RELIANCE STANDARD LIFE INSURANCE COMPANY
2001 Market St., Suite 1500, Philadelphia, PA 19103-7090

IMPORTANT NOTICE

To obtain information or to make a complaint:

You may call Reliance Standard Life Insurance Company's toll-free telephone number for information or to make a complaint at

1-800-HELP-RSL

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

1-800-252-3439

You may write the Texas Department of Insurance

P.O. Box 149104
Austin, Texas 78714-9104
FAX # (512) 475-1771

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim, you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Par obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de Reliance Standard Life Insurance Company para informacion o para someter una queja al:

1-800-HELP-RSL

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas

P.O. Box 149104
Austin, Texas 78714-9104
FAX # (512) 475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con la compania primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

RELIANCE STANDARD
Life Insurance Company

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

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. VIP530415 issued to Southeast Texas Government Employee Benefits Pool, the Policyholder.

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

SECRETARY

PRESIDENT

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THISPOLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WORKERS COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

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SCHEDULE OF BENEFITS

ELIGIBLE CLASSES: Full-time employees who are Actively at Work and earning an annual salary of at least $15,000.00, except if you are employed on a temporary or seasonal basis.

WAITING PERIOD: None

INDIVIDUAL EFFECTIVE DATE: The first day of the first month coinciding with or next following the date you complete your enrollment form, if in an Eligible Class.

INDIVIDUAL REINSTATEMENT: Six (6) Months

DISABILITY BENEFIT

ELIMINATION PERIOD: 90 consecutive days of Disability

BENEFIT: If an eligible employee, you may elect an amount of insurance, in increments of $100 from $500 to $6,000 per month up to 60% of your Covered Earnings, payable in accordance with the section entitled Benefit Determination.

MINIMUM BENEFIT: In no event will the benefit payable to you be less than $100.00 per month.

MAXIMUM DURATION OF BENEFITS:

Benefits will not accrue beyond the longer of: the Duration of Benefits; or Normal Retirement Age; specified below.

Age at Disablement	Duration of Benefits
61 or less	To Age 65
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 or more	12 months

OR

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

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

BENEFIT PAYMENT MODE: Monthly

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

Contributions for you are being made on a post-tax basis. This means that your Benefit will be treated as non-taxable for the purposes of filing your Federal Income Tax Return. It is recommended that you contact your personal tax advisor. A change in the contribution basis may affect the premiums, tax treatment and eligibility for these benefits.

DEFINITIONS

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

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

"Actively at Work" and "Active Work" means on any given day you are actually performing the material duties pertaining to your job in the place where and the manner and number of hours in which your 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 an Injury or Sickness.

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

"Benefit" means the benefit shown on the Schedule of Benefits payable in accordance with the section entitled Benefit Determination.

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

"Covered Earnings" means your basic monthly salary received from the employer on the day just before the date of Disability. Covered Earnings do not include commissions, overtime pay, bonuses, benefits, the employer's contributions toward benefits, or any other special compensation. However, Covered Earnings will include commissions received from your employer averaged over the lesser of:

(1) the number of months worked; or
(2) the 36 months;

as of the first of the month just before the date of Disability.

If you are an hourly paid employee, the number of hours worked during a regular work week, not to exceed forty (40) hours per week will be used to determine Covered Earnings.

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

(1) during the Elimination Period you cannot with reasonable accommodations as defined under the Americans With Disabilities Act ("ADA") of 1990, as amended perform the material duties of your Own Occupation; and
(2) after the Elimination Period:
    (a) for the first 24 months for which a benefit is payable you cannot with reasonable accommodations as defined under the Americans With Disabilities Act ("ADA") of 1990, as amended perform the material duties of your Own Occupation; and
    (b) after a benefit has been paid for 24 months, you cannot with reasonable accommodations as defined under the Americans With Disabilities Act ("ADA") of 1990, as amended perform the material duties of Any Occupation.

We consider you to be Disabled if due to any Injury or Sickness you are capable of only performing the material duties of your Own Occupation or Any Occupation, as applicable above, on a part-time basis or some of the material duties on a full-time basis.

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

"Elimination Period" means a period of consecutive days of Disability where you are not Actively at Work, as shown on the Schedule of Benefits page, for which no benefit is payable. It begins on the first day of Disability.

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

"Full-time", for the purpose of determining eligibility, means working for the Policyholder for a minimum of 30 hours during a person's regular work week.

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

“Injury“ means bodily Injury resulting directly from an accident, independent of all other causes. The Injury must cause Disability which begins while insurance coverage is in effect for you. Injury does not include the risk of being injured.

“Own Occupation” means the occupation you are routinely performing when Disability begins. We will look at your occupation as it is normally performed in the national economy, and not how the work tasks are performed for a specific employer or at a specific location.

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

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

“Rehabilitative Employment“ means work in any gainful occupation for which your training, education or experience will reasonably allow. The work must be supervised by a Physician or a licensed or certified rehabilitation counselor approved by us. Rehabilitative Employment includes work performed while Disabled, but does not include performing all the material duties of your regular occupation on a full-time basis.

“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; or (3) retirement benefits under the United States Social Security Act of 1935, as amended, or under any similar plan or act.

“Retirement Benefits” means money you are entitled to receive upon early or normal retirement or disability retirement under:

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

Retirement Benefits do not include:

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

“Sickness“ means illness or disease causing Disability which begins while insurance coverage is in effect for you, but does not include the risk of Sickness. Sickness includes pregnancy, childbirth, miscarriage or abortion, or any complications therefrom.

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

TRANSFER OF COVERAGE PROVISION

This Transfer of Coverage Provision is applicable to you only if you were insured under a Prior Plan and are subject to sections A, B or C below. In such case, any benefit payable under this provision will be in accordance with the provisions of the Policy less any benefit for which the Prior Plan is liable. However, in no event will the benefit payable be greater than that which would have been paid under the Prior Plan's schedule of benefits.

Benefits will end on the earlier of the following dates:

(1) the Maximum Duration of Benefits as shown on the Schedule of Benefits; or
(2) the date benefits would have ended under the terms of the Prior Plan if it had remained in force.

(A) Failure to be Actively at Work due to Injury or Sickness

The Policy will cover you, subject to premium payments, if:
(1) you were insured under the Prior Plan at the time of transfer; and
(2) you are not Actively at Work due to Injury or Sickness on the effective date of the Policy; and
(3) the Disability begins on or after the Policy's effective date.

(B) Continuity of Coverage With Respect to Recurrent Disabilities

The following provision will apply if you were insured under a Prior Plan.

The Elimination Period under the Policy will be waived for a Disability which begins while you are insured under this Policy if all of the following conditions are met:
(1) the Disability results from the same or related causes as a Disability for which benefits were payable under the Prior Plan;
(2) benefits are not payable for a Disability under the Prior Plan solely because it is not in effect;
(3) an Elimination Period would not apply to the Disability if the Prior Plan had not ended;
(4) you were Actively at Work for more than 14 consecutive days while covered under the Policy; and
(5) the Disability begins within 6 months of your return to Active Work.

(C) Pre-existing Conditions

Benefits may be payable if the Disability results from a Pre-existing Condition (as defined on the Limitations page) if you were:
(1) Actively at Work and insured under the Policy on its effective date; and
(2) insured under the Prior Plan at the time of transfer; and
(3) unable to satisfy the Pre-existing Condition provision under the Policy.

In order to receive benefits, you must satisfy the Pre-existing Condition provision under the Prior Plan had that plan remained in force.

"Prior Plan" means any policy of group disability coverage that has been replaced by coverage under part or all of this Policy. It must have been sponsored by you. The replacement can be complete or in part for the eligible class to which you belong.

GENERAL PROVISIONS

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

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

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

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

NOT IN LIEU OF WORKER'S COMPENSATION: The Policy is not a Worker's Compensation Policy. It does not provide Worker's Compensation benefits.

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

CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice must be given to us within thirty-one (31) days after the loss occurs, or as soon as reasonably possible. The notice should be sent to us at our Administrative Office or to our authorized agent. The notice should include your name, the Policyholder's name and the Policy Number.

CLAIM FORMS: When we receive the notice of claim, we will send the Claimant the claim forms to file with us. We will send them within fifteen (15) days after we receive notice. If we do not, then proof of Disability will be met by giving us a written statement of the type and extent of the Disability. The statement must be sent within ninety (90) days after the loss began.

WRITTEN PROOF OF LOSS: For any loss, written proof must be sent to us within 90 days after the commencement of the period for which we may be liable. If it is not reasonably possible to give proof within such time, 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 from the time proof is otherwise required, unless you are legally incapable of doing so.

PAYMENT OF CLAIMS: When we receive written proof of Disability covered by the Policy, we will pay any benefits due. Benefits that provide for periodic payment will be paid for each period as we become liable.

We will pay benefits to you, if living, or else to your estate.

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

Reliance Standard Life Insurance Company and/or its appointed claims administrator shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. Reliance Standard Life Insurance Company is not the Plan Administrator. 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.

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

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

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

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

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

to determine the existence of any Disability which is the basis for a claim. This right may be used as often as it is reasonably required while a claim is pending or in payment status. We also have the right to have a Claimant interviewed by a vocational counselor.

We may require that an autopsy be performed unless prohibited by law.

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

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

ELIGIBILITY REQUIREMENTS: You are eligible for insurance under the Policy if you are a member of an Eligible Class as shown on the Schedule of Benefits page.

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

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

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

CHANGES IN BENEFIT: Increases in the Benefit are effective on the date of the change, provided you are Actively at Work on the effective date of the change. If you are not Actively at Work on that date, the effective date of the change will be deferred until the date you return to Active Work for one full day.

Decreases in the Benefit are effective on the date the change occurs.

Premium increases due to you entering into a higher age bracket will occur on the Policy Anniversary coinciding with or next following the Insured's last birthday.

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

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

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

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

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

BENEFIT PROVISIONS

INSURING CLAUSE: We will pay a benefit if you:
(1) are Disabled as the result of a Sickness or Injury covered by the Policy;
(2) are under the Regular Care of a Physician;
(3) have completed the Elimination Period; and
(4) submit satisfactory proof of Disability to us.

BENEFIT DETERMINATION: The amount payable is the benefit shown on the Schedule of Benefits, less Other Income Benefits.

We will pay at least the Minimum Benefit, as shown on the Schedule of Benefits page.

OTHER INCOME BENEFITS: Other Income Benefits are:
(1) disability income benefits you are eligible to receive under any group insurance plan(s);
(2) disability income benefits you are eligible to receive under any governmental retirement system, except benefits payable under a federal government employee pension benefit;
(3) all permanent as well as temporary disability benefits, including any damages or settlement made in place of such benefits (whether or not liability is admitted) you are eligible to receive under:
    (a) Worker's Compensation Laws;
    (b) occupational disease law;
    (c) any other laws of like intent as (a) or (b) above; and
    (d) any compulsory benefit law;
(4) any of the following that you are eligible to receive:
    (a) any formal salary continuance plan;
    (b) wages, salary or other compensation, excluding the amount allowable under the Rehabilitative Employment provision; and
    (c) commissions or monies, including vested renewal commission, but, excluding commissions or monies that you earned prior to Disability which are paid after Disability has begun;
(5) that part of disability or Retirement Benefits paid for by the Policyholder that you are receiving under a group retirement plan, provided such benefit does not reduce the amount of your accrued normal Retirement Benefits then funded;
(6) disability or Retirement Benefits under the United States Social Security Act, the Canadian pension plans, federal or provincial plans, or any similar law for which:
    (a) you are eligible to receive because of your Disability or eligibility for Retirement Benefits; and
    (b) your dependents are eligible to receive due to (a) above; and
(7) individual disability income benefits to the extent that the sum of the Benefit on the Schedule of Benefits page and Other Income Benefits exceeds 100% of Covered Earnings.

Benefits above will be estimated if the benefits:
(1) have not been applied for; or
(2) have been applied for and a decision is pending; or
(3) have been denied and the denial may be appealed.

The Benefit will be reduced by the estimated amount. If benefits have been estimated, the Benefit will be adjusted when we receive proof:
(1) of the amount awarded; or
(2) benefits have been denied and the denial cannot be further appealed.

Retirement Benefits under number 6 above will not apply to disabilities which begin after age 70 if you are already receiving Social Security Retirement Benefits while continuing to work beyond age 70.

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

For each day of a period of disability less than a full week or month, the amount payable will be $1/7^{th}$ or $1/30^{th}$ of the Benefit, determined by the definition of Disabled.

For the purposes of the Other Income Benefits provision, amounts that you are eligible to receive means the total benefit amount for which a claim may be asserted before any reduction for taxes or other offsets. This includes amounts which may be payable to a third party on behalf of you.

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

LUMP SUM PAYMENTS: If Other Income Benefits are paid in a lump sum, the Benefit Determination will be calculated as if such sum were prorated over the lesser of:

(1) the period of time stated in the settlement agreement, if any; or
(2) the number of months we expect the Insured to remain disabled based on actuarial tables of disabled lives; or
(3) the number of months remaining between:
    (a) the earlier of the date the settlement agreement was executed or the date the lump sum payment was made; and
    (b) the Maximum Duration of Benefits.

TERMINATION OF BENEFIT: The Benefit will stop on the earliest of:
(1) the date we determine you are no longer Disabled;
(2) the date you die;
(3) the Maximum Duration of Benefits, as shown on the Schedule of Benefits page, has ended;
(4) the date you fail to furnish written proof of Disability, satisfactory to us;
(5) the date no further benefits are payable under any provision in the Policy that limits the benefit duration;
(6) the date you are no longer receiving or refuse to receive Regular Care;
(7) the date you fail to submit to any medical or vocational examination required by us;
(8) the date you cease to reside in the United States or Canada. You will be considered to reside outside the United States or Canada when you have been outside the United or Canada for 6 months or more during any 12 consecutive month period;
(9) the date you fail to report any Other Income Benefits;
(10) the dates during which you are confined in any penal or correctional institution;
(11) the date you become eligible for benefits under any other group disability plan provided by the Policyholder, if such date occurs after the date that the Policy terminates;
(12) the date you are asymptomatic.

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

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

This recurrent disability section will not apply to you if you become eligible for insurance coverage under any other group disability insurance plan.

REHABILITATIVE EMPLOYMENT

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

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

RETURN TO WORK INCENTIVE

During a period of Disability for which a benefit is payable, if you perform Rehabilitative Employment, we will not offset earnings from Rehabilitative Employment for the first twelve (12) months you are performing such Rehabilitative Employment until the sum of:

(1) the benefit prior to offsets with Other Income Benefits; and

(2) earnings from Rehabilitative Employment;

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

CHILD CARE EXPENSE CREDIT

We will allow a Child Care credit if:

(1) you are receiving benefits under the Return to Work Incentive provision;

(2) your Child(ren) is (are) under 14 years of age;

(3) the child care is provided by a non-relative; and

(4) the charges for child care are documented by a receipt from the caregiver, including social security number or taxpayer identification number.

During the twelve (12) month period in the Return to Work Incentive provision, an amount equal to actual expenses incurred for child care, up to a maximum of $250 per month, will be added to your Covered Earnings when calculating the benefit under the Return to Work Incentive provision.

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

EXCLUSIONS

1. We will not pay a benefit for any Disability caused by:
   (1) an act of war, declared or undeclared;
   (2) an intentionally self-inflicted Injury, while sane or insane;
   (3) your committing or attempting to commit a felony;
   (4) an Injury or Sickness that occurs while you are confined in any penal or correctional institution.

2. During the first 6 months of Disability, we will not pay a benefit for a Disability caused by:
   (1) cosmetic surgery or treatment primarily to change appearance;
   (2) in vitro fertilization;
   (3) embryo transfer procedures;
   (4) artificial insemination;
   (5) sex change surgery;
   (6) reversal of sterilization;
   (7) liposuction;
   (8) radial keratotomy.

LIMITATIONS

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

(1) the Disability begins in the first 24 months after your effective date; and
(2) you have received medical treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines for the Sickness or Injury, whether specifically diagnosed or not, causing such Disability, during the 6 months immediately prior to your effective date of insurance.

Benefits will not be paid for a Disability:

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

a Pre-existing Condition unless you have been Actively at Work for one (1) full day following the end of 24 consecutive months from your effective date of insurance.

With respect to your 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 Disability:

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

a Pre-existing Condition unless you have been Actively at Work for one (1) full day following the end of 24 consecutive months from the effective date of the Benefit increase.

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

(1) the Disability begins in the first 24 months after your effective date of the Benefit increase; and
(2) you have received medical treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines for the Sickness or Injury, whether specifically diagnosed or not, causing such Disability, during the 6 months immediately prior to the effective date of the Benefit increase.

MENTAL OR NERVOUS DISORDERS, SUBSTANCE ABUSE AND OTHER DISORDERS

Benefits for Disability caused by or contributed to by Mental or Nervous Disorders/Substance Abuse/Other Disorders will not be payable beyond an aggregate lifetime maximum duration of twenty-four (24) months unless you are in a Hospital or Institution at the end of the twenty-four (24) month period. The Benefit will be payable while so confined, but not beyond the Maximum Duration of Benefits as shown on the Schedule of Benefits page.

If you were confined in a Hospital or Institution during a period of Disability as described above, and:

(1) Disability continues beyond discharge; and
(2) the period of confinement was for at least fourteen (14) consecutive days;

then upon discharge, benefits will be payable, while Disability continues, for the greater of:

(1) the unused portion of the twenty-four (24) month period; or
(2) ninety (90) days;

but in no event beyond the Maximum Duration of Benefits, as shown on the Schedule of Benefits page.

Mental or Nervous Disorders are those conditions not otherwise limited in this provision that are described in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association (DSM).

If you are not confined in a Hospital or Institution, benefits for Disability due to Substance Abuse will be payable only while you are a participant in a Substance Abuse Rehabilitation Program, but not beyond the aggregate lifetime maximum duration of twenty-four (24) months. However, in no event will benefits be payable beyond the maximum Duration of Benefits as shown on the Schedule of Benefits page.

"Substance Abuse" means the pattern of pathological use of a Substance which is characterized by:

(1) impairments in social and/or occupational functioning;
(2) debilitating physical condition;
(3) inability to abstain from or reduce consumption of the Substance; or
(4) the need for daily Substance use for adequate functioning.

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

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

Other Disorders are any of the following:

(1) Chronic fatigue syndrome;
(2) Environmental Allergic or Reactive Illness;
(3) Fibromyalgia;
(4) Self-Reported Conditions;
(5) Musculoskeletal and connective tissue disorders of the neck and back, including any disease, disorder, sprain and strain of the joints and adjacent muscles of the cervical, thoracic and lumbrosacral regions and their surrounding soft tissue.

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

(1) Arthritis
(2) Demyelinating diseases
(3) Myelitis
(4) Myelopathies
(5) Osteopathies
(6) Radiculopathies documented by electromyogram
(7) Ruptured intervertebral discs
(8) Scoliosis
(9) Spinal fractures
(10) Spinal tumors, malignancy or vascular malformations
(11) Spondylolisthesis, Grade II or higher
(12) Traumatic spinal cord necrosis

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

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

SPECIFIC INDEMNITY BENEFIT

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

(1) the Loss must occur within one hundred and eighty (180) days of the accident; and
(2) you must live past the later of: (a) 90 days from the date of the accident; or (b) the Elimination Period.

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

*The Number of Benefit Payments cannot exceed the Maximum Duration of Benefits as shown on the Schedule of Benefits.

"Loss(es)" with respect to:

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

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

The amount payable is the Benefit, as shown on the Schedule of Benefits page, with no reduction from Other Income Benefits. The Number of Benefit Payments will not cease if you return to Active Work.

If death occurs after we begin paying benefits, but before the Specific Indemnity benefit has been paid according to the above schedule, the balance remaining at time of death will be paid to your estate, unless a beneficiary is on record with us under the Policy.

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

SURVIVOR BENEFIT

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

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

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

"Survivor" means your spouse. If the spouse dies before you or you were legally separated, then your natural, legally adopted or step-children, who are under age twenty-six (26) will be the Survivor(s).

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

CONVERSION PRIVILEGE

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

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

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

(2) Written application for conversion coverage must be made by you within 31 days of termination of insurance under the Policy;

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

(4) Proof of health is not required.

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

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

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

Conversion is not available if:

(1) the Policy terminates; or

(2) the Policy is amended to exclude your eligible class; or

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

(4) you retire or die; or

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

(6) you are Disabled under the Policy; or

(7) you become covered under another disability plan.

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

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

FAMILY AND MEDICAL LEAVE OF ABSENCE EXTENSION

We will allow your coverage to continue, for up to 12 weeks in a 12 month period, if you are eligible for, and the Policyholder has approved, a Family and Medical Leave of Absence under the terms of the Family and Medical Leave Act of 1993, as amended, for any of the following reasons:

(1) To provide care after the birth of a son or daughter; or
(2) To provide care for a son or daughter upon legal adoption; or
(3) To provide care after the placement of a foster child in your home; or
(4) To provide care to a spouse, son, daughter, or parent due to serious illness; or
(5) To take care of your own serious health condition as explained below.

If you, due to your own serious health condition, meet the definition of Disability as well as all other requirements in the Policy, you will be considered Disabled and eligible to receive a benefit. All premiums will be waived as long as you are receiving such benefit. If you, due to your own serious health condition, are working on a reduced leave schedule or an intermittent leave schedule, as described by the Family and Medical Leave Act of 1993, as amended, but are not considered Disabled under the Policy, Premium payments will be continued under this extension.

You will not qualify for the Family and Medical Leave of Absence Extension unless we have received proof from the Policyholder, in a form satisfactory to us, that you have been granted a leave under the terms of the Family and Medical Leave Act of 1993, as amended. Such proof: (1) must outline the terms of your leave; and (2) give the date the leave began; and (3) the date it is expected to end; and (4) must be received by us within thirty-one (31) days after a claim for benefits has been filed with us.

If the Policyholder grants you a Family and Medical Leave of Absence, the following applies:

(1) While you are on an approved Family and Medical Leave of Absence, the required premium must be paid according to the terms specified in the Policy to keep the insurance in force.

(2) While you are on an approved Family and Medical Leave of Absence, you will be considered Actively at Work in all instances unless such leave is due to your own illness, injury, or disability.

(3) Changes such as revisions to coverage because of age, class, or salary changes will apply during the leave except that increases in amount of insurance, whether automatic or subject to election, are not effective if you are not Actively at Work until such time as you return to Active Work for one full day.

(4) If you become Disabled while on a Family and Medical Leave of Absence, any benefit which becomes payable will be based on your Covered Earnings immediately prior to the date of Disability.

(5) Coverage will terminate if you do not return to work as scheduled according to the terms of your agreement with the Policyholder. In no case will coverage be extended under this benefit beyond 12 weeks in a 12 month period. Insurance will not be terminated if you become Disabled during the period of the leave and are eligible for benefits according to the terms of the Policy.

All other terms and conditions of the Policy will remain in force while you are on an approved Family and Medical Leave of Absence.

MILITARY SERVICES LEAVE OF ABSENCE EXTENSION

We will allow your coverage to continue, for up to 12 weeks in a 12 month period, if you enter the military service of the United States. While you are on a Military Services Leave of Absence, the required premium must be paid according to the terms specified in the Policy to keep the insurance in force. Changes such as revisions to coverage because of age, class or salary changes will apply during the leave except that increases in amount of insurance, whether automatic or subject to election, are not effective until you have returned to Active Work from Military Services Leave of Absence for one full day. All other terms and conditions of the Policy will remain in force during this continuation period. Your continued coverage will cease on the earliest of the following dates:

(1) the date the Policy terminates; or
(2) the date ending the last period for which any required premium was paid; or
(3) 12 weeks from the date your continued coverage began.

The Policy, however, does not cover any loss which occurs while on active duty in the military service if such loss is caused by or arises out of such military service, including but not limited to war or act of war (whether declared or undeclared) and is also subject to any other exclusions listed in the Exclusions provision.

Claims Procedures and ERISA Rights Statement

CLAIM PROCEDURES FOR CLAIMS FILED WITH
RELIANCE STANDARD LIFE INSURANCE COMPANY
ON OR AFTER JANUARY 1, 2002

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

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 that 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 an 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 an 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) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.

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 advise was obtained in connection with a claimant's adverse benefit determination shall be identified, without regard to the whether the advise 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 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 advise was obtained in connection with a claimant's adverse benefit determination shall be identified, without regard to the whether the advise was relied upon in making the benefit determination; and
(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 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 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);
(5) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; and
(6) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency" (where applicable).

DEFINITIONS

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

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

The term "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 similarity 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 advise 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.

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE, ACCIDENT, HEALTH AND HOSPITAL SERVICE INSURANCE GUARANTY ASSOCIATION

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association (the "Association"), to protect policyholders if their life or health insurance company fails to or cannot meet its contractual obligations. Only the policyholders of insurance companies which are members of the Association are eligible for this protection. However, even if a company is a member of the Association, protection is limited and policyholders must meet certain guidelines to qualify. (The law is found in the Texas Insurance Code, Article 21.28-D).

BECAUSE OF STATUTORY LIMITATIONS ON POLICYHOLDER PROTECTION, IT IS POSSIBLE THAT THE ASSOCIATION MAY NOT COVER YOUR POLICY OR MAY NOT COVER YOUR POLICY IN FULL.

Eligibility for Protection by the Association

When an insurance company which is a member of the Association is designated as imparted by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

(1) **residents of Texas** at the time that their insurance company is impaired
(2) **residents of other states,** ONLY if the following conditions are met:

(1) The policyholder has a policy with a company based in Texas;
(2) The company has never held a license in the policyholder's state of residence;
(3) The policyholder's state of residence has a similar guaranty association; and
(4) The policyholder is **not eligible** for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

(1) up to a total of $200,000 for one or more policies for each individual covered.

Life Insurance:

(1) net cash surrender value up to a total of $100,000 under one or more policies on any one life; or
(2) death benefits up to a total of $300,000 under one or more policies on any one life.

Individual Annuities:

(1) net cash surrender amount up to a total of $100,000 under one or more policies owned by one contractholder.

Group Annuities:

(1) net cash surrender amount up to $100,000 in allocated benefits under one or more policies owned by one contractholder; or
(2) net cash surrender amount up to $5,000,000 in unallocated benefits under one contractholder regardless of the number of contracts.

THE INSURANCE COMPANY AND ITS AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE ASSOCAITON FOR THE PURPOSE OF SALES, SOLICITATION, OR INDUCEMENT TO PURCHASE ANY FORM OF INSURANCE.

When you are selecting an insurance company, you should not rely on coverage by the Association.

Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association
301 Congress, Suite 500
Austin, Texas 78701

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-25203439