RELIANCE STANDARD LIFE INSURANCE COMPANY
1700 Market Street, Suite 1200, Philadelphia, PA 19103-3938

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't you may lose your right to appeal.

Reliance Standard Life Insurance Company

To get information or file a complaint with your insurance company or HMO:

Call: Consumer Complaint Coordinator at 1-800-351-7500
Toll free: 1-800-351-7500
Email: consumer.complaints@rsli.com
Mail:
1700 Market Street
Suite 1200
Philadelphia, PA 19103-3938

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call: 1-800-252-3439
Online: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail:
MC 111-1A
P.O. Box 149091
Austin, TX 78714

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presenter una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Reliance Standard Life Insurance Company

Para obtener información o para presenter una queja ante su compañía de seguros o HMO.

Llame a: Consumer Complaint Coordinator al 1-800-351-7500
Teléfono gratuito: 1-800-351-7500
Correo electrónico: consumer.complaints@rsli.com
Dirección postal:
1700 Market Street
Suite 1200
Philadelphia, PA 19103-3938

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presenter una queja ante el estado:

Llame: 1-800-252-3439
En línea: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal:
MC 111-1A
P.O. Box 149091
Austin, TX 78714

RELIANCE STANDARD
LIFE INSURANCE COMPANY

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

CERTIFICATE OF INSURANCE

POLICY NUMBER: SR 228267 **POLICY EFFECTIVE DATE:** September 1, 2021
POLICYHOLDER: Consolidated Communications Holdings, Inc.

We certify that we insure the persons below as described in the Classification of Insured for the benefits set forth in the Policy.

This Certificate is subject to the terms and conditions of the Policy. It is not a contract of insurance. It only describes the main provisions of the Policy.

This Certificate replaces any other Certificate we may have issued under the Policy.

SCHEDULE OF BENEFITS

(Insurance applies only to those Coverages for which an amount is specified)
INDIVIDUAL EFFECTIVE DATE: The Policy Effective Date, or the date a person becomes an Insured, whichever is later.
CLASSIFICATION OF INSURED:

CLASS 1: Each active, full-time Non-Bargaining Employee

CLASS 2: Each Spouse of a Class 1 Insured

CLASS 3: Each Dependent Child of a Class 1 Insured

"Spouse", means the Insured's legal spouse.

"Dependent Child", means:
(1) the Insured's unmarried child(ren), under the age of 20, who are financially dependent upon the Insured for support. Adoptive, foster, and step-children are considered Dependents if they are in the Insured's custody; and
(2) the Insured's unmarried child(ren), attending a college or other school on a full-time basis, who are financially dependent upon the Insured for support, up to age 26; and
(3) the Insured's child(ren) beyond the limiting age who are incapable of self-sustaining employment by reason of intellectual disability or physical handicap and who are chiefly dependent on the Insured for support and maintenance.

A person may not have coverage both as an Insured employee and as an Insured spouse or child. Coverage as an employee will apply in the event a spouse or child is also an employee.

CERTIFICATE OF INSURANCE

SCHEDULE OF BENEFITS (Continued)

CLASS	Hazard Code	Accidental Death and Dismemberment Principal Sum
1	SR-16	Three (3) times Annual Salary, subject to a maximum Principal Sum of $1,000,000.
2	SR-18	$50,000
3	SR-18	$25,000

CLASS 1: "Annual Salary" means the Insured's base annual salary received from the Policyholder on the day before the date of Loss. In determining Annual Salary, overtime pay, bonuses, and any other special compensation which is not specifically received as base salary shall be excluded. However, “Annual Salary” will include commissions received from the Policyholder averaged over the lesser of the:

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

as of the day before the date of Loss.

With respect to hourly employees who are insured, the number of hours worked during a regularly scheduled work week, not to exceed 40 hours per week, times 52 weeks, will be used to determine Annual Salary.

AGGREGATE LIMIT OF LIABILITY $3,000,000 PER ACCIDENT. The maximum we will pay for all Losses due to one accident will be the Aggregate Limit of Liability stated above.

If the Aggregate Limit of Liability is not enough to pay the full benefit to each Insured who suffers a Loss, the benefits payable to each person will be reduced in equal proportion. The proportion will be determined by dividing the Aggregate Limit of Liability by the total of all benefits payable without the limit.

Changes in Benefit: Changes in the benefit amount because of a change in age, class or salary, whichever is applicable, are effective on the date of the change, provided you are actively at work on the date of the change. If you are not actively at work when the change should take effect, the change will take effect on the day after you have been actively at work for one full day.

DEFINITIONS

"Bodily Injury(ies)," called "Injury(ies) means Loss caused by an accident and which:
(1) results directly and independently from all other causes; and
(2) occurs while the Policy is in force for the Insured; and
(3) results from a hazard shown in the Description of Hazards, which applies to the Insured.

"Claimant" means the person who makes a claim for benefits under the Policy.

"Insured" means a person described in the Schedule of Benefits for whom insurance is in effect under a hazard which is a part of the Policy.

"Loss(es)" is as defined on the Description of Coverage page.

"Physician" means any 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 for which claim is made. The Physician may not be the Insured or a member of his/her immediate family.

"Premium Due Date" is the effective date of:
(1) the Policy; or
(2) the renewal of the Policy.

"Principal Sum" means the amount of insurance provided to an Insured. Only a portion of the Principal Sum is payable for certain Injuries. The Principal Sum does not apply to Weekly Indemnity or Medical Expense when they are a part of the Policy.

The Principal Sum applicable to Insured persons of the Policyholder shall be the percentage shown in the following schedule:

AGE AT DATE OF LOSS	% OF PRINCIPAL SUM
Less than age 75	100%
Age 75 or more but less than 80	50%
Age 80 or more	25%

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

Other definitions appear in the Policy as required in a specific section.

POLICY EXPIRATION

"Expiration Date" is the date insurance under the Policy will end. It will end on the last day for which premium has been paid:
(1) if we do not consent to renew the Policy for further consecutive terms; or
(2) if the Policyholder does not provide us with the information we need to make a renewal offer.

INDIVIDUAL TERMINATIONS

Insurance will end on the earliest of the following:
(1) the date the Policy ends; or
(2) the Premium Due Date if the required Premium is not paid; or
(3) the date the Insured is no longer a member of a class stated on the Schedule of Benefits page.

Any Loss which occurs before insurance ends will not be affected.

EXPOSURE

If an Insured is exposed to the elements due to an accident covered by the Policy, and sustains a Loss, we will pay benefits for that Loss.

DISAPPEARANCE

We will presume an Insured suffered Loss of life due to an accident if:
(1) he/she is riding in a conveyance that is involved in an accident covered by the Policy; and
(2) as a result of the accident, the conveyance is wrecked, sinks or disappears; and
(3) his/her body is not found within one (1) year of the accident.

DESCRIPTION OF COVERAGE

ACCIDENTAL DEATH AND DISMEMBERMENT

If Injury results in any one of the following specific Losses within one (1) year from the date of the accident, we will pay the benefit specified. However, only one benefit (the larger) will be paid for more than one Loss resulting from any one accident.

FOR LOSS OF:

Life	The Principal Sum
Both Hands or Both Feet	The Principal Sum
Speech and Hearing	The Principal Sum
One Hand and One Foot	The Principal Sum
Entire Sight of Both Eyes	The Principal Sum
One Hand or One Foot and the Entire Sight of One Eye	The Principal Sum
One Hand or One Foot	One-Half The Principal Sum
Speech or Hearing	One-Half The Principal Sum
The Entire Sight of One Eye	One-Half The Principal Sum
The Thumb and Index Finger of the Same Hand	One-Fourth The Principal Sum

"Loss" means, with regard to:

(1) hand or foot, actual severance through or above the wrist or ankle joints;
(2) sight, entire and irrecoverable loss of sight;
(3) speech, entire and irrecoverable loss of the function;
(4) hearing, entire and irrecoverable loss of the function;
(5) thumb and index finger, actual severance through or above the metacarpophalangeal joint.

SEAT BELT BENEFIT

DESCRIPTION OF COVERAGE:

We will pay an additional sum equal to 10% of the Insured's Principal Sum if:

(1) the Insured dies as the result of a Bodily Injury sustained while riding in or operating a Four-Wheel Vehicle;
(2) a police report establishes that the Insured was wearing a Seat Belt at the time; and,
(3) Accidental Death benefits are payable for the Insured's death hereunder.

No benefit will be paid for any loss sustained:

(1) while driving or riding in any Four-Wheel Vehicle used: in a race; in a speed or endurance test; or for acrobatic or stunt driving;
(2) if the Insured is not wearing a Seat Belt for any reason; or
(3) while the Insured is sharing a Seat Belt.

DEFINITIONS

"Seat Belt" means an unaltered Seat Belt or lap and shoulder restraint. In the case of small children the restraint must:

(1) meet the standards of the National Safety Council; and
(2) must be properly secured and utilized in accordance with applicable State law and the recommendations of its manufacturer for children of like age and weight.

An air bag is not considered a Seat Belt.

"Four-Wheeled Vehicle" means a vehicle listed below provided it is duly licensed for passenger use and designated primarily for use on public streets and highways:

(1) a private passenger automobile;
(2) a station wagon; or
(3) a van, jeep, or truck-type vehicle which has a manufacturer's rated load capacity of 2,000 pounds or less; or
(4) a self-propelled motor home.

DESCRIPTION OF HAZARDS

ALL ACCIDENT PROTECTION--(EXCEPT OWNED AIRCRAFT)
BUSINESS COVERAGE ONLY (INCLUDES PERSONAL DEVIATIONS)

SR-16
Hazard Code

With respect to Class 1:

We will cover an Insured for Loss, on a business trip for the Policyholder, from all accidents. The business trip must require the Insured to travel away from the premises of his/her regular place of employment. For the purpose of going on the trip, the trip will begin on the last to occur:

(1) when the Insured leaves his/her home; or
(2) when the Insured leaves his/her place of regular employment.

The trip will end on the first to occur:

(1) when the Insured returns to his/her home; or
(2) when the Insured returns to his/her place of regular employment.

When flying in an aircraft, insurance will apply only while riding as a passenger, not as a pilot or crewmember in (including getting into or out of):

(1) any civilian aircraft which:
    a. has a valid airworthiness certificate;
    b. is piloted by a person holding a valid Certificate of Competency for that type of aircraft; and
    c. both certificates have been issued by the proper government agency of the country of origin of the pilot and aircraft;
(2) any transport aircraft operated by the Military Airlift Command (MAC) of the United States or by the similar air transport service of any country.

"On a business trip for the Policyholder" means any travel authorized by or at the direction of the Policyholder the purpose of which is to further Policyholder business. Everyday travel to and from work is not included. Personal deviations from the trip are included. The Insured is not covered during a bona fide vacation.

EXCLUSIONS

We will not pay for any Loss due to:

(1) war or act of war, declared or undeclared;
(2) suicide or attempted suicide (in Missouri, while sane);
(3) self-inflicted Injuries;
(4) sickness or disease, or diagnostic tests or treatment, except infection which occurs directly from an accidental cut or wound;
(5) Myocardial infarction (heart attack);
(6) service in the armed forces of any country;
(7) committing or attempting to commit a felony;
(8) riding in an aircraft owned, leased or operated on behalf of (a) the Policyholder or employer or a subsidiary or affiliate of the Policyholder or employer; or (b) the Insured or member of his/her household;
(9) accident occurring while the aircraft is used for training or instruction, unless we agree in writing to provide coverage;
(10) flying which requires a special permit or waiver, unless we agree in writing to provide coverage;
(11) accident occurring while the aircraft is used for aerial photography, unless we agree in writing to provide coverage; or
(12) driving or riding as a passenger in any automobile used; (a) in a race, speed or endurance test; or (b) for acrobatic or stunt driving.

DESCRIPTION OF HAZARDS

SPECIAL ACTIVITIES

SR-18
Hazard Code

With respect to Class 2 & 3:

We will cover an Insured for Loss sustained anywhere in the world while engaged in the activity shown below. The activity must be supervised or sponsored by the Policyholder.

Travel by the Insured is covered while traveling directly between his home premises and the place of such activity.

ACTIVITY: We will cover Spouses while traveling with his/her Spouse who is an Insured Person on a business trip authorized by the Policyholder and at the expense of the Policyholder including trips for the purposes of relocation.

We will cover Eligible Dependent Children of the Insured Person while traveling with their Parent on a trip for the purposes of relocating the Insured Persons Family due to the reassignment or the new employment of an Insured Person and provided the expense of such trip is paid for by the Policyholder.

When flying in an aircraft, insurance will apply while riding as a passenger, not as a pilot or crew member, in (including getting into or out of):

(1) any civilian aircraft which:

(a) has a valid airworthiness certificate;
(b) is piloted by a person holding a valid Certificate of Competency for that type or aircraft;
(c) both certificates have been issued by the proper government agency of the country or origin of the pilot and aircraft;
(d) is not an aircraft that is owned by, leased by, or operated on behalf of: (a) the Policyholder or employer, or a subsidiary or affiliate of the Policyholder or employer; or (b) the Insured or a member of his household (unless we agree in writing to provide coverage); and

(2) any transport aircraft operated by the Military Airlift Command (MAC) of the United States or by the similar air transport service of any country.

EXCLUSIONS

We will not pay for any Loss due to:

(1) war or act of war, declared or undeclared;
(2) suicide or attempted suicide (in Missouri, while sane);
(3) self-inflicted injuries;
(4) sickness or disease, or diagnostic tests or treatment, except infection which occurs directly from an accidental cut or wound;
(5) Myocardial infraction (heart attack);
(6) service in the armed forces of any country;
(7) committing or attempting to commit a felony.

GENERAL PROVISIONS

NOTICE OF CLAIM

Written notice must be given to us within thirty-one (31) days after any Loss occurs, or as soon as reasonably possible. The notice should be sent to us at our Administrative Offices or to our authorized agent. The notice should include the Insured's name and the Policy Number.

CLAIM FORMS

When we receive written notice of a claim, we will send claim forms to the Claimant within fifteen (15) days. If we do not, the insured will satisfy the requirements of written proof of Loss by sending us written proof as shown below. The proof must describe the occurrence, extent and nature of the Loss.

WRITTEN PROOF OF LOSS

For any covered Loss, written proof must be sent to us at within ninety (90) days. If it is not reasonably possible to give proof within ninety (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 1 year, unless the Claimant is legally incapable of doing so.

TIME PAYMENT OF CLAIMS

When we receive written proof of Loss, we will pay any benefits due within sixty (60) days. Benefits that provide for periodic payment will be paid monthly. Any balance unpaid at the end of our liability will be paid as soon as possible after receipt of written proof of loss.

PAYMENT OF CLAIMS

If the Insured dies, we will pay the death benefit as follows:

(1) to the beneficiary, if any, named and on file with the plan administrator, (or if we and the Policyholder agree, on file with the Policyholder) at the time of the Insured's death; or
(2) to the beneficiary named on the Group Life Policy issued to the Policyholder or any subsidiary, if the designation is in effect at the time of the Insured's death; or
(3) to the first of the following classes to survive the Insured;
    a. the Insured's Spouse, if any;
    b. the Insured's children, if any, but if the child died before the Insured did, the child's descendants, by the branch;
    c. the Insured's parents, equally, or to the survivor;
    d. the Insured's brothers and sisters, equally, or to the survivor;
(4) the Insured's estate.

Any other accrued benefits unpaid at the Insured's death may be paid either to the beneficiary designated, if any, or to the Insured's estate. All other indemnities will be paid to the Insured.

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

PHYSICAL EXAMINATION AND AUTOPSY

We have the right to have a doctor of our choice examine the Insured as often as reasonably necessary. This section applies while a claim is pending or while we are paying benefits. We also have the right to request an autopsy in case of death, unless the law forbids it. We will pay the cost of both the examination and the autopsy.

LEGAL ACTION

No lawsuit or action in equity can be brought to recover on the Policy:

(1) before sixty (60) days following the date proof of Loss was furnished to us; or
(2) after three (3) years following the date proof of Loss is required (in South Carolina, six (6) years; in Kansas, five (5) years).

TIME LIMIT ON CERTAIN DEFENSES

Any statements made by the Policyholder, any Insured, or on behalf of any Insured to persude 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 an Insured is covered. The following rules apply to each statement:

(1) No statement will be used in a contest unless:
    a. it is in a written form signed by the Insured, or on behalf of the Insured; and
    b. a copy of such written instrument is or has been furnished to the Insured, the Insured's beneficiary or legal representative.
(2) If the statement relates to an Insured's insurability, it will not be used to contest the validity of insurance which has been in force, before the contest, for at least two years during the lifetime of the Insured.

BENEFICIARY

We will furnish form to the Policyholder on which the Insured may name the beneficiary. The Insured can change the beneficiary by notifying the plan administrator of the change in writing. The consent of a revocable beneficiary is not needed. The change will take effect only when it is received by a plan administrator authorized by us. We cannot attest to the validity of such a change.

ASSIGNMENT

Ownership of nay benefit provided under the Policy may be transferred by assignment. An irrevocable beneficiary must give written consent to assign this insurance. Written request for the assignment must be made in duplicate at our Administrative Offices. Once recorded by us, an assignment will take effect on the date it was signed. We are not liable for any action we take before the assignment is recorded.

NOT IN LIEU OF WORKER'S COMPENSATION

This Policy is not a Worker's Compensation Policy. It does not provide Worker's Compensation benefits.

Secretary

President

INDEX

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION (For insurers declared insolvent or impaired on or after September 1, 2011)

Texas law establishes a system to protect Texas policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association ("the Association") administers this protection system. Only the policyholders of insurance companies that are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

It is possible that the Association may not protect all or part of your policy because of statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas **(regardless of where the policyholder lived when the policy was issued)**
- Residents of other states, ONLY if the following conditions are met:
  1. The policyholder has a policy with a company domiciled in Texas;
  2. The policyholder's state of residence has a similar guaranty association; and
  3. The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, or $200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on a single life; or
- Death benefits up to a total of $300,000 under one or more policies on a single life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of $250,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of $250,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contract holder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

These limits are applied for each insolvent insurance company.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.

Texas Life and Health Insurance
Guaranty Association
515 Congress Avenue, Suite 1875
Austin, Texas 78701
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.state.tx.us

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:

Reliance Standard Life Insurance Company: 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 (30 days in NH) 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 (30-day period in NH), 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 (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; 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 above) 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 "us" or "our" refers to Reliance Standard Life Insurance Company.

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 "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 U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the 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 Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory of 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.