

Insurance coverage continued under this provision for the Insured Person or his/her 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 the Insured Person reaches age 70; or
(3) at any time coverage would normally terminate according to the terms of this Policy had the Insured Person continued to be an Eligible Person.

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

If this Policy terminates subsequent to the Insured Person's election to continue his/her coverage and that of his/her Insured Dependents, in accordance with the Portability provision, such coverage will be continued in accordance with the provisions of the Insured Person's 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 the Insured sustains 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 the Insured sustains 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 the Insured sustains 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 the Insured sustains 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 the Insured sustains Burns in more than one 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 the Insured requires skin grafting as a result of a Burn sustained in a Covered Accident and was 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 an Insured suffers 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 the Insured is 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 the Insured sustains 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 the Insured sustains an Injury as a result of a Covered Accident to his or her 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 will be paid for each person insured per Covered Accident.

DIAGNOSTIC EXAMINATION: A Diagnostic Examination benefit will be payable if the Insured 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 the Insured sustains 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 the Insured sustains more than one dislocation as a result of such Covered Accident, we will pay one benefit, which is the highest.

EMERGENCY TREATMENT: An Emergency Treatment benefit will be payable if the Insured sustains an Injury as a result of a Covered Accident and:

(1) he or she 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 the Insured receives 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 the Insured sustains an Injury to his or her 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 the Insured sustains 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 the Insured sustains 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 the Insured sustains an Injury due to a Covered Accident and requires Hospital Confinement and:

(1) Hospital Confinement occurs within 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.

The Insured 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 the Insured sustains an Injury due to a Covered Accident and requires 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.

The Insured may also be eligible for an Intensive Care Unit (ICU) Confinement benefit.

Hospital Confinement: A Hospital Confinement benefit will be payable for each day the Insured is 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 the Insured is on any given day.

Intensive Care Unit (ICU) Confinement: An ICU Confinement benefit will be payable for each day the Insured is 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 the Insured is on any given day. If the Insured exhausts the ICU Confinement benefit before such confinement is over, a Hospital Confinement benefit may be payable.

LACERATIONS: A Laceration benefit will be payable if the Insured is Injured as a result of a Covered Accident and sustains 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 the Insured sustains an Injury as a result of a Covered Accident which requires a Medical Appliance to assist him or her with mobility provided such appliance is prescribed by a Physician or Medical Professional and received by the Insured 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 the Insured Dependent child sustains an Injury as a result of a Covered Accident while participating in an Organized Youth Sport. The 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 the Insured sustains an Injury due to a Covered Accident that results in Paralysis and:

(1) the Insured loses 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 the Insured sustains 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 the Insured sustains an Injury as a result of a Covered Accident and is 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 the Insured is 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 the Insured has 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 the Insured is 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 the Insured requires 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 the Insured 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 the Insured is 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 the Insured receives benefits under the Hospital Confinement or ICU Confinement benefits.

SURGERY:

Abdominal or Thoracic Surgery: An Abdominal or Thoracic Surgery benefit will be payable if the Insured sustains 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 the Insured sustains 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 the Insured sustains a ruptured disc in the spine 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 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 the Insured sustains 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 the Insured sustains an Injury due to a Covered Accident and:

(1) he or she 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 the Insured sustains 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 each Insured, up to a maximum of 4 benefits per family, provided he/she:

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

Health screening tests covered under this 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 the Insured may receive under this Policy.

BENEFICIARY AND FACILITY OF PAYMENT

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

The Insured 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.

The Insured 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 an Insured's beneficiary dies at the same time as the Insured, or within 15 days after his/her death but before we receive written proof of the Insured's death, payment will be made as if the Insured survived the beneficiary, unless noted otherwise in another provision of this Policy.

If the Insured has not named a beneficiary, or an Insured's named beneficiary is not surviving at the Insured's death, any benefits due shall be paid to the first of the following classes to survive the Insured:

(1) the Insured's legal spouse;
(2) the Insured's surviving children (including legally adopted children), in equal shares;
(3) the Insured's surviving parents, in equal shares;
(4) the Insured's surviving siblings, in equal shares; or, if none of the above,
(5) the Insured's 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 the Insured has not named a beneficiary or the beneficiary is not surviving at the Insured's 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 the Insured's last illness, death or burial. Payment may also be made to the executor or administrator of the Insured's estate, or to any relative of the Insured 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 Insured'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 the Insured's or 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 an Insured dies, 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 the Insured.

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 the Insured 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 this Policy within 60 days after written proof of claim has been given as required by this Policy. No action may be brought after 3 years from the time written proof of claim is required to be submitted.

PREMIUMS

PREMIUM PAYMENT: All premiums are to be paid by you to us, or to an authorized agent, on or before the due date. The premium due dates are stated on the face page of this Policy.

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

We reserve the right to adjust the premium rate on any premium due date:

(1) after coverage has been in force for twenty-four (24) months; or
(2) if the coverage is changed by amendment.

We will not change the premium rate more than once in any 12 month period unless the coverage is changed. We will notify you in writing at least 31 days before a premium change is made due to (1) above.

GRACE PERIOD: You may pay the premium up to sixty (60) days after the date it is due. This Policy stays in force during this time. If the premium is not paid during the grace period, this Policy will be cancelled at the end of the grace period. You will still owe us the premium up to the date this Policy is cancelled.

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 the Insured Person's coverage and that of any Insured Dependent, if applicable, in accordance with your 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 such Insured Person and his/her Dependents, if applicable, continues to be paid during the leave; and
(2) you have approved the Insured Person's leave in writing and provide a copy of such approval within thirty-one (31) days of our request.

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

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

Military Services Leave of Absence:

We will continue the Insured Person's coverage and that of any Insured Dependents, if applicable, in accordance with your policies regarding Military Services Leave of Absence under USERRA if the premium for such Insured Person and his or her 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.

This Policy, while coverage is being continued under this 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 the Insured Person is on a Family and Medical Leave of Absence for any reason other than his or her own illness or injury, or Military Services Leave of Absence, he or she 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 an Insured Person who is not considered Actively at Work until the Insured Person has 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 this Policy.

The Insured Person's coverage and that of any Insured Dependent's, if applicable, will cease under this extension on the earliest of:

(1) the date this Policy terminates; or
(2) the end of the period for which premium has been paid for the Insured Person and Insured Dependent, if applicable; or
(3) the date such leave should end in accordance with your 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 you choose not to continue the Insured Person's coverage during a Family and Medical Leave of Absence and/or Military Services Leave of Absence, the Insured Person's coverage as well as any Dependent coverage, if applicable, will be reinstated in accordance with the Family and Medical Leave of Absence and USERRA.

EXCLUSIONS

This 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) the Insured 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 you, the Insured, or any other employer of the Insured, unless a specific written agreement has been obtained from us; or

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

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

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

NOTICE OF PROTECTION PROVIDED BY THE
INDIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies.

Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only for companies placed in rehabilitation or liquidation on or after January 1, 2013.

Life Insurance

- $300,000 in death benefits
- $100,000 in cash surrender or withdrawal values

Health Insurance

- $500,000 in basic hospital, medical and surgical or major medical insurance benefits
- $300,000 in disability and long term care insurance
- $100,000 in other types of health insurance

Annuities

- $250,000 in present value of annuity benefits (including cash surrender or withdrawal values)
- $5,000,000 for covered unallocated annuities

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to basic hospital, medical and surgical or major medical insurance benefits.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than those given in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this notice.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
3502 Woodview Trace Suite 100
Indianapolis, IN 46268
317-636-8204

Indiana Department of Insurance
311 West Washington Street, Suite 103
Indianapolis IN 46204
317-232-2385

The policy or contract that this notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.

Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this notice and Indiana law, Indiana law will control.

Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.

NOTICE TO POLICYHOLDERS/INSUREDS

Questions regarding your policy or coverage should be directed to:

Reliance Standard Life Insurance Company
1700 Market Street, Suite 1200
Philadelphia, PA 19103-3938
(267) 256-3500

Toll-free telephone number: 1-800-644-1103

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 103
Indianapolis, IN 46204-2787

Consumer Hotline: 1-800-622-4461; (317)-232-2385

Complaints can be filed electronically at www.in.gov/idoi.