RELIANCE STANDARD
LIFE INSURANCE COMPANY

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

1700 Market Street, Suite 1200, Phila., PA 19103-3938 (800) 351-7500

POLICYHOLDER: Unified School District 495 Fort Larned **POLICY NUMBER:** VCI 802562

EFFECTIVE DATE: October 1, 2020

ANNIVERSARY DATES: October 1, 2021 and each October 1st thereafter.

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

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

We agree to provide insurance to you in exchange for the payment of premium and a signed Application. This Policy provides benefits if an Insured suffers Critical Illness as defined herein, subject to any limitations and exclusions set forth. It insures the eligible persons for the Amount of Insurance shown on the Schedule of Benefits. The insurance is subject to the terms and conditions of this Policy. In the event of a conflict between this Policy and the Certificate, the terms of the Policy control.

The Effective Date of this Policy is shown above. Insurance starts and ends at 12:01 A.M., Local Time, at your main address. It stays in effect as long as premium is paid when due. The "POLICY TERMINATION" section of the GENERAL PROVISIONS explains when the insurance can be ended.

This Policy is signed by our President and Secretary.

Secretary

President

READ THIS POLICY CAREFULLY. PRE-EXISTING CONDITION LIMITATIONS ARE APPLICABLE TO COVERAGE UNDER THIS POLICY.

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

THIS POLICY IS OPTIONALLY RENEWABLE.

GROUP CRITICAL ILLNESS POLICY

RELIANCE STANDARD LIFE INSURANCE COMPANY
Home Office: Schaumburg, Illinois
Administrative Office: Philadelphia, Pennsylvania

GROUP POLICY NUMBER:	VCI 802562	**POLICY EFFECTIVE DATE:**	October 1, 2020
POLICY DELIVERED IN:	Kansas	**ANNIVERSARY DATE:**	October 1st in each year

Application is made to us by: Unified School District 495 Fort Larned

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

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

Signed at _____ this_____day of _____.

Policyholder: _____

By: _____
(Signature)

_____
(Title)

Please sign and return.

*BC1COAPVCI 80256210/01/2020*RSL
*BC2COAPUnified School District 495 Fort Larned

RELIANCE STANDARD LIFE INSURANCE COMPANY
Home Office: Schaumburg, Illinois
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Signed at _____ this_____day of _____.

Policyholder: _____

By: _____
(Signature)

_____
(Title)

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

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

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

SERVICE WAITING PERIOD: 30 days of continuous employment.

INDIVIDUAL EFFECTIVE DATE: The first day of the month coinciding with or next following the date an Eligible Person completes his/her enrollment form.

INDIVIDUAL REINSTATEMENT: 6 months

MINIMUM PARTICIPATION REQUIREMENTS: Participation Percentage: 10% Number of Insured Persons: 10

AMOUNT OF INSURANCE:

Eligible Person: $5,000.

Dependent Coverage:

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

Spouse: $5,000.

Child: $1,250. Child coverage is guaranteed issue and is not subject to proof of good health.

For Insureds age 70 and over, the Amount of Insurance is subject to automatic reduction. Upon the Insured's attainment of the specified age below, the Amount of Insurance will be reduced to the applicable percentage. This reduction also applies to Insureds who are age 70 or over on their Individual Effective Date.

Age	Percentage of available or in force amount at age 69
70+	50%

CRITICAL ILLNESSES:

Alzheimer's Disease	100% of the Amount of Insurance
Carcinoma in Situ	25% of the Amount of Insurance
Coma	100% of the Amount of Insurance
Coronary Artery Disease	25% 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
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 October 1st coinciding with or next following the date of the change, provided the Insured Person is Actively at Work on the effective date of the change. If the Insured Person is not Actively at Work when the change would otherwise take effect, the change will take effect on the day after the Insured Person has returned to Active Work in an eligible class for one full day. However, if the increase results in an Amount of Insurance that exceeds the guaranteed issue amount, the increase will take effect on the first day of the month coinciding with or next following the date we approve proof of good health provided the Insured Person is Actively at Work. If the Insured Person is not Actively at Work, the change will take effect on the day after the Insured Person has returned to Active Work in an Eligible Class for one full day.

Decreases in the Amount of Insurance are effective on the October 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 the Eligible Person (a) applies within 31 days of such life event; and (b) was 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 your 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, as shown on file with us, applications for employees, and spouses under age 60, 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 you during the "Enrollment Period";
(2) the employee and/or the spouse was not previously declined for group critical illness insurance coverage with us; and
(3) the employee and/or the 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 October 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.

Spouses age 60 and over are subject to our approval of proof of good health and such amounts of insurance will not be effective until approved by us.

CONTRIBUTIONS:

Insured Person: 100%
Insured Dependent: 100%

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

DEFINITIONS

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

"You," "your" and "yours" means the entity to which this Policy is issued and which is deemed the Policyholder.

"Actively at Work" and "Active Work" means the Insured Person actually performing on a Full-time basis each and every duty pertaining to his/her 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 the Insured 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 this Policy.

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

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

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

(1) made while the Insured's coverage is in force under this 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 this Policy.

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

"Full-time" means working for you for a minimum of 30 hours during a person's 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 GIeason 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 this 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 the parents, siblings, spouse or children of the Insured.

"Injury" means bodily injury to the Insured resulting directly from an accident, independent of all other causes.

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

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

"Insured Person" means a person who meets the eligibility requirements of this Policy as stated in Eligible Classes and is enrolled for this insurance, and whose insurance under this 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 the Insured 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 the Insured or a member of his/her 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 the Insured’s Critical Illness that has the purpose of maximizing the Insured’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 the Insured's condition.

CERTAIN RESPONSIBILITIES OF THE POLICYHOLDER

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

Compliance with the Employee Retirement Income Security Act (ERISA)

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

Distribution of Certificates of Insurance

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

Enrollment Periods

It is your responsibility to provide us with written notice and obtain our written approval at least 31 days prior to conducting an annual enrollment period.

Maintenance of Records

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

Premium Rate Changes

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

Reporting of Eligibility and Coverage Amounts

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

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

Timely Payment of Premiums

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

TRANSFER OF INSURANCE COVERAGE

If the Insured was covered under any Prior Plan prior to this Policy's Effective Date, the Insured will be insured under this Policy, provided;

(1) the Insured was insured under the Prior Plan on the date of the transfer; and
(2) premiums are paid; and
(3) either;
    (a) the Insured Person is Actively at Work and meets all of the requirements for being an Eligible Person under this Policy on its Effective Date; or
    (b) the Insured Person is not Actively at Work due to Injury or Sickness on the Effective Date of this Policy, but would otherwise qualify as an Eligible Person.

With respect to Dependent coverage, the Effective Date of Dependent Insurance confinement limitation will not apply to any Dependent who was insured under the Prior Plan on the last day the Prior Plan was in effect up to the amount that was in effect under such Prior Plan. Any requested increases in the Amount of Dependent Insurance are subject to the Effective Date of Dependent Insurance confinement limitation.

Service Waiting Period Credit

Time used to satisfy the Service Waiting Period of the Prior Plan will be credited toward satisfaction of the Service Waiting Period of this Policy.

Pre-existing Conditions Limitation Credit

If the Insured was insured under a Prior Plan immediately before he/she became an Insured under this Policy, credit will be given under this Policy equivalent to any time period the Insured was insured under the Prior Plan. However, such credit will not apply to any coverage applied for under this Policy that is in excess of the Amount of Insurance such Insured was covered for under the Prior Plan.

If this Policy provides coverage for Critical Illnesses not insured under the Prior Plan, benefits for those Critical Illnesses will be subject to the Pre-existing Conditions Limitation under this Policy.

"Prior Plan" means any similar policy or plan of group or individual Critical Illness coverage sponsored by you, which has been replaced by coverage entirely or in part under this Policy. In the event that you acquire employees due to acquisition of another company after the Effective Date of this Policy, Prior Plan will include the policy or plan of group or individual Critical Illness coverage sponsored by such company, which has been replaced by coverage entirely or in part under this Policy, on the date of acquisition under which those acquired employees and Dependents (if applicable) were insured. At our request, you must provide us with proof of such Prior Plan.

GENERAL PROVISIONS

ENTIRE CONTRACT:

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

CHANGES:

No agent has authority to change or waive any part of this Policy. To be valid, any change or waiver must be in writing. It must also be signed by one of our executive officers and attached to this Policy.

INCONTESTABILITY:

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

Any statements made by you or any Insured, or on behalf of any Insured to persuade us to provide coverage, will be deemed a representation, not a warranty. This provision limits our use of these statements in contesting the 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 or 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. Also, we will not use such statements to contest a benefit increase after such benefit increase has been in force for two years during the lifetime of the Insured.

RECORDS MAINTAINED:

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

CLERICAL ERROR:

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

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

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 this Policy. If appropriate, a fair adjustment of premium will be made to correct a clerical error. Such adjustments will be limited to the 12 month period preceding the date we receive proof from you that an adjustment due to overpayment of premium should be made or the date we discover that premium has been underpaid.

MISSTATEMENT OF FACTS:

If relevant facts about any Insured were misstated:

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

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

ASSIGNMENT:

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

CONFORMITY WITH STATE LAWS:

Any section of this Policy, which on its effective date, conflicts with the laws of the state in which this Policy is issued, and that is not otherwise pre-empted, is amended by this provision. This Policy is amended to meet the minimum requirements of those laws.

CERTIFICATE OF INSURANCE:

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

POLICY TERMINATION:

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

We may cancel this Policy:

(1) if the premium is not paid at the end of the grace period; or
(2) if the number of Insured Persons is less than the Minimum Participation Number on the Schedule of Benefits; or
(3) on any Policy Anniversary after coverage has been in force for 12 months; or
(4) if the Participation Percentage is less than the Minimum Participation Percentage on the Schedule of Benefits.

If we cancel because of (1) above, this Policy will be cancelled at the end of the grace period. If we cancel because of (2), (3) or (4) we will give you 31 days written notice prior to the date of cancellation.

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

NOT IN LIEU OF WORKERS' COMPENSATION:

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

INDIVIDUAL ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

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

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

ELIGIBILITY REQUIREMENTS: A person is eligible for insurance under this Policy if he/she:

(1) is a member of an Eligible Class, as shown on the Schedule of Benefits page; and
(2) has 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 you for the period specified on the Schedule of Benefits has satisfied the Service Waiting Period.

EFFECTIVE DATE OF INDIVIDUAL INSURANCE: If you pay the entire premium, the insurance up to the guaranteed issue amount for an Eligible Person will go into effect on the date stated on the Schedule of Benefits.

If an Eligible Person pays a part of the premium, he/she must apply within 31 days of the date he/she is first eligible for insurance coverage for the insurance to go into effect. He/she will become insured on the later of:

(1) the Individual Effective Date stated on the Schedule of Benefits, if he/she applies on or before that date; or
(2) the first day of the month coinciding with or next following the date he/she applies, if he/she applies within 31 days from the date he/she first met the eligibility requirements; or
(3) the first day of the month coinciding with or next following the date we approve any required proof of good health. We require proof of good health if a person applies:
    (a) after 31 days from the date he/she first becomes eligible; or
    (b) after he/she terminated this insurance but he/she remained in a class eligible for this insurance; or
    (c) for an Amount of Insurance greater than he/she was 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.

Proof of good health forms are available from us upon request. It is your responsibility to provide proof of good health forms to Eligible Persons when required.

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

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

TERMINATION OF INDIVIDUAL INSURANCE: The insurance of an Insured will terminate on the first of the following to occur:

(1) the date this Policy terminates; or
(2) the last day of the Policy month in which the Insured Person ceases 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 this Policy; or
(5) the date the Insured enters military service on active duty (not including Reserve or National Guard).

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

(1) twelve months, if due to Injury or Sickness; or

(2) one month, if due to temporary lay-off or approved leave of absence.

INDIVIDUAL REINSTATEMENT: Insurance may be reinstated if a former Insured Person has been:

(1) on an approved leave of absence; or

(2) on temporary lay-off.

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

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

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

DEPENDENT CRITICAL ILLNESS INSURANCE

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

When an Insured Dependent 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 the Insured unless another individual has been designated as beneficiary.

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

ELIGIBILITY: An Eligible Person is eligible to enroll his/her Dependents on the date he/she becomes an Insured Person.

EFFECTIVE DATE OF DEPENDENT INSURANCE: If you pay 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 coinciding with or next following the date the Insured Person becomes eligible to enroll his/her Dependents; or
(2) the first day of the month coinciding with or next following the date the dependent meets the definition of Dependent.

If you require an Insured Person to pay a portion of the Dependent premium, he/she may insure his/her Dependents by making written application. In this case, the insurance for Dependents will take effect on the later of:

(1) the first day of the month coinciding with or next following the date the Insured Person becomes eligible to enroll his/her Dependents; or
(2) the first day of the month coinciding with or next following the date the dependent meets the definition of Dependent, if application is made on or before that date; or
(3) the first day of the month coinciding with or next following the date of application, 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 coinciding with or next following the date we approve any required proof of good health. Proof of good health forms are available from us upon request. It is your responsibility to provide proof of good heath forms to Eligible Persons when required. We require proof of good health if an Insured Person makes 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 (other than newborn children) who is confined in a Hospital or Medical Facility 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 date the Insured Dependent spouse reaches age 75; or
(4) the end of the period for which premium has been paid by you or the Insured; or
(5) the date all benefits available under this Policy have been paid on behalf of all Insured Dependents; or
(6) the date the Insured Person's insurance terminates; or
(7) the date the Insured Person retires from employment with you.

NEWBORN CHILDREN: If a child is born to an Insured Person who has 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) the Insured Person requests, 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 the Insured Person for support, provided they otherwise meet the definition of Dependent.

PORTABILITY

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

(1) notifies us in writing within 31 days from the date insurance coverage is terminated under this Policy; and
(2) remits the necessary premiums when due.

The Amount of Insurance available under the Portability provision will be the current Amount of Insurance the Insured is insured for under this Policy on the last day the Insured Person was Actively at Work.

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

Insurance coverage continued under this provision for an Insured and his/her Insured Dependents will terminate on the first of the following to occur:

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

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

If this Policy terminates subsequent to the Insured Person's election to continue his/her coverage and that of his/her Insured Dependents in accordance with this Portability provision, such coverage will be continued in accordance with the provisions of the Insured Person’s certificate.

BENEFIT PROVISIONS

We will pay a lump sum benefit in the amount shown in the Schedule of Benefits to the Insured if the Insured is Diagnosed with a Critical Illness shown 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) the Insured's coverage must be in force under this Policy at the time of Diagnosis of a Critical Illness; and
(3) any exclusions, limitations or conditions expressed in this 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 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 the Insured 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 the Insured is 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 death of the Insured 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.

The Insured'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 the Insured does not meet the criteria for placement on the registry because his/her condition is too far advanced or is 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 the Insured'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.

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 twelve (12) 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 the 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 the Insured would have been entitled to in accordance with the Beneficiary and Facility of Payment provisions in this 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 this Policy at the time the test was performed; and
(3) has not already had one of the following health screening tests performed at any time during the same 12 month period.

Health screening tests covered under this Policy are:

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

The Wellness Benefit is paid in addition to any other benefits the Insured may receive under this Policy.

BENEFICIARY AND FACILITY OF PAYMENT

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

If the Insured names more than one beneficiary to share the benefit, he/she 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 the Insured wishes to change the designation. His/her consent is also not needed to make any changes in this Policy.

If the beneficiary dies at the same time as the Insured, or within 15 days after his/her death but before we received written proof of the Insured's death, payment will be made as if the Insured survived the beneficiary, unless noted otherwise.

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

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

Benefits payable at the death of an Insured Dependent will be paid to the Insured Person 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 the Insured has not named a beneficiary, or the named beneficiary is not surviving at the Insured's death, we may pay up to $1,000 of the benefit to the person(s) who, in our opinion, have incurred expenses in connection with Insured's 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 Insured's name and the Policy Number.

CLAIM FORMS: When we receive written notice of a claim, we will send claim forms to the claimant within 15 days. If we do not, the claimant will satisfy the requirements of written proof of 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 the Insured's expense, all of the following information:

(1) the date of Diagnosis;
(2) a completed claim form signed by the Insured and the Insured'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 immediately. Benefits that provide for periodic payment will be paid accordingly.

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

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

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

PREMIUMS

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

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:

(1) on any premium due date after this Policy is in force for twenty-four (24) months; or
(2) when the extent of coverage is changed by amendment; or
(3) on any premium due date on or after this Policy has been in force of 12 months if the entire group's Amount of Insurance or number of Insureds (excluding Dependents) changes by 25% or more from such group's entire Amount of Insurance or number of Insureds on the Policy's Effective Date.

We will not change the premium rates due to (1) above more than once in any 12 month period. We will tell you in writing at least 31 days before the date of a change due to (1) or (3) above.

Premium increases due to the Insured entering into a higher age bracket will occur on the October 1st coinciding with or next following the Insured Person's last birthday.

For purposes of determining premium under this Policy, a Dependent spouse's age will be considered to be the same as the Insured Person's age.

GRACE PERIOD: You may pay the premium up to thirty-one (31) days after the date it is due. This Policy stays in force during this time. If the premium is not paid during the grace period, this Policy will be cancelled at the end of the grace period. You will still owe us the premium up to the date this Policy is cancelled.

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

Family and Medical Leave of Absence:

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

(1) the premium for such Insured Person and his/her Dependents, if applicable, continues to be paid during the leave; and
(2) you have approved the Insured Person's leave in writing and provide a copy of such approval within 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 the Insured Person's coverage and that of any Insured Dependents, if applicable, in accordance with your policies regarding Military Services Leave of Absence under USERRA if the premium for such Insured Person and his/her 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.

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

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

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

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

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

LIMITATIONS

PRE-EXISTING CONDITIONS: The Insured will be considered to have a Pre-existing Condition and will be subject to a Pre-existing Conditions Limitation if:

(1) a Critical Illness is Diagnosed in the first twelve (12) months after the Insured's effective date; and
(2) he/she has received medical Treatment, consultation, care or services, including diagnostic procedures, or prescribed drugs or medicines, for a Sickness or Injury, whether specifically diagnosed or not, causing or contributing to such Critical Illness, during the twelve (12) months immediately prior to the Insured's effective date of insurance.

Benefits will not be paid for a Critical Illness:

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

a Pre-existing Condition unless the Critical Illness is Diagnosed after a continuous period of twelve (12) consecutive months commencing on or after the effective date of insurance.

With respect to persons electing a benefit increase (whether an increase from coverage under a Prior Plan, if applicable, or under this Policy) any benefit increase will not be paid for a Critical Illness:

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

a Pre-existing Condition unless the Critical Illness is Diagnosed after a continuous period of twelve (12) consecutive months commencing on or after the effective date of the benefit increase.

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

(1) the Critical Illness is Diagnosed in the first twelve (12) months after the effective date of the benefit increase; and
(2) he/she has received medical Treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines, in connection with such Sickness or Injury, whether specifically diagnosed or not, causing or contributing to such Critical Illness, during the twelve (12) months immediately prior to the effective date of the benefit increase.

"Pre-existing Condition" means any Sickness or Injury, whether specifically diagnosed or not, for which the Insured received medical Treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines, during the twelve (12) months immediately prior to such Insured's effective date of insurance.

A Pre-existing Conditions Limitation will not apply to a Recurrence of a Critical Illness.

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) the Insured's commission or attempted commission of a felony;
  (d) the Insured's use of alcohol or drugs unless taken as prescribed by a Physician;
  (e) a Sickness or Injury that occurs while the Insured 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) the Insured'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 twelve (12) months after the previous Critical Illness was Diagnosed.

RELIANCE STANDARD LIFE INSURANCE COMPANY

GENERAL PURPOSES AND LIMITATIONS OF THE
KANSAS LIFE AND HEALTH
INSURANCE GUARANTY ASSOCIATION
K.S.A. 40-3001 et. seq.

DISCLAIMER

THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION MAY NOT PROVIDE COVERAGE FOR ALL OR A PORTION OF THIS POLICY. IF COVERAGE IS PROVIDED, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS AND EXCLUSIONS, AND IS CONDITIONED UPON RESIDENCY IN THIS STATE. THEREFORE, YOU SHOULD NOT RELY UPON COVERAGE BY THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELECTING AN INSURANCE COMPANY OR IN SELECTING AN INSURANCE POLICY. INSURANCE COMPANIES AND THEIR AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELLING YOU ANY FORM OF AN INSURANCE POLICY, OR TO INDUCE YOU TO PURCHASE ANY FORM OF AN INSURANCE POLICY. EITHER THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION OR THE KANSAS INSURANCE DEPARTMENT WILL RESPOND TO ANY QUESTIONS YOU MAY HAVE REGARDING THIS DOCUMENT.

Kansas Life and Health Insurance Guaranty Association
3745 SW Wanamaker Road, Suite C
Topeka, KS 66610

Kansas Insurance Department
1300 SW Arrowhead Road
Topeka, KS 66604

This is a brief summary of the Kansas Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. If there is any inconsistency between this notice and Kansas law, then Kansas law will control.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Kansas law, with funding from assessments paid by other insurance companies. This safety net was created under Kansas law, which determines who and what is covered and the amounts of coverage. The basic protections provided by the Association are:

- Life Insurance
  $300,000 in death benefits
  $100,000 in cash surrender or withdrawal values
- Health Insurance
  $500,000 in hospital, medical and surgical insurance benefits
  $300,000 in disability insurance benefits
  $300,000 in long-term care insurance benefits
  $100,000 in other types of health insurance benefits
- Annuities
  $250,000 in withdrawal and cash values

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