reliancestandard
LIFE INSURANCE COMPANY

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WHERE TO FIND: **Page**

CERTIFICATE OF INSURANCE

We certify that you, provided you belong to a class described on the Schedule of Benefits, are insured for the benefits which apply to your class under Group Policy No. VCI 877139 issued to Gorman & Company, LLC, 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.

Secretary

President

READ THIS CERTIFICATE CAREFULLY.

THE POLICY PROVIDES A LIMITED BENEFIT FOR CERTAIN CRITICAL ILLNESSES. THE POLICY IS NOT A MEDICARE SUPPLEMENT POLICY OR MEDICAL INSURANCE POLICY. RECEIPT OF BENEFITS UNDER THE POLICY MAY AFFECT ELIGIBILITY FOR MEDICAID OR OTHER GOVERNMENT BENEFITS AND/OR ENTITLEMENTS.

THE POLICY IS OPTIONALLY RENEWABLE.

This Group Critical Illness Certificate amends the previous Group Critical Illness Certificates and is dated August 29, 2024.

GROUP CRITICAL ILLNESS CERTIFICATE

SCHEDULE OF BENEFITS

EFFECTIVE DATE: January 1, 2023, as amended in the Policy through July 1, 2024

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

SERVICE WAITING PERIOD: 30 days of continuous employment.*

*Time served as a Part-Time employee will count towards satisfaction of the Service Waiting Period.

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

INDIVIDUAL REINSTATEMENT: 6 months

AMOUNT OF INSURANCE:

Eligible Person: Increments of $5,000 from a minimum of $5,000 to a maximum of $20,000.

Dependent Coverage:

Spouse: Increments of $5,000 from a minimum of $5,000 to a maximum of $20,000 not to exceed 100% of your approved Amount of Insurance.

Child: 25% of your approved Amount of Insurance, up to $5,000. Child coverage is guaranteed issue and is not subject to proof of good health.

CRITICAL ILLNESSES:

Alzheimer's Disease	100% of the Amount of Insurance
Carcinoma in Situ	50% of the Amount of Insurance
Coma	100% of the Amount of Insurance
Coronary Artery Disease	50% of the Amount of Insurance
Heart Attack	100% of the Amount of Insurance
Life Threatening Cancer	100% of the Amount of Insurance
Major Organ Failure	100% of the Amount of Insurance
Motor Neuron Diseases	100% of the Amount of Insurance
Multiple Sclerosis	100% of the Amount of Insurance
Parkinson's Disease	100% of the Amount of Insurance
Ruptured Cerebral, Carotid or Aortic Aneurysm	100% of the Amount of Insurance
Skin Cancer	5% of the Amount of Insurance
Stroke	100% of the Amount of Insurance

CHILDHOOD CRITICAL ILLNESSES:

(Applicable to Insured Dependent Children only)

Cerebral Palsy	100% of the Amount of Insurance
Cleft Lip or Palate	100% of the Amount of Insurance

Cystic Fibrosis	100% of the Amount of Insurance
Down Syndrome	100% of the Amount of Insurance
Muscular Dystrophy	100% of the Amount of Insurance
Spina Bifida	100% of the Amount of Insurance
Type 1 Diabetes	100% of the Amount of Insurance
RECURRENCE(S)	50% of the benefit payable (not applicable to Skin Cancer)
SUBSEQUENT OCCURRENCE(S)	100% of the benefit payable
LIFETIME MAXIMUM BENEFIT	1000% of the Amount of Insurance
WELLNESS BENEFIT	$50

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

Decreases in the Amount of Insurance are effective on the January 1st coinciding with or next following the date of the change.

If an increase in, or initial application for, the Amount of Insurance is due to a life event change (such as marriage, birth or specific changes in employment status), proof of good health will not be required for amounts up to the guaranteed issue amount, provided you: (a) apply within 31 days of such life event; and (b) were not previously declined for group critical illness coverage with us; and (c) did not have a prior application withdrawn or marked incomplete for any reason.

APPROVED ENROLLMENT PERIODS: It is the Policyholder's responsibility to provide us with written notice of the beginning and end dates of the Annual Enrollment Period. This notice should be provided to us at least 31 days prior to conducting the Approved Enrollment Period. The terms of the Approved Enrollment Period will be as follows:

During an Approved Enrollment Period, beginning November 1 and ending on December 31, applications for employees and spouses who were previously eligible and are now applying for initial insurance coverage or are insured and are applying for additional insurance coverage will not require proof of good health for insurance coverage up to the guarantee issue limits stated in the Policy, provided:

(1) the application is complete, signed, and received by the Policyholder during the "Enrollment Period";
(2) you and/or your spouse were not previously declined for group critical illness insurance coverage with us; and
(3) you and/or your spouse did not have an application withdrawn or marked as incomplete for any reason.

Insurance coverage applied for during this "Enrollment Period" will be effective on January 1st following the Approved Enrollment Period, provided the employee is Actively at Work, the spouse is not confined in a Hospital, Medical Facility or at home, applicable premium is paid and any applicable service waiting period has been satisfied.

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

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

DEFINITIONS

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

"You," "your" and "yours" means a person who meets the eligibility requirements of the Policy as stated in Eligible Classes and is enrolled for this insurance, and whose insurance under the Policy is in effect.

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

"Breslow method" means a method for determining the prognosis for you or your Insured Dependent with melanoma by measuring the thickness of such melanoma.

"CIN Grading System" means a system used to determine the severity of cervical intraepithelial neoplasia (CIN) and refers to new abnormal cell growth. The CIN Grading System grades the degree of cell abnormality numerically, with CIN I being the lowest and CIN III the highest.

"Critical Illness" means a serious medical condition listed on the Schedule of Benefits and defined in the Benefit Provisions section of the Policy.

"Dependents" as used in the DEPENDENT INSURANCE section, means:

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

"Diagnosis/Diagnosed" means the diagnosis of a Critical Illness by a Physician that must be:

(1) made while your or your Insured Dependent's coverage is in force under the Policy; and
(2) in writing; and
(3) based on objective clinical findings or laboratory tests that are supported by medical records and any other diagnostic requirements defined in the Policy.

"Eligible Person" means a person who meets the eligibility requirements of the Policy.

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

"Glasgow Coma Scale" means a system for assessing the severity of brain impairment in an individual with a brain injury that uses the sum of scores given for eye-opening, verbal, and motor responses. A high score of 15 indicates no impairment and a score of 7 or less indicates severe impairment.

"Gleason Score" means a system of grading prostate cancer tissue based on how it looks under a microscope. Gleason scores range from 2 to 10 and indicate how likely it is that a tumor will spread. A low Gleason Score means the cancer tissue is similar to normal prostate tissue and the tumor is less likely to spread. A high Gleason Score means the cancer tissue is very different from normal and the tumor is more likely to spread.

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

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

"Injury" means bodily injury to you or your Insured Dependent resulting directly from an accident, independent of all other causes.

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

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

"Modified Rankin Scale" means a commonly used scale for measuring the degree of disability or dependence in the daily activities of people who have suffered a stroke. The Modified Rankin Scale runs from 0 to 6 with 0 indicating no symptoms and 6 indicating that the patient has passed away. A score of 5 indicates severe disability causing you or Insured Dependent to be bedridden, incontinent and in need of constant nursing care.

"Physician" means a duly licensed: (a) medical or osteopathic doctor; or (b) medical practitioner who is recognized by the law of the jurisdiction in which Treatment is provided as qualified to treat the type of Critical Illness for which claim is made. The Physician may not be you or a member of your Immediate Family.

"Rancho Los Amigos Scale" means a system used by the medical profession for measuring levels of awareness, cognition, behavior and interaction with the environment. A score of Level VII means no impairment and a Level V or less indicates severe impairment.

"Recurrence" means the Diagnosis of the same Critical Illness for which a benefit has been previously paid.

"Sickness" means illness, disease, pregnancy or complications from pregnancy requiring the care of a Physician.

"Subsequent Occurrence" means the Diagnosis of a different Critical Illness from one for which a benefit has been previously paid.

"TNM scale" means the cancer staging system developed and maintained by The American Joint Committee on Cancer (AJCC) and the International Union Against Cancer (IUAC).

"Transplant List" means the list maintained by the United Network of Organ Sharing (UNOS) or its medically recognized successor organization, acting as the administrator for the Organ Procurement and Transplantation Network (OPTN).

"Treatment" means care consistent with the Diagnosis of your or your Insured Dependent's Critical Illness that has the purpose of maximizing your or your Insured Dependent's medical improvement. It must be provided by a Physician whose specialty or experience is most appropriate for such Critical Illness and conforms to generally accepted medical standards to effectively manage and treat your or your Insured Dependent's condition.

GENERAL PROVISIONS

INCONTESTABILITY:

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

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

(a) it is in a written form signed by you or any Insured Dependent, or on your behalf or any Insured Dependent's behalf; and

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

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

CLERICAL ERROR:

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

(1) will not terminate insurance that would otherwise have been effective; and

(2) will not continue insurance that would otherwise have ceased or should not have been in effect.

If appropriate, a fair adjustment of premium will be made to correct a clerical error.

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

MISSTATEMENT OF FACTS:

If relevant facts about any person were misstated:

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

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

ASSIGNMENT:

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

NOT IN LIEU OF WORKERS' COMPENSATION:

The Policy is not a Workers' Compensation Policy. It does not provide Workers' Compensation benefits.

INDIVIDUAL ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

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

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

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

SERVICE WAITING PERIOD: A person who is continuously employed on a Full-time basis with the Policyholder for the period specified on the Schedule of Benefits has satisfied the Service Waiting Period.

EFFECTIVE DATE OF INDIVIDUAL INSURANCE: If the Policyholder pays the entire premium, the insurance for an Eligible Person will go into effect on the date stated on the Schedule of Benefits.

If you, as an Eligible Person, pay a part of the premium, you must apply within 31 days of the date you are first eligible for insurance coverage and in writing on a form provided by us for the insurance to go into effect. You will become insured on the later of:

(1) the Individual Effective Date stated on the Schedule of Benefits, if you apply on or before that date; or
(2) the first day of the month following the date you apply, if you apply within 31 days from the date you first met the eligibility requirements; or
(3) the first day of the month following the date we approve any required proof of good health. We require proof of good health if you apply:
    (a) after 31 days from the date you first become eligible; or
    (b) after you terminated this insurance but you remained in a class eligible for this insurance; or
    (c) for an Amount of Insurance greater than you were insured for with the prior group Critical Illness plan, if applicable; or
    (d) after being eligible for coverage under a prior group Critical Illness plan for more than 31 days but did not elect to be covered under that prior plan; or
(4) the date premium is remitted.

If an Eligible Person has been previously declined for coverage by us, had an application withdrawn or marked incomplete for any reason, or voluntarily terminated his/her insurance coverage with us, all future requests for coverage are subject to submission and our approval of proof of good health. However, proof of good health will not be required if an Eligible Person who voluntarily terminated his/her insurance coverage with us makes a future request due to a life event change or during any approved enrollment period.

Insurance applied for during a Reliance Standard approved enrollment that takes place beyond the Eligible Person's initial enrollment period or beyond the Eligible Person's initial eligibility period will become effective according to the specific rules for such enrollment. (See Approved Enrollment Periods on the Schedule of Benefits section, if applicable.)

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

If you are not Actively at Work on the day your insurance is to go into effect, the insurance will go into effect on the day you return to Active Work for one full day.

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

(1) the date the Policy terminates; or
(2) the date you cease to be in a class eligible for this insurance; or
(3) the end of the period for which premium has been paid; or
(4) the date when the lifetime maximum benefit has been paid under the Policy; or
(5) the date you enter military service on active duty (not including Reserve or National Guard).

CONTINUATION OF INDIVIDUAL INSURANCE: Your insurance and that of any Insured Dependents may be continued, by payment of premium, beyond the date you cease to be eligible for this insurance, but not longer than:

(1) 12 months, if due to Injury or Sickness; or
(2) 1 month, if due to approved leave of absence; or
(3) 1 month, if due to temporary lay-off.

INDIVIDUAL REINSTATEMENT: Insurance may be reinstated if you, as a former Insured have been:

(1) on an approved leave of absence; or

(2) on temporary lay-off.

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

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

If you, as an Eligible Person, request insurance after previously terminating insurance at your request or for failure to pay premium when due, proof of good health must be approved by us before your insurance coverage may be reinstated.

DEPENDENT CRITICAL ILLNESS INSURANCE

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

When an Insured Dependent is Diagnosed with a Critical Illness in accordance with the Critical Illness Benefit provision we will pay the applicable benefit shown on the Schedule of Benefits. Only dependents that meet the definition of Dependent can be insured for this benefit.

Any benefit payable for an Insured Dependent will be paid to you unless another individual has been designated as beneficiary.

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

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

EFFECTIVE DATE OF DEPENDENT INSURANCE: If the Policyholder pays the entire premium, the insurance up to any guaranteed issue amount for a Dependent will become effective on the later of:

(1) the first day of the month following the date you become eligible to enroll your Dependents for Dependent insurance; or
(2) the first day of the month following the date the dependent meets the definition of Dependent.

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

(1) the first day of the month following the date you become eligible to enroll your Dependents for Dependent Insurance; or
(2) the first day of the month following the date the dependent meets the definition of Dependent, if application is made on or before that date; or
(3) the first day of the month following the date of application, if application is made within 31 days from the date the Dependent first becomes eligible for this insurance; or
(4) the first day of the month following the date we approve any required proof of good health. We require proof of good health if you make application for Dependent spouse insurance:
    (a) after 31 days from the date the Dependent spouse first becomes eligible for this insurance; or
    (b) after a prior termination of insurance as long as the Dependent spouse remained eligible for Dependent insurance; or
    (c) for an Amount of Insurance greater than he/she was insured for with the prior group critical illness plan; or
    (d) after the Dependent spouse was eligible for coverage under a prior group critical illness plan for more than 31 days but did not elect to be covered under that prior plan; or
(5) the date premium is remitted.

If the Dependent spouse has been previously declined for coverage by us, had an application withdrawn or marked incomplete for any reason or voluntarily terminated his/her insurance coverage with us, all future requests for coverage are subject to submission and our approval of proof of good health. However, proof of good health will not be required if the Dependent who voluntarily terminated his/her insurance coverage with us makes a future request for insurance coverage due to a life event change or during any approved enrollment period.

Insurance applied for during a Reliance Standard approved enrollment that takes place beyond the Insured's initial enrollment period or beyond the Insured's initial eligibility period will become effective according to the specific rules for such enrollment. (See Approved Enrollment Periods on the Schedule of Benefits section, if applicable.)

For a Dependent who is confined in a Hospital or Medical Facility (other than newborn children) or at home on the date on which he/she would otherwise become insured, insurance will be effective as of the date the confinement ends.

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

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

(1) the date this Section terminates; or
(2) the date the dependent is no longer a Dependent as defined; or
(3) the end of the period for which premium has been paid by you or the Policyholder; or
(4) the date all benefits available under the Policy have been paid on behalf of all Insured Dependents; or
(5) the date your insurance terminates; or
(6) the date you retire from employment with the Policyholder.

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

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

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

The above coverage will also be extended to newly adoptive, foster or step children, as of the date they become financially dependent on you for support, provided they otherwise meet the definition of Dependent.

PORTABILITY

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

(1) notify us in writing within 31 days from the date insurance coverage is terminated under the Policy; and
(2) remit the necessary premium when due.

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

The premium charged to continue coverage will be based on the prevailing rate charged to all Insureds who choose to continue coverage under this provision. The premium will be billed directly to you on a quarterly basis.

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

(1) the end of the period for which premium has been paid;
(2) the date you reach age 70;
(3) at any time coverage would normally terminate according to the terms of the Policy had you continued to be an Eligible Person; or
(4) the date the Insured Dependent spouse attains age 75, with respect to Insured Dependent spouse coverage continued this provision.

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

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

BENEFIT PROVISIONS

We will pay a lump sum benefit in the amount shown in the Schedule of Benefits to you if you or any Insured Dependent are Diagnosed by a Physician with a Critical Illness as defined below. Payment of the benefit is subject to all of the following:

(1) the Diagnosis must have been made within the United States or its territories; and
(2) you and your Insured Dependents' coverage must be in force under the Policy at the time of Diagnosis of a Critical Illness; and
(3) any exclusions, limitations or conditions expressed in the Policy; and
(4) any age reductions shown on the Schedule of Benefits.

CRITICAL ILLNESSES:

"Alzheimer's Disease" means the development of multiple, progressive cognitive deficits manifested by memory impairment (impaired ability to learn new information or to recall previously learned information) and one or more of the following cognitive disturbances:

(1) aphasia (language disturbance);
(2) apraxia (impaired ability to carry out motor activities despite intact motor function);
(3) agnosia (failure to recognize or identify objects despite intact sensory function); and
(4) disturbance in executive functioning (i.e. planning, organizing, sequencing, abstracting).

Diagnosis of Alzheimer's Disease must be supported by all of the following:

(1) formal neuropsychological testing confirming dementia;
(2) laboratory tests have been completed as part of the evaluation to rule out etiologies other than Alzheimer's Disease; and
(3) magnetic resonance imaging, computerized tomography or other reliable imaging techniques that have been completed as part of the evaluation to rule out etiologies other than Alzheimer's Disease.

A Critical Illness benefit will not be payable for Alzheimer's Disease for:

(1) other central nervous system conditions that may cause deficits in memory and cognition (e.g., cerebrovascular disease, Parkinson's disease, normal-pressure hydrocephalus);
(2) systemic conditions that are known to cause dementia (e.g., ETOH (Ethanol) abuse, hypothyroidism, vitamin B12 or folic acid deficiency, niacin deficiency, hypercalcemia, neurosyphilis);
(3) substance-induced conditions; or
(4) any form of dementia that is not diagnosed as Alzheimer's Disease.

"Carcinoma in situ" means cancer in which the tumor cells still lie within the tissue of the site of origin without having invaded neighboring tissue.

The term "Carcinoma in situ" does not mean:

(1) pre-malignant lesions such as intraepithelial neoplasia;
(2) malignant melanoma of less than .75 mm. maximum thickness as determined by histological examination using the Breslow method; or
(3) benign tumors or polyps.

Carcinoma in situ must be Diagnosed pursuant to a pathological diagnosis. We will, however, pay benefits based on a clinical diagnosis if pathological diagnosis is impossible because it is life threatening or medically inappropriate.

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

Benefits will not be paid when a Coma has been medically induced.

"Coronary Artery Disease" means narrowing or blockage of one or more coronary arteries resulting from plaque buildup. As a result of the Diagnosis of Coronary Artery Disease, the Physician must recommend that you or your Insured Dependent undergo a surgical procedure of a coronary artery bypass graft. However, if a Physician determines in writing at the time the care is being given that you or your Insured Dependent are too ill to safely undergo such procedure, the requirement that the procedure be recommended will be waived.

No benefit is payable for Coronary Artery Disease if a Physician recommends balloon or laser angioplasty, stent procedures, or other minimally invasive procedure to increase blood flow.

"Heart Attack" (acute myocardial infarction) means the death of a segment of the heart muscle resulting from blockage of one or more coronary arteries.

The Diagnosis of a Heart Attack (acute myocardial infarction) must be based on:

(1) typical symptoms of Heart Attack such as, but not limited to, chest pain, shortness of breath, or pain or discomfort in one or both arms; and
(2) new electrocardiographic changes consistent with and supporting diagnosis of Heart Attack (acute myocardial infarction); and
(3) a concurrent diagnostic elevation of cardiac enzymes above generally accepted laboratory levels of normal.

The death of the heart muscle coincidental with your death or of your Insured Dependent from other causes will not be considered a Heart Attack.

"Life Threatening Cancer" means a malignant neoplasm (including hematologic malignancy) which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue, and which is not specifically excluded. Leukemias and lymphomas are included.

The following types of cancer are not considered a Life Threatening Cancer:

(1) Prostate cancer diagnosed as less than T2NOMO according to the TNM scale or classified as less than Gleason Score 7;
(2) Carcinoma in situ, including cervical dysplasia, CIN-1, CIN-2 and CIN-3, according to the CIN Grading System;
(3) Pre-malignant lesions (such as intraepithelial neoplasia);
(4) All tumors histologically described as:
    (a) benign;
    (b) pre-malignant;
    (c) non-invasive;
    (d) low-malignancy potential; or
    (e) borderline malignant;
(5) All skin cancers, unless there is evidence of metastasis or the tumor is a malignant melanoma .75 mm. maximum thickness or greater as determined by histological examination using the Breslow method;
(6) Chronic lymphocytic leukemia which has not progressed to a) Rai Stage II; or b) Binet Stage B;
(7) Papillary carcinoma of the thyroid which does not exceed one cm in diameter and is limited to the thyroid; or
(8) Non-invasive papillary cancer of the bladder which does not exceed TaNOMO according to the TNM scale.

A positive Diagnosis of Life Threatening Cancer must be confirmed by pathological confirmation. We will, however, pay benefits based on a clinical diagnosis if pathological diagnosis is impossible because it is life threatening or medically inappropriate.

"Major Organ Failure" means irreversible failure of the heart, kidney(s), liver, lung(s), small intestine, pancreas, or kidney-pancreas as a result of a disease and, for which a transplantation of the organ(s) or tissue from a suitable human donor is required.

You or your Insured Dependent's condition must meet the criteria for placement on the registry with the Organ Procurement and Transplantation Network/United Network for Organ Sharing (OPTN/UNOS) or its medically recognized successor organization. If you or your Insured Dependent do not meet the criteria for placement on the registry because you or your Insured Dependent's condition is too far advanced or you or your Insured Dependent are too ill to proceed with a transplant, this requirement will not apply.

Major Organ Failure also includes disease of the bone marrow and which requires the replacement of your or your Insured Dependent's bone marrow by allogeneic and/or umbilical cord blood transplant.

"Motor Neuron Diseases" are diseases that are marked by muscular weakness and atrophy with spasticity and hyperreflexia due to a loss of motor neurons of the spinal cord, medulla or cortex. Motor Neuron Diseases covered are:

(1) Amyotrophic Lateral Sclerosis (ALS, also known as Lou Gehrig's Disease);
(2) Progressive Lateral Sclerosis;
(3) Progressive Bulbar Palsy; or
(4) Progressive Muscular Atrophy.

Kennedy Disease and other motor neuron diseases not listed above are not covered.

"Multiple Sclerosis (MS)" means a chronic disease involving damage to the sheaths of nerve cells (myelin) in the brain and spinal cord. Symptoms may include numbness, impairment of speech and of muscular coordination, blurred vision, and severe fatigue. Such symptoms must be present for at least six months.

Diagnosis criteria:

(1) damage to two separate areas of the central nervous system;
(2) evidence that the damage occurred at least one month apart; and
(3) all other possible causes are ruled out.

A Critical Illness Benefit for Multiple Sclerosis is not paid for Guillain-Barre Syndrome.

"Parkinson's Disease" means a disease of the nervous system marked by tremor, muscular stiffness, and slow, imprecise movement. It is associated with degeneration of the basil ganglia and a deficiency of the neurotransmitter dopamine.

Diagnosis must be made with two out of four of the following symptoms present:

(1) shake or tremor;
(2) slow movement;
(3) stiffness or rigidity; or
(4) balance difficulties and falls.

"Ruptured Cerebral, Carotid or Aortic Aneurysm" means a localized, blood-filled dilation of a blood vessel caused by disease or weakening of the vessel wall in the brain, carotid arteries, or aorta, spilling blood into the surrounding tissues (called a hemorrhage). Diagnosis must be supported by medical records which include radiographically specific studies such as, but not limited to, angiography, CT scan, MRI, or ultrasound.

"Skin Cancer" means:

(1) a malignant melanoma of less than .75 mm. maximum thickness as determined by histological examination using the Breslow method; or
(2) basal cell carcinoma; or
(3) squamous cell carcinoma of the skin.

A Diagnosis of Skin Cancer must be based on a pathological diagnosis. However, a clinical diagnosis is acceptable if a pathological diagnosis cannot be made.

A life-time maximum of one benefit per Insured is payable.

"Stroke" means a cerebrovascular event resulting in infarction (death) of brain tissue which is caused by hemorrhage, embolism or thrombosis evident from neuroimaging (CT, MRI, MRA, PET Tomography or similar imaging technique). Such event must produce measurable, neurological deficit(s) in accordance with a score of 3 or greater on the Modified Rankin Scale persisting for at least 30 consecutive days following the occurrence of the stroke.

Stroke does not include Transient Ischemic Attack (TIA), attacks of vertebrobasilar ischemia, transient global amnesia, chronic cerebrovascular insufficiency or any other cerebrovascular events such as migraine, hypoxia, traumatic Injury to the brain or blood vessels or vascular disease affecting the eye, optic nerve or vestibular functions.

CHILDHOOD CRITICAL ILLNESSES: (Applicable to Insured Dependent children only)

"Cerebral Palsy" means a group of disorders affecting development of movement, muscle tone and posture causing activity limitation, attributed to an insult to the immature, developing brain, most often before birth. Diagnosis must be supported by abnormal brain imaging (CT, MRI or equivalent) while the Insured Dependent Child is under age five.

No benefit will be payable for motor deficits due to an underlying medical condition (syndrome, genetic or hereditary condition).

"Cleft Lip" is a narrow opening or gap in the skin of the upper lip that extends all the way to the base of the nose, including unilateral clefting and bilateral clefting.

"Cleft Palate" is an opening between the roof of the mouth and the nasal cavity.

If Cleft Lip and Cleft Palate are both present, only one benefit is payable.

"Cystic Fibrosis" means an inherited, life-threatening disorder that affects the cells that produce mucus, sweat and digestive juices that causes severe damage to the lungs and digestive system. The Diagnosis must be based on a sweat test with results of chloride concentrations greater than 60 mmol/L.

"Down Syndrome" means an extra full or partial copy of chromosome 21.

"Muscular Dystrophy" means a group of genetic diseases characterized by progressive weakness and degeneration of the skeletal or voluntary muscles that control movement. Diagnosis must be based on one of the following testing methods:

(1) electromyography/nerve conduction velocity; or
(2) muscle biopsy; or
(3) blood enzyme tests.

"Spina Bifida" means a congenital condition of meningocele or myelomeningocele. A Diagnosis of Spina Bifida must be supported by:

(1) CT or MRI scan; and
(2) physical exam.

Spina Bifida does not include Spina Bifida occulta.

"Type 1 Diabetes" means diabetes which results from auto-immune destruction of insulin-producing cells in the pancreas. Diagnosis must be based on blood tests and confirmed presence of GAD antibodies which cause an autoimmune reaction to beta cells.

CONCURRENT DIAGNOSIS OF MORE THAN ONE CRITICAL ILLNESS: If the Insured can qualify for benefits for more than one Critical Illness at the same time, (within the Recurrence or Subsequent Occurrence separation period), we will only pay for one Critical Illness with the highest benefit.

RECURRENCE(S) OF A CRITICAL ILLNESS: Once an Insured has been Diagnosed with a Critical Illness and a Critical Illness Benefit has become payable, a benefit will be payable for a Recurrence of the same Critical Illness, provided the Recurrence is Diagnosed at least six (6) months after the previous Critical Illness was Diagnosed.

The benefit payable for a Recurrence will be as shown on the Schedule of Benefits.

SUBSEQUENT OCCURRENCE(S) OF A CRITICAL ILLNESS: Once an Insured has been Diagnosed with a Critical Illness and a Critical Illness Benefit has become payable, benefits will be payable for subsequent and unrelated Critical Illnesses if the Critical Illness is Diagnosed at least six (6) months after the previous Critical Illness was Diagnosed.

The benefit payable for Subsequent Occurrence(s) will be as shown on the Schedule of Benefits.

DEATH OF THE INSURED: If an Insured is Diagnosed with a Critical Illness and is eligible for a benefit but dies before a benefit is paid, we will pay the lump sum amount you or your Insured Dependent would have been entitled to in accordance with the Beneficiary and Facility of Payment provisions in the Policy.

WELLNESS BENEFIT

We will pay the amount shown on the Schedule of Benefits for one health screening test performed during a 12 month period for each Insured, up to a maximum of four benefits per family, provided he/she:

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

Health screening tests covered under the Policy are:

(1) ALT/AST (liver function test);
(2) Biopsy for cancer;
(3) Blood test for triglycerides;
(4) Bone density testing (DEXA scan);
(5) Bone marrow testing;
(6) CA 15-3 (blood test for breast cancer);
(7) CA 125 (blood test for ovarian cancer);
(8) CEA (blood test for colon cancer);
(9) Chest X-ray;
(10) Colonoscopy;
(11) Echocardiogram;
(12) Electrocardiogram;
(13) Fasting blood glucose test;
(14) Flexible sigmoidoscopy;
(15) Genetic tests;
(16) Hemoccult stool analysis;
(17) Hepatitis screening;
(18) Human Immunodeficiency Virus (HIV) screening;
(19) Mammography;
(20) Pap test;
(21) PSA (blood test for prostate cancer);
(22) Serum cholesterol test to determine level of HDL and LDL;
(23) Serum Protein Electrophoresis (blood test for myeloma);
(24) Skin cancer screening;
(25) Stress test;
(26) Ultrasound screening (of the breast, of the abdominal aorta for abdominal aortic aneurysms, of carotid arteries (carotid doppler), or for cancer detection); and
(27) Any other preventative health screenings, including, but not limited to, tests, diagnostic procedures, routine examinations and immunizations.

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

BENEFICIARY AND FACILITY OF PAYMENT

BENEFICIARY: The beneficiary to receive benefits at your death will be as named in writing by you. This beneficiary designation must be on file with the Policyholder or the Plan Administrator and will be effective on the date you sign it. Any payment made by us before receiving the designation shall fully discharge us to the extent of that payment.

If you name more than one beneficiary to share the benefit, you must state the percentage of the benefit that is to be paid to each beneficiary. Otherwise, they will share the benefit equally.

The beneficiary's consent is not needed if you wish to change the designation. His/her consent is also not needed to make any changes in the Policy.

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

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

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

Benefits payable at the death of an Insured Dependent will be paid to you unless another individual has been designated as beneficiary.

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

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

If you have not named a beneficiary, or the named beneficiary is not surviving at your death, we may pay up to $2,500 of the benefit to the person(s) who, in our opinion, have incurred expenses in connection with your last illness, death or burial.

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

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

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

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

CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice must be given to us within 31 days after the date of the Diagnosis of a Critical Illness, or as soon as reasonably possible. The notice should be sent to us at our Administrative Offices or to our authorized agent. The notice should include the Policyholder's Name, your or your Insured Dependent's name and the Policy Number.

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

PROOF OF LOSS: For any covered Critical Illness or health screening test, written proof must be sent to us within 90 days. If it is not reasonably possible to give proof within 90 days, the claim is not affected if the proof is sent as soon as reasonably possible. In any event, proof must be given within one year, unless the claimant is legally incapable of doing so.

Proof of Loss for a covered Critical Illness must include, at your expense, all of the following information:

(1) the date of Diagnosis;
(2) a completed claim form signed by you or your Insured Dependent and your or your Insured Dependent's Physician(s);
(3) supporting documentation from the Physician, including but not limited to, clinical, radiological, pathological; histological or laboratory evidence of Critical Illness; and
(4) the name and address of any Hospital or Medical Facility, as well as the Physician, providing Treatment prior to the Diagnosis.

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

PAYMENT OF CLAIMS: All benefits will be paid to you, if living. Any benefits unpaid at the time of death will be paid to the beneficiary.

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

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

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

PREMIUMS

PREMIUM RATES: The premium due is based on the coverage requested. Premium rates are based on the age attained on the Premium due date. We have the right to change the premium rates. We will give written notice of our intention to change such rates to the Policyholder at least 60 days prior to the effective date of the rate change.

Premium increases due to you entering into a higher age bracket will occur on the January 1st coinciding with or next following your last birthday.

Premium increases due to your Insured Dependent spouse entering into a higher age bracket will occur on the January 1st coinciding with or next following his/her last birthday.

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

Family and Medical Leave of Absence:

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

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

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

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

Military Services Leave of Absence:

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

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

While 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 or class, 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 for you if you are not considered Actively at Work until you have returned to Active Work for one full day.

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

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

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

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

EXCLUSIONS

EXCLUSIONS: A Critical Illness benefit will not be paid:

(1) if the Critical Illness is caused by or contributed to by one of the following:
   (a) an act of war, declared or undeclared;
   (b) intentionally self-inflicted Injury;
   (c) your or your Insured Dependent's commission or attempted commission of a felony;
   (d) your or your Insured Dependent's use of alcohol or drugs unless taken as prescribed by a Physician;
   (e) a Sickness or Injury that occurs while you or your Insured Dependent is confined in a penal or correctional institution;
   (f) cosmetic or elective surgery that is not medically necessary;
   (g) committing or attempting to commit suicide while sane or insane;
   (h) your or your Insured Dependent's participation in a riot or insurrection;
(2) for a Critical Illness Diagnosed outside of the United States unless such Diagnosis is confirmed within the United States. If such Diagnosis is confirmed within the United States, the Critical Illness will be deemed to have occurred on the date Diagnosis was made outside the United States;
(3) for a Critical Illness which is Diagnosed less than six (6) months from a different Critical Illness for which benefits have been paid; or
(4) for the same Critical Illness as a Critical Illness for which a benefit has been paid if it is Diagnosed less than six (6) months after the previous Critical Illness was Diagnosed.

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

Reliance Standard Life Insurance Company
Plaza East Office Center
330 E. Kilbourn Ave.
Suite 1225
Milwaukee, WI 53202
(877) 328-5285
(414) 226-2095

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance
Complaints Department
Post Office Box 7873
Madison, WI 53707-7873
1-800-236-8517
608-266-0103

SUMMARY PLAN DESCRIPTION

The following section entitled Summary Plan Description was prepared by Reliance Standard Life Insurance Company at the request of and on behalf of the Plan Sponsor. Reliance Standard Life Insurance Company assumes no responsibility for the accuracy or sufficiency of the information in this section.

SUMMARY PLAN DESCRIPTION

The following information and the description of benefits provided in this booklet constitute the Summary Plan Description.

PLAN NAME:	Voluntary Group Critical Illness Insurance
PLAN SPONSOR:	Gorman & Company, LLC 200 N. Main St. Oregon, WI 53575 (608) 835-5534
SPONSOR'S EMPLOYER IDENTIFICATION NUMBER:	82-3739186
PLAN NUMBER:	501
TYPE OF PLAN:	Critical Illness Benefit Plan
PLAN BENEFITS:	Fully Insured - Voluntary Group Critical Illness Insurance Benefits
TYPE OF ADMINISTRATION:	The plan is administered in accordance with the terms of the Group Policy issued by the Reliance Standard Life Insurance Company, 1700 Market Street, Suite 1200, Philadelphia, PA 19103-3938.
PLAN ADMINISTRATOR:	The Plan Sponsor named above.
AGENT FOR SERVICE OF LEGAL PROCESS:	The Plan Sponsor named above.
PLAN YEAR:	The plan's fiscal records are kept on a calendar year basis beginning January 1st.
PLAN COSTS:	The cost of the benefits provided under the plan are paid for by the employee.
QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) DETERMINATIONS:	A plan participant or beneficiary can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order (QMCSO) determinations from the Plan Administrator named above.
AMENDMENT AND TERMINATION:	The Plan Sponsor reserves the right, at any time, to amend or terminate the Plan or amend or eliminate benefits under the Plan for any reason.

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.