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**GROUP LIFE, ACCIDENTAL DEATH  
AND DISMEMBERMENT AND  
VOLUNTARY ACCIDENTAL DEATH  
AND DISMEMBERMENT INSURANCE  
PROGRAM**

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**BMH, Inc.**



**GROUP LIFE AND ACCIDENTAL  
DEATH AND DISMEMBERMENT  
INSURANCE**



# **RELIANCE STANDARD LIFE INSURANCE COMPANY**

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

## **CERTIFICATE OF INSURANCE**

We certify that you (provided you belong to a class described on the Schedule of Benefits and your completed enrollment card is attached) are insured, for the benefits which apply to your class, under Group Policy No. GL 668955 issued to BMH, Inc., the Policyholder.

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

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

  
Secretary

  
President

## **GROUP LIFE INSURANCE CERTIFICATE**

This Group Life Certificate amends all previous Group Life Certificates and is dated June 16, 2017.

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## **SCHEDULE OF BENEFITS**

**EFFECTIVE DATE:** October 1, 2013, as amended in the Policy through July 1, 2017

**ELIGIBLE CLASSES:** Each active Physician and Key Employee scheduled to work a minimum of 40 hours per pay period earning \$115,000 or more per year, except any person employed on a temporary or seasonal basis.

**WAITING PERIOD:** First of the month coinciding with or next following 90 days of continuous employment. \*

\* Time served working for the Policyholder prior to becoming an Eligible Person will count towards satisfying the Waiting Period. If you transfer directly from Idaho Doctor's Hospital, time served working for Idaho Doctor's Hospital will count towards satisfying the Policyholder's Waiting Period.

**INDIVIDUAL EFFECTIVE DATE:** The date the Waiting Period is completed.

**INDIVIDUAL REINSTATEMENT:** 12 months

### **AMOUNT OF INSURANCE:**

**Basic Life and Accidental Death and Dismemberment:** Three (3) times Earnings, rounded to the next higher \$1,000, subject to a maximum Amount of Insurance of \$1,000,000.

**Supplemental Life** (Applicable only to you if you elected Supplemental coverage and are paying the applicable premium): \$10,000 increments to the lesser of: (1) five (5) times Earnings; or (2) \$500,000.

The combined Basic and Supplemental maximum Amount of Insurance cannot exceed \$1,000,000.

Amounts of basic insurance over the guaranteed issue amount of \$500,000 are subject to our approval of your proof of good health. However, any proof of good health required due to late application for this insurance (See EFFECTIVE DATE OF INDIVIDUAL INSURANCE) will be at no expense to us.

Amounts of supplemental insurance over the guaranteed issue amount

of \$150,000 are subject to our approval of your proof of good health. However, any proof of good health required due to late application for this insurance (See EFFECTIVE DATE OF INDIVIDUAL INSURANCE) will be at no expense to us.

For Insureds age 65 and over, the Amount of Basic Life and Accidental Death and Dismemberment Insurance and Supplemental Life Insurance is subject to automatic reduction. Upon the Insured's attainment of the specified age below, the Amount of Basic Life and Accidental Death and Dismemberment Insurance and Supplemental Life Insurance will be reduced to the applicable percentage. This reduction also applies to Insureds who are age 65 or over on their Individual Effective Date.

Age	Percentage of available or in force amount at age 64
65-69	65%
70+	50%

#### **Basic Dependent Life:**

Spouse Amount: \$10,000

Child Amount: birth and over: \$10,000

The Spouse Amount of Insurance will reduce in the same manner as your Amount of Insurance upon your spouse's attainment of reducing ages.

#### **Supplemental Dependent Life:**

Spouse Amount: \$5,000 increments to the lesser of: (1) 100% of your Amount of Insurance; or (2) \$500,000.

Child Amount: birth and over: \$10,000

Amounts of Insurance for spouses over the guaranteed issue amount of \$25,000 are subject to our approval of your spouse's proof of good health. However, any proof of good health required due to late application for this insurance (See EFFECTIVE DATE OF DEPENDENT INSURANCE) will be at no expense to us.

The Spouse Amount of Insurance will reduce in the same manner as your Amount of Insurance upon your spouse's attainment of reducing ages.

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



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

With respect to increases in the Amount of Insurance, you must be Actively At Work on the date of the change. If you are not Actively At Work when the change should take effect, the change will take effect on the day after you have been Actively At Work in an Eligible Class for one full day. However, if you have the right to choose your amount of Supplemental insurance, proof of good health will be required when you change your selection to increase the amount of your Supplemental insurance. Such proof must be approved by us for the increase to take effect.

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

Premium changes due to your age will occur on the October 1<sup>st</sup> 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 provided you apply within thirty-one (31) days of such life event.

**CONTRIBUTIONS:** You are not required to contribute toward the cost of the Basic Insurance. You are required to contribute toward the cost of the Supplemental Insurance. It is applicable to you only if you elected Supplemental coverage and are paying the applicable premium. You are required to contribute toward the cost of Dependent Life Insurance.

## DEFINITIONS

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

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

"Actively at work" and "active work" means actually performing each and every duty pertaining to your job in the place where and the manner in which the job is normally performed. This includes approved time off such as vacation, jury duty and funeral leave, but does not include time off as a result of injury or illness.

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

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

"Earnings", as used in the SCHEDULE OF BENEFITS section, means your gross annual salary received from the Policyholder on the first of the month just before the date of loss, prior to any deductions to a Section 125 plan, flexible spending account and pre-tax contributions to a qualified deferred compensation plan. Earnings does not include commissions, overtime pay, bonuses, incentive pay or any other special compensation not received as basic salary.

If hourly employees are insured, the number of hours scheduled to work during a regularly scheduled work week, not the hours actually worked, not to exceed forty (40) hours per week, times fifty-two (52) weeks, will be used to determine annual earnings.

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

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

- (1) hand or foot, means the complete severance through or above

the wrist or ankle joint;

- (2) the eye, speech or hearing, means total and irrecoverable loss thereof.

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

- (1) your legal spouse who is not legally separated or divorced from you; and
- (2) your unmarried child(ren), from birth to 26 years, who is financially dependent upon you for support. Adoptive, foster and step-children are considered Dependents if they are in your custody; and
- (3) your child(ren) beyond the limiting age who is incapable of self-sustaining employment by reason of intellectual disability or physical handicap and who is chiefly dependent on you for support and maintenance.

"Injury" means accidental bodily injury that is caused directly and independently of all other causes by accidental means and which occurs while your coverage under the Policy is in force.

## **GENERAL PROVISIONS**

### **INCONTESTABILITY**

Any statement made in the Policyholder's application will be deemed a representation, not a warranty. We cannot contest the validity of the Policy after it has been in force for two (2) years from the date of issue, except for non-payment of premium. All other Policy terms will remain applicable.

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 are or any Insured Dependent is covered. The following rules apply to each statement:

- (1) No statement will be used in a contest unless:
  - (a) it is in a written form signed by 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, 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.

### **ASSIGNMENT**

Ownership of any benefit provided under the Policy may be transferred by assignment. An irrevocable beneficiary must give written consent to assign this insurance. Written request for assignment must be made in duplicate at our Administrative Offices. Once recorded by us, an assignment will take effect on the date it was signed. We are not liable for any action we take before the assignment is recorded.

### **REPLACEMENT COVERAGE**

If the Policy replaces previous coverage within sixty (60) days from the

date of discontinuation of the prior policy, we will cover you and, if applicable, Dependents who were previously covered.

### **MISSTATEMENT OF AGE AND/OR TOBACCO USE**

If your age and/or tobacco use are misstated, the premium will be adjusted, if necessary. If your insurance is affected by the misstated age and/or tobacco use, it will also be adjusted. The insurance will be changed to the amount you are entitled to at your correct age and/or tobacco use.

## EFFECTIVE DATE AND TERMINATION

**EFFECTIVE DATE OF INDIVIDUAL INSURANCE:** If the Policyholder pays the entire premium, the insurance up to the guaranteed issue Amount of Insurance, if applicable, for an Eligible Person will go into effect on the date stated on the Schedule of Benefits.

Amounts of Insurance over the guaranteed issue Amount of Insurance shown on the Schedule of Benefits must be applied for in writing and are subject to proof of good health.

Insurance will be effective on the date we approve such proof of good health.

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

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

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

If you have been previously declined for coverage by us, had an application withdrawn or marked incomplete for any reason, or voluntarily terminated your insurance coverage with us, all future requests for coverage are subject to submission and our approval of proof of good health. However, proof of good health will not be required if after you voluntarily terminated your insurance coverage with us you make a future request due to a life event change or during any approved enrollment period.

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

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

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

- (1) the date the Policy terminates; or
- (2) the 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 for you;  
or
- (4) the date you enter military service on active duty (not including Reserve or National Guard).

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

- (1) twelve (12) months, if due to illness or injury; or
- (2) the end of the month, if due to temporary lay-off or approved leave of absence.

**REINSTATEMENT:** Your insurance may be reinstated if you are a former Insured who has been:

- (1) on an approved leave of absence,
- (2) on a temporary lay-off; or
- (3) rehired after employment had been terminated.

You must return to active work 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 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.

If you request insurance after terminating insurance at your own 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.



## CONVERSION PRIVILEGE

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

- A. If the insurance ceases due to termination of employment or membership in any of the Policy's classes, an individual Life Insurance Policy may be issued. You are entitled to a policy without disability or supplemental benefits. You must make written application for the policy within thirty-one (31) days after you terminate. The first premium must also be paid within that time. The issuance of the policy is subject to the following conditions:
  - (1) The policy will, at your option, be on any one of our forms, except for term life insurance. It will be the standard type issued by us for the age and amount applied for;
  - (2) The policy issued will be for an amount not over what you had before you terminated;
  - (3) The premium due for the policy will be at our usual rate. This rate will be based on the amount of insurance, class of risk and your age at date of policy issue; and
  - (4) Proof of good health is not required.
- B. If the insurance ceases due to the termination or amendment of the Policy, an individual Life Insurance Policy can be issued. You must have been insured for at least five (5) years under the Policy and/or the prior carrier. The same rules as in A above will be used, except that the face amount will be the lesser of:
  - (1) The amount of your Group Life benefit under the Policy. This amount will be less any amount you are entitled to under any group life policy issued by us or another insurance company; or
  - (2) \$5,000.
- C. If the insurance reduces, as may be provided in the Policy, an individual Life Insurance Policy can be issued. The same rules as in A above will be used, except that the face amount will not be greater than the amount which ceased due to the reduction.

- D. If you die during the time provided in A above in which you are entitled to apply for an individual policy, we will pay the benefit under the Group Policy that you were entitled to convert. This will be done whether or not you applied for the individual policy.
- E. Any policy issued with respect to A, B or C above will be put in force at the end of the thirty-one (31) day period in which application must be made.
- F. If you are entitled to have an individual policy issued to you without proof of health, then you must be given notice of this right at least fifteen (15) days before the end of the period specified above. Such notice must be: (1) in writing; and (2) presented or mailed to you by the Policyholder. If not, you will have an additional period in order to do so. This additional period will end fifteen (15) days after you are given notice. This period will not extend beyond sixty (60) days after the expiration date of the period provided above. This insurance will not be continued beyond the period provided in A above.

## **BENEFICIARY AND FACILITY OF PAYMENT**

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

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

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

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

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

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

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

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

If you have not named a beneficiary, or the named beneficiary is not surviving at your death, we may pay up to \$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.

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

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

## **SETTLEMENT OPTIONS**

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

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

Settlement Options are described in the Policy.

## **WAIVER OF PREMIUM IN EVENT OF TOTAL DISABILITY**

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

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

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

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

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

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

- (1) the date you no longer meet the definition of Total Disability; or
- (2) the date you refuse to be examined; or
- (3) the date you fail to furnish the required proof of Total Disability;  
or
- (4) the date you become age 65; or
- (5) the date you retire.

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

**ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE**

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

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

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



## **EXCLUSIONS**

A benefit will not be payable for a loss:

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

## **SEAT BELT AND AIR BAG BENEFIT**

### **Seat Belt Benefit**

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

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

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

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

### **Air Bag Benefit**

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

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

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

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

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

## **EXCLUSIONS**

No benefit is payable for any loss sustained by you:

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

## CLAIMS PROVISIONS

**NOTICE OF CLAIM:** Written notice must be given to us within 31 days after the Loss occurs, or as soon as reasonably possible. The notice should be sent to us at our Administrative Offices or to our authorized agent. The notice should include your name and the Policy Number.

**CLAIM FORMS:** When we receive written notice of a claim, we will send claim forms to the claimant within 15 days. If we do not, the claimant will satisfy the requirements of written proof of loss by sending us written proof as shown below. The proof must describe the occurrence, extent and nature of the loss.

**PROOF OF LOSS:** For any covered Loss, written proof must be sent to us within 90 days. If it is not reasonably possible to give proof within 90 days, the claim is not affected if the proof is sent as soon as reasonably possible. In any event, proof must be given within 1 year, unless the claimant is legally incapable of doing so.

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

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.

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

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

## **DEPENDENT LIFE 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 dies, we will pay the applicable benefit shown on the Schedule of Benefits to you. If you are deceased, then the benefit will be paid to your beneficiary. Only dependents who meet the definition of Dependents can be insured for this benefit.

A person may not have coverage 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.

### **EFFECTIVE DATE OF DEPENDENT INSURANCE**

If the Policyholder pays the entire premium, the insurance up to the guaranteed issue Amount of Insurance for Dependents will become effective on the later of:

- (1) the date you become eligible for Dependent Life Insurance; or
- (2) the date the dependent meets the definition of Dependent.

Amounts of Insurance over the guaranteed issue Amount of Insurance shown on the Schedule of Benefits for the Dependent spouse must be applied for in writing and are subject to proof of good health. Insurance will be effective the date we approve such proof of good health.

If you 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 date you become eligible for Dependent Life Insurance; or
- (2) the date the dependent meets the definition of Dependent, if application is made on or before that date; or
- (3) 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 date we approve any required proof of good health. Proof of good health forms are available from us upon request. It is the Policyholder's responsibility to provide proof of good health forms to you when required. We require proof of good health if you make application for dependent insurance on your spouse:
- (a) after thirty-one (31) days from the date the Dependent first becomes eligible for this insurance; or
  - (b) after a prior termination of insurance as long as you remained in a class eligible for dependent insurance; or
  - (c) for an Amount of Insurance greater than the guaranteed issue Amount of Insurance shown on the Schedule of Benefits, if applicable; or
- (5) the date premium is remitted.

If the Dependent spouse has been previously declined for coverage by us, had an application withdrawn or marked incomplete for any reason or voluntarily terminated his/her insurance coverage with us, all future requests for coverage, are subject to submission and our approval of proof of good health. However, proof of good health will not be required if the Dependent who voluntarily terminated his/her insurance coverage with us makes a future request for insurance coverage due to a life event change or during any approved enrollment period.

After this insurance is in force for one Dependent child, application is not required for added Dependent children.

For Dependents (other than newborns) who are confined in a hospital or at home on the date on which they would otherwise become insured, insurance will be effective as of the date the confinement ends.

## **TERMINATION OF DEPENDENT LIFE 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 end of the period for which premium has been paid by you or the Policyholder; or
- (4) the date your insurance terminates; or
- (5) the date you retire from employment with the Policyholder.

## **CONVERSION OF DEPENDENT LIFE INSURANCE**

If the insurance of an insured Dependent terminates because:

- (1) you terminate employment or membership in the classes eligible for this insurance; or
- (2) you die; or
- (3) the Dependent ceases to be eligible for this insurance;

then you may convert the Dependent's insurance to an individual policy. The conversion is subject to the following rules:

- (1) a written application for the conversion policy must be received by us within thirty-one (31) days after the Dependent's insurance terminates. The first premium must be sent in with the application; and
- (2) the premium due for the policy will be at our usual rates. This rate will be based on the Amount of Insurance, class of risk and the age of the Dependent on the date the policy is issued; and
- (3) the policy may be any life plan we currently issue, except term insurance; and
- (4) proof of good health is not required; and

- (5) the policy issued will be for an amount not over what the Dependent had before termination under the Policy; and
- (6) the policy issued will not have disability or supplemental benefits.

If the Dependent's insurance ceases due to termination or amendment of the Policy, an individual policy can be issued. The Dependent must have been insured for at least five (5) years under the Policy and/or the prior carrier. The same rules as shown in the previous paragraph will be used, except that the face amount will be the lesser of:

- (1) the amount of Dependent life insurance under the Policy. This amount will be less any amount of group life insurance the Dependent receives or becomes eligible for within thirty-one (31) days after the Policy terminates; or
- (2) \$5,000.

If an insured Dependent should die within thirty-one (31) days of the date his/her insurance ceased, we will pay the benefit he/she had under the Policy. This will be done whether or not you applied for the individual policy on behalf of the insured Dependent.

Any individual policy issued with respect to this section will be effective at the end of the thirty-one (31) day period in which application must be made.

If an insured Dependent is entitled to have an individual policy issued to him/her without proof of health, then you must be given notice of this right at least fifteen (15) days before the end of the period specified above. Such notice must be: (1) in writing; and (2) presented or mailed to you by the Policyholder. If not, you will have an additional period in order to do so. This additional period will end fifteen (15) days after you are given notice. This period will not extend beyond sixty (60) days after the expiration date of the period provided above. This insurance will not be continued beyond the period provided in (1) above.



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

### **Family and Medical Leave of Absence:**

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

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

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

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

### **Military Services Leave of Absence:**

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

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

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

While you are on a Family and Medical Leave of Absence for any reason other than your own illness, injury or disability or Military Services Leave of Absence you will be considered Actively at Work. Any changes such as revisions to coverage due to age, class or salary changes, as

applicable, will apply during the leave except that increases in the amount of insurance, whether automatic or subject to election, will not be effective if you are not considered Actively at Work until you have returned to Active Work for one (1) full day.

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

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

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

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

## PORTABILITY

You may continue insurance coverage under the Policy and that of your insured Dependents, if any, 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 the insured Dependent having reached the maximum age for benefits, provided you:

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

The amount of coverage available under the Portability provision will be the current amount of coverage you and that of your insured Dependents, if any, are insured for under the Policy on the last day you were Actively at Work. However, the amount of coverage for an Insured/Insured Dependent will never be more than:

- (1) the highest amount of life insurance available to Eligible Persons; or
- (2) a total of \$300,000 from all RSL group life and accidental death and dismemberment insurance combined,

whichever is less.

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

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

Insurance coverage continued under this provision for you and/or your insured Dependents, if any, will terminate on the first of the following to occur:

- (1) the end of the period for which premium has been paid; or
- (2) the date you are covered under another group term life insurance policy; or
- (3) the date you reach age 65; or

- (4) at any time coverage would normally terminate according to the terms of the Policy had the Insured continued to be an eligible Person.

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

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

If insurance coverage terminates due to (3) above, it may be converted to an individual life insurance policy. The conversion will be subject to the terms and conditions set forth under the Conversion Privilege.

## **GROUP TERM LIFE INSURANCE LIVING BENEFIT RIDER**

**THIS RIDER ADDS AN ACCELERATED BENEFIT PROVISION. RECEIPT OF THIS ACCELERATED BENEFIT WILL REDUCE THE DEATH BENEFIT AND MAY BE TAXABLE. INSURED'S SHOULD SEEK ASSISTANCE FROM THEIR PERSONAL TAX ADVISOR.**

Attached to Group Policy Number: GL 668955

Issued to Group Policyholder: BMH, Inc.

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

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

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

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

"Death Benefit" means the insurance amount payable under the Certificate at death of the Insured, subject to all Certificate provisions dealing with changes in the amount of insurance and reductions or termination for age or retirement. It does not include any amount that is only payable in the event of Accidental Death.

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

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

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

"Terminally Ill" or "Terminal Illness" refers to an Insured's illness or physical condition that is Certified by a Physician to reasonably be expected to result in death in less than 12 months.

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

All pronouns include either gender unless the context indicates otherwise.

**DESCRIPTION OF COVERAGE:** This benefit is payable to the Insured if, after having been covered under this Rider for at least 60 days, an Insured is Certified as Terminally Ill. In order for this benefit to be paid:

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

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

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

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

- (1) The Death Benefit payable for such Insured will be reduced by an amount equal to the Living Benefit paid to such Insured. The amount of the Living Benefit plus the corresponding Death Benefit will not exceed the amount that would have been paid as the Death Benefit in the absence of this Rider.
- (2) Any amount of insurance that would otherwise be continued under a Waiver of Premium provision will be reduced proportionately, as will the maximum Face Amount available under the Conversion Privilege.

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


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

the first of the following:

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

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

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

  
Secretary

# **GROUP ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE**





# RELIANCE STANDARD LIFE INSURANCE COMPANY

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

## CERTIFICATE OF INSURANCE

**POLICYHOLDER:** BMH, Inc.

**GROUP POLICY NUMBER:** VAR 672929

**POLICY EFFECTIVE DATE:** October 1, 2013, as amended in the Policy through July 1, 2017

Subject to the terms of the Group Policy, we certify that you are insured for the benefits which apply to your class as described on the Schedule of Benefits, provided you are an Insured Person, as defined. The Group Policy Number, Policyholder, and Policy Effective Date are listed above. This Certificate is not a contract of insurance. It contains only the major terms of insurance coverage and payment of benefits under the Policy. It replaces all Certificates that may have been issued to you earlier.

This Certificate is signed by our President and Secretary.

  
Secretary

  
President

## GROUP ACCIDENT CERTIFICATE

This Group Accident Certificate amends the previous Group Accident Certificates and is dated June 16, 2017.

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## **SCHEDULE OF BENEFITS**

**ELIGIBILITY:** Each active Physician and Key Employee scheduled to work a minimum of 40 hours per pay period earning \$115,000 or more per year, except any person employed on a temporary or seasonal basis.

**WAITING PERIOD:** First of the month coinciding with or next following 90 days of continuous employment. \*

\* Time served working for the Policyholder prior to becoming an Eligible Person will count towards satisfying the Waiting Period. If you transfer directly from Idaho Doctor's Hospital, time served working for Idaho Doctor's Hospital will count towards satisfying the Policyholder's Waiting Period.

**INDIVIDUAL EFFECTIVE DATE:** The date the Waiting Period is completed.

**INDIVIDUAL REINSTATEMENT:** 12 months

**AMOUNT OF INSURANCE/PRINCIPAL SUM:**

**INSURED PERSONS:**

\$10,000 increments to the lesser of: (1) five (5) times Earnings; or (2) \$500,000.

For Insured Persons age 65 and over, the Amount of Principal Sum is subject to automatic reduction. Upon the Insured Person's attainment of the specified age below, the Amount of Principal Sum will be reduced to the applicable percentage. This reduction also applies to Insured Persons who are age 65 or over on their Individual Effective Date.

<b>Age</b>	<b>Percentage of available or in force amount at age 64</b>
65-69	65%
70+	50%

**INSURED DEPENDENTS:**

Spouse Amount: \$5,000 increments to the lesser of: (1) 100% of your Amount of Insurance; or (2) \$500,000.

Child Amount: birth and over: \$10,000

The Spouse Amount of Insurance will reduce in the same manner as your Amount of Insurance upon your Spouse's attainment of reducing ages.

**CHANGES IN AMOUNT OF INSURANCE:** Increases and decreases in the Amount of Insurance because of changes in class and earnings are effective on the first of the month coinciding with or next following the date of the change. Increases and decreases in the Amount of Insurance because of changes in age are effective on the October 1st coinciding with or next following the date of the change.

With respect to increases in the Amount of Insurance, you must be Actively at Work on the date of the change. If you are not Actively at Work when the change should take effect, the change will take effect on the day after you have been Actively At Work for one full day.

Increases and decreases in the Amount of Insurance because of your elections will take effect on the first of the month coinciding with or next following the date we receive the election request.

With respect to increases in the Amount of Insurance, you must be Actively at Work on the date the increase is to take effect. If you are not Actively at Work on the date the increase is to take effect, such increase will take effect on the date you return to work.

**CONTRIBUTIONS:** You are not required to contribute toward the cost of your insurance coverage. You are not required to contribute toward the cost of the Dependent insurance coverage.

## DEFINITIONS

"Actively at Work" and "Active Work" means you are actually performing 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 illness.

"Dependents" means:

- (1) your legal spouse who is not legally separated or divorced from you; and
- (2) your unmarried child(ren), under 26 years, who receives more than one-half of his financial support from you. Adoptive, foster and step-children are considered Dependents if they are in your custody.

Additionally, with respect to an adoptive child:

- (1) Such child is a "Dependent" from the date he is placed with you. "Placed" means physical placement in the care of you. In those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, "placed" means when you sign an agreement for such child's adoption and sign an agreement assuming financial responsibility for such child.
- (2) Prior to legal finalization of adoption, the child will no longer be an "adoptive" child nor a "Dependent" as of the first of the following to occur:
  - (a) as of the date he is removed permanently from the placement with you and the legal obligation terminates; or
  - (b) as of the date you rescind, in writing, the agreement of the adoption or agreement assuming financial responsibility.

NOTE: An Eligible Person may not have coverage both as an Insured Person and as an Insured Dependent. Only one Insured spouse may cover the eligible children as Insured Dependents. If insurance is in force for an Insured Dependent, any newly eligible Dependents will be automatically covered.

"Earnings" means the basic gross annual wages received from the Policyholder on the first of the month just before the date of the Injury, prior to any deductions to a Section 125 plan, flexible spending account and pre-tax contributions to a qualified deferred compensation plan. Earnings does not include commissions, overtime pay, bonuses, incentive pay or any other special compensation not received as basic wages.

If hourly employees are insured, the number of hours scheduled to work during a regularly scheduled work week, not the hours actually worked, not to exceed 40 hours per week, times 52 weeks, will be used to determine annual Earnings.

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

"Insured Person" means a person who meets the Eligibility requirements of the Policy and is enrolled for this insurance, and whose insurance under the Policy is in effect.

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

"Insured" means either an Insured Person or an Insured Dependent unless the context indicates otherwise.

"Injury" means accidental bodily injury to an Insured which is caused directly and independently of all other causes by accidental means and which occurs while the Insured's coverage under the Policy is in force.

"Policyholder", shall also include an associated or affiliated company, when referring to premium payments; Active Work; or Earnings.

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

"You", "your", and "yours" means the Insured Person.

## GENERAL PROVISIONS

**CHANGES:** No agent has authority to change or waive any part of the Policy. To be valid, any change or waiver must be in writing, signed by a President, Vice President or Secretary and attached to the Policy.

**INCONTESTABILITY:** Any statements made by the Policyholder, any Insured Person, or any Insured Dependent, or on behalf of any Insured Person or any Insured Dependent to persuade us to provide coverage, will be deemed a representation, not a warranty. This provision limits our use of these statements in contesting the amount of insurance for which an Insured is covered. The following rules apply to each statement:

- (1) No statement will be used in a contest unless:
  - (a) it is in a written form signed by 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 years during your or any Insured Dependent's lifetime.

**ASSIGNMENT:** Ownership of any benefit provided under the Policy may be transferred by assignment. An irrevocable beneficiary must give written consent to assign this insurance. Written request for assignment must be made in duplicate at our Administrative Offices. Once recorded by us, an assignment will take effect on the date it was signed. We are not liable for any action we take before the assignment is recorded.

**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.



Clerical Errors include (but are not limited to) the payment of premium for coverage not provided by the 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 the Policyholder 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 has been misstated, benefits will be those that apply to his correct age.

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

**PRONOUNS:** All pronouns include either gender unless the context indicates otherwise.

**REPLACEMENT:** If the Policy replaces previous coverage within 60 days from the date of discontinuance of the prior policy, we will cover you and, if applicable, dependents who were previously covered.

## **INDIVIDUAL ELIGIBILITY, EFFECTIVE DATE AND TERMINATION**

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

**EFFECTIVE DATE OF INDIVIDUAL INSURANCE:** Your insurance will go into effect on the Individual Effective Date as shown on the Schedule of Benefits.

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

Changes in your amount of insurance are effective as shown on the Schedule of Benefits.

**TERMINATION OF INDIVIDUAL INSURANCE:** Your coverage 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 for your coverage.

Any loss which occurs prior to the termination of this insurance coverage will not be affected.

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

- (1) 12 months, if you cease to be eligible due to illness or Injury; or
- (2) the end of the month, if you cease to be eligible due to temporary lay-off or approved leave of absence.

**INDIVIDUAL REINSTATEMENT:** Insurance may be reinstated if you are a former Insured Person who has been:

- (1) on an approved leave of absence;
- (2) on temporary lay-off; or
- (3) rehired after employment had been terminated.

You must return to Active Work with the Policyholder within the period of time shown on the Schedule of Benefits (INDIVIDUAL REINSTATEMENT). You must also be a member of a class eligible for this insurance. The insurance will go into effect on the date you return to Active Work.

## **DEPENDENT INSURANCE**

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

**EFFECTIVE DATE OF DEPENDENT INSURANCE:** Your Dependent insurance will become effective on the later of:

- (1) the date you become eligible to enroll his eligible dependents; or
- (2) the date the dependent meets the definition of Dependent.

After this insurance is in force for one Dependent, application is not required for added Dependents.

**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;
- (2) the end of the period for which premium for Dependent insurance has been paid;
- (3) the date your insurance terminates; or
- (4) the date the dependent is no longer a Dependent as defined. However, coverage for an Insured Dependent child which would otherwise cease when such child attains the maximum age, will not cease while your insurance coverage remains in force if:
  - (a) the child is medically certified as disabled and financially dependent upon you; and
  - (b) proof of the above conditions is received by us within 120 days after the date this insurance coverage would otherwise end.

We may ask from time to time if the Insured Dependent child remains a disabled and dependent person. This request may be made within 31 days of the time such Insured Dependent attains the maximum age, and later as required. After the 2 year period that follows such Dependent's attainment of the maximum age, this request may not be made more often than once a year. If we do not ask, insurance coverage for such Insured Dependent child will continue as long as:

- (a) your coverage remains in effect;
- (b) the Insured Dependent child remains in the same condition; and
- (c) the proper premium is paid.

Proof of the Insured Dependent child's status as a disabled and dependent person must be furnished to us within 31 days of the inquiry. If it is not, we may stop the insurance of such Insured Dependent when he attains the maximum age, or later.

Any loss which occurs prior to the termination of this insurance coverage will not be affected.

**NEWLYWED PROVISION:** If you marry and had not previously elected Dependent coverage, your new spouse shall automatically become an Insured Dependent.

Such spouse shall be an Insured Dependent for 31 days. He shall then cease to be an Insured Dependent unless:

- (1) you request, in writing and within such 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 had not elected Dependent coverage, such child shall be an Insured Dependent from the moment of birth.

With respect to your adoptive newborn child, such child shall be an Insured Dependent from the moment of birth, provided he is placed with you within 60 days of birth.

The newborn child shall be an Insured Dependent for 31 days. He shall then cease to be an Insured Dependent unless:

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

The above coverage will also be extended to the following children as of the date they become financially dependent on you for support, provided they otherwise meet the definition of Dependent:

- (1) newly adoptive children placed with you more than 60 days after birth;
- (2) foster children; or
- (3) step children.

"Placed" means physical placement in your care. In those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, "placed" means when you sign an agreement for such child's adoption and sign an agreement assuming financial responsibility for such child.

## **CONVERSION PRIVILEGE**

You can use this privilege when your Accidental Death and Dismemberment insurance coverage is no longer in force for any reason, except termination of the group Policy. Insured Dependents can use this Conversion Privilege if they cease to be eligible for any reason other than termination of the group Policy. Written application for the converted policy must be made within 31 days after coverage ends. The first premium must also be paid within that time. The issuance of the converted policy is subject to the following conditions:

- (1) the converted policy will take effect on the date of the termination of this insurance, or on the date of application for the converted policy, whichever is later;
- (2) proof of health will not be required; and
- (3) the premium will be applicable to the class of risk to which the Insured belongs, at his attained age, and to the form and amount of insurance provided.

The converted policy's Principal Sum will be the lower of:

- (1) the Amount of Principal Sum applicable to the Insured under the Policy; or
- (2) \$250,000.

The converted policy may provide that it will be renewable on any anniversary with our consent, subject to a maximum age limit.

The converted policy may exclude any condition or hazard which applied to the Insured at the time coverage terminated. Benefits will not be paid under the converted policy for a claim originating under the Policy.

The Insured may convert to any individual Accidental Death and Dismemberment policy we offer in the state where he lives.

## **BENEFICIARY AND FACILITY OF PAYMENT**

**BENEFICIARY:** If you die, any death benefit payable and any other accrued benefits will be paid to the beneficiary named in records maintained by the Policyholder. A beneficiary designation will be effective as of the date you signed it. Any payment made by us before receiving the designation shall fully discharge us to the extent of that payment.

You will be the beneficiary of any benefit payable at the death of an Insured Dependent, unless another beneficiary has been named and placed on file as required.

You can change the beneficiary by telling us in writing on our form. The consent of a revocable beneficiary is not needed. The change will take effect only when it is received and approved by us or an authorized Plan Administrator. We cannot attest to the validity of such a change.

If an Insured's beneficiary dies at the same time as the Insured, or within 15 days after his death but before we receive written proof of the Insured's death, payment will be made as if the Insured survived the beneficiary, unless noted otherwise in another provision of this Certificate.

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

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

**FACILITY OF PAYMENT:** If a beneficiary, in our opinion, cannot give a valid release (and no guardian has been appointed), we may pay the benefit to the person who has custody or is the main support of the



beneficiary. Payment to a minor shall not exceed \$1,000.

If the Insured has not named a beneficiary or the beneficiary is not surviving at the Insured's death, we may pay up to \$2,500 of the benefit to the person(s) who, in our opinion, has incurred expenses in connection with the Insured's last illness, death or burial. Payment may also be made to the executor or administrator of the Insured's estate, or to any relative of the Insured by blood or marriage.

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.

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

## CLAIMS PROVISIONS

**NOTICE OF CLAIM:** Written notice must be given to us within 31 days after the Loss occurs, or as soon as reasonably possible. The notice should be sent to us at our Administrative Offices or to our authorized agent. The notice should include the Insured's name and the Policy Number.

**CLAIM FORMS:** When we receive written notice of a claim, we will send claim forms to the claimant within 15 days. If we do not, the claimant will satisfy the requirements of written proof of loss by sending us written proof as shown below. The proof must describe the occurrence, extent and nature of the loss.

**PROOF OF LOSS:** For any covered Loss, written proof must be sent to us within 90 days. If it is not reasonably possible to give proof within 90 days, the claim is not affected if the proof is sent as soon as reasonably possible. In any event, proof must be given within 1 year, unless the claimant is legally incapable of doing so.

**TIME PAYMENT OF CLAIMS:** When we receive written proof of loss, we will pay any benefits due. Benefits that provide for periodic payment will be paid accordingly.

**PAYMENT OF CLAIMS:** If you die, we will pay any death benefit and any other accrued benefits in accordance with the Beneficiary and Facility of Payment provisions. All other benefits will be paid to you.

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.

**PHYSICAL EXAMINATION AND AUTOPSY:** We have the right to have a doctor of our choice examine the Insured as often as we think necessary. This section applies while a claim is pending or while we are paying benefits. We also have the right to make an autopsy in case of death, unless the law forbids it. We will pay for the cost of both the examination and the autopsy.

**LEGAL ACTION:** No lawsuit or action in equity can be brought to recover on the Policy:

- (1) before 60 days following the date written proof of loss was furnished to us; or
- (2) after 3 years following the date written proof of loss is required (6 years in South Carolina and 5 years in Kansas).

## SETTLEMENT OPTIONS

You may elect a single sum payment or a different way in which the beneficiary will receive payment of the Principal Sum. If other than a single sum payment is desired, you must provide a written request to us, for our approval, at our Administrative Office. If the option covers less than the full amount due, we must be advised of what part is to be under an option. Amounts under \$2,000 or option payments of less than \$20 each are not allowed.

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

If a beneficiary dies while receiving payments under one of these options and there is no contingent beneficiary, the balance will be paid in one sum to the beneficiary's estate, unless otherwise agreed to in the instructions for settlement.

Requests for settlement options other than the 3 set out in the Policy may be made. A mutual agreement must be reached between the individual entitled to elect and us.

**OPTION A - FIXED TIME PAYMENT OPTION:** Equal monthly payments will be made for any period chosen, up to 30 years. The amount of each payment depends on the amount applied, the period selected and the payment rates we are using when the first payment is due. The rate of any monthly payment will not be less than shown in the table below. We reserve the right to change the minimum monthly payment. These changes will apply only to requests for settlement elected after the change.

**Option A Table**  
**Minimum Monthly Payment Rates for each \$1,000 Applied**

<u>Years</u>		<u>Years</u>		<u>Years</u>		<u>Years</u>		<u>Years</u>	
1	\$84.47	7	\$13.16	13	\$7.71	19	\$5.73	25	\$4.71
2	42.86	8	11.68	14	7.26	20	5.51	26	4.59
3	28.99	9	10.53	15	6.87	21	5.32	27	4.47
4	22.06	10	9.61	16	6.53	22	5.15	28	4.37
5	17.91	11	8.86	17	6.23	23	4.99	29	4.27
6	15.14	12	8.24	18	5.96	24	4.84	30	4.18

**OPTION B - FIXED AMOUNT PAYMENT OPTION:** Each payment will be for an agreed fixed amount. The amount of each payment will not be less than \$20 for each \$2000 applied. Interest will be credited and added each month on the unpaid balance. This interest will be at a rate set by us, but not less than the equivalent of 3% per year. Payments continue until the amount we hold runs out. The last payment will be for the balance only.

**OPTION C - INTEREST PAYMENT OPTION:** We will hold any amount applied under this section. Interest on the unpaid balance will be paid each month at a rate set by us. This rate will not be less than the equivalent of 3% per year.

## **ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT**

### **DESCRIPTION OF COVERAGE**

**LOSS OF LIFE, LIMB, SIGHT, SPEECH OR HEARING:** If, due to Injury, an Insured suffers any one of the following specific Losses within 365 days from the date of the accident we will pay the Benefit Amount listed below. However, if more than one listed loss results from any one accident, we will only pay the one largest applicable benefit as listed below.

#### **LOSS**

#### **BENEFIT AMOUNT:**

Loss of Life .....	the Insured's Principal Sum
Loss of Two or More Members .....	the Insured's Principal Sum
Loss of Speech and Hearing .....	the Insured's Principal Sum
Loss of One Member .....	1/2 of the Insured's Principal Sum
Loss of Speech or Hearing .....	1/2 of the Insured's Principal Sum
Loss of Thumb and Index Finger of the Same Hand .....	1/4 of the Insured's Principal Sum

#### **DEFINITIONS:**

"Member(s)" means: hand, foot or eye.

"Loss(es)" must result directly and independently from Injury, with no other contributing cause. As used in this benefit with respect to:

- (1) a hand or foot, Loss means the complete severance through or above the wrist or ankle joints;
- (2) an eye, Loss means the total and irrecoverable loss of sight;
- (3) speech, Loss means the total and irrecoverable loss of the function;
- (4) hearing, Loss means the total and irrecoverable loss of the hearing in both ears;
- (5) a thumb and index finger, Loss means the complete severance through or above the metacarpophalangeal joint.

## **COVERAGE FOR MEMBERS OF RESERVE-NATIONAL GUARD**

**DESCRIPTION OF COVERAGE:** We will pay plan benefits for a loss due to Injury of any Insured which is sustained while such Insured is a member of an organized Reserve Corps or National Guard Unit and is:

- (1) attending any regularly scheduled or routine training of less than 60 days, or is enroute to or from such training;
- (2) attending a Service School no matter how long it is, or is enroute to or from that school;
- (3) taking part in any authorized inactive duty training; or
- (4) taking part as a unit member in a parade or exhibition authorized by official orders.

No benefit is payable for any loss that occurs during active duty.

### **DEFINITION:**

"Service School" means one operated by or on behalf of the United States of America or Canada.

## **COVERAGE OF EXPOSURE AND DISAPPEARANCE**

### **DESCRIPTION OF COVERAGE**

**EXPOSURE:** Any loss that is due to exposure will be covered as if it were due to Injury, provided such loss results directly and independently of all other causes from accidental exposure to the elements which occurs while the Insured's coverage under the Policy is in force.

**DISAPPEARANCE:** We will presume an Insured suffered loss of life due to an Injury, if:

- (1) while covered under the Policy, such Insured is riding in a conveyance that is involved in an accident, not excluded from coverage;
- (2) the conveyance is wrecked, sinks or disappears as a result of such accident; and
- (3) the Insured's body is not found within 1 year of the accident.



## **SEAT BELT AND AIR BAG BENEFIT**

**DESCRIPTION OF COVERAGE:** We will pay a sum equal to 10% of the Insured's Principal Sum if:

- (1) the Insured dies as the result of a bodily Injury sustained while riding in or operating a Four-Wheel Vehicle;
- (2) a police report establishes that the Insured was properly strapped in a Seat Belt at the time;
- (3) Loss of Life benefits are payable for the Insured's death hereunder.

We will pay an additional 5% if the Insured is driving in or riding in a Four-Wheel Vehicle which is equipped with a factory-installed Supplemental Restraint System. The Insured must be positioned in a seat which is designed to be protected by an air bag and must be properly strapped in the Seat Belt when the air bag inflates. In addition to the above requirements, the police report must establish that the air bag inflated properly upon impact.

The total maximum benefit payable is \$25,000.

No benefit will be paid for any loss sustained:

- (1) while driving or riding in any Four-Wheel Vehicle used: in a race; in a speed or endurance test; or for acrobatic or stunt driving; or
- (2) if the Insured is not wearing a Seat Belt for any reason; or
- (3) while the Insured is sharing a Seat Belt; or
- (4) due to a defect in the Supplemental Restraint System's diagnostic system.

If the police report does not clearly establish that the Insured was or was not wearing a Seat Belt at the time of the accident causing the Insured's death, we will pay a sum equal to \$1,000 in lieu of the benefit described above.

## **DEFINITIONS:**

"Seat Belt" means an unaltered Seat Belt or lap and shoulder restraint and includes a government approved child restraint device when used in accordance with manufacturer's directions. In the case of small children the restraint must:

- (1) meet the standards of the National Safety Council; and
- (2) must be properly secured and utilized in accordance with applicable State law and the recommendations of its manufacturer for children of like age and weight.

An air bag is not considered a Seat Belt.

"Supplemental Restraint System" means an air bag which inflates for added protection to the head and chest areas.

"Four-Wheel Vehicle" means a vehicle listed below provided it is: duly licensed for passenger use; and designated primarily for use on public streets and highways:

- (1) a private passenger automobile; or
- (2) a station wagon; or
- (3) a van, jeep, or truck-type vehicle which has a manufacturer's rated load capacity of 2,000 pounds or less; or
- (4) a self-propelled motor home.

## TOTAL LOSS OF USE BENEFIT

**DESCRIPTION OF COVERAGE:** We will pay the benefit shown below if, due to Injury, an Insured suffers a Total Loss of Use that is listed below, provided:

- (1) the Insured suffers such Total Loss of Use within 1 year of the Injury;
- (2) the Total Loss of Use continues for a period of 12 consecutive months after the onset;
- (3) it is shown by proper medical authority at the end of these 12 months that the Total Loss of Use has been continuous and will be permanent; and
- (4) no benefit is payable for such loss under the Accidental Death and Dismemberment Benefit of this Certificate.

**BENEFITS:** Only one benefit (the larger) will be paid for more than one Total Loss of Use resulting from any one accident.

### For Total Loss of Use of:

### Benefit Amount:

Both Arms and Both Legs .....	the Insured's Principal Sum
Both Arms .....	2/3 of the Insured's Principal Sum
Both Legs .....	2/3 of the Insured's Principal Sum
One Arm and One Leg .....	2/3 of the Insured's Principal Sum
Both Arms and One Leg or Both Legs and One Arm .....	3/4 of the Insured's Principal Sum
One Arm or One Leg .....	1/2 of the Insured's Principal Sum

In no event will the total of all benefits paid for any one Insured for any one accident, under this benefit and the Accidental Death and Dismemberment Benefit, exceed that Insured's Principal Sum.

**DEFINITION:**

"Total Loss of Use" means loss of the ability to function because of:

- (1) incurable paralysis; or
- (2) stiffening.

In addition, "Total Loss of Use" must affect the entire arm or leg from the shoulder or hip, including the hand or foot attached to it.

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

### **Family and Medical Leave of Absence:**

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

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

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

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

### **Military Services Leave of Absence:**

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

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

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

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

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

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

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

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

## EXCLUSIONS

The Policy does not cover any loss:

- (1) to which sickness, disease, or myocardial infarction, including medical or surgical treatment thereof, is a contributing factor; or
- (2) caused by suicide, or intentionally self-inflicted injuries; or
- (3) caused by or resulting from war or any act of war, declared or undeclared; or
- (4) caused by an accident that occurs while in the armed forces of any country, except as shown under the Reserve-National Guard Benefit (any premium paid to us for any period not covered by the Policy while the Insured is in such service will be returned pro rata); or
- (5) caused by or resulting from riding in, getting into or out of any aircraft, unless:
  - (a) the Insured is a passenger (not a pilot or crew member) in a tested and approved civilian aircraft being operated as passenger transport in compliance with the then current rules of the authority having jurisdiction over its operation; and
  - (b) the aircraft is not owned, leased or operated by or on behalf of the Policyholder, the Insured, or any other employer of the Insured, unless a specific written agreement has been obtained from us; or
- (6) sustained during the Insured's commission or attempted commission of an assault or felony; or
- (7) to which the Insured's acute or chronic alcoholic intoxication is a contributing factor; or
- (8) to which the Insured's voluntary consumption of an illegal or controlled substance or a non-prescribed narcotic or drug is a contributing factor.

# **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.

**RELIANCE STANDARD**  
LIFE INSURANCE COMPANY  
A MEMBER OF THE TOKIO MARINE GROUP

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

GL 668955  
VAR 672929  
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