reliancestandard
LIFE INSURANCE COMPANY

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

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We certify that the Person whose name appears on the enrollment card attached to this Certificate is insured for the benefits which apply to his/her class, under Group Policy No. VPL 301500 issued to Dalton Public Schools, 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. It replaces all certificates that may have been issued to you earlier.

Secretary

President

GROUP LONG TERM DISABILITY INSURANCE CERTIFICATE

The laws of the State of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

This Group Long Term Disability Certificate amends the previous Group Long Term Disability Certificates and is dated September 15, 2023.

SCHEDULE OF BENEFITS

EFFECTIVE DATE: May 1, 2014, as amended in the Policy through September 1, 2023

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

WAITING PERIOD: 30 days of continuous employment.

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

INDIVIDUAL REINSTATEMENT: 6 months

LONG TERM DISABILITY BENEFIT

ELIMINATION PERIOD: 90 consecutive days of Total Disability.

MONTHLY BENEFIT: If an Eligible Person, you may elect an amount of insurance in increments of $100 from a minimum of $500 to a maximum of $5,000 per month up to 60% of your Covered Monthly Earnings (rounded to the next higher increment), payable in accordance with the section entitled Benefit Provisions.

The benefit amount payable is the Monthly Benefit elected by you, less Other Income Benefits as shown below.

We will pay at least the Minimum Monthly Benefit as follows.

OTHER INCOME BENEFITS: Other Income Benefits are:

(1) disability income benefits you are eligible to receive because of your Total Disability under any group insurance plan(s);
(2) disability income benefits you are eligible to receive because of your Total Disability under any governmental retirement system, except benefits payable under a federal government employee pension benefit;
(3) all benefits (except medical or death benefits) including any settlement made in place of such benefits (whether or not liability is admitted) you are eligible to receive because of your Total disability under:
    (a) Workers' Compensation Laws;
    (b) occupational disease law;
    (c) any other laws of like intent as (a) or (b) above; and
    (d) any compulsory benefit law;
(4) any of the following that you are eligible to receive from the Policyholder:
    (a) any formal salary continuance plan;
    (b) wages, salary or other compensation, excluding the amount allowable when engaged in Rehabilitative Employment; and
    (c) commissions or monies, including vested renewal commissions, but, excluding commissions or monies that you earned prior to Total Disability which are paid after Total Disability has begun;
(5) that part of disability benefits paid for by the Policyholder which you are eligible to receive because of your Total disability under a group retirement plan; and
(6) that part of Retirement Benefits paid for by the Policyholder which you are eligible to receive under a group retirement plan; and
(7) disability or Retirement Benefits under the United States Social Security Act, the Canadian pension plans, or any other government plan for which:
    (a) you are eligible to receive because of your Total Disability or eligibility for Retirement Benefits; and
    (b) your dependents are eligible to receive due to (a) above.

Disability and early Retirement Benefits will be offset only if such benefits are elected by you or if election would not reduce the amount of your accrued normal Retirement Benefits then funded.

Retirement Benefits under number (7) above will not apply to disabilities which begin after age 70 if you are already receiving Social Security Retirement Benefits while continuing to work beyond age 70.

MINIMUM MONTHLY BENEFIT: In no event will the Monthly Benefit payable to you be less than $100.

MAXIMUM MONTHLY BENEFIT: $5,000

MAXIMUM DURATION OF BENEFITS: Benefits will not accrue beyond the longer of: the Duration of Benefits; or Normal Retirement Age; specified below:

Age at Disablement	Duration of Benefits (in years)
61 or less	To Age 65
62	3 ½
63	3
64	2 ½
65	2
66	1 ¾
67	1 ½
68	1 ¼
69 or more	1

OR

Normal Retirement Age as defined by the 1983 Amendments to the United States Social Security Act and determined by your year of birth, as follows:

Year of Birth	Normal Retirement Age
1937 or before	65 years
1938	65 years and 2 months
1939	65 years and 4 months
1940	65 years and 6 months
1941	65 years and 8 months
1942	65 years and 10 months
1943 thru 1954	66 years
1955	66 years and 2 months
1956	66 years and 4 months
1957	66 years and 6 months
1958	66 years and 8 months
1959	66 years and 10 months
1960 and after	67 years

CHANGES IN MONTHLY BENEFIT: Increases in the Monthly Benefit are effective on the first of the month 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 on that date, the effective date of the increase in the benefit amount will be deferred until the date you return to Active Work. Decreases in the Monthly Benefit are effective on the first of the month coinciding with or next following the date the change occurs. However, changes in the Monthly Benefit because of a change in Earnings are effective as explained in the definition of Covered Monthly Earnings.

Premium changes due to your age will occur on the Policy Anniversary Date coinciding with or next following the birthday that causes you to enter the next age bracket.

If an increase in, or initial application for, the Monthly Benefit is due to a life event change (such as marriage, birth or specific changes in employment status), proof of health will not be required for amounts up to the guaranteed issue amount, provided you apply within thirty-one (31) days of such life event.

APPROVED ENROLLMENT PERIODS: It is the Policyholder's responsibility to provide us with written notice at least thirty-one (31) days prior to conducting an Annual Enrollment Period of the beginning and end dates of such enrollment period. The terms of the Approved Enrollment Period will be as follows:

During an Approved Enrollment Period, beginning October 10 and ending on November 10, applications for employees who were previously eligible and are now applying for initial insurance coverage or for employees who are insured and applying for additional insurance coverage will not require proof of health, provided:

(1) the application is complete, signed, and received by the Policyholder during the Approved Enrollment Period;
(2) the employee was not previously declined for group disability insurance coverage by us; and
(3) the employee did not have an application withdrawn or marked as incomplete for any reason.

Insurance coverage applied for during this Approved Enrollment Period will be effective on the January 1st following the Approved Enrollment Period, provided the employee is Actively at Work, applicable premium is paid and any applicable service waiting period has been satisfied.

CONTRIBUTIONS: You are required to contribute toward the cost of this insurance.

Contributions for you are being made on a post-tax basis. For purposes of filing your Federal Income Tax Return, this means that under the law as of the date the Policy was issued, your Monthly Benefit might be treated as non-taxable. It is recommended that you contact your personal tax advisor.

DEFINITIONS

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

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

"Actively at Work" and "Active Work" mean actually performing on a Full-time basis the material duties pertaining to your job in the place where and the manner in which the job is normally performed. This includes approved time off such as vacation, jury duty and funeral leave, but does not include time off as a result of an Injury or Sickness.

"Any Occupation" means an occupation normally performed in the national economy for which you are reasonably suited based upon your education, training or experience.

"Claimant" means you made a claim for benefits under the Policy for a loss covered by the Policy as a result of your Injury or Sickness.

"Covered Monthly Earnings" means your monthly salary received from the Policyholder on the first of the month just before the date of Total Disability. Covered Monthly Earnings does not include commissions, overtime pay, bonuses, incentive pay or any other special compensation not received as Covered Monthly Earnings.

"Covered Monthly Earnings", with respect to hourly employees, means your monthly salary received from the Policyholder averaged over the lesser of:

(1) the number of months worked; or
(2) the 12 calendar months;

as of the first of the month just prior to the date Total Disability began.

"Elimination Period" means a period of consecutive days of Total Disability, as shown on the Schedule of Benefits page, for which no benefit is payable. It begins on the first day of Total Disability.

Interruption Period: If, during the Elimination Period, you return to Active Work for less than 30 days, then the same or related Total Disability will be treated as continuous. Days that you are Actively at Work during this interruption period will not count towards the Elimination Period. This interruption of the Elimination Period will not apply to you if you become eligible under any other group long term disability insurance plan.

"Full-time" means working for the Policyholder for a minimum of 20 hours during your regular work week.

"Hospital" or "Institution" means a facility licensed to provide care and Treatment for the condition causing your Total Disability.

"Injury" means bodily Injury resulting directly from an accident, independent of all other causes. The Injury must cause Total Disability which begins while your insurance coverage is in effect.

"Physician" means a duly licensed practitioner who is recognized by the law of the state in which treatment is received as qualified to treat the type of Injury or Sickness for which a claim is made. The Physician may not be you or a member of your immediate family.

"Regular Care" means Treatment that is administered as frequently as is medically required according to guidelines established by nationally recognized authorities, medical research, healthcare organizations, governmental agencies or rehabilitative organizations. Care must be rendered personally by your Physician according to generally accepted medical standards in your locality, be of a demonstrable medical value and be necessary to meet your basic health needs.

"Regular Occupation" means the occupation you are routinely performing when Total Disability begins. We will look at your occupation as it is normally performed in the national economy, and not the unique duties performed for a specific employer or in a specific locale.

"Retirement Benefits" mean money which you are entitled to receive upon early or normal retirement or disability retirement under:

(1) any plan of a state, county or municipal retirement system, if such pension benefits include any credit for employment with the Policyholder;
(2) Retirement Benefits under the United States Social Security Act of 1935, as amended, or under any similar plan or act; or
(3) an employer's retirement plan where payments are made in a lump sum or periodically and do not represent contributions made by you.

Retirement Benefits do not include:

(1) a federal government employee pension benefit;
(2) a thrift plan;
(3) a deferred compensation plan;
(4) an individual retirement account (IRA);
(5) a tax sheltered annuity (TSA);
(6) a stock ownership plan; or
(7) a profit sharing plan; or
(8) section 401(k), 403(b) or 457 plans.

"Sickness" means illness or disease causing Total Disability which begins while your insurance coverage is in effect. Sickness includes pregnancy, childbirth, miscarriage or abortion, or any complications therefrom.

"Totally Disabled" and "Total Disability" mean, that as a result of an Injury or Sickness:

(1) during the Elimination Period and for the first 24 months for which a Monthly Benefit is payable, you cannot perform the material duties of your Regular Occupation;
    (a) "Partially Disabled" and "Partial Disability" mean that as a result of an Injury or Sickness you are capable of performing the material duties of your Regular Occupation on a part-time basis or some of the material duties on a full-time basis. If you are Partially Disabled you will be considered Totally Disabled, except during the Elimination Period;
    (b) "Residual Disability" means being Partially Disabled during the Elimination Period. Residual Disability will be considered Total Disability; and
(2) after a Monthly Benefit has been paid for 24 months, you cannot perform the material duties of Any Occupation. We consider you Totally Disabled if due to an Injury or Sickness you are capable of only performing the material duties on a part-time basis or part of the material duties on a full-time basis.

If you are employed by the Policyholder and require a license for such occupation, the loss of such license for any reason does not in and of itself constitute "Total Disability".

"Treatment" means care consistent with the diagnosis of your Injury or Sickness that has its purpose of maximizing your medical improvement. It must be provided by a Physician whose specialty or experience is most appropriate for the Injury or Sickness and conform with generally accepted medical standards to effectively manage and treat your Injury or Sickness.

TRANSFER OF INSURANCE COVERAGE

If you were covered under any group long term disability insurance plan maintained by the Policyholder prior to the Policy's Effective Date, you will be insured under the Policy, provided that you are Actively At Work and meet all of the requirements for being an Eligible Person under the Policy on its Effective Date.

If you were covered under the prior group long term disability plan maintained by the Policyholder prior to the Policy's Effective Date, but were not Actively at Work due to Injury or Sickness on the Effective Date of the Policy and would otherwise qualify as an Eligible Person, coverage will be allowed under the following conditions:

(1) You must have been insured with the prior carrier on the date of the transfer; and

(2) Premiums must be paid; and

(3) Total Disability must begin on or after the Policy's Effective Date.

If you are receiving long term disability benefits, become eligible for coverage under another group long term disability insurance plan, or have a period of recurrent disability under the prior group long term disability insurance plan, you will not be covered under the Policy. If premiums have been paid on your behalf under the Policy, those premiums will be refunded.

Pre-existing Conditions Limitation Credit

If you are an Eligible Person on the Effective Date of the Policy, any time used to satisfy the Pre-existing Conditions Limitation of the prior group long term disability insurance plan will be credited towards the satisfaction of the Pre-existing Conditions Limitation of the Policy.

Waiting Period Credit

If you are an Eligible Person on the Effective Date of the Policy, any time used to satisfy any Waiting Period of the prior group long term disability insurance plan will be credited towards the satisfaction of the Waiting Period of the Policy.

GENERAL PROVISIONS

TIME LIMIT ON CERTAIN DEFENSES: After the Policy has been in force for two (2) years from its Effective Date, no statement made by you on a written application for insurance shall be used to reduce or deny a claim after your insurance coverage, with respect to which claim has been made, has been in effect for two (2) years.

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

(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 twelve (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.

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

WAIVER OF PREMIUM: No premium is due us while you are receiving Monthly Benefits from us. Once Monthly Benefits cease due to the end of your Total Disability, premium payments must begin again if insurance is to continue.

CLAIMS PROVISIONS

FILING A CLAIM:
Written notice of a claim must be given to us within thirty (30) days after the date your disability begins, or as soon thereafter as reasonably possible. Notice means providing us with enough information so that we are able to identify you as an insured under a long term disability policy issued by Reliance Standard Life Insurance Company. Written proof of your claim must be sent to us within ninety (90) days after the end of the Elimination Period. If written proof is not given in that time, the claim will not be invalidated nor reduced if it is shown that written proof was given as soon as reasonably possible. In any event, proof must be given within one (1) year after the date that proof of claim is otherwise required, unless you are legally incapable of doing so. The notice and proof of claim should be sent to us by mail to Reliance Standard Claims, P.O. Box 8330, Philadelphia, PA 19101-8330, by email to ClaimsIntake@rsli.com, by fax to (267)256-4262, or electronically to https://rslclaims.com/. Notice or proof of claim sent to another location will not constitute valid notice or proof of claim.

Claim forms and other information needed to provide proof of your claim should be filed promptly. You can access claim forms through our online website at https://customercare.rsli.com/Forms/ or you can call the customer care center at 1-800-351-7500 to request a claim form from us. Our standard claim form includes a section to complete for you, the Policyholder, and the Physician providing you Regular Care for the Sickness or Injury causing your Total Disability. You are responsible for giving the Policyholder and your Physician the appropriate section of the claim form for their completion. The completed form must be sent to us within the timeframes stated above for providing proof of claim.

If you request a claim form from us and do not receive the claim form or electronic access to the claim form within 10 days after your request, then proof of claim will be met by giving us a written statement of your claim, including the occurrence, character and extent of the Total Disability for which the claim is made, within the time period required for providing proof of claim. This written statement of your claim must include enough information for us to begin processing the claim, including your name, address, telephone number, Policy number, your employer's name and address, and the Policyholder's name and address (if different from the employer).

WRITTEN PROOF OF LOSS: We will evaluate your written proof of claim to determine if you have provided satisfactory proof of loss and to determine the amount of any benefits that may be payable. Your proof of loss must include the following items, provided at your expense:

(1) That you are under the Regular Care of a Physician;

(2) The date your Total Disability began;

(3) The cause of your Total Disability as determined by objective medical evidence, diagnostic studies, and examinations acceptable to the medical community;

(4) The extent of your Total Disability, including all restrictions and/or limitations;

(5) The name and address of all pharmacies, Hospital(s) or Institution(s) where you received Treatment, including all Physicians who prescribed medications or provided Regular Care;

(6) Documentation of your Covered Monthly Earnings and all income received while Totally Disabled, including all earnings, income or benefits of any kind that you may be receiving or eligible to receive while also claiming disability benefits under the Policy;

(7) Documentation that you have applied for all Other Income Benefits that you may be eligible for during the period of Total Disability for which you are claiming disability benefits under the Policy;

(8) Written authorization for you to release and for us to obtain medical, employment, and financial, information and any other information we may reasonably require to determine your eligibility to receive benefits under the Policy and the amount of benefits payable under the Policy. This includes your receipt of or eligibility for Other Income Benefits and signing a reimbursement agreement upon our request; and

(9) Tax returns, including all associated schedules and worksheets, business records, accountant's statements, and any other information we deem necessary to determine eligibility for benefits and the amount of benefits payable under the Policy.

You are required to send proof of your continuing eligibility to receive disability benefits under the Policy and the amount of those benefits. This may include sending proof that you are under the Regular Care of a Physician and/or any other information required above for proof of loss. We have the right to make this request as often as it is reasonably required during any ongoing review of benefit eligibility and while a claim is pending, including during any appeal from an adverse

claim decision. We must receive this proof no later than 45 calendar days from the date we ask for it. In some cases, we will require you to give us authorization to obtain additional medical and non-medical information as part of your proof of claim. We have the right to terminate our payments to you if you do not cooperate with our requests for information or do not submit the information requested by us.

APPLYING FOR OTHER INCOME BENEFITS: We will require you to apply for any Other Income Benefits that you may be eligible for during the period of Disability for which you are claiming benefits under the Policy. We may also require that you appeal a denial of your claim for these Other Income Benefits.

We will also require you to apply for disability benefits that may be available to you under the Social Security Act. If we disagree with the Social Security Administration's denial of your application, you will be required to follow the Social Security Administration's appeal process and to continue in that process to the highest level of appeals. We will provide you with assistance during the application process for Social Security Disability benefits. We are unable to provide assistance during other Social Security application process.

PAYMENT OF CLAIMS: When we receive satisfactory written proof of your loss, we will pay any benefits due. Benefits that provide for periodic payment will be paid not less frequently than monthly for each period as we become liable.

We will pay benefits to you, if living. Benefit payments that become due, or if any amount for which we are liable remains unpaid after your death, will be made to your estate. If there are legal impediments to payment of benefits that depend on the actions of parties other than us, we may hold further benefits due until such impediments are resolved and sufficient evidence of the same is provided. Legal impediments to payment may include, but are not limited to, the establishment of guardianships and conservatorships, or the appointment and qualification of trustees, executors and administrators, as applicable.

If you have died and we have not paid all benefits due, we may pay up to $1,000.00 to any relative by blood or marriage, or to the executor or administrator of your estate. The payment will only be made to persons entitled to it. An expense incurred as a result of your last illness, death or burial will entitle a person to this payment. The payments will cease when a valid claim is made for the benefit. We will not be liable for any payment we have made in good faith.

To the extent that you are entitled to an award of pre-judgment interest by a court, the interest rate to be applied will be no higher than the rate for post-judgment interest pursuant to U.S.C. Section 1961.

AUTHORITY TO MAKE BENEFIT DETERMINATIONS: Reliance Standard Life Insurance Company shall serve as the claims review fiduciary with respect to the insurance Policy and certificate. The claims review fiduciary has the discretionary authority to interpret the Policy and the certificate and to determine eligibility for benefits and the amount of any benefits payable. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.

RECOVERY OF OVERPAYMENTS: We have the right to recover overpayments that occur due to:

(1) Fraud;
(2) An error we make in processing your claim;
(3) Payment we made that should have been made under another group plan; or
(4) Your receipt of Other Income Benefits for periods during which you have already received disability benefits under the Policy.

If we determine that we should have paid you a different benefit amount from the amount actually paid on your claim, we will adjust the benefit accordingly. If we determine that we overpaid your claim, then we require that you repay us in full. We will determine the method by which you will repay us. You will reimburse us for all overpayments. We have the right to obtain any information relating to sources of Other Income Benefits.

We reserve the right to demand an immediate refund from you of any overpayment, to take legal action, or to apply any future payments that are determined to be due to you under the Policy, including any applicable minimum benefits, toward any outstanding overpayment balances until we are reimbursed in full. We have the right to recover overpayments from your eligible survivors or estate. We reserve the right to deduct from your claim payment any unpaid premium due for your coverage. We will not recover more money from you than the benefit amounts we paid to you.

If the overpayment is due to your receipt of amounts from a third party by judgment, settlement or otherwise for a Total Disability caused or contributed to by an act or omission of the third party, you are obligated to repay us for the

overpayment in full regardless of whether you have been fully compensated for your injuries.

If the overpayment results from our having made a payment to you that should have been made under another group plan, we may recover such overpayment from one or more of the following:

(1) any other insurance company;
(2) any other organization; or
(3) any person to or for whom payment was made.

SUBROGATION: If Monthly Benefits are paid or payable to you under the Policy as the result of any act or omission of a third party, we will be subrogated to all rights of recovery you may have in respect to such act or omission. You must execute and deliver to us such instruments and papers as may be required and do whatever else is needed to secure such rights. You must avoid doing anything that would prejudice our rights of subrogation. If you notify us before filing suit or settling your claim against such third party, the amount to which we are subrogated will be reduced by a pro rata share of your costs of recovery, including reasonable attorney fees. If suit or action is filed, we may record a notice of payments of Monthly Benefits, and such notice shall constitute a lien on any judgment recovered. If you or your legal representative fail to bring suit or action promptly against such third party, we may institute such suit or action in our name or in your name. We are entitled to retain from any judgment recovered the amount of Monthly Benefits paid or to be paid to you or on your behalf, together with our costs of recovery, including attorney fees. The remainder of such recovery, if any, shall be paid to you or as the court may direct. If we bring a legal action against the third party on your behalf, we will not reduce your Monthly Benefits by any other amounts you receive from the third party.

NOTIFICATION OF CLAIM DECISIONS: We will send you written notice of our claim decision within a reasonable period of time, but not later than 45 days after we receive proof of your claim. If it is determined that an extension of time is needed to make a benefit determination, we will send you a written notice within this initial 45 day timeframe that an additional 30 days is needed. If, prior to the end of the first 30-day extension period, it is determined that, due to matters beyond our control, a claim decision cannot be made within that extension period, we will send you written notice during the initial 30 day extension that the period for making the determination may be extended for up to an additional 30 days. This notice will include the date by which a decision is expected to be made. 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 you will have 45 days within which to provide the specified information. The period of time within which a benefit decision 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 decision accompanies the filing. In the event that a period of time is extended due to your failure to submit information necessary to decide a claim, the period for making the benefit decision shall be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

For any adverse benefit decision, our notice will include:

(1) The specific reason or reasons for such decision;

(2) Reference to specific plan/Policy provisions on which the decision was based;

(3) A description of the additional material or information necessary for you 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 your 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 decision;

(5) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
   a) The views presented by you to the plan of health care professionals treating you and vocational professionals who evaluated you;
   b) The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit decision, without regard to whether the advice was relied upon in making the benefit decision; and
   c) A disability determination regarding you made by the Social Security Administration;

(6) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan that we relied upon in making the adverse decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist;

(7) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to a claim for benefits; and

(8) Information concerning your right to request that we review our decision.

The notification will be provided in a culturally and linguistically appropriate manner.

REVIEW OF ADVERSE BENEFIT DECISIONS: You may appeal any adverse benefit decision we may make on all or part of your claim. This appeal must be in writing and must be received by us no more than 180 days after you receive notice of the adverse benefit decision. Only one appeal is allowed. As part of the appeal process, you will:

(1) Be provided with the opportunity to send us written comments, documents, records, and other information related to your claim for benefits in conjunction with your timely appeal; and

(2) Be provided, upon request and free of charge, reasonable access to, and copies of, all non-privileged documents, records, and other information relating to your claim for benefits.

We will review your appeal promptly after receiving your request. We will advise you of the results of our review within 45 days after we receive your 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, we will give you written notice of the extension prior to the termination of the initial 45-day period. In no event will 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 made.

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 accompanies the filing. In the event that a period of time is extended as described above due to your failure to submit information necessary to decide the 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 you until the date on which you respond to the request for additional information.

Our decision on your appeal will be in writing and will include the specific reason or reasons for the decision and reference to specific plan/Policy provisions on which the decision was based. For any adverse benefit decision on your appeal, our notice will also include:

(1) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;

(2) A description of your right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), as well as a description of any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim;

(3) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

   a. The views presented by you to the plan of health care professionals treating you and vocational professionals who evaluated you;

   b. The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit decision, without regard to whether the advice was relied upon in making the benefit decision; and

   c. A disability determination regarding you made by the Social Security Administration; and

(4) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan that we relied upon in making the adverse decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and

(5) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to a claim for benefits.

The notification will be provided in a culturally and linguistically appropriate manner.

ARBITRATION OF CLAIMS: Any claim or dispute arising from or relating to our determination regarding your Total Disability may be settled by arbitration when agreed to by you and us in accordance with the Rules for Health and Accident Claims of the American Arbitration Association or by any other method agreeable to you and us. In the case of a claim under an Employee Retirement Income Security Act (hereinafter referred to as ERISA) Plan, your ERISA claim appeal remedies, if applicable, must be exhausted before the claim may be submitted to arbitration. Judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction over such awards.

Unless otherwise agreed to by you and us, any such award will be binding on you and us for a period of twelve (12) months after it is rendered, assuming that the award is not based on fraudulent information and you continue to be Totally Disabled. At the end of such twelve (12) month period, the issue of Total Disability may again be submitted to arbitration in accordance with this provision.

Any costs of said arbitration proceedings levied by the American Arbitration Association or the organization or person(s) conducting the proceedings will be paid by us.

PHYSICAL EXAMINATION AND AUTOPSY: We will, at our expense, have the right to have you interviewed and/or examined:

(1) physically;
(2) psychologically; and/or
(3) psychiatrically;

to determine the existence of any Total Disability which is the basis for a claim. We may require you to be interviewed or examined by Physician(s), other medical practitioner(s), or vocational expert(s) of our choice. Such interviews or examinations may include vocational testing and evaluations, or any other type of testing and evaluations we determine necessary to administer the terms and conditions of the Policy. This right may be used as often as it is reasonably required during any ongoing review of benefit eligibility and while a claim is pending, including during any appeal from an adverse benefit decision.

We can have an autopsy made unless prohibited by law.

We have the right to deny the claim and terminate benefit payments if you interfere with or do not cooperate with our requests for a physical examination or autopsy. You have no right to videotape or record the physical examination by any means, nor do you have the right to have a witness present during any examination and/or testing.

LEGAL ACTIONS: No legal action may be brought against us to recover on the Policy within sixty (60) days after written proof of loss has been given as required by the Policy. No action may be brought after three (3) years from the time written proof of loss is received. If your claim is subject to ERISA, no legal action may be brought or any benefits paid unless there has been full compliance with all Policy terms, including the exhaustion of all appeal procedures included above under the REVIEW OF ADVERSE BENEFIT DECISIONS provision.

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

ELIGIBILITY REQUIREMENTS: You are eligible for insurance under the Policy if you:

(1) are a member of an Eligible Class, as shown on the Schedule of Benefits page; and
(2) have completed the Waiting Period, as shown on the Schedule of Benefits page.

WAITING PERIOD: If you are continuously employed on a Full-time basis with the Policyholder for the period specified on the Schedule of Benefits page, then you have satisfied the Waiting Period.

EFFECTIVE DATE OF YOUR INSURANCE: You must apply in writing for the insurance to go into effect. You will become insured on the latest of:

(1) Your Effective Date, as shown on the Schedule of Benefits page, if you apply on or before that date;
(2) on the first of the month coinciding with or next following the date you apply, if you apply within thirty-one (31) days from the date you first met the Eligibility Requirements; or
(3) on the first of the month coinciding with or next following the date we approve any required proof of health acceptable to us. We require this proof if you apply:
    (a) after thirty-one (31) days from the date you first met the Eligibility Requirements; or
    (b) after you terminated this insurance but remained in an Eligible Class, as shown on the Schedule of Benefits page; or
    (c) after being eligible for coverage under a prior plan for more than thirty-one (31) days but did not elect to be covered under that prior plan; or
(4) the date premium is remitted.

The insurance for you will not go into effect on a date you are not Actively at Work because of a Sickness or Injury. The insurance will go into effect after you are Actively at Work for one (1) full day in an Eligible Class, as shown on the Schedule of Benefits page.

TERMINATION OF YOUR INSURANCE: Your insurance will terminate on the first of the following to occur:

(1) the date the Policy terminates;
(2) the date you cease to meet the Eligibility Requirements;
(3) the end of the period for which Premium has been paid for you; or
(4) the date you enter military service (not including Reserve or National Guard).

YOUR REINSTATEMENT: If you are terminated, your insurance may be reinstated if you return to Active Work with the Policyholder within the period of time as shown on the Schedule of Benefits page. You must also be a member of an Eligible Class, as shown on the Schedule of Benefits page, and have been:

(1) on a leave of absence approved by the Policyholder; or
(2) on temporary lay-off.

You will not be required to fulfill the Eligibility Requirements of the Policy again. The insurance will go into effect after you return to Active Work for one (1) full day. If you return after having resigned or having been discharged, you will be required to fulfill the Eligibility Requirements of the Policy again. If you return after terminating insurance at your request or for failure to pay Premium when due, proof of health acceptable to us must be submitted before you may be reinstated.

BENEFIT PROVISIONS

INSURING CLAUSE: We will pay a Monthly Benefit if you:

(1) are Totally Disabled as the result of a Sickness or Injury covered by the Policy;
(2) are under the Regular Care of a Physician;
(3) have completed the Elimination Period; and
(4) submit satisfactory proof of Total Disability to us.

Please refer to the Schedule of Benefits for the MONTHLY BENEFIT and OTHER INCOME BENEFITS.

Benefits you are entitled to receive under OTHER INCOME BENEFITS will be estimated if the benefits:

(1) have not been applied for; or
(2) have been applied for and a decision is pending; or
(3) have been denied and the denial may be appealed.

The Monthly Benefit will be reduced by the estimated amount. If benefits have been estimated, the Monthly Benefit will be adjusted when we receive proof:

(1) of the amount awarded; or
(2) that benefits have been denied and the denial cannot be further appealed.

If we have underpaid any benefit for any reason, we will make a lump sum payment. If we have overpaid any benefit for any reason, the overpayment must be repaid to us. At our option, we may reduce the Monthly Benefit or ask for a lump sum refund. If we reduce the Monthly Benefit, the Minimum Monthly Benefit, if any, as shown on the Schedule of Benefits page, would not apply. Interest does not accrue on any underpaid or overpaid benefit unless required by applicable law.

For each day of a period of Total Disability less than a full month, the amount payable will be 1/30th of the Monthly Benefit.

COST OF LIVING FREEZE: After the initial deduction for any Other Income Benefits, the Monthly Benefit will not be further reduced due to any cost of living increases payable under these Other Income Benefits.

LUMP SUM PAYMENTS: If Other Income Benefits are paid in a lump sum, the sum will be prorated over the period of time to which the Other Income Benefits apply. If no period of time is given, the sum will be prorated over sixty (60) months.

TERMINATION OF MONTHLY BENEFIT: The Monthly Benefit will stop on the earliest of:

(1) the date you cease to be Totally Disabled;
(2) the date you die;
(3) the Maximum Duration of Benefits, as shown on the Schedule of Benefits page, has ended;
(4) the date you fail to furnish the required proof of Total Disability;
(5) the date you cease to be under the Regular Care of a Physician;
(6) the date you refuse to undergo, at our request and at our expense, an examination, diagnostic study, or testing. The examination, diagnostic study, or testing may be performed by a Physician, vocational expert, rehabilitation specialist, or other health care professional;
(7) the date you decline treatment options recommended by your Physician and within generally accepted medical standards, for a Sickness or Injury for which you are claiming benefits under the Policy. Treatment options may include, but are not limited to, taking prescribed medications, participating in therapy, undergoing testing, and use of medical equipment;
(8) the date you refuse to return to work with the assistance of:
    a. Modifications made to your work environment, functional occupational requirements, or work schedule; or
    b. Adaptive equipment or devices;

    that a qualified Physician has indicated will accommodate the restrictions and/or limitations of the Sickness or Injury for which you are claiming benefits under the Policy and will enable you to perform the material duties of an occupation from which you must be considered Totally Disabled in order to receive Monthly Benefits under the Policy; or
(9) the date you reside outside the United States or Canada. We will consider you residing outside of these countries if you have been outside the United States or Canada for a total period of 3 months or more during

any 6 consecutive months of your receipt of Monthly Benefits under the Policy.

RECURRENT DISABILITY: If, after a period of Total Disability for which benefits are payable, you return to Active Work for at least six (6) consecutive months, any recurrent Total Disability for the same or related cause will be part of a new period of Total Disability. A new Elimination Period must be completed before any further Monthly Benefits are payable.

If you return to Active Work for less than six (6) months, a recurrent Total Disability for the same or related cause will be part of the same Total Disability. A new Elimination Period is not required. Our liability for the entire period will be subject to the terms of the Policy for the original period of Total Disability.

If you become eligible for insurance coverage under any other group long term disability insurance plan, then this Recurrent Disability section will not apply to you.

EXCLUSIONS

We will not pay a Monthly Benefit for any Total Disability caused by:

(1) an act of war, declared or undeclared; or
(2) an intentionally self-inflicted Injury; or
(3) your committing a felony; or
(4) an Injury or Sickness that occurs while you are confined in any penal or correctional institution.

LIMITATIONS

MENTAL OR NERVOUS DISORDERS: Monthly Benefits for Total Disability caused by or contributed to by mental or nervous disorders will not be payable beyond an aggregate lifetime maximum duration of twenty-four (24) months unless you are in a Hospital or Institution at the end of the twenty-four (24) month period. The Monthly Benefit will be payable while so confined, but not beyond the Maximum Duration of Benefits.

If you were confined in a Hospital or Institution and:
(1) Total Disability continues beyond discharge;
(2) the confinement was during a period of Total Disability; and
(3) the period of confinement was for at least fourteen (14) consecutive days;
then upon discharge, Monthly Benefits will be payable for the greater of:
(1) the unused portion of the twenty-four (24) month period; or
(2) ninety (90) days;
but in no event beyond the Maximum Duration of Benefits, as shown on the Schedule of Benefits page.

Mental or Nervous Disorders are defined to include disorders which are diagnosed to include a condition such as:
(1) bipolar disorder (manic depressive syndrome);
(2) schizophrenia;
(3) delusional (paranoid) disorders;
(4) psychotic disorders;
(5) depressive disorders;
(6) anxiety disorders;
(7) somatoform disorders (psychosomatic illness);
(8) eating disorders; or
(9) mental illness.

SUBSTANCE ABUSE: Monthly Benefits for Total Disability due to alcoholism or drug addiction will be payable while you are a participant in a Substance Abuse Rehabilitation Program. The Monthly Benefit will not be payable beyond twenty-four (24) months.

If, during a period of Total Disability due to Substance Abuse for which a Monthly Benefit is payable, you are able to perform Rehabilitative Employment, the Monthly Benefit, less 50% of any of the money received from this Rehabilitative Employment will be paid until: (1) you are performing all the material duties of your Regular Occupation on a full-time basis; or (2) the end of twenty-four (24) consecutive months from the date that the Elimination Period is satisfied, whichever is earlier. All terms and conditions of the Rehabilitation Benefit will apply to Rehabilitative Employment due to Substance Abuse.

"Substance Abuse" means the pattern of pathological use of a Substance which is characterized by:
(1) impairments in social and/or occupational functioning;
(2) debilitating physical condition;
(3) inability to abstain from or reduce consumption of the Substance; or
(4) the need for daily Substance use for adequate functioning.

"Substance" means alcohol and those drugs included on the Department of Health, Retardation and Hospitals' Substance Abuse list of addictive drugs, except tobacco and caffeine are excluded.

A Substance Abuse Rehabilitation Program means a program supervised by a Physician or a licensed rehabilitation specialist approved by us.

PRE-EXISTING CONDITIONS LIMITATIONS OR EXCLUSIONS: You will be considered to have a Pre-existing Condition and will be subject to the Pre-existing Conditions Limitation if:
(1) the Total Disability begins in the first twelve (12) consecutive months after your effective date; and
(2) you have received medical Treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines for the Sickness or Injury, whether specifically diagnosed or not, causing such Total Disability, during the three (3) months immediately prior to your effective date of insurance.

Benefits will not be paid for a Total Disability:

(1) caused by;
(2) contributed to by; or
(3) resulting from;

a Pre-existing Condition unless you have been Actively at Work for one (1) full day following the end of twelve (12) consecutive months from your effective date of insurance.

With respect to persons electing a benefit increase (whether an increase from coverage under a prior plan, if applicable, or under the Policy), any benefit increase will not be paid for a Total Disability:

(1) caused by;
(2) contributed to by; or
(3) resulting from;

a Pre-existing Condition unless you have been Actively at Work for one (1) full day following the end of twelve (12) consecutive months from the effective date of the increase.

You will be considered to have a Pre-existing Condition and will be subject to the Pre-existing Conditions Limitation due to a benefit increase if:

(1) the Total Disability begins in the first twelve (12) months after the effective date of the increase; and
(2) you have received medical Treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines for the Sickness or Injury, whether specifically diagnosed or not, causing such Total Disability, during the three (3) months immediately prior to your effective date of the increase.

With respect to persons electing to change their level of coverage during an approved enrollment period, any benefit increase (due to this change) will not be paid for a Total Disability:

(1) caused by;
(2) contributed to by; or
(3) resulting from;

a Pre-existing Condition unless you have been Actively at Work for one (1) full day following the end of twelve (12) consecutive months from the effective date of the increase. A Pre-existing Condition means any Sickness or Injury for which you received medical Treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines for the Sickness or Injury, whether specifically diagnosed or not, causing such Total Disability, during the three (3) months immediately prior to the effective date of the increase (with respect to any increase in benefits).

LIMITATIONS - OTHER LIMITED BENEFITS

1. Monthly Benefits will be limited to a total of 24 months in your lifetime for all Total Disabilities caused or contributed to by:

   - Chronic fatigue syndrome; or
   - Environmental Allergic or Reactive Illness; or
   - Self-Reported Conditions.

   No Monthly Benefits are payable beyond the 24 month maximum benefit period or the Maximum Duration of Benefits shown in the Schedule of Benefits, whichever is less.

2. Monthly Benefits will be limited to a total of 24 months in your lifetime for all Total Disabilities contributed to or caused by musculoskeletal and connective tissue disorders of the neck and back, including any disease, disorder, sprain and strain of the joints and adjacent muscles of the cervical, thoracic and lumbosacral regions and their surrounding soft tissue.

   No Monthly Benefits are payable beyond the 24 month maximum benefit period or the Maximum Duration of Benefits shown in the Schedule of Benefits, whichever is less.

Total Disabilities caused by the following musculoskeletal and connective tissue disorders will be treated the same as any other Total Disability and the 24 month maximum benefit period will not apply:

- Arthritis
- Demyelinating diseases
- Myelitis
- Myelopathies
- Osteopathies
- Radiculopathies documented by electromyogram
- Ruptured intervertebral discs
- Scoliosis
- Spinal fractures
- Spinal tumors, malignancy or vascular malformations
- Spondylolisthesis, Grade II or higher
- Traumatic spinal cord necrosis

"Environmental Allergic Or Reactive Illness" means an illness which results from your inability to function due to physical or mental symptoms contributed to or caused by an allergic reaction from physical contact with or exposure to any static or airborne substances.

"Self-Reported Conditions" means those conditions which, when reported by your Physician, cannot be verified using generally accepted standard medical procedures and practices. Examples of such conditions include, but are not limited to, headaches, dizziness, fatigue, loss of energy, or pain.

SPECIFIC INDEMNITY BENEFIT

If you suffer any one of the Losses listed below from an accident resulting in an Injury, we will pay a guaranteed minimum number of Monthly Benefit payments, as shown below. However:

(1) the Loss must occur within one hundred and eighty (180) days; and
(2) you must live past the Elimination Period.

For Loss of:	Number of Monthly Benefit Payments:
Both Hands	46 Months
Both Feet	46 Months
Entire Sight in Both Eyes	46 Months
Hearing in Both Ears	46 Months
Speech	46 Months
One Hand and One Foot	46 Months
One Hand and Entire Sight in One Eye	46 Months
One Foot and Entire Sight in One Eye	46 Months
One Arm	35 Months
One Leg	35 Months
One Hand	23 Months
One Foot	23 Months
Entire Sight in One Eye	15 Months
Hearing in One Ear	15 Months

"Loss(es)" with respect to:
(1) hand or foot, means the complete severance through or above the wrist or ankle joint;
(2) arm or leg, means the complete severance through or above the elbow or knee joint; or
(3) sight, speech or hearing, means total and irrecoverable Loss thereof.

If more than one (1) Loss results from any one accident, payment will be made for the Loss for which the greatest number of Monthly Benefit payments is provided.

The amount payable is the Monthly Benefit, as shown on the Schedule of Benefits page, with no reduction from Other Income Benefits. The number of Monthly Benefit payments will not cease if you return to Active Work. If death occurs after we begin paying Monthly Benefits, but before the Specific Indemnity Benefit has been paid according to the above schedule, the balance remaining at time of death will be paid to your estate, unless a beneficiary is on record with us under the Policy.

Benefits may be payable longer than shown above as long as you are still Totally Disabled, subject to the Maximum Duration of Benefits, as shown on the Schedule of Benefits page.

SURVIVOR BENEFIT - LUMP SUM

We will pay a benefit to your Survivor when we receive proof that you died while:

(1) you were receiving Monthly Benefits from us; and
(2) you were Totally Disabled for at least one hundred and eighty (180) consecutive days.

The benefit will be an amount equal to 3 times your last Monthly Benefit. The last Monthly Benefit is the benefit you were eligible to receive right before your death. It is not reduced by wages earned while in Rehabilitative Employment.

A benefit payable to a minor may be paid to the minor's legally appointed guardian. If there is no guardian, at our option, we may pay the benefit to an adult that has, in our opinion, assumed the custody and main support of the minor. We will not be liable for any payment we have made in good faith.

"Survivor" means your spouse. If the spouse dies before you or if you were legally separated, then your natural, legally adopted or step-children, who are under age twenty-five (25) will be the Survivors. If there are no eligible Survivors, payment will be made to your estate, unless a beneficiary is on record with us under the Policy.

WORK INCENTIVE AND CHILD CARE BENEFITS

WORK INCENTIVE BENEFIT

During the first twelve (12) months of Rehabilitative Employment during which a Monthly Benefit is payable, we will not offset earnings from such Rehabilitative Employment until the sum of:

(1) the Monthly Benefit prior to offsets with Other Income Benefits; and
(2) earnings from Rehabilitative Employment;

exceed 100% of your Covered Monthly Earnings. If the sum above exceeds 100% of Covered Monthly Earnings, our Benefit Amount will be reduced by such excess amount until the sum of (1) and (2) above equals 100%.

CHILD CARE BENEFIT

We will allow a Child Care Benefit if:

(1) you are receiving benefits under the Work Incentive Benefit;
(2) your Child(ren) is (are) under 14 years of age;
(3) the child care is provided by a non-relative; and
(4) the charges for child care are documented by a receipt from the caregiver, including social security number or taxpayer identification number.

During the twelve (12) month period in which you are eligible for the Work Incentive Benefit, an amount equal to actual expenses incurred for child care, up to a maximum of $250 per month, will be added to your Covered Monthly Earnings when calculating the Benefit Amount under the Work Incentive Benefit.

Child(ren) means: your unmarried child(ren), including any foster child, adopted child or step child who resides in your home and is financially dependent on you for support and maintenance.

CONVERSION PRIVILEGE

If insurance ceases due to termination of employment, you can use this privilege to convert to a Long Term Disability Policy currently made available by us for conversion.

The issuance of the conversion coverage is subject to the following conditions:

(1) You must have been covered for a total of at least twelve (12) consecutive months under the Policy and/or another Group Long Term Disability Policy provided by the Policyholder;

(2) You must make written application for conversion coverage within thirty-one (31) days of termination of insurance under the Policy;

(3) The first premium must be paid within thirty-one (31) days of termination of insurance under the Policy; and

(4) Evidence of Insurability is not required.

The MAXIMUM AMOUNT OF COVERAGE that you can convert is equal to the lesser of:

(1) the Monthly Benefit for which you would have been eligible at the time of conversion; or

(2) 60% of your Covered Monthly Earnings to a maximum of $3,000 per month.

Conversion is not available if:

(1) the Policy terminates; or

(2) the Policy is amended to exclude the eligible class to which you belong; or

(3) you cease to be a member of an eligible class; or

(4) you retire or die; or

(5) you fail to pay the required premium when due; or

(6) you are Totally Disabled under the Policy; or

(7) you become covered under another Group Long Term Disability plan.

The conversion coverage will become effective on the day immediately following the date that insurance ceased under the Policy, provided that you have applied and been approved for conversion coverage, and premium was paid within thirty-one (31) days of termination of insurance under the Policy.

The conversion coverage will remain in force for twelve (12) months from the effective date of conversion if the premium continues to be paid when due.

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 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 continues to be paid during the leave; and
(2) the Policyholder has approved your leave in writing and provides a copy of such approval within thirty-one (31) days of our request.

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

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

Military Services Leave of Absence:

We will continue your coverage in accordance with the Policyholder's policies regarding Military Services Leave of Absence under USERRA if the premium for you 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, injury or disability or Military Services Leave of Absence you will be considered Actively at Work. Any changes such as revisions to coverage due to age, class or salary changes, as applicable, will apply during the leave except that increases in the amount of insurance, whether automatic or subject to election, will not be effective if you are not considered Actively at Work until you have returned to Active Work for one (1) full day.

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

Your coverage will cease under this extension on the earliest of:

(1) the date the Policy terminates; or
(2) the end of the period for which premium has been paid for you; or
(3) the date such leave should end in accordance with the Policyholder's policies regarding Family and Medical Leave of Absence and Military Services Leave of Absence in compliance with the Family and Medical Leave Act of 1993, as amended and USERRA. Coverage will not be terminated if you become Totally Disabled during the period of the leave and are eligible for benefits according to the terms of the Policy. Any Monthly Benefit which becomes payable will be based on your Covered Monthly Earnings immediately prior to the date of Total Disability.

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 will be reinstated.

REHABILITATION BENEFIT

"Rehabilitative Employment" means work in Any Occupation for which your training, education or experience will reasonably allow. The work must be approved by a Physician or a licensed or certified rehabilitation specialist approved by us. Rehabilitative Employment includes work performed while Partially Disabled, but does not include performing all the material duties of your Regular Occupation on a full-time basis.

If you are receiving a Monthly Benefit because you are considered Totally Disabled under the terms of the Policy and are able to perform Rehabilitative Employment, we will continue to pay the Monthly Benefit less an amount equal to 50% of earnings received through such Rehabilitative Employment.

If you are able to perform Rehabilitative Employment when Totally Disabled due to Substance Abuse, we will continue to pay the Monthly Benefit less an amount equal to 50% of earnings received through such Rehabilitative Employment. This Monthly Benefit is payable for a maximum of twenty-four (24) consecutive months from the date the Elimination Period is satisfied.

You will be considered able to perform Rehabilitative Employment if a Physician or licensed or certified rehabilitation specialist approved by us determines that you can perform such employment. If you refuse such Rehabilitative Employment, or have been performing Rehabilitative Employment and refuse to continue such employment, even though a Physician or licensed or certified rehabilitation specialist approved by us has determined that you are able to perform Rehabilitative Employment, the Monthly Benefit will be reduced by 50%, without regard to the Minimum Monthly Benefit.

RELIANCE STANDARD LIFE INSURANCE COMPANY

AMENDATORY RIDER

It is hereby understood and agreed that the Certificate to which this Rider is attached shall be amended by the addition of the following:

Applicable to Vermont Residents Only

The following sections/provisions of the Certificate are amended to comply with Vermont law:

1. **Schedule of Benefits section, Elimination Period provision.**

   The Elimination Period will be the lesser of the number of days shown on the Schedule of Benefits in the certificate or:

   For Benefit Periods 2 years and greater: 365 days.

   For Benefit Periods greater than 1 year but less than 2 years: 180 days.

2. **Limitations section, Mental or Nervous Disorders and/or Substance Abuse, if such limitations are included in the Certificate.**

   If the Certificate contains limitations in coverage for mental or nervous disorders and/or substance abuse, such limitations will not apply to Vermont residents. Coverage for these conditions will be treated the same as other conditions that may entitle you to full benefits.

3. **Limitations section, Pre-existing Conditions, if such limitation is included in the Certificate.**

   The pre-existing condition provision time period in the definition of Pre-existing Condition shall be the lesser of the time period shown on the Limitations form in the Certificate or twelve (12) months.

   The period of time during which you become Totally Disabled due to a Pre-existing Condition and a benefit is not payable for such Total Disability is the lesser of the time period as shown in the certificate or twelve (12) months.

All other terms and conditions remain unchanged.

RELIANCE STANDARD LIFE INSURANCE COMPANY

Secretary

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.