RELIANCE STANDARD
LIFE INSURANCE COMPANY

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

WHERE TO FIND: **Page**

CERTIFICATE OF INSURANCE

We certify that you, provided you belong to a class described on the Schedule of Benefits, are insured for the benefits which apply to your class under Group Policy No. VCI 800753 issued to Illinois Eastern Community College District #529, the Policyholder.

This Certificate is not a contract of insurance. It contains only the major terms of insurance coverage and payment of benefits under the Policy.

Secretary

President

READ THIS CERTIFICATE CAREFULLY. PRE-EXISTING CONDITIONS LIMITATIONS APPLY.

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

THE POLICY IS OPTIONALLY RENEWABLE.

NO BENEFITS ARE PAYABLE FOR ANY CRITICAL ILLNESS DIAGNOSED DURING THE BENEFIT WAITING PERIOD.

The term "Spouse" as used in this Certificate includes a civil union partner, and the term "Marriage" includes a civil union.

GROUP CRITICAL ILLNESS CERTIFICATE

SCHEDULE OF BENEFITS

EFFECTIVE DATE: January 1, 2017

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

BENEFIT WAITING PERIOD: 30 days

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

INDIVIDUAL REINSTATEMENT: 6 months

AMOUNT OF INSURANCE:

Employee Coverage: Each Eligible Person may elect an Amount of Insurance in increments of $1,000 from a minimum of $5,000 to a maximum of $50,000 which will apply to all Categories.

Any Employee Amount of Insurance over the guaranteed issue amount of $15,000 is subject to our approval of such person's good health.

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

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

Dependent Coverage:

Spouse Amount of Insurance: Each eligible Dependent spouse, who is under the age of 70 is eligible for coverage in increments of $1,000 from a minimum of $5,000 to a maximum of $50,000 not to exceed 100% of your approved Amount of Insurance which will apply to all Categories. The 100% cap based on your approved Amount of Insurance does not apply when your Amount of Insurance is reduced due to age.

Any Dependent spouse Amount of Insurance over the guaranteed issue amount of $15,000 is subject to our approval of the Dependent spouse's good health.

The Dependent spouse Amount of Insurance will reduce in the same manner as your Amount of Insurance upon the Dependent spouse's attainment of the reducing age(s).

Child Amount of Insurance: 25% of your approved Amount of Insurance, up to $12,500. Child coverage is all guaranteed issue and is not subject to proof of good health.

The Child Amount of Insurance will continue at 25% of your Amount of Insurance prior to any reductions due to age.

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

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

Premium changes due to your age will occur on the December 1st coinciding with or next following the birthday that causes you to enter the next age bracket.

If an increase in, or initial application for, the Amount of Insurance is due to a life event change (such as marriage, birth or specific changes in employment status), proof of good health will not be required for amounts up to the guaranteed issue amount, provided you apply within thirty-one (31) days of such life event.

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

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

BENEFITS FOR CRITICAL ILLNESSES DIAGNOSED UNDER THE POLICY

CATEGORY 1	
Carcinoma in Situ-Partial Benefit	25% of the Amount of Insurance
Life Threatening Cancer	100% of the Amount of Insurance
CATEGORY 2	
Coronary Artery Bypass - Partial Benefit	25% of the Amount of Insurance
Heart Attack (myocardial infarction)	100% of the Amount of Insurance
Stroke	100% of the Amount of Insurance
CATEGORY 3	
Kidney (Renal) Failure	100% of the Amount of Insurance
Major Organ Transplant	100% of the Amount of Insurance
ALL CATEGORIES:	
Recurrence(s) in the Same Category	50% of the Amount of Insurance except Carcinoma in situ and Coronary By-Pass which is 12.5%.
Subsequent Occurrence(s) in a Different Category	100% of the Amount of Insurance except Carcinoma in situ and Coronary By-Pass which is 25%.
Lifetime Maximum Benefit Per Category	200% of the Amount of Insurance
Wellness Benefit:	$50

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

"Benefit Waiting Period" means the period of time, shown on the Schedule of Benefits page, after your Individual Effective Date of coverage that you and any Insured Dependents must be covered under the Policy before being diagnosed with a Critical Illness for which benefits may be payable. A new Benefit Waiting Period applies to any increases in the Amount of Insurance on the effective date of such increase.

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

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

"Critical Illness" means a serious sickness or medical procedure required to treat a serious sickness or injury as defined in the Benefit Provisions of the Policy.

"Dependents" means:

(1) your legal spouse; and
(2) your unmarried child(ren), including adoptive, foster and stepchildren who are financially dependent upon you for support and under age:
    (a) 26; or
    (b) 30 if the Dependent is:
        (i) an Illinois resident;
        (ii) served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States, and
        (iii) has received a release or discharge other than a dishonorable discharge.

When an unmarried Insured Dependent reaches the maximum age, coverage will not cease while this insurance coverage remains in force for you if: (a) the child is unable to provide self-support due to mental retardation or physical handicap; and (b) he is chiefly dependent on you for support; and (c) proof of the above conditions is received as set forth under the section entitled, TERMINATION OF DEPENDENT INSURANCE.

A child who is in the custody of the insured, pursuant to an interim court order of adoption vesting temporary care of the child in the insured, will be considered to be an adopted child, regardless of whether a final order granting adoption is ultimately issued.

Additionally, if your domestic partnership or civil union is legally recognized under applicable state law and is in effect, your:

(1) domestic partner or civil union partner; and
(2) child(ren), provided he/she otherwise meets the definition of Dependent, of such legally recognized domestic partnership or civil union will be considered your "Dependent".

When your domestic partner or civil union partner is covered under the Policy, the word "spouse" as it appears in the Policy will be deemed to mean "domestic partner" and "civil union partner", unless the context indicates otherwise.

"Eligible Person" means a person who meets the Eligibility Requirements of the Policy.

"Diagnosis/Diagnosed" means the diagnosis by a Physician that must be:
(1) made while you or your Insured Dependent's coverage is in force under the Policy; and

(2) made after the Benefit Waiting Period as shown on the Schedule of Benefits; and
(3) in writing; and
(4) based on objective clinical findings or laboratory tests that are supported by medical records and any other diagnostic requirements defined in the Policy.

"Full-time" means working for the Policyholder for a minimum of 40 hours during your regular scheduled work week.

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

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

"Immediate Family" means the parents, siblings, spouse or children of you or your Insured Dependent.

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

"Insured" means a person who meets the eligibility requirements of the Policy and is enrolled for this insurance.

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

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

"Recurrence" means the Diagnosis by a Physician of a Critical Illness in the same Category as a Critical Illness Diagnosed for which a Critical Illness Benefit has been paid.

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

"Subsequent Occurrence" means the Diagnosis by a Physician of a Critical Illness Diagnosed in a different Category from a Critical Illness Diagnosed for which a Critical Illness Benefit has been paid under the Policy.

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

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

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

GENERAL PROVISIONS

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

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

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

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

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

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

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

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

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

MISSTATEMENT OF AGE: If your or your Insured Dependent's age is misstated, the premium will be adjusted if necessary. If your or your Insured Dependent's insurance is affected by the misstated age, it will also be adjusted. The insurance coverage will be changed to the amount you or your Insured Dependent are entitled to at the correct age.

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

NOT IN LIEU OF WORKERS' COMPENSATION: The Policy is not a Workers' Compensation Policy. It does not provide Workers' Compensation benefits.

INDIVIDUAL ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

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

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

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

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

(1) the Individual Effective Date stated on the Schedule of Benefits, if you apply on or before that date; or
(2) the first day of the month coinciding with or next following the date you apply, if you apply within thirty-one (31) days from the date you first met the eligibility requirements; or
(3) the first day of the month coinciding with or next following the date we approve any required proof of good health. We require proof of good health if 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 shown on the Schedule of Benefits; or
    (d) for an Amount of Insurance greater than he/she was insured for with the prior group critical illness carrier, if applicable; or
    (e) after being eligible for coverage under a prior group critical illness 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.

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

If you, as an Eligible Person, are not Actively at Work on the day your insurance is to go into effect, the insurance will go into effect on the day you return to Active Work for one (1) full day.

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

(1) the date the Policy terminates; or
(2) the last day of the Policy month in which you cease to be in a class eligible for this insurance; or
(3) the end of the period for which premium has been paid; or
(4) the date when all Critical Illness benefits applicable to you under the Policy have been paid; or
(5) the date you enter military service (not including Reserve or National Guard).

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

(1) twelve (12) months, if due to Sickness or Injury; or

(2) one (1) month, if due to temporary lay-off or approved leave of absence.

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

(1) on an approved leave of absence; or

(2) on temporary lay-off.

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

You, as a former Insured, will not be required to fulfill the eligibility requirements of the Policy again. The insurance will go into effect on the day you return to Active Work. However, if you return after having resigned or having been discharged, you will be required to fulfill the eligibility requirements of the Policy again.

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

BENEFIT PROVISIONS

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

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

Critical Illnesses are separated by categories as follows:

CATEGORY 1 – Cancer Related Critical Illnesses

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

The term "Carcinoma in situ" does not mean:

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

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

Benefits will not be paid under Carcinoma in situ and Life Threatening Cancer if you or your Insured Dependent is eligible for benefits under both Critical Illnesses. We will, however, pay the highest benefit.

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

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

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

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

Benefits will not be paid under Carcinoma in situ and Life Threatening Cancer if you or your Insured Dependent is eligible for benefits under both Critical Illnesses. We will, however, pay the highest benefit.

CATEGORY 2 – Cardiovascular Related Critical Illnesses

"Coronary Artery Bypass" means the use of a non-coronary blood vessel or blood vessels (either artery or vein) to surgically bypass obstructions in a native coronary artery or arteries supplying blood to the heart.

The term "Coronary Artery Bypass" does not mean any other procedure such as, but not limited to, balloon or laser angioplasty, stent procedures or other minimally invasive procedures performed to increase blood flow.

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

In order to be covered under this provision, the Diagnosis by a Physician of Heart Attack (acute myocardial infarction) must be based on:

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

Benefits will not be payable for a Heart Attack that occurs within twenty-four (24) hours of a medical procedure.

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

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

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

CATEGORY 3 – Other Critical Illnesses

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

If a Critical Illness benefit has been paid under Kidney (Renal) Failure, we will not pay a benefit under Major Organ Transplant for a kidney transplant.

"Major Organ Transplant" means that you or your Insured Dependent has been Diagnosed by a Physician as requiring the replacement of a irreversibly failing organ with an organ transplanted from a suitable human donor and you or your Insured Dependent has either been placed on the Transplant List or been the recipient of such major organ transplant performed under generally accepted medical procedures. Organs covered by this definition are limited to the entire liver, kidney, lung, heart, pancreas or pancreas-kidney.

If a Critical Illness benefit has been paid under Kidney (Renal) Failure, we will not pay a benefit under Major Organ Transplant for a kidney transplant.

BENEFIT AMOUNT: Benefits for the Diagnosis of a Critical Illness defined above will be payable at the Amount of Insurance as specified on the Schedule of Benefits.

CONCURRENT DIAGNOSIS OF MORE THAN ONE CRITICAL ILLNESS: If you or your Insured Dependent can qualify for benefits for more than one Critical Illness at the same time, we will only pay for one (1) Critical Illness with the highest benefit.

RECURRENCE(S) OF A CRITICAL ILLNESS IN THE SAME CATEGORY: Once you or your Insured Dependent have been Diagnosed with a Critical Illness and a Critical Illness Benefit has become payable, Recurrences of a Critical Illness in the same Category will be covered up to the Lifetime Maximum Benefit shown on the Schedule of Benefits provided the Recurrence is diagnosed at least eighteen (18) months after the previous Critical Illness was Diagnosed.

If the Recurrence is diagnosed less than eighteen (18) months after the Diagnosis, no benefit will be payable for that Recurrence. However, a later Recurrence, if any, may be covered.

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

SUBSEQUENT OCCURRENCE(S) OF A CRITICAL ILLNESS IN A DIFFERENT CATEGORY: Once a Critical Illness has been Diagnosed in a particular Category under the Policy, coverage will continue and benefits will be payable for subsequent and unrelated Critical Illnesses in a different Category if the Critical Illness is Diagnosed at least six (6) months after the date of the Diagnosis of the prior Critical Illness.

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

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

LIMITATIONS

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

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

Benefits will not be paid for a Critical Illness:

(1) caused by; or
(2) resulting from;

a Pre-existing Condition unless the Critical Illness is diagnosed after twelve (12) consecutive months from your or your Insured Dependent's effective date of insurance.

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

(1) caused by; or
(2) resulting from;

a Pre-existing Condition unless the Critical Illness is diagnosed after twelve (12) consecutive months from the effective date of the benefit increase.

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

(1) the Critical Illness is diagnosed in the first twelve (12) months after the effective date of the benefit increase; and
(2) you or your Insured Dependent have received medical Treatment, consultation, care or services, including diagnostic procedures or took prescribed drugs or medicines for a Sickness or Injury, whether specifically diagnosed or not, causing or contributing to such Critical Illness, during the twelve (12) months immediately prior to the effective date of the benefit increase.

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

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

EXCLUSIONS

EXCLUSIONS: A Critical Illness benefit will not be paid:

(1) if caused by one of the following:
  (a) an act of war, declared or undeclared;
  (b) intentionally self-inflicted Injury;
  (c) your or your Insured Dependent's commission or attempted commission of a felony;
  (d) your or your Insured Dependent's use of alcohol or drugs unless taken as prescribed by a Physician;
  (e) a Sickness or Injury that occurs while you or the Insured Dependent are confined in a penal or correctional institution;
  (f) cosmetic or elective surgery that is not medically necessary;
  (g) committing or attempting to commit suicide while sane or insane;
  (h) your or the Insured Dependent's participation in a riot or insurrection;

(2) for a Critical Illness Diagnosed outside of the United States unless such Diagnosis is confirmed within the United States. If such Diagnosis is confirmed within the United States, the Critical Illness will be deemed to have occurred on the date Diagnosis was made outside the United States;

(3) for a Critical Illness Diagnosed in one Category that follows by less than six (6) months a Critical Illness Diagnosed in another Category for which benefits have been paid;

(4) for a Critical Illness in the same Category as a Critical Illness Diagnosed for which a benefit has been paid if it is Diagnosed less than eighteen (18) months after the previous Critical Illness was Diagnosed;

(5) for a Critical Illness which is Diagnosed during the Benefit Waiting Period; or

(6) for a Heart Attack that occurs within twenty-four (24) hours of a medical procedure.

WELLNESS BENEFIT

We will pay you the amount shown on the Schedule of Benefits for one (1) health screening test performed during a twelve (12) month period for you and your Insured Dependents* provided you:

(1) supply written proof satisfactory to us that such a health screening test has been performed; and
(2) were covered under the Policy at the time the test was performed; and
(3) have not already received a benefit under this provision at any time during the same twelve (12) month period.

Health screening tests covered under the Policy are:

(1) Stress test on a bicycle or treadmill;
(2) Fasting blood glucose test;
(3) Blood test for triglycerides;
(4) Serum cholesterol test to determine level of HDL and LDL;
(5) Bone marrow testing;
(6) Breast ultrasound;
(7) CA 15-3 (blood test for breast cancer);
(8) CA 125 (blood test for ovarian cancer);
(9) CEA;
(10) Chest X-ray;
(11) Colonoscopy;
(12) Flexible sigmoidoscopy;
(13) Hemoccult stool analysis;
(14) Mammography;
(15) Pap smear;
(16) PSA (blood test for prostate cancer); and
(17) Serum Protein Electrophoresis (blood test for myeloma).

*Only one (1) Wellness Benefit will be paid in a twelve (12) month period for all Insured Dependent children as a group.

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

PREMIUMS

PREMIUM RATES: The premium due is based on the coverage requested. Premium rates are based on the age attained on the Premium due date. We have the right to change the premium rates. We will give written notice of our intention to change such rates to the Policyholder at least thirty-one (31) days prior to the effective date of the rate change.

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

BENEFICIARY AND FACILITY OF PAYMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CLAIMS PROVISIONS

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

CLAIM FORMS: When we receive written notice of a claim, we will send claim forms to the claimant within fifteen (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 Critical Illness or health screening test, written proof must be sent to us within ninety (90) days. If it is not reasonably possible to give proof within ninety (90) days, the claim is not affected if the proof is sent as soon as reasonably possible. In any event, proof must be given within one (1) year, unless the claimant is legally incapable of doing so.

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

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

Proof of Loss for a covered health screening test must include, at your expense, all of the following information:

(1) a completed claim form signed by you or your Insured Dependent and your or your Insured Dependent's Physician(s); and
(2) supporting documentation from the Physician, including but not limited to laboratory evidence that a health screening test from the list of covered health screening tests in the Policy has been performed and the date on which such test was performed.

TIME OF PAYMENT OF CLAIMS: When we receive satisfactory written proof of loss, we will pay any benefits due within thirty (30) days. Claims not paid within that time shall pay interest at a rate of 9% per annum from the thirtieth (30th) day. Benefits that provide for periodic payment will be paid accordingly.

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

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

LEGAL ACTION: No legal action may be brought against us to recover on the Policy within 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 from the time written proof of loss is required to be submitted.

DEPENDENT CRITICAL ILLNESS INSURANCE

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

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

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

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

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

EFFECTIVE DATE OF DEPENDENT INSURANCE: If the Policyholder pays the entire premium, the insurance for a Dependent will become effective on the later of:

(1) the first day of the month coinciding with or next following the date you become eligible for Dependent insurance; or
(2) the first day of the month coinciding with or next following the date the dependent meets the definition of Dependent.

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

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

For a Dependent who is confined in a hospital or at home on the date on which he/she would otherwise become insured, insurance will be effective as of the date the confinement ends.

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

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

(1) the date this Section terminates; or
(2) the date the dependent is no longer a Dependent as defined; or
(3) the date the Insured Dependent spouse reaches age 75; or
(4) the end of the period for which premium has been paid by you or the Policyholder; or
(5) the date all benefits available under the Policy have been paid on behalf of all Insured Dependents; or
(6) the date your insurance terminates; or
(7) the date you retire.

NEWLYWED PROVISION: At your marriage if you did not previously elect Dependent coverage, your new spouse shall automatically become an Insured Dependent.

Such spouse shall be an Insured Dependent for thirty-one (31) days. He/she shall then cease to be an Insured Dependent unless:

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

DOMESTIC PARTNER/CIVIL UNION PARTNER PROVISION: With respect to an Insured who had not previously elected Dependent coverage, your civil union/domestic partner shall automatically become an Insured Dependent spouse at the time your civil union or domestic partnership is legally recognized under applicable state law.

Such domestic partner/civil union shall be an Insured Dependent for thirty-one (31) days. He/she shall then cease to be an Insured Dependent unless:

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

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

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

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

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

The above coverage will also be extended to any children of a civil union or domestic partnership legally recognized under applicable state law, provided they otherwise meet the definition of Dependent.

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

Family and Medical Leave of Absence:

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

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

Military Services Leave of Absence:

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

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

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

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

PORTABILITY

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

(1) notify us in writing within thirty-one (31) days from the date insurance coverage is terminated under the Policy; and
(2) remit the necessary premium when due; and
(3) have been covered for twelve (12) months under the Policy and/or the prior group critical illness insurance policy.

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

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

If your and your Insured Dependent's Critical Illness coverage under the Policy includes the Wellness Benefit then such benefits may be continued under the Policy.

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

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

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

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

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 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 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. 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 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 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; 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 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.