RELIANCE STANDARD LIFE INSURANCE COMPANY

1700 Market Street, Suite 1200, Philadelphia, PA 19103-3938

Have a complaint or need help?

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

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

Reliance Standard Life Insurance Company

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

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

The Texas Department of Insurance.

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

Call: 1-800-252-3439.
Online: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov

Mail:
MC 111-1A
P.O. Box 149091
Austin, TX 78714

¿Tiene una queja o necesita ayuda?

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

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

Reliance Standard Life Insurance Company

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

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

El Departamento de Seguros de Texas

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

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

reliancestandard
LIFE INSURANCE COMPANY

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

POLICYHOLDER: Michaels Stores, Inc **POLICY NUMBER:** VPL 303642

EFFECTIVE DATE: July 1, 2021, as amended through December 1, 2024

ANNIVERSARY DATES: July 1, 2022 and each July 1st thereafter.

PREMIUM DUE DATES: The first Premium is due on the Effective Date. Further Premiums are due monthly, in advance, on the first day of each month.

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

Reliance Standard Life Insurance Company is referred to as "we", "our" or "us" in this Policy.

The Policyholder and any subsidiaries, divisions or affiliates are referred to as "you", "your" or "yours" in this Policy.

We agree to provide insurance to you in exchange for the payment of Premium and a signed Application. This Policy provides income replacement benefits for Total Disability from Sickness or Injury. It insures those Eligible Persons for the Monthly Benefit shown on the Schedule of Benefits. The insurance is subject to the terms and conditions of this Policy.

The Effective Date of this Policy is shown above. This Policy stays in effect as long as Premium is paid when due. The "TERMINATION OF THIS POLICY" section of the GENERAL PROVISIONS explains when the insurance terminates.

This Policy is signed by our President and Secretary.

Secretary

President

GROUP LONG TERM DISABILITY INSURANCE
NON-PARTICIPATING

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, 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 WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

This Long Term Disability Policy amends the Long Term Disability Policy previously issued to you by us. It is issued on December 17, 2024.

RELIANCE STANDARD LIFE INSURANCE COMPANY

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

GROUP POLICY NUMBER:	VPL 303642	**POLICY EFFECTIVE DATE:**	July 1, 2021, as amended through December 1, 2024
POLICY DELIVERED IN:	Texas	**ANNIVERSARY DATE:**	July 1st in each year

Application is made to us by: Michaels Stores, Inc

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

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

Signed at _____ this_____day of _____.

Policyholder: _____

By: _____
(Signature)

_____
(Title)

Please sign and return.

*BC1COAPVPL 30364212/01/2024*RSL
*BC2COAPMichaels Stores, Inc

RELIANCE STANDARD LIFE INSURANCE COMPANY

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

GROUP POLICY NUMBER:	VPL 303642	**POLICY EFFECTIVE DATE:**	July 1, 2021, as amended through December 1, 2024
POLICY DELIVERED IN:	Texas	**ANNIVERSARY DATE:**	July 1st in each year

Application is made to us by: Michaels Stores, Inc

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

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

Signed at _____ this_____day of _____.

Policyholder: _____

By: _____
(Signature)

_____
(Title)

TABLE OF CONTENTS

Page

SCHEDULE OF BENEFITS

NAME OF SUBSIDIARIES, DIVISIONS OR AFFILIATES TO BE COVERED: ALL

"Affiliate" means any corporation, partnership, or sole proprietor under the common control of the Policyholder.

ELIGIBLE CLASSES: Each active, Full-time hourly Team Member, except a Hourly Manager and Hourly Assistant Store Manager and any person employed on a temporary or seasonal basis.

WAITING PERIOD: 30 days of continuous employment.

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

INDIVIDUAL REINSTATEMENT: 30 Days

MINIMUM PARTICIPATION REQUIREMENTS: Percentage: 30%* Number of Insureds: 10

*The Minimum Participation Percentage requirement shown is applied across all voluntary group disability policies issued to the Policyholder.

LONG TERM DISABILITY BENEFIT

ELIMINATION PERIOD: 90 consecutive days of Total Disability.

MONTHLY BENEFIT: Each Eligible Person may elect an amount of insurance equal to 60% of his/her Covered Monthly Earnings, payable in accordance with the section entitled Benefit Amount.

MINIMUM MONTHLY BENEFIT: In no event will the Monthly Benefit payable to an Insured be less than $100.

MAXIMUM MONTHLY BENEFIT: $5,000

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 (in years)
61 or less	To Age 65
62	3 ½
63	3
64	2 ½
65	2
66	1 ¾
67	1 ½
68	1 ¼
69 or more	1

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

CHANGES IN MONTHLY BENEFIT: Increases in the Monthly Benefit are effective on the date of the change, provided the Insured is Actively at Work on the effective date of the change. If the Insured is not Actively at Work on that date, the effective date of the increase in the benefit amount will be deferred until the date the Insured returns to Active Work. Decreases in the Monthly Benefit are effective on the date the change occurs.

Premium changes due to an Insured's age will occur on the July 1st coinciding with or next following the birthday that causes the Insured to enter the next age bracket.

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

APPROVED ENROLLMENT PERIODS: It is your responsibility to provide us with written notice at least thirty-one (31) days prior to conducting an Annual Enrollment Period of the beginning and end dates of such enrollment period. The terms of the Approved Enrollment Period will be as follows:

During an Approved Enrollment Period, beginning May 6 and ending on June 30, applications for employees who were previously eligible and are now applying for initial insurance coverage will not require proof of health, provided:

(1) the application is complete, signed, and received by you during the Approved Enrollment Period;
(2) the employee was not previously declined for group disability insurance coverage by us; and
(3) the employee did not have an application withdrawn or marked as incomplete for any reason.

Insurance coverage applied for during this Approved Enrollment Period will be effective on the July 1st following the Approved Enrollment Period, provided the employee is Actively at Work, applicable premium is paid and any applicable service waiting period has been satisfied.

CONTRIBUTIONS: Insured: 100%

Contributions for the Insured are being made on a post-tax basis. For purposes of filing the Insured's Federal Income Tax Return, this means that under the law as of the date this Policy was issued, the Insured's Monthly Benefit might be treated as non-taxable. It is recommended that the Insured contact his/her personal tax advisor.

DEFINITIONS

"Actively at Work" and "Active Work" mean actually performing on a Full-time basis the material duties pertaining to his/her job in the place where and the manner in which the job is normally performed. This includes approved time off such as vacation, jury duty and funeral leave, 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 an Insured is reasonably suited based upon his/her education, training or experience.

"Claimant" means an Insured who makes a claim for benefits under this Policy for a loss covered by this Policy as a result of an Injury to or a Sickness of the Insured.

"Covered Monthly Earnings" means the Insured's monthly salary received from you on the day just before the date of Total Disability, prior to any deductions to a 401(k) and Section 125 plan. Covered Monthly Earnings does not include commissions, overtime pay, bonuses, incentive pay or any other special compensation not received as Covered Monthly Earnings.

If hourly paid employees are insured, the number of hours worked during a regular work week, not to exceed forty (40) hours per week, times 4.333, will be used to determine Covered Monthly Earnings. If an employee is paid on an annual basis, then the Covered Monthly Earnings will be determined by dividing the basic annual salary by 12.

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

"Elimination Period" means a period of consecutive days of Total Disability, as shown on the Schedule of Benefits page, for which no benefit is payable. It begins on the first day of Total Disability.

Interruption Period: If, during the Elimination Period, an Insured returns to Active Work for less than 30 days, then the same or related Total Disability will be treated as continuous. Days that the Insured is Actively at Work during this interruption period will not count towards the Elimination Period. This interruption of the Elimination Period will not apply to an Insured who becomes eligible under any other group long term disability insurance plan.

"Full-time" means working for you 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 the Insured's Total Disability.

"Injury" means bodily Injury resulting directly from an accident, independent of all other causes. The Injury must cause Total Disability which begins while insurance coverage is in effect for the Insured.

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

"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 the Insured or a member of his/her immediate family.

"Premium" means the amount of money needed to keep this Policy in force.

"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 the Insured's Physician according to generally accepted medical standards in the Insured's locality, be of a demonstrable medical value and be necessary to meet his/her basic health needs.

"Regular Occupation" means the occupation the Insured is routinely performing when Total Disability begins. We will look at the Insured's occupation as it is normally performed in the national economy, and not the unique duties performed for a specific employer or in a specific locale.

"Retirement Benefits" mean money which the Insured is 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 you;
(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 an Insured.

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 (TSA);
(6) a stock ownership plan; or
(7) a profit sharing plan; or
(8) section 401(k), 403(b) or 457 plans.

"Sickness" means illness or disease causing Total Disability which begins while insurance coverage is in effect for the Insured. Sickness includes pregnancy, childbirth, miscarriage or abortion, or any complications therefrom.

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

(1) during the Elimination Period and for the first 24 months for which a Monthly Benefit is payable, an Insured cannot perform the material duties of his/her Regular Occupation;
    (a) "Partially Disabled" and "Partial Disability" mean that as a result of an Injury or Sickness an Insured is capable of performing the material duties of his/her Regular Occupation on a part-time basis or some of the material duties on a full-time basis. An Insured who is Partially Disabled will be considered Totally Disabled, except during the Elimination Period;
    (b) "Residual Disability" means being Partially Disabled during the Elimination Period. Residual Disability will be considered Total Disability; and
(2) after a Monthly Benefit has been paid for 24 months, an Insured cannot perform the material duties of Any Occupation. We consider the Insured Totally Disabled if due to an Injury or Sickness he or she is capable of only performing the material duties on a part-time basis or part of the material duties on a full-time basis.

If an Insured is employed by you and requires a license for such occupation, the loss of such license for any reason does not in and of itself constitute "Total Disability".

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

CERTAIN RESPONSIBILITIES OF THE POLICYHOLDER

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

Annual Enrollment Periods

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

Compliance With Americans With Disabilities Act (ADA)

It is your responsibility to establish and maintain procedures which comply with the employer responsibilities of the Americans With Disabilities Act of 1990, as amended.

Compliance With The Employee Retirement Income Security Act (ERISA)

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

Distribution Of Certificates Of Insurance

A Certificate of Insurance will be provided to you for each Insured covered under this Policy. The Certificate will outline the insurance coverage, and explain the provisions, benefits and limitations of this Policy. It is your responsibility to distribute the appropriate Certificates and any updates or other notices from us to each Insured.

Maintenance Of Records

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

Reporting Of Eligibility And Coverage Amounts

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

It is your responsibility to provide accurate census and salary information on all Insureds on or before each Anniversary Date, if we request such information.

Timely Payment Of Premiums

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

TRANSFER OF INSURANCE COVERAGE

If an employee was covered under any group long term disability insurance plan maintained by you prior to this Policy's Effective Date, that employee will be insured under this Policy, provided that he/she is Actively At Work and meets all of the requirements for being an Eligible Person under this Policy on its Effective Date.

If an employee was covered under the prior group long term disability insurance plan maintained by you prior to this Policy's Effective Date, but was not Actively at Work due to Injury or Sickness on the Effective Date of this Policy and would otherwise qualify as an Eligible Person, coverage will be allowed under the following conditions:

(1) The employee must have been insured with the prior carrier on the date of the transfer; and

(2) Premiums must be paid; and

(3) Total Disability must begin on or after this Policy's Effective Date.

If an employee is receiving long term disability benefits, becomes eligible for coverage under another group long term disability insurance plan, or has a period of recurrent disability under the prior group long term disability insurance plan, that employee will not be covered under this Policy. If premiums have been paid on the employee's behalf under this Policy, those premiums will be refunded.

Pre-existing Conditions Limitation Credit

If an employee is an Eligible Person on the Effective Date of this Policy, any time used to satisfy the Pre-existing Conditions Limitation of the prior group long term disability insurance plan will be credited towards the satisfaction of the Pre-existing Conditions Limitation of this Policy.

Waiting Period Credit

If an employee is an Eligible Person on the Effective Date of this Policy, any time used to satisfy any Waiting Period of the prior group long term disability insurance plan will be credited towards the satisfaction of the Waiting Period of this Policy.

GENERAL PROVISIONS

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

CHANGES: No agent has authority to change or waive any part of this Policy. To be valid, any change or waiver must be in writing, signed by either our President, a Vice President, or a Secretary. The change or waiver must also be attached to this Policy.

TIME LIMIT ON CERTAIN DEFENSES: After this Policy has been in force for two (2) years from its Effective Date, no statement made by you shall be used to void this Policy; and no statement by any Insured on a written application for insurance shall be used to reduce or deny a claim after the Insured's insurance coverage, with respect to which claim has been made, has been in effect for two (2) years.

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

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

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

Clerical Errors include (but are not limited to) the payment of premium for coverage not provided by this Policy. If appropriate, a fair adjustment of premium will be made to correct a clerical error. Such adjustments will be limited to the twelve (12) month period preceding the date we receive proof from you that an adjustment due to overpayment of premium should be made or the date we discover that premium has been underpaid.

MISSTATEMENT OF AGE: If an Insured's age is misstated, the Premium will be adjusted. If the Insured's benefit is affected by the misstated age, it will also be adjusted. The benefit will be changed to the amount the Insured is entitled to at his/her correct age.

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

CONFORMITY WITH STATE LAWS: Any section of this Policy, which on its Effective Date, conflicts with the laws of the state in which this Policy is issued, is amended by this provision. This Policy is amended to meet the minimum requirements of those laws.

CERTIFICATE OF INSURANCE: We will send to you an individual certificate for each Insured. The certificate will outline the insurance coverage, state this Policy's provisions that affect the Insured, and explain to whom benefits are payable.

TERMINATION OF THIS POLICY: You may cancel this Policy at any time by giving us written notice. This Policy will be cancelled on the date we receive your notice or, if later, the date requested in your notice.

This Policy will terminate at the end of the Grace Period if Premium has not been paid by that date.

We may cancel this Policy within thirty-one (31) days of written notice prior to the date of cancellation, only:

(1) if the number of Insureds is less than the Minimum Participation Number shown on the Schedule of Benefits; or
(2) if the percentage of Eligible Persons insured is less than the Minimum Participation Percentage shown on the Schedule of Benefits.

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

Termination of this Policy will not affect any claim which was covered prior to termination, subject to the terms and conditions of this Policy.

CLAIMS PROVISIONS

FILING A CLAIM:
Written notice of a claim must be given to us within thirty (30) days after the date the Insured's disability begins or as soon thereafter as reasonably possible. Notice means providing us with enough information so that we are able to identify the Insured as being covered under a long term disability policy issued by Reliance Standard Life Insurance Company. Written proof of the Insured's claim must be sent to us within ninety (90) days after the end of the Elimination Period. If written proof is not given in that time, the claim will not be invalidated nor reduced if it is shown that written proof was given as soon as reasonably possible. In any event, proof must be given within one (1) year after the date that proof of claim is otherwise required, unless the Insured is legally incapable of doing so. The notice and proof of claim should be sent to us by mail to Reliance Standard Claims, P.O. Box 8330, Philadelphia, PA 19101-8330, by email to ClaimsIntake@rsli.com, by fax to (267)256-4262, or electronically to https://rslclaims.com/. Notice or proof of claim sent to another location will not constitute valid notice or proof of claim.

Claim forms and other information needed to provide proof of the Insured's claim should be filed promptly. Insureds can access claim forms through our online website at https://customercare.rsli.com/Forms/ or can call the customer care center at 1-800-351-7500 to request a claim form from us. Our standard claim form includes a section to complete for the Insured, you, and the Physician providing the Insured Regular Care for the Sickness or Injury causing the Insured's Total Disability. The Insured is responsible for giving you and his or her Physician the appropriate section of the claim form for their completion. The completed form must be sent to us within the timeframes stated above for providing proof of claim.

If the Insured requests a claim form from us and does not receive the claim form or electronic access to the claim form within 15 days after the request, then proof of claim will be met by giving us a written statement of the Insured's claim, including the occurrence, character and extent of the Total Disability for which the claim is made, within the time period required for providing proof of claim. This written statement of the Insured's claim must include enough information for us to begin processing the claim, including the Insured's name, address, telephone number, the Policy number, the employer's name and address, and your name and address (if different from the employer).

WRITTEN PROOF OF LOSS: We will evaluate the Insured's written proof of claim to determine if the Insured has provided satisfactory proof of loss and to determine the amount of any benefits that may be payable. The Insured's proof of loss must include the following items, provided at the Insured's expense:

(1) That the Insured is under the Regular Care of a Physician;

(2) The date the Insured's Total Disability began;

(3) The cause of the Insured's Total Disability as determined by objective medical evidence, diagnostic studies, and examinations acceptable to the medical community;

(4) The extent of the Insured's Total Disability, including all restrictions and/or limitations;

(5) The name and address of all pharmacies, Hospital(s) or Institution(s) where the Insured received Treatment, including all Physicians who prescribed medications or provided Regular Care;

(6) Documentation of the Insured's Covered Monthly Earnings and all income received while Totally Disabled, including all earnings, income or benefits of any kind that the Insured may be receiving or eligible to receive while also claiming disability benefits under the Policy;

(7) Documentation that the Insured has applied for all Other Income Benefits that the Insured may be eligible for during the period of Total Disability for which the Insured is claiming disability benefits under the Policy;

(8) Written authorization for the Insured to release and for us to obtain medical, employment, and financial, information and any other information we may reasonably require to determine the Insured's eligibility to receive benefits under the Policy and the amount of benefits payable under the Policy. This includes the Insured's receipt of or eligibility for Other Income Benefits and signing a reimbursement agreement upon our request; and

(9) Tax returns, including all associated schedules and worksheets, business records, accountant's statements, and any other information we deem necessary to determine eligibility for benefits and the amount of benefits payable under the Policy.

The Insured is required to send proof of the Insured's continuing eligibility to receive disability benefits under the Policy and the amount of those benefits. This may include sending proof that the Insured is under the Regular Care of a Physician and/or any other information required above for proof of loss. We have the right to make this request as often as it is reasonably required during any ongoing review of benefit eligibility and while a claim is pending, including during any appeal from an adverse claim decision. We must receive this proof no later than 45 calendar days from the date we

ask for it. In some cases, we will require the Insured to give us authorization to obtain additional medical and non-medical information as part of the Insured's proof of claim. We have the right to terminate our payments to the Insured if the Insured does not cooperate with our requests for information or does not submit the information requested by us.

APPLYING FOR OTHER INCOME BENEFITS: We will require the Insured to apply for any Other Income Benefits that the Insured may be eligible for during the period of Disability for which the Insured is claiming benefits under the Policy. We may also require that the Insured appeal a denial of the Insured's claim for these Other Income Benefits.

We will also require the Insured to apply for disability benefits that may be available to the Insured under the Social Security Act. If we disagree with the Social Security Administration's denial of the Insured's application, the Insured will be required to follow the Social Security Administration's appeal process and to continue in that process to the highest level of appeals. We will provide the Insured with assistance during the application process for Social Security Disability benefits. We are unable to provide assistance during other Social Security application process.

PAYMENT OF CLAIMS: When we receive satisfactory written proof of the Insured's loss, we will pay any benefits due. Benefits that provide for periodic payment will be paid not less frequently than monthly for each period as we become liable.

We will pay benefits to the Insured, if living. Benefit payments that become due, or if any amount for which we are liable remains unpaid after the Insured's death, will be made to the Insured's estate. If there are legal impediments to payment of benefits that depend on the actions of parties other than us, we may hold further benefits due until such impediments are resolved and sufficient evidence of the same is provided. Legal impediments to payment may include, but are not limited to, the establishment of guardianships and conservatorships, or the appointment and qualification of trustees, executors and administrators, as applicable.

If the Insured has 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 the Insured's estate. The payment will only be made to persons entitled to it. An expense incurred as a result of the Insured's 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.

To the extent that the Insured is entitled to an award of pre-judgment interest by a court, the interest rate to be applied will be no higher than the rate for post-judgment interest pursuant to U.S.C. Section 1961.

AUTHORITY TO MAKE BENEFIT DETERMINATIONS: Reliance Standard Life Insurance Company shall serve as the claims review fiduciary with respect to the insurance Policy and certificate. The claims review fiduciary has the discretionary authority to interpret the Policy and the certificate and to determine eligibility for benefits and the amount of any benefits payable. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.

RECOVERY OF OVERPAYMENTS: We have the right to recover overpayments that occur due to:

(1) Fraud;
(2) An error we make in processing the Insured's claim;
(3) Payment we made that should have been made under another group plan; or
(4) The Insured's receipt of Other Income Benefits for periods during which the Insured has already received disability benefits under the Policy.

If we determine that we should have paid the Insured a different benefit amount from the amount actually paid on the Insured's claim, we will adjust the benefit accordingly. If we determine that we overpaid the Insured's claim, then we require that the Insured repay us in full. We will determine the method by which the Insured will repay us. The Insured will reimburse us for all overpayments. We have the right to obtain any information relating to sources of Other Income Benefits.

We reserve the right to demand an immediate refund from the Insured of any overpayment, to take legal action, or to apply any future payments that are determined to be due to the Insured under the Policy, including any applicable minimum benefits, toward any outstanding overpayment balances until we are reimbursed in full. We have the right to recover overpayments from the Insured's eligible survivors or estate. We reserve the right to deduct from the Insured's claim payment any unpaid premium due for the Insured's coverage. We will not recover more money from the Insured than the benefit amounts we paid to the Insured.

If the overpayment is due to the Insured's receipt of amounts from a third party by judgment, settlement or otherwise for a

Total Disability caused or contributed to by an act or omission of the third party, the Insured is obligated to repay us for the overpayment in full regardless of whether the Insured has been fully compensated for the Insured's injuries.

If the overpayment results from our having made a payment to the Insured that should have been made under another group plan, we may recover such overpayment from one or more of the following:

(1) any other insurance company;
(2) any other organization; or
(3) any person to or for whom payment was made.

SUBROGATION: If Monthly Benefits are paid or payable to the Insured under the Policy as the result of any act or omission of a third party, we will be subrogated to all rights of recovery the Insured may have in respect to such act or omission. The Insured must execute and deliver to us such instruments and papers as may be required and do whatever else is needed to secure such rights. The Insured must avoid doing anything that would prejudice our rights of subrogation. If the Insured notifies us before filing suit or settling the Insured's claim against such third party, the amount to which we are subrogated will be reduced by a pro rata share of the Insured's costs of recovery, including reasonable attorney fees. If suit or action is filed, we may record a notice of payments of Monthly Benefits, and such notice shall constitute a lien on any judgment recovered. If the Insured or the Insured's legal representative fail to bring suit or action promptly against such third party, we may institute such suit or action in our name or in the Insured's name. We are entitled to retain from any judgment recovered the amount of Monthly Benefits paid or to be paid to the Insured or on the Insured's behalf, together with our costs of recovery, including attorney fees. The remainder of such recovery, if any, shall be paid to the Insured or as the court may direct. If we bring a legal action against the third party on the Insured's behalf, we will not reduce the Insured's Monthly Benefits by any other amounts the Insured receives from the third party.

NOTIFICATION OF CLAIM DECISIONS: We will send the Insured written notice of our claim decision within a reasonable period of time, but not later than 45 days after we receive proof of the Insured's claim. If it is determined that an extension of time is needed to make a benefit determination, we will send the Insured a written notice within this initial 45 day timeframe that an additional 30 days is needed. If, prior to the end of the first 30-day extension period, it is determined that, due to matters beyond our control, a claim decision cannot be made within that extension period, we will send the Insured written notice during the initial 30 day extension that the period for making the determination may be extended for up to an additional 30 days. This notice will include the date by which a decision is expected to be made. 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 Insured will have 45 days within which to provide the specified information. The period of time within which a benefit decision 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 decision accompanies the filing. In the event that a period of time is extended due to the Insured's failure to submit information necessary to decide a claim, the period for making the benefit decision shall be tolled from the date on which the notification of the extension is sent to the Insured until the date on which the Insured responds to the request for additional information.

For any adverse benefit decision, our notice will include:

(1) The specific reason or reasons for such decision;
(2) Reference to specific plan/Policy provisions on which the decision was based;
(3) A description of the additional material or information necessary for the Insured 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 Insured'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 decision;
(5) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
    a) The views presented by the Insured to the plan of health care professionals treating the Insured and vocational professionals who evaluated the Insured;
    b) The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the Insured's adverse benefit decision, without regard to whether the advice was relied upon in making the benefit decision; and
    c) A disability determination regarding the Insured made by the Social Security Administration;
(6) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan that we relied upon in making the adverse decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist;
(7) A statement that the Insured is entitled to receive, upon request and free of charge, reasonable access to, and

copies of, all documents, records, and other information relevant to a claim for benefits; and
(8) Information concerning the Insured's right to request that we review our decision.

The notification will be provided in a culturally and linguistically appropriate manner.

REVIEW OF ADVERSE BENEFIT DECISIONS: The Insured may appeal any adverse benefit decision we may make on all or part of the Insured's claim. This appeal must be in writing and must be received by us no more than 180 days after the Insured receives notice of the adverse benefit decision. Only one appeal is allowed. As part of the appeal process, the Insured will:

(1) Be provided with the opportunity to send us written comments, documents, records, and other information related to the Insured's claim for benefits in conjunction with the Insured's timely appeal; and
(2) Be provided, upon request and free of charge, reasonable access to, and copies of, all non-privileged documents, records, and other information relating to the Insured's claim for benefits.

We will review the Insured's appeal promptly after receiving the Insured's request. We will advise the Insured of the results of our review within 45 days after we receive the Insured'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, we will give the Insured written notice of the extension prior to the termination of the initial 45-day period. In no event will 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 made.

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 accompanies the filing. In the event that a period of time is extended as described above due to the Insured's failure to submit information necessary to decide the 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 Insured until the date on which the Insured responds to the request for additional information.

Our decision on the Insured's appeal will be in writing and will include the specific reason or reasons for the decision and reference to specific plan/Policy provisions on which the decision was based. For any adverse benefit decision on the Insured's appeal, our notice will also include:

(1) A statement that the Insured 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 Insured's claim for benefits;
(2) A description of the Insured'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), as well as a description of any applicable contractual limitations period that applies to the Insured's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim;
(3) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
    a. The views presented by the Insured to the plan of health care professionals treating the Insured and vocational professionals who evaluated the Insured;
    b. The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the Insured's adverse benefit decision, without regard to whether the advice was relied upon in making the benefit decision; and
    c. A disability determination regarding the Insured made by the Social Security Administration; and
(4) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan that we relied upon in making the adverse decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and
(5) A statement that the Insured is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to a claim for benefits.

The notification will be provided in a culturally and linguistically appropriate manner.

ARBITRATION OF CLAIMS: Any claim or dispute arising from or relating to our determination regarding the Insured's Total Disability may be settled by arbitration when agreed to by the Insured and us in accordance with the Rules for Health and Accident Claims of the American Arbitration Association or by any other method agreeable to the Insured and us. In the case of a claim under an Employee Retirement Income Security Act (hereinafter referred to as ERISA) Plan, the Insured's 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 the Insured and us, any such award will be binding on the Insured and us for a period of twelve (12) months after it is rendered, assuming that the award is not based on fraudulent information and the Insured continues to be Totally Disabled. At the end of such twelve (12) month period, the issue of Total 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 the Insured interviewed and/or examined:

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

to determine the existence of any Total Disability which is the basis for a claim. We may require the Insured to be interviewed or examined by Physician(s), other medical practitioner(s), or vocational expert(s) of our choice. Such interviews or examinations may include vocational testing and evaluations, or any other type of testing and evaluations we determine necessary to administer the terms and conditions of the Policy. This right may be used as often as it is reasonably required during any ongoing review of benefit eligibility and while a claim is pending, including during any appeal from an adverse benefit decision.

We can have an autopsy made unless prohibited by law.

We have the right to deny the claim and terminate benefit payments if the Insured interferes with or does not cooperate with our requests for a physical examination or autopsy. The Insured has no right to videotape or record the physical examination by any means, nor does the Insured have the right to have a witness present during any examination and/or testing.

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 from the time written proof of loss is received. If the Insured's claim is subject to ERISA, no legal action may be brought or any benefits paid unless there has been full compliance with all Policy terms, including the exhaustion of all appeal procedures included above under the REVIEW OF ADVERSE BENEFIT DECISIONS provision.

INDIVIDUAL ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

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

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

(1) is a member of an Eligible Class, as shown on the Schedule of Benefits page; and
(2) has completed the Waiting Period, as shown on the Schedule of Benefits page.

WAITING PERIOD: A person who is continuously employed on a Full-time basis with you for the period specified on the Schedule of Benefits page has satisfied the Waiting Period.

EFFECTIVE DATE OF INDIVIDUAL INSURANCE: An Eligible Person must apply in writing for the insurance to go into effect. He/she will become insured on the latest of:

(1) the Individual Effective Date as shown on the Schedule of Benefits page, if he/she applies on or before that date;
(2) on the first of the month coinciding with or next following the date he/she applies, if he/she applies within thirty-one (31) days from the date he/she first met the Eligibility Requirements; or
(3) on the first of the month coinciding with or next following 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 he/she first met the Eligibility Requirements; or
    (b) after he/she 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 thirty-one (31) days but did not elect to be covered under that prior plan; or
(4) the date premium is remitted.

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

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

(1) the date this Policy terminates;
(2) the date the Insured ceases to meet the Eligibility Requirements;
(3) the end of the period for which Premium has been paid for the Insured; or
(4) the date the Insured enters military service (not including Reserve or National Guard).

INDIVIDUAL REINSTATEMENT: The insurance of a terminated person may be reinstated if he/she returns to Active Work with you within the period of time as shown on the Schedule of Benefits page. He/she 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 you; or
(2) on temporary lay-off.

The person will not be required to fulfill the Eligibility Requirements of this Policy again. The insurance will go into effect after he/she returns to Active Work for one (1) full day. If a person returns after having resigned or having been discharged, he/she will be required to fulfill the Eligibility Requirements of this Policy again. If a person returns after terminating insurance at his/her request or for failure to pay Premium when due, proof of health acceptable to us must be submitted before he/she may be reinstated.

PREMIUMS

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

PREMIUM RATE: We will furnish to you the Premium Rate on this Policy's Effective Date and when it is changed. We have the right to change the Premium Rate:

(1) when the extent of coverage is changed by amendment;
(2) on any Premium Due Date after the third Policy Anniversary;
(3) on any Premium Due Date on or after the first Policy Anniversary if your entire group's Covered Monthly Earnings changes by 25% or more from such group's Covered Monthly Earnings on the last Policy Anniversary; or
(4) at any time if there is a change in federal or state laws, insurance programs or retirement benefits that would impact our liability.

We will not change the Premium Rate due to (2) or (3) above more than once in any twelve (12) month period. We will tell you in writing at least sixty (60) days before the date of a change due to (2), (3) or (4) above.

GRACE PERIOD: You may pay the Premium up to ninety (90) days after the date it is due. This Policy stays in force during this time. If the Premium is not paid during the grace period, this Policy will terminate. You will still owe us the Premium up to the date this Policy terminates.

WAIVER OF PREMIUM: No Premium is due us for an Insured while he/she is receiving Monthly Benefits from us. Once Monthly Benefits cease due to the end of his/her Total Disability, Premium payments must begin again if insurance is to continue.

BENEFIT PROVISIONS

INSURING CLAUSE: We will pay a Monthly Benefit if an Insured:

(1) is Totally Disabled as the result of a Sickness or Injury covered by this Policy;
(2) is under the Regular Care of a Physician;
(3) has completed the Elimination Period; and
(4) submits satisfactory proof of Total Disability to us.

BENEFIT AMOUNT: To figure the benefit amount payable:

(1) multiply an Insured's Covered Monthly Earnings by the benefit percentage(s), as shown on the Schedule of Benefits page;
(2) take the lesser of the amount:
    (a) of step (1) above; or
    (b) the Maximum Monthly Benefit, as shown on the Schedule of Benefits page; and
(3) subtract Other Income Benefits, as shown below, from step (2) above.

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

OTHER INCOME BENEFITS: Other Income Benefits are:

(1) disability income benefits an Insured is eligible to receive because of his/her Total Disability under any group insurance plan(s);
(2) disability income benefits an Insured is eligible to receive because of his/her Total Disability under any governmental retirement system, except benefits payable under a federal government employee pension benefit;
(3) all benefits (except medical or death benefits) including any settlement made in place of such benefits (whether or not liability is admitted) an Insured is eligible to receive because of his/her Total Disability under:
    (a) Workers' 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 the Insured is eligible to receive from you:
    (a) any formal salary continuance plan;
    (b) wages, salary or other compensation, excluding the amount allowable when engaged in Rehabilitative Employment; and
    (c) commissions or monies, including vested renewal commissions, but, excluding commissions or monies that the Insured earned prior to Total Disability which are paid after Total Disability has begun;
(5) that part of disability benefits paid for by you that an Insured is eligible to receive because of his/her Total Disability under a group retirement plan; and
(6) that part of Retirement Benefits paid for by you that an Insured is eligible to receive under a group retirement plan; and
(7) disability or Retirement Benefits under the United States Social Security Act, the Canadian pension plans, or any other government plan for which:
    (a) an Insured is eligible to receive because of his/her Total Disability or eligibility for Retirement Benefits; and
    (b) an Insured's dependents are eligible to receive due to (a) above.

Disability and early Retirement Benefits will be offset only if such benefits are elected by the Insured or if election would not reduce the amount of his/her accrued normal Retirement Benefits then funded.

Retirement Benefits under number (7) above will not apply to disabilities which begin after age 70 for those Insureds already receiving Social Security Retirement Benefits while continuing to work beyond age 70.

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 Monthly Benefit will be reduced by the estimated amount. If benefits have been estimated, the Monthly Benefit will be adjusted when we receive proof:

(1) of the amount awarded; or
(2) that benefits have been denied and the denial cannot be further appealed.

If we have underpaid any benefit for any reason, we will make a lump sum payment. If we have overpaid any benefit for any reason, the overpayment must be repaid to us. At our option, we may reduce the Monthly Benefit or ask for a lump sum refund. If we reduce the Monthly Benefit, the Minimum Monthly 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 Total Disability less than a full month, the amount payable will be 1/30th of the Monthly Benefit.

COST OF LIVING FREEZE: After the initial deduction for any Other Income Benefits, the Monthly 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 sum will be prorated over the period of time to which the Other Income Benefits apply. If no period of time is given, the sum will be prorated over sixty (60) months.

TERMINATION OF MONTHLY BENEFIT: The Monthly Benefit will stop on the earliest of:

(1) the date the Insured ceases to be Totally Disabled;
(2) the date the Insured dies;
(3) the Maximum Duration of Benefits, as shown on the Schedule of Benefits page, has ended;
(4) the date the Insured fails to furnish the required proof of Total Disability;
(5) the date the Insured refuses to accept or to continue Rehabilitative Employment when such employment has been properly approved;
(6) the date the Insured ceases to be under the Regular Care of a Physician;
(7) the date the Insured refuses to undergo, at our request and at our expense, an examination, diagnostic study, or testing. The examination, diagnostic study, or testing may be performed by a Physician, vocational expert, rehabilitation specialist, or other health care professional;
(8) the date the Insured declines treatment options recommended by his or her Physician and within generally accepted medical standards, for a Sickness or Injury for which the Insured is claiming benefits under the Policy. Treatment options may include, but are not limited to, taking prescribed medications, participating in therapy, undergoing testing, and use of medical equipment;
(9) the date the Insured refuses to return to work with the assistance of:
    a. Modifications made to the Insured's work environment, functional occupational requirements, or work schedule; or
    b. Adaptive equipment or devices;

    that a qualified Physician has indicated will accommodate the restrictions and/or limitations of the Sickness or Injury for which the Insured is claiming benefits under the Policy and will enable the Insured to perform the material duties of an occupation from which the Insured must be considered Totally Disabled in order to receive Monthly Benefits under the Policy; or
(10) the date the Insured resides outside the United States or Canada. We will consider the Insured to reside outside of these countries if the Insured has been outside the United States or Canada for a total period of 3 months or more during any 6 consecutive months of the Insured's receipt of Monthly Benefits under the Policy.

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

If an Insured returns to Active Work for less than six (6) months, a recurrent Total Disability for the same or related cause will be part of the same Total 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 Total Disability.

This Recurrent Disability section will not apply to an Insured who becomes eligible for insurance coverage under any other group long term disability insurance plan.

WORKSITE MODIFICATION PROVISION

If an Insured is Totally Disabled, participating in a rehabilitation program and receiving a Monthly Benefit and he/she is able to return to Active Work should you make a modification to the Insured's worksite, then you may be eligible for Worksite Modification Reimbursement.

You will be reimbursed for 100% of the actual and reasonable expenses paid for eligible worksite modifications to accommodate the Insured's return to Active Work, up to a maximum reimbursement of $2,000.00.

Eligible worksite modifications include:

1. providing the Insured with a more accessible parking space or entrance**;** or

2. removing items from the worksite which represent barriers or hazards to the Insured; or

3. special seating, furniture or equipment for the Insured's work station; or

4. providing special training materials or translation services during the Insured's training; or

5. any other services that we deem necessary to help the Insured return to Active Work with you.

In order for this reimbursement to be payable, the Insured must have a Total Disability that results solely from the Insured's inability to perform his or her Regular Occupation at your worksite. The Insured must also have the physical and mental abilities needed to perform his or her Regular Occupation or another occupation at your worksite, but only with the help of the proposed worksite modification.

A worksite modification may first be proposed by either you, the Insured or his or her Physician, or by us. A written proposal must then be developed with input from you, the Insured or his or her Physician. The proposal must state the purpose of the proposed worksite modification, the times, dates and costs of the modifications. Any proposal must be in writing and is subject to our approval, your approval and the approval of the Insured prior to any reimbursement being paid.

Once the worksite modification has been approved in writing, you must make the worksite modification. Upon receipt of proof satisfactory to us that the modifications for the Insured have been made as approved and you have paid the person or organization that provided the worksite modification, we will then reimburse you up to the limit shown above.

EXCLUSIONS

We will not pay a Monthly Benefit for any Total Disability caused by:

(1) an act of war, declared or undeclared; or
(2) an intentionally self-inflicted Injury; or
(3) the Insured committing a felony; or
(4) an Injury or Sickness that occurs while the Insured is confined in any penal or correctional institution.

LIMITATIONS

MENTAL OR NERVOUS DISORDERS: Monthly Benefits for Total Disability caused by or contributed to by mental or nervous disorders will not be payable beyond an aggregate lifetime maximum duration of twenty-four (24) months unless the Insured is in a Hospital or Institution at the end of the twenty-four (24) month period. The Monthly Benefit will be payable while so confined, but not beyond the Maximum Duration of Benefits.

If an Insured was confined in a Hospital or Institution and:

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

then upon discharge, Monthly Benefits will be payable 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 defined to include disorders which are diagnosed to include a condition such as:

(1) bipolar disorder (manic depressive syndrome);
(2) schizophrenia;
(3) delusional (paranoid) disorders;
(4) psychotic disorders;
(5) depressive disorders;
(6) anxiety disorders;
(7) somatoform disorders (psychosomatic illness);
(8) eating disorders; or
(9) mental illness.

SUBSTANCE ABUSE: Monthly Benefits for Total Disability due to alcoholism or drug addiction will be payable while the Insured is a participant in a Substance Abuse Rehabilitation Program. The Monthly Benefit will not be payable beyond twenty-four (24) months.

If, during a period of Total Disability due to Substance Abuse for which a Monthly Benefit is payable, an Insured is able to perform Rehabilitative Employment, the Monthly Benefit, less 50% of any of the money received from this Rehabilitative Employment will be paid until: (1) the Insured is performing all the material duties of his/her Regular Occupation on a full-time basis; or (2) the end of twenty-four (24) consecutive months from the date that the Elimination Period is satisfied, whichever is earlier. All terms and conditions of the Rehabilitation Benefit will apply to Rehabilitative Employment due to Substance Abuse.

"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 included on the Department of Health, Retardation and Hospitals' Substance Abuse list of addictive drugs, except tobacco and caffeine are excluded.

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

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

(1) the Total Disability begins in the first twelve (12) consecutive months after the Insured's effective date; and
(2) he/she has 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 Total Disability, during the three (3) months immediately prior to the Insured's effective date of insurance.

Benefits will not be paid for a Total Disability:

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

a Pre-existing Condition unless the Insured has been Actively at Work for one (1) full day following the end of twelve (12) consecutive months from the Insured's effective date of insurance.

With respect to persons electing to change their level of coverage during an approved enrollment period, any benefit increase (due to this change) will not be paid for a Total Disability:

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

a Pre-existing Condition unless the Insured has been Actively at Work for one (1) full day following the end of twelve (12) consecutive months from the effective date of the increase. A Pre-existing Condition means any Sickness or Injury for which the Insured 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 Total Disability, during the three (3) months immediately prior to the effective date of the increase (with respect to any increase in benefits).

LIMITATIONS - OTHER LIMITED BENEFITS

1. Monthly Benefits will be limited to a total of 24 months in the Insured's lifetime for all Total Disabilities caused or contributed to by:

   - Chronic fatigue syndrome; or
   - Environmental Allergic or Reactive Illness; or
   - Self-Reported Conditions.

   No Monthly Benefits are payable beyond the 24 month maximum benefit period or the Maximum Duration of Benefits shown in the Schedule of Benefits, whichever is less.

2. Monthly Benefits will be limited to a total of 24 months in the Insured's lifetime for all Total Disabilities caused by or contributed to 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 lumbosacral regions and their surrounding soft tissue.

   No Monthly Benefits are payable beyond the 24 month maximum benefit period or the Maximum Duration of Benefits shown in the Schedule of Benefits, whichever is less.

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

- Arthritis
- Demyelinating diseases
- Myelitis
- Myelopathies
- Osteopathies
- Radiculopathies documented by electromyogram
- Ruptured intervertebral discs
- Scoliosis
- Spinal fractures
- Spinal tumors, malignancy or vascular malformations
- Spondylolisthesis, Grade II or higher
- Traumatic spinal cord necrosis

"Environmental Allergic or Reactive Illness" means an illness which results from the Insured's 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 the Insured's 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 the Insured suffers any one of the Losses listed below from an accident resulting in an Injury, we will pay a guaranteed minimum number of Monthly Benefit payments, as shown below. However:

(1) the Loss must occur within one hundred and eighty (180) days; and
(2) the Insured must live past the Elimination Period.

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

"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 Monthly Benefit payments is provided.

The amount payable is the Monthly Benefit, as shown on the Schedule of Benefits page, with no reduction from Other Income Benefits. The number of Monthly Benefit payments will not cease if the Insured returns to Active Work.

If death occurs after we begin paying Monthly 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 the Insured's estate, unless a beneficiary is on record with us under this Policy.

Benefits may be payable longer than shown above as long as the Insured is still Totally Disabled, subject to the Maximum Duration of Benefits, as shown on the Schedule of Benefits page.

SURVIVOR BENEFIT - LUMP SUM

We will pay a benefit to an Insured's Survivor when we receive proof that the Insured died while:

(1) he/she was receiving Monthly Benefits from us; and
(2) he/she was Totally Disabled for at least one hundred and eighty (180) consecutive days.

The benefit will be an amount equal to 3 times the Insured's last Monthly Benefit. The last Monthly Benefit is the benefit the Insured was eligible to receive right before his/her death. It is not reduced by wages earned while in Rehabilitative Employment.

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.

"Survivor" means an Insured's spouse; or a civil union partner or domestic partner where legally recognized under applicable state law or named on an affidavit of domestic partnership on file with you. If the spouse, civil union partner or domestic partner dies before the Insured, or if the Insured was legally separated or the civil union or domestic partnership was no longer in effect, then the Insured's natural, legally adopted children, step-children, or children of a civil union or domestic partnership or named on such affidavit who are under age twenty-five (25) will be the Survivors. If there are no eligible Survivors, payment will be made to the Insured's estate, unless a beneficiary is on record with us under this Policy.

WORK INCENTIVE AND CHILD CARE BENEFITS

WORK INCENTIVE BENEFIT

During the first twelve (12) months of Rehabilitative Employment during which a Monthly Benefit is payable, we will not offset earnings from such Rehabilitative Employment until the sum of:

(1) the Monthly Benefit prior to offsets with Other Income Benefits; and
(2) earnings from Rehabilitative Employment;

exceed 100% of the Insured's Covered Monthly Earnings. If the sum above exceeds 100% of Covered Monthly Earnings, our Benefit Amount will be reduced by such excess amount until the sum of (1) and (2) above equals 100%.

CHILD CARE BENEFIT

We will allow a Child Care Benefit to an Insured if:

(1) the Insured is receiving benefits under the Work Incentive Benefit;
(2) the Insured's 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 which the Insured is eligible for the Work Incentive Benefit, an amount equal to actual expenses incurred for child care, up to a maximum of $250.00 per month, will be added to the Insured's Covered Monthly Earnings when calculating the Benefit Amount under the Work Incentive Benefit.

Child(ren) means: the Insured's unmarried child(ren), including any foster child, adopted child, step-child, or child of a civil union or domestic partnership where legally recognized under applicable state law or named on an affidavit of domestic partnership on file with you who resides in the Insured's home and is financially dependent on the Insured for support and maintenance.

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

Family and Medical Leave of Absence:

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

(1) the premium for such Insured continues to be paid during the leave; and
(2) you have approved the Insured's leave in writing and provide a copy of such approval within thirty-one (31) days of our request.

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

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

Military Services Leave of Absence:

We will continue the Insured's coverage in accordance with your policies regarding Military Services Leave of Absence under USERRA if the premium for such Insured continues to be paid during the leave.

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

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

While the Insured is on a Family and Medical Leave of Absence for any reason other than his or her own illness, injury or disability or Military Services Leave of Absence he or she will be considered Actively at Work. Any changes such as revisions to coverage due to age, class or salary changes, as applicable, will apply during the leave except that increases in the amount of insurance, whether automatic or subject to election, will not be effective for an Insured who is not considered Actively at Work until the Insured has 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 this Policy.

The Insured's coverage will cease under this extension on the earliest of:

(1) the date this Policy terminates; or
(2) the end of the period for which premium has been paid for the Insured; or
(3) the date such leave should end in accordance with your policies regarding Family and Medical Leave of Absence and Military Services Leave of Absence in compliance with the Family and Medical Leave Act of 1993, as amended and USERRA. Coverage will not be terminated for an Insured who becomes Totally Disabled during the period of the leave and who is eligible for benefits according to the terms of this Policy. Any Monthly Benefit which becomes payable will be based on the Insured's Covered Monthly Earnings immediately prior to the date of Total Disability.

Should you choose not to continue the Insured's coverage during a Family and Medical Leave of Absence and/or Military Services Leave of Absence, the Insured's coverage will be reinstated.

REHABILITATION BENEFIT

"Rehabilitative Employment" means work in Any Occupation for which the Insured's training, education or experience will reasonably allow. The work must be approved by a Physician or a licensed or certified rehabilitation specialist approved by us. Rehabilitative Employment includes work performed while Partially Disabled, but does not include performing all the material duties of his/her Regular Occupation on a full-time basis.

If an Insured is receiving a Monthly Benefit because he/she is considered Totally Disabled under the terms of this Policy and is able to perform Rehabilitative Employment, we will continue to pay the Monthly Benefit less an amount equal to 50% of earnings received through such Rehabilitative Employment.

If an Insured is able to perform Rehabilitative Employment when Totally Disabled due to Substance Abuse, we will continue to pay the Monthly Benefit less an amount equal to 50% of earnings received through such Rehabilitative Employment. This Monthly Benefit is payable for a maximum of twenty-four (24) consecutive months from the date the Elimination Period is satisfied.

An Insured will be considered able to perform Rehabilitative Employment if a Physician or licensed or certified rehabilitation specialist approved by us determines that he/she can perform such employment. If an Insured refuses such Rehabilitative Employment, benefits under this Policy will terminate. If an Insured has been performing Rehabilitative Employment, and refuses to continue such employment, even though a Physician or licensed or certified rehabilitation specialist approved by us has determined that he/she is able to perform Rehabilitative Employment, benefits under this Policy will terminate.

RELIANCE STANDARD LIFE INSURANCE COMPANY

AMENDATORY RIDER

It is hereby understood and agreed that the Policy will be amended by the addition of the following:

Applicable to Vermont Residents Only

The following sections/provisions of this Policy are amended to comply with Vermont law:

1. **Schedule of Benefits section, Elimination Period provision.**

   The Elimination Period will be the lesser of the number of days shown on the Schedule of Benefits in this policy or:

   For Benefit Periods 2 years and greater: 365 days.

   For Benefit Periods greater than 1 year but less than 2 years: 180 days.

2. **Limitations section, Mental or Nervous Disorders and/or Substance Abuse, if such limitations are included in this Policy.**

   If this Policy contains limitations in coverage for mental or nervous disorders and/or substance abuse, such limitations will not apply to Vermont residents. Coverage for these conditions will be treated the same as other conditions that may entitle the Insured to full benefits.

3. **Limitations section, Pre-existing Conditions, if such limitation is included in this Policy.**

   The pre-existing condition provision time period in the definition of Pre-existing Condition shall be the lesser of the time period shown on the Limitations form in this policy or twelve (12) months.

   The period of time during which the Insured becomes Totally Disabled due to a Pre-existing Condition and a benefit is not payable for such Total Disability is the lesser of the time period as shown in this policy or twelve (12) months.

All other terms and conditions remain unchanged.

RELIANCE STANDARD LIFE INSURANCE COMPANY

Secretary

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

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

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

Eligibility for Protection by the Association

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

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

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

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

Life Insurance:

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

Individual Annuities:

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

Group Annuities:

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

Aggregate Limit:

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

These limits are applied for each insolvent insurance company.

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

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

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