



reliancestandard

LIFE INSURANCE COMPANY

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

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CERTIFICATE OF INSURANCE

We certify that you (provided you belong to a class described on the Schedule of Benefits) are insured, for the benefits which apply to your class, under Group Policy No. GL 645991 issued to Thornton Township High School #205, the Policyholder.

When loss of life covered under the Policy occurs, we will pay the amount stated on the Schedule of Benefits to the named beneficiary, subject to provisions entitled Beneficiary and Facility of Payment.

This Certificate is not a contract of insurance. It contains only the major terms of insurance coverage and payment of benefits under the Policy. It replaces all certificates that may have been issued to you earlier.


Secretary


President

If you have any questions about your insurance, or need assistance, please call (800) 922-0509.

GROUP LIFE INSURANCE CERTIFICATE

This Group Life Certificate amends all previous Group Life Certificates and is dated August 26, 2024.

SCHEDULE OF BENEFITS

EFFECTIVE DATE: July 1, 2012, as amended in the Policy through July 1, 2024

ELIGIBLE CLASSES: Each active, Full-time 10 month Exempt* Employee and 12 month Exempt* Employee, except any person employed on a temporary or seasonal basis.

*as defined by the Fair Labor Standard Act, as amended

INDIVIDUAL EFFECTIVE DATE: The day you become eligible.

AMOUNT OF INSURANCE:

Basic Life and Accidental Death and Dismemberment: \$50,000.

The Life amount will be reduced by any benefit paid under the Accelerated Benefit Rider.

CHANGES IN AMOUNT OF INSURANCE: Increases and decreases in the Amount of Insurance because of changes in age are effective on the July 1st coinciding with or next following the date of the change. Increases and decreases in the Amount of Insurance because of changes in class or earnings (if applicable) are effective on the date of the change.

With respect to increases in the Amount of Insurance, you must be 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 in an Eligible Class for one full day.

CONTRIBUTIONS: You are not required to contribute toward the cost of the Basic Insurance.

DEFINITIONS

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

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

"Actively at work" and active work" means actually performing on a Full-time basis each and every duty pertaining to your job in the place where and the manner in which the job is normally performed. This includes approved time off such as vacation, jury duty and funeral leave. This also includes time periods when you are not required to physically be at work as the school is closed to students for a holiday or scheduled school vacation. Under no circumstances, does it include time off as a result of injury or illness.

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

"The date you retire" or "retirement" means the effective date of your:

- (1) retirement pension benefits under any plan of a federal, state, county or municipal retirement system, if such pension benefits include any credit for employment with the Policyholder;
- (2) retirement pension benefits under any plan which the Policyholder sponsors, or makes or has made contributions;
- (3) retirement benefits under the United States Social Security Act of 1935, as amended, or under any similar plan or act.

"Total Disability" as used in the WAIVER OF PREMIUM IN EVENT OF TOTAL DISABILITY section, means your complete inability to engage in any type of work for wage or profit for which you are suited by education, training or experience.

"Loss" as used in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section, with respect to:

- (1) hand or foot, means the complete severance through or above the wrist or ankle joint;
- (2) the eye, speech or hearing, means total and irrecoverable loss thereof.

"Injury" means accidental bodily injury which is caused directly by accidental means and which occurs while your coverage under the Policy is in force.

GENERAL PROVISIONS

INCONTESTABILITY

We cannot contest the validity of the Policy after it has been in force for two (2) years from the date of issue, except for non-payment of premium. All other Policy terms will remain applicable.

This provision limits our use of any statements made by the Policyholder, you, or on your behalf in contesting the amount of insurance for which you are covered. The following rules apply to each statement:

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

REPRESENTATIONS

Any statement made in the Policyholder's application will be deemed a representation, not a warranty. Any statements made by the Policyholder, you, or on your behalf to persuade us to provide coverage, will be deemed a representation, not a warranty.

ASSIGNMENT

Ownership of any benefit provided under the Policy may be transferred by assignment. An irrevocable beneficiary must give written consent to assign this insurance. Written request for 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.

EFFECTIVE DATE AND TERMINATION

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

If you pay a part of the premium, you must apply in writing for the insurance to go into effect. You will become insured on the later of:

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

Proof of good health forms are available from us upon request. It is the Policyholder's responsibility to provide proof of good health forms to you when required.

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

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

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

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

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

- (1) twelve (12) months, if due to illness or injury; or
- (2) one (1) month, if due to temporary lay-off or approved leave of absence; or
- (3) three (3) months, while on a scheduled school break.

CONVERSION PRIVILEGE

You can use this privilege when your insurance is no longer in force. It has several parts. They are:

- A. If the insurance ceases due to termination of employment or membership in any of the Policy's classes, an individual Life Insurance Policy may be issued. You are entitled to a policy without disability or supplemental benefits. You must make written application for the policy within thirty-one (31) days after you terminate. The first premium must also be paid within that time. The issuance of the policy is subject to the following conditions:
 - (1) The policy will, at your option, be on any one of our forms, except for term life insurance. It will be the standard type issued by us for the age and amount applied for;
 - (2) The policy issued will be for an amount not over what you had before you terminated;
 - (3) The premium due for the policy will be at our usual rate. This rate will be based on the amount of insurance, class of risk and your age at date of policy issue; and
 - (4) Proof of good health is not required.
- B. If the insurance ceases due to the termination or amendment of the Policy, an individual Life Insurance Policy can be issued. You must have been insured for at least five (5) years under the Policy and/or the prior carrier. The same rules as in A above will be used, except that the face amount will be the lesser of:
 - (1) The amount of your Group Life benefit under the Policy. This amount will be less any amount you are entitled to under any group life policy issued by us or another insurance company; or
 - (2) \$10,000.
- C. If the insurance reduces, as may be provided in the Policy, an individual Life Insurance Policy can be issued. The same rules as in A above will be used, except that the face amount will not be greater than the amount which ceased due to the reduction.
- D. If you die during the time provided in A above in which you are entitled to apply for an individual policy, we will pay the benefit under the Group Policy that you were entitled to convert. This will be done whether or not you applied for the individual policy.
- E. Any policy issued with respect to A, B or C above will be put in force at the end of the thirty-one (31) day period in which application must be made.
- F. If you are entitled to have an individual policy issued to you without proof of health, then you must be given notice of this right at least fifteen (15) days before the end of the period specified above. Such notice must be: (1) in writing; and (2) presented or mailed to you by the Policyholder. If not, you will have an additional period in order to do so. This additional period will end fifteen (15) days after you are given notice. This period will not extend beyond sixty (60) days after the expiration date of the period provided above. This insurance will not be continued beyond the period provided in A above.

BENEFICIARY AND FACILITY OF PAYMENT

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

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

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

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

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

- (1) your legal spouse, legally recognized civil union/domestic partner;
- (2) your surviving child(ren) (including legally adopted child(ren)), in equal shares;
- (3) your surviving parents, in equal shares;
- (4) your surviving siblings, in equal shares; or, if none of the above,
- (5) your estate.

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

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

If you have not named a beneficiary, or the named beneficiary is not surviving at your death, we may pay up to \$2,000 of the benefit to the person(s) who, in our opinion, have incurred expenses in connection with your last illness, death or burial.

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

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

The benefit will be held with interest at a rate set by us.

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

SETTLEMENT OPTIONS

You may elect a different way in which payment of the Amount of Insurance can be made. You must provide a written request to us, for our approval, at our Administrative Office. If the option covers less than the full amount due, we must be advised of what part is to be under an option. Amounts under \$2,000 or option payments of less than \$20.00 each are not eligible.

If no instructions for a settlement option are in effect at the death of an Insured, the beneficiary may make the election, with our consent.

Settlement Options are described in the Policy.

WAIVER OF PREMIUM IN EVENT OF TOTAL DISABILITY

We will extend the Amount of Insurance during a period of Total Disability for one (1) year if:

- (1) you become totally disabled prior to age 60;
- (2) the Total Disability begins while you are insured;
- (3) the Total Disability begins while the Policy is in force;
- (4) the Total Disability lasts for at least 6 months;
- (5) the premium continues to be paid; and
- (6) we receive proof of Total Disability within one (1) year from the date it began.

After proof of Total Disability is approved by us, neither you or the Policyholder is required to pay premiums. Also, any premiums paid from the start of the Total Disability will be returned.

We will ask you to submit annual proof of continued Total Disability. The Amount of Insurance may then be extended for additional one (1) year periods. You may be required to be examined by a Physician approved by us as part of the proof. We will not require you to be examined more than once a year after the insurance has been extended two (2) full years.

The Amount of Insurance extended will be limited to the amount of basic group life coverage on your life that was in force at the time that Total Disability began excluding any additional benefits. This amount will not increase. This amount will reduce or cease at any time it would reduce or cease if you had not been totally disabled. If you die, we will be liable under this extension only if written proof of death is received by us.

The Amount of Insurance extended for you will cease on the earliest of:

- (1) the date you no longer meet the definition of Total Disability; or
- (2) the date you refuse to be examined; or
- (3) the date you fail to furnish the required proof of Total Disability; or
- (4) the date you become age 70; or
- (5) the date you retire.

You may use the conversion privilege when this extension ceases. Please refer to the Conversion Privilege section for rules. You are not entitled to conversion if you return to work and are again eligible for the insurance under the Policy. If you use the conversion privilege, benefits will not be payable under the Waiver of Premium in Event of Total Disability provision unless the converted policy is surrendered to us.

If you qualify for benefits in accordance with the Waiver of Premium in Event of Total Disability provision because you have been diagnosed by a Physician as totally disabled due to the following Condition(s) or Procedure(s), as later defined;

- (1) Life Threatening Cancer; or
- (2) Heart Attack (Myocardial Infarction); or
- (3) Kidney (Renal) Failure; or
- (4) Receipt of Major Organ Transplant; or
- (5) Stroke,

we will pay you an additional, one time, lump sum benefit in an amount equal to 10% of the death benefit under the basic life portion of the Policy up to a maximum of \$100,000.

This lump sum benefit applies only to the first Condition or Procedure to occur among those hereinafter defined which qualifies you for waiver of premium benefits. No further lump sum benefits will be payable under this provision during the same or any subsequent periods of Total Disability, or as a result of the occurrence of any other Condition or Procedure.

Definition(s):

"Condition(s) or Procedure(s)" mean only the following:

"Life Threatening Cancer" means a malignant neoplasm (including hematologic malignancy), as diagnosed by a Physician who is a board certified oncologist, and which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue, and which is not specifically excluded. The following types of cancer are not considered a Life Threatening Cancer: (1) early prostate cancer diagnosed as T2c or less according to the TNM scale; (2) colorectal cancer diagnosed as T2, N1, M0 or less according to the TNM scale; (3) breast cancer diagnosed as T3, N2, M0 or less according to the TNM scale; (4) First Carcinoma in Situ; (5) pre-malignant lesions (such as intraepithelial neoplasia); (6) brain glioma; (7) benign tumors or polyps; (8) tumors in the presence of the Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS); or (9) any skin cancer other than invasive malignant melanoma in the dermis or deeper, or skin malignancies that have become Life Threatening Cancers.

"First Carcinoma in Situ" means the first diagnosis of cancer in which the tumor cells still lie within the tissue of the site of origin without having invaded neighboring tissue. First Carcinoma in Situ must be diagnosed pursuant to a pathological diagnosis or clinical diagnosis.

"Heart Attack (Myocardial Infarction)" means the death of a segment of the heart muscle as a result of a blockage of one or more coronary arteries. In order to be covered under this provision, the diagnosis by a Physician of Heart Attack (Myocardial Infarction) must be based on:

- (1) new electrocardiographic changes consistent with and supporting a diagnosis of Heart Attack (Myocardial Infarction); and
- (2) a concurrent diagnostic elevation of cardiac enzymes; and
- (3) therapeutic and functional classifications, 3 or above and C or above respectively, according to the New York Heart Association.

"Kidney (Renal) Failure" means the chronic irreversible failure of both of the kidneys (end stage renal disease), which requires treatment with dialysis on a regular basis. Kidney Failure is covered under this provision only if the diagnosis has been made by a Physician who is a board certified nephrologist.

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

"Receipt of Major Organ Transplant" means that you have been the recipient of a major organ transplant and that there is clinical evidence of major organ(s) failure which, according to the diagnosis of a Physician, required your failing organ(s) or tissue to be replaced with organ(s) or tissue from a suitable donor under generally accepted medical procedures. Organs or tissues covered by this definition are limited to liver, kidney, lung, entire heart, pancreas, or pancreas-kidney.

"Stroke" means a cerebrovascular accident or infarction (death) of brain tissue, as diagnosed by a Physician, which is caused by hemorrhage, embolism, or thrombosis producing measurable, neurological deficit persisting for at least one hundred eighty (180) days following the occurrence of the Stroke. Stroke does not include Transient Ischemic Attack (TIA) or other cerebral vascular events.

Receipt of this additional lump sum payment may be taxable. You should seek assistance from your own personal tax advisor.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

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

If you suffer any one of the losses listed below, as a result of an injury, we will pay the benefit shown. The loss must be caused solely by an accident which occurs while you are insured, and must occur within 365 days of the accident. Only one benefit (the larger) will be paid for more than one loss resulting from any one accident. The Amount of Insurance can be found on the Schedule of Benefits.

LOSS OF:	AMOUNT OF INSURANCE:
Life	The Full Amount
Both Hands	The Full Amount
Both Feet	The Full Amount
The Sight of Both Eyes	The Full Amount
Speech and Hearing	The Full Amount
One Hand and One Foot	The Full Amount
One Hand and the Sight of One Eye	The Full Amount
One Foot and the Sight of One Eye	The Full Amount
One Hand	One-Half of the Amount
One Foot	One-Half of the Amount
Speech or Hearing	One-Half of the Amount
The Sight of One Eye	One-Half of the Amount

EXCLUSIONS

A benefit will not be payable for a loss:

- (1) caused by suicide or intentionally self-inflicted injuries; or
- (2) caused by or resulting from war or any act of war, declared or undeclared; or
- (3) caused by sickness or disease; or
- (4) sustained during your commission or attempted commission of an assault or felony; or
- (5) caused by your acute or chronic alcoholic intoxication; or
- (6) caused by your voluntary consumption of an illegal or controlled substance or a non-prescribed narcotic or drug.

TOTAL LOSS OF USE

We will pay a Total Loss of Use Benefit according to the Schedule of Losses below if, due to an Injury sustained while insured under the Policy, you suffer such a loss within 1 year of the date the Injury occurred provided:

- (1) we receive proof that you have experienced a permanent Total Loss of Use for 12 consecutive months from the date the Injury occurred; and
- (2) no benefit is payable under the Policy for the same loss under the Accidental Death and Dismemberment Benefit.

"Total Loss of Use" means the permanent inability to use an entire arm, leg or combination of arms and legs, starting at the shoulder or hip and including the hand or foot, due to incurable paralysis, stiffening of joints, or any other Injury that may cause the limb(s) to become permanently non-functional.

SCHEDULE OF LOSSES

For Total Loss of Use of:	Benefit Amount:
Both Arms and Both Legs	The Full Amount
Both Arms and One Leg or Both Legs and One Arm	3/4 of the Full Amount
Both Arms	2/3 of the Full Amount
Both Legs	2/3 of the Full Amount
One Arm and One Leg	2/3 of the Full Amount
One Arm or One Leg	1/2 of the Full Amount

The Full Amount can be found in the Schedule of Benefits. Only one benefit (the larger) will be paid for more than one loss resulting from any one accident. In no event will the total of all benefits paid under the Policy to you for any one accident, under this benefit and the Accidental Death and Dismemberment Benefit exceed your Amount of Accidental Death and Dismemberment Benefit shown in the Schedule of Benefits.

A benefit will not be payable for a loss:

- (1) caused by suicide or intentionally self-inflicted injuries; or
- (2) caused by or resulting from war or any act of war, declared or undeclared; or
- (3) caused by sickness or disease; or
- (4) sustained during your commission or attempted commission of an assault or felony; or
- (5) caused by your acute or chronic alcoholic intoxication; or
- (6) caused by your voluntary consumption of an illegal or controlled substance or a non-prescribed narcotic or drug.

SEAT BELT AND AIR BAG BENEFIT

Seat Belt Benefit

We will pay an additional Seat Belt Benefit if, due to an Injury sustained while driving or riding in a private passenger Four-Wheel Vehicle, you suffer loss of life for which an Accidental Death Benefit is payable under the Policy.

Once we receive the police accident report which confirms that you were properly strapped in a Seat Belt at the time of the accident, we will pay a benefit equal to 10% of the Accidental Death Benefit payable under the Policy.

If the police report does not clearly establish that you were or were not wearing a Seat Belt at the time of the accident which caused your death, the benefit payable will be \$1,000 in lieu of the benefit described above.

"Seat Belt" means an unaltered factory-installed lap and/or shoulder restraint designed to keep a person steady in a seat.

Air Bag Benefit

In addition to the Seat Belt Benefit, we will also pay an Air Bag Benefit if such private passenger Four-Wheel Vehicle is equipped with a factory-installed Air Bag and the police accident report clearly establishes that you were positioned in a seat which is designed to be protected by an Air Bag and were properly strapped in the Seat Belt when the Air Bag inflated.

Once we receive the police accident report which confirms that the Air Bag inflated properly upon impact, we will pay a benefit equal to 5% of the Accidental Death Benefit payable under the Policy.

"Air Bag" means an unaltered factory-installed supplemental restraint system designed to inflate upon impact to protect a person from bodily Injury during an accident.

"Four-Wheel Vehicle" means a private passenger automobile, a truck-type vehicle which has a manufacturer's rated load capacity of 2,000 pounds or less, or a self-propelled motor home, all of which are registered for private passenger use and designated for transportation on public roadways.

Maximum Benefit Payable – The total combined maximum benefit payable under the Seat Belt and Air Bag Benefit is \$25,000.

EXCLUSIONS

No benefit is payable for any loss sustained by you:

- (1) if you were driving or riding in any private passenger Four-Wheel Vehicle which was being used in a race, speed or endurance test, or for acrobatic or stunt driving at the time of the accident;
- (2) if you were not wearing a Seat Belt for any reason;
- (3) while you were sharing a Seat Belt.

CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice must be given to us within 31 days after the 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 your 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, extent and nature of the loss.

PROOF OF LOSS: For any covered Loss, 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 1 year, unless the claimant is legally incapable of doing so.

PAYMENT OF CLAIMS: Payment will be made as soon as proper proof is received. All benefits will be paid to you, if living. Any benefits unpaid at the time of death, or due to death, will be paid to the beneficiary.

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

LEGAL ACTION: No legal action may be brought against us to recover on the Policy within 60 days after written proof of loss has been given as required by the Policy. No action may be brought after three (3) years (Kansas, five (5) years; South Carolina and Michigan, six (6) years) from the time written proof of loss is required to be submitted.

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

Family and Medical Leave of Absence:

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

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

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

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

Military Services Leave of Absence:

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

As long as the above requirement is satisfied, we will continue coverage until the end of the period required by USERRA.

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

While you are on a Family and Medical Leave of Absence for any reason other than your own illness, injury or disability or Military Services Leave of Absence you will be considered Actively at Work. Any changes such as revisions to coverage due to age, class or salary changes, as applicable, will apply during the leave except that increases in the amount of insurance, whether automatic or subject to election, will not be effective if you are not considered Actively at Work until you have returned to Active Work for one (1) full day.

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

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

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

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

PORTABILITY

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

- (1) notify us in writing within thirty-one (31) days from the date you cease to be eligible; and
- (2) remit the necessary premiums when due; and
- (3) are not approved for extension of coverage under the Waiver of Premium in Event of Total Disability provision, if applicable; and
- (4) have not been terminated under the Waiver of Premium in Event of Total Disability provision, if applicable; and
- (5) have been covered for twelve (12) months under the Policy and/or the prior group life insurance policy.

Such coverage may be continued for a period of two (2) years beginning on the date you are no longer an Eligible Person.

The amount of coverage available under the Portability provision will be the current amount of coverage you are insured for under the Policy on the last day you were Actively at Work. However, the amount of coverage will never be more than:

- (1) the highest amount of life insurance available to Eligible Persons; or
- (2) a total of \$500,000 from all RSL group life and accidental death and dismemberment insurance combined, whichever is less.

The premium charged to continue coverage will be based on the prevailing rate charged to Insureds who choose to continue coverage under the Portability provision. Such premium will be billed directly to you on a quarterly, semi-annual or annual basis.

If your coverage under the Policy includes Accidental Death and Dismemberment, then such benefits may be continued under the Policy.

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

- (1) the date the Policy terminates; or
- (2) the end of the period for which premium has been paid; or
- (3) the date you are covered under another group term life insurance policy; or
- (4) at the end of the two (2) year period; or
- (5) at any time coverage would normally terminate according to the terms of the Policy had you continued to be an Eligible Person.

In addition, coverage will reduce at any time it would normally reduce according to the terms of the Policy had you continued to be an Eligible Person.

If insurance coverage terminates due to (1) or (4) above, it may be converted to an individual life insurance policy. The conversion will be subject to the terms and conditions set forth under the Conversion Privilege.

GROUP TERM LIFE INSURANCE ACCELERATED BENEFIT RIDER

THIS RIDER ADDS AN ACCELERATED BENEFIT PROVISION. RECEIPT OF THIS ACCELERATED BENEFIT WILL REDUCE THE DEATH BENEFIT AND MAY BE TAXABLE. IN ADDITION, RECEIPT OF THIS BENEFIT MAY AFFECT THE INSURED'S ELIGIBILITY FOR MEDICAID OR OTHER GOVERNMENT BENEFITS OR ENTITLEMENTS. INSURED'S SHOULD SEEK ASSISTANCE FROM THEIR PERSONAL TAX ADVISOR.

Attached to Group Policy Number: GL 645991

Issued to Group Policyholder: Thornton Township High School #205

This Rider is attached to and made a part of the Policy indicated above. Your Certificate is hereby amended, in consideration of the application for this coverage, by the addition of the following benefit. In this Rider, Reliance Standard Life Insurance Company will be referred to as "we", "us", "our".

DEFINITIONS: This section gives the meaning of terms used in this Rider. The Definitions of the Policy and Certificate also apply unless they conflict with Definitions given here.

"Certified" or "Certification" refers to a written statement, made by a Physician on a form provided by us, as to the Insured's Terminal Illness.

"Certificate" means the document, issued to each Insured, which explains the terms of his coverage under the Group Life Insurance Policy.

"Death Benefit" means the insurance amount payable under the Certificate at death of the Insured. It does not include any amount that is only payable in the event of Accidental Death.

"Insured" means only a primary Insured. Dependents are not eligible for coverage under this Accelerated Benefit Rider.

"Physician" means a duly licensed practitioner, acting within the scope of his license, who is recognized by the law of the state in which diagnosis is received. The Physician may not be the Insured or a member of his immediate family.

"Policy" means the Group Life Insurance Policy issued to the Group Policyholder under which the Insured is covered.

"Terminally Ill" or "Terminal Illness" refers to an Insured's illness or physical condition that is Certified by a Physician to reasonably be expected to result in death in less than 24 months.

"Written Request" means a request made, in writing, by the Insured to us.

All pronouns include either gender unless the context indicates otherwise.

DESCRIPTION OF COVERAGE: This benefit is payable to the Insured if the Insured's coverage is in force and the Insured is Certified as Terminally Ill: at any time for loss resulting from accidental injury; or after having been insured under this Rider for at least 30 days prior to a loss resulting from sickness. In order for this benefit to be paid:

- (1) the Insured must make a Written Request; and
- (2) we must receive from any assignee or irrevocable beneficiary their signed acknowledgment and agreement to payment of this benefit.

We may, at our option, confirm the terminal diagnosis with a second medical exam performed at our own expense.

AMOUNT OF THE ACCELERATED BENEFIT: The Accelerated Benefit will be an amount equal to 75% of the Death Benefit applicable to the Insured under the Policy on the date of the Certification of Terminal Illness, subject to a maximum benefit of \$500,000. This benefit may be paid as a single lump sum or in installment payments mutually agreed to by us and the Insured. The Accelerated Benefit is payable one time only for any Insured under this Rider.

EFFECT OF BENEFIT: If an Insured becomes eligible for, and elects to receive this benefit, it will have the following effects:

- (1) The Death Benefit payable for such Insured will be reduced by an amount equal to the Accelerated Benefit paid such Insured. Such reduced amount of insurance will be subject to all Certificate provisions dealing with changes in the amount of insurance and reductions or termination for age or retirement. The amount of the Accelerated Benefit plus the corresponding Death Benefit will not exceed the amount that would have been paid as the Death Benefit in the absence of this Rider.
- (2) Any amount of insurance that would otherwise be continued under a Waiver of Premium provision will be reduced proportionately, as will the maximum Face Amount available under the Conversion Privilege.

MISSTATEMENT OF AGE OR SEX: The Accelerated Benefit will be adjusted to reflect the amount of benefit that would have been purchased by the actual premium paid at the correct age and sex.

TERMINATION OF AN INDIVIDUAL'S COVERAGE UNDER THIS RIDER: The coverage of any Insured under this Rider will terminate on the first of the following:

- (1) the date his coverage under the Policy terminates;
- (2) the date of payment of the Accelerated Benefit for his Terminal Illness; or
- (3) the date he attains age 75.

ADDITIONAL PROVISIONS: This Rider takes effect on the Effective Date shown. It will terminate on the date the Group Policy terminates. It is subject to all the terms of the Group Policy not inconsistent herewith.

In witness whereof, we have caused this Rider to be signed by our Secretary.


Secretary

**ACCELERATED BENEFIT RIDER DISCLOSURE
FOR RIDER LRS-8596-001-0200 IL**

The Accelerated Benefit option is an advance payment of life insurance proceeds under our group term life insurance program. This option allows the Insured to access the face amount of his insurance coverage prior to death if he is diagnosed as having less than 24 months to live. There are no restrictions placed on how the proceeds may be used.

ELIGIBILITY: The Insured is eligible to exercise the Accelerated Benefit option if, after having been covered under the Rider for at least thirty (30) days (this thirty (30) day elimination period does not apply with respect to a condition resulting from an accident), he has been diagnosed as having a medical condition which will result in a drastically limited life-span and his doctor certifies that death will occur within 24 months. We reserve the right to investigate further to verify eligibility.

THE BENEFIT: The Accelerated Benefit Option pays 75% of the death benefit, to a maximum of \$500,000, in a single lump sum or in installment payments mutually agreed to by us and the Insured. The portion of the death benefit which is not accelerated is payable to his beneficiary at his death.

There is no additional premium charge for the Accelerated Benefit Rider. There is no reduction in the premium for the group term life insurance coverage if benefits become payable under this Rider.

If the group Policy and/or the Insured's life insurance benefits under the Group Policy terminate, all of the Insured's rights under the Accelerated Benefit Rider also terminate.

EFFECT OF BENEFIT: Receipt of the Accelerated Benefit may be taxable and could adversely affect the Insured's eligibility for Medicaid or other government benefits or entitlements. It is recommended that the Insured consult his personal tax advisor for clarification of the current tax law with respect to accelerated death benefits.

**NOTICE OF
PROTECTION PROVIDED BY
ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION**

This notice provides a **brief summary** description of the Illinois Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Illinois law that determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity or health insurance company becomes financially unable to meet its obligations and is placed into Receivership by the Insurance Department of the state in which the company is domiciled. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Illinois law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association per insolvency 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, except special rules apply to hospital, medical and surgical insurance benefits for which the maximum amount of protection is \$500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also residency requirements and other limitations under Illinois law.

To learn more about these protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ilhiga.org or contact:

*Illinois Life and Health
Insurance Guaranty Association
8420 West Bryn Mawr Avenue, Suite 550
Chicago, Illinois 60631-3404
(773) 714-8050*

*Illinois Department of Insurance
4th Floor
320 West Washington Street
Springfield, Illinois 62767
(217) 782-4515*

Insurance companies and agents are not allowed by Illinois law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Illinois law, then Illinois law will control.

**Claim Procedures and
ERISA Statement of Rights**

**CLAIM PROCEDURES FOR CLAIMS FILED WITH
RELIANCE STANDARD LIFE INSURANCE COMPANY
ON OR AFTER APRIL 1, 2018**

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed form along with any requested information to:

Reliance Standard Life Insurance Company
Claims Department
P.O. Box 8330
Philadelphia, PA 19101-8330

Claim forms are available from your benefits representative or may be requested by writing to the above address or by calling 1-800-644-1103.

In the event of any *Adverse Benefit Determination* (defined below), the claimant (or their authorized representative) may appeal that *Adverse Benefit Determination* in accordance with the following procedures. This opportunity to appeal exists without regard to the applicability of the Employee Retirement Income Security Act of 1974 as amended ("ERISA"), 29 U.S.C. 1001 *et seq.*

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION

Non-Disability Benefit Claims

If a non-disability claim is wholly or partially denied, the claimant shall be notified of the Adverse Benefit Determination within a reasonable period of time, but not later than 90 days after our receipt of the claim, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the benefit determination is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing.

Disability Benefit Claims

In the case of a claim for disability benefits, the claimant shall be notified of the Adverse Benefit Determination within a reasonable period of time, but not later than 45 days after our receipt of the claim. This period may be extended for up to 30 days, provided that it is determined that such an extension is necessary due to matters beyond our control and that notification is provided to the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If, prior to the end of the first 30-day extension period, it is determined that, due to matters beyond our control, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the claimant is notified, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which a decision is expected to be rendered. In the case of any such extension, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

Non-Disability Benefit Claims

A Claimant shall be provided with written notification of any Adverse Benefit Determination. The notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and
4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an Adverse Benefit Determination on Review.

Disability Benefit Claims

A claimant shall be provided with written notification of any Adverse Benefit Determination. The notification shall be set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an Adverse Benefit Determination on Review; and
5. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
 - a) The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
 - b) The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination; and
 - c) A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;
6. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist;
7. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant (defined below) to a claim for benefits; and
8. The notification shall be provided in a Culturally and Linguistically Appropriate (defined below) manner.

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

Appeals of Adverse Benefit Determinations may be submitted in accordance with the following procedures to:

Reliance Standard Life Insurance Company
Quality Review Unit
P.O. Box 8330
Philadelphia, PA 19101-8330

Non-Disability Benefit Claims

1. Claimants (or their authorized representatives) must appeal within 60 days following their receipt of a notification of an Adverse Benefit Determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
5. No deference to the initial Adverse Benefit Determination shall be afforded upon appeal;

6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual; and
7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant's Adverse Benefit Determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination.

Disability Benefit Claims

1. Claimants (or their authorized representatives) must appeal within 180 days following their receipt of a notification of an Adverse Benefit Determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant (defined below) to the claimant's claim for benefits;
4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
5. No deference to the initial Adverse Benefit Determination shall be afforded upon appeal;
6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant's Adverse Benefit Determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination;
8. In deciding the appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, the individual conducting the appeal shall consult with a health care professional:
 - (a) who has appropriate training and experience in the field of medicine involved in the medical judgment; and
 - (b) who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal; nor the subordinate of any such individual.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

Non-Disability Benefit Claims

The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Disability Benefit Claims

The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 45 days after receipt of the claimant's timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on

review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

Non-Disability Benefit Claims

A claimant shall be provided with written notification of the benefit determination on review. In the case of an Adverse Benefit Determination on Review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant (defined below) to the claimant's claim for benefits; and
4. A statement of the claimant's right to bring an action under section 502(a) of ERISA (where applicable).

Disability Benefit Claims

A claimant must be provided with written notification of the determination on review. In the case of Adverse Benefit Determination on Review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant (defined below) to the claimant's claim for benefits;
4. A statement of the claimant's right to bring an action under section 502(a) of ERISA (where applicable) as well as a description of any applicable contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim;
5. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
 - a) The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
 - b) The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination; and
 - c) A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;
6. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist;
7. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant (defined below) to a claim for benefits; and
8. The notification shall be provided in a Culturally and Linguistically Appropriate (defined below) manner.

REQUESTS CONCERNING ALLEGED VIOLATION OF THESE PROCEDURES

In the event that a claimant requests a written explanation of any alleged violation of these procedures, such explanation should be provided within 10 days, including a specific description of any basis for asserting that any violation should not cause any administrative remedies available under the plan to be exhausted (where applicable).

DEFINITIONS

The term "Adverse Benefit Determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan.

The term "Culturally and Linguistically Appropriate Manner" means:

- Oral language services (such as telephone customer assistance hotline) that includes answering questions in any Applicable Non-English Language and providing assistance with filing claims and appeals in any Applicable Non-English Language must be provided;
- A notice in any Applicable Non-English Language must be provided upon request; and
- A statement prominently displayed in any Applicable Non-English Language clearly indicating how to access the language services provided must be included in the English versions of all notices.

The term "Applicable Non-English Language" means:

With respect to an address in any United States county to which a notice is sent, a non-English language is an Applicable Non-English Language if ten percent or more of the population residing in the county is literate only in the same non-English language as determined in guidance published by the United States Secretary of Health and Human Services.

The term "us" or "our" refers to Reliance Standard Life Insurance Company.

The term "Relevant" means:

A document, record, or other information shall be considered relevant to a claimant's claim if such document, record or other information:

- Was relied upon in making the benefit determination;
- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
- Demonstrates compliance with administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants; or
- In the case of a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit of the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The term "Reliance Standard Life Insurance Company" means Reliance Standard Life Insurance Company and/or its authorized claim administrators.

ERISA STATEMENT OF RIGHTS

As a participant in the Group Insurance Plan, you may be entitled to certain rights and protections in the event that the Employee Retirement Income Security Act of 1974 (ERISA) applies. ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including

insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefits plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interests of you and other Plan Participants and Beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

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

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal Court. If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.