
**GROUP VOLUNTARY LONG TERM
DISABILITY INSURANCE PROGRAM**

IBEW

CERTIFICATE OF INSURANCE

We certify that the Person whose name appears on the enrollment card attached to this Certificate is insured for the benefits which apply to his/her class, under Group Policy No. VPL 300728 issued to IBEW Local Union 134, the Policyholder.

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


Secretary


President

GROUP LONG TERM DISABILITY INSURANCE CERTIFICATE

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SCHEDULE OF BENEFITS

EFFECTIVE DATE: August 1, 2010

ELIGIBLE CLASSES: Each active, Full-time union Employee earning an annual salary of at least \$15,000, except any person employed on a temporary or seasonal basis.

YOUR EFFECTIVE DATE: The first day of the month following the date you complete your enrollment form.

INDIVIDUAL REINSTATEMENT: 12 month

LONG TERM DISABILITY BENEFIT

ELIMINATION PERIOD: 180 consecutive days of Total Disability.

MONTHLY BENEFIT: If an Eligible Person, you may elect an amount of insurance equal to 60% of your Covered Monthly Earnings, payable in accordance with the section entitled Benefit Provisions.

To figure this benefit amount payable:

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

We will pay at least the Minimum Monthly Benefit as follows.

OTHER INCOME BENEFITS: Other Income Benefits are:

- (1) disability income benefits you are eligible to receive because of your Total Disability under any group insurance plan(s);
- (2) disability income benefits you are eligible to receive because of your Total Disability under any governmental retirement system, except benefits payable under a federal government employee pension benefit;
- (3) all benefits (except medical or death benefits) including any settlement made in place of such benefits (whether or not liability is admitted) you are eligible to receive because of your Total disability under:
 - (a) Workers' Compensation Laws;
 - (b) occupational disease law;
 - (c) any other laws of like intent as (a) or (b) above; and
 - (d) any compulsory benefit law;

- (4) any of the following that you are eligible to receive from the Policyholder:
 - (a) any formal salary continuance plan;
 - (b) wages, salary or other compensation excluding the amount allowable when engaged in Rehabilitative Employment; and
 - (c) commissions or monies, including vested renewal commissions, but, excluding commissions or monies that you earned prior to Total Disability which are paid after Total Disability has begun;
- (5) that part of disability benefits paid for by the Policyholder which you are eligible to receive because of your Total disability under a group retirement plan; and
- (6) that part of Retirement Benefits paid for by the Policyholder which you are eligible to receive under a group retirement plan; and
- (7) disability or Retirement Benefits under the United States Social Security Act, the Canadian pension plans, or any other government plan for which:
 - (a) you are eligible to receive because of your Total Disability or eligibility for Retirement Benefits; and
 - (b) your dependents are eligible to receive due to (a) above.

Disability and early Retirement Benefits will be offset only if such benefits are elected by you or do not reduce the amount of your accrued normal Retirement Benefits then funded.

Retirement Benefits under number 7 above will not apply to disabilities which begin after age 70 if you are already receiving Social Security Retirement Benefits while continuing to work beyond age 70.

MINIMUM MONTHLY BENEFIT: In no event will the Monthly Benefit payable to you be less than \$50.

MAXIMUM MONTHLY BENEFIT: \$5,000

MAXIMUM DURATION OF BENEFITS: Benefits will not accrue beyond the duration specified below:

<u>Age at Disablement</u>	<u>Duration of Benefits</u>
Less than 62	The lesser of: (1) 60 months; or (2) to age 65
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 or more	12 months

CHANGES IN MONTHLY BENEFIT: Increases in the Monthly Benefit are effective on the January 1st coinciding with or next following the date of the change, provided you are Actively at Work on the effective date of the change. If you are not Actively at Work on that date, the effective date of the increase in the benefit amount will be deferred until the date you return to Active Work. Decreases in the Monthly Benefit are effective on the January 1st coinciding with or next following the date the change occurs.

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

If an increase in, or initial application for, the Monthly Benefit is due to a life event change (such as marriage, birth or specific changes in employment status), proof of health will not be required provided you apply within 31 days of such life event.

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

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

DEFINITIONS

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

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

"Actively at Work" and "Active Work" mean actually performing on a Full-time basis the material duties 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 an Injury or Sickness.

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

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

"Covered Monthly Earnings" means your monthly salary received from the Policyholder on the January 1st just before the date of Total Disability, prior to any deductions to a 401(k) or Section 125 plan. Covered Monthly Earnings does not include commissions, overtime pay, bonuses or any other special compensation not received as Covered Monthly Earnings.

If you are an hourly paid employee, the number of hours worked per year, not to exceed 2,080 hours during the prior 12 months, will be used to determine the annual earnings, divided by 12.

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

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

"Full-time" means working for the Policyholder for a minimum of 1,200 hours per year

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

"Injury" means bodily Injury resulting directly from an accident, independent of disease or bodily infirmity. The Injury must cause Total Disability which begins while your insurance coverage is in effect.

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

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

"Regular Occupation" means the occupation you are routinely performing when Total Disability begins. The primary source we will use to determine your occupation is the Dictionary of Occupational Titles published by the Department of Labor, or its replacement(s).

"Retirement Benefits" mean money which you are entitled to receive upon early or normal retirement or disability retirement under:

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

Retirement Benefits do not include:

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

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

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

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

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

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

TRANSFER OF INSURANCE COVERAGE

If you were covered under any group long term disability insurance plan maintained by the Policyholder prior to the Policy's Effective Date, you will be insured under the Policy, provided that you are Actively At Work and meet all of the requirements for being an Eligible Person under the Policy on its Effective Date.

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

- (1) You must have been insured with the prior carrier on the date of the transfer; and
- (2) Premiums must be paid; and
- (3) Total Disability must begin on or after the Policy's Effective Date.

If you are receiving long term disability benefits, become eligible for coverage under another group long term disability insurance plan, or have a period of recurrent disability under the prior group long term disability insurance plan, you will not be covered under the Policy. If premiums have been paid on your behalf under the Policy, those premiums will be refunded.

Pre-existing Conditions Limitation Credit

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

GENERAL PROVISIONS

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

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

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

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

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

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

CLAIMS PROVISIONS

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

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

WRITTEN PROOF OF TOTAL DISABILITY: For any Total Disability covered by the Policy, written proof must be sent to us within ninety (90) days after the Total Disability occurs. If written proof is not given in that time, the claim will not be invalidated nor reduced if it is shown that written proof was given as soon as was reasonably possible. In any event, proof must be given within one (1) year after the Total Disability occurs, unless you are legally incapable of doing so.

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

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

If you died and we have not paid all benefits due, we may pay up to \$1,000 to any relative by blood or marriage, or to the executor or administrator of your estate. The payment will only be made to persons entitled to it. An expense incurred as a result of your last illness, death or burial will entitle a person to this payment. The payments will cease when a valid claim is made for the benefit. We will not be liable for any payment we have made in good faith.

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

arbitrators may be entered in any court having jurisdiction over such awards.

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

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

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

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

to determine the existence of any Total Disability which is the basis for a claim. This right may be used as often as it is reasonably required while a claim is pending.

We can have an autopsy made unless prohibited by law.

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

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

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

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

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

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

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

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

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

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

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

BENEFIT PROVISIONS

INSURING CLAUSE: We will pay a Monthly Benefit if you:

- (1) are Totally Disabled as the result of a Sickness or Injury covered by the Policy;
- (2) are under the regular care of a Physician;
- (3) have completed the Elimination Period; and
- (4) submit satisfactory proof of Total Disability to us.

Please refer to the Schedule of Benefits for the MONTHLY BENEFIT and OTHER INCOME BENEFITS.

Benefits you are entitled to receive under OTHER INCOME BENEFITS will be estimated if the benefits:

- (1) have not been applied for; or
- (2) have been applied for and a decision is pending; or
- (3) have been denied and the denial may be appealed.

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

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

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

For each day of a period of Total Disability less than a full month, the amount payable will be 1/30th of the Monthly Benefit.

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

LUMP SUM PAYMENTS: If Other Income Benefits are paid in a lump sum, the sum will be prorated over the period of time to which the Other Income benefits apply. If no period of time is given, the sum will be prorated over sixty (60) months.

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

- (1) the date you cease to be Totally Disabled;
- (2) the date you die;
- (3) the Maximum Duration of Benefits, as shown on the Schedule of Benefits page, has ended; or
- (4) the date you fail to furnish the required proof of Total Disability.

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

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

If you become eligible for insurance coverage under any other group long term disability insurance plan, then this recurrent disability section will not apply to you.

EXCLUSIONS

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

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

LIMITATIONS

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

If you were confined in a Hospital or Institution and:

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

then upon discharge, Monthly Benefits will be payable for the greater of:

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

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

Mental or Nervous Disorders are defined to include disorders which are diagnosed to include a condition such as:

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

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

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

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

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

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

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

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

- (1) the Total Disability begins in the first twelve (12) months after your effective date; and
- (2) you have been diagnosed or treated by a legally qualified Physician with consultation, advice or Treatment occurring during the three (3) months immediately prior to your effective date of insurance.

Benefits will not be paid for a Total Disability:

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

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

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

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

a Pre-existing Condition unless you have been Actively at Work for one (1) full day following the end of twelve (12) consecutive months measured from the date of such election. A Pre-existing Condition means any Sickness or Injury for which you were diagnosed or treated by a legally qualified Physician with consultation, advise or Treatment occurring during the three (3) months immediately prior to the date of such election (with respect to any increase in benefits).

LIMITATIONS - OTHER LIMITED BENEFITS

1. Monthly Benefits will be limited to a total of 24 months in your lifetime for all Total Disabilities caused by:
 - Chronic fatigue syndrome; or
 - Environmental Allergic or Reactive Illness; or
 - Self-Reported Conditions.

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

2. Monthly Benefits will be limited to a total of 24 months in your lifetime for all Total Disabilities caused by musculoskeletal and connective tissue disorders of the neck and back, including any disease, disorder, sprain and strain of the joints and adjacent muscles of the cervical, thoracic and lumbosacral regions and their surrounding soft tissue.

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

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

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

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

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

SPECIFIC INDEMNITY BENEFIT

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

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

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

"Loss(es)" with respect to:

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

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

The amount payable is the Monthly Benefit, as shown on the Schedule of Benefits page, with no reduction from Other Income Benefits. The number of Monthly Benefit payments will not cease if you return to Active Work. If death occurs after we begin paying Monthly Benefits, but before the Specific Indemnity Benefit has been paid according to the above schedule, the balance remaining at time of death will be paid to your

estate, unless a beneficiary is on record with us under the Policy.

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

SURVIVOR BENEFIT - LUMP SUM

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

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

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

“Survivor” means your spouse. If your spouse dies before you or if you were divorced, then your natural, legally adopted or step-children, who are under age twenty-five (25) will be the Survivor(s). If there are no eligible Survivors, payment will be made to your estate, unless a beneficiary is on record with us under the Policy.

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

WORK INCENTIVE AND CHILD CARE BENEFITS

WORK INCENTIVE BENEFIT

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

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

(2) earnings from Rehabilitative Employment;

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

CHILD CARE BENEFIT

We will allow a Child Care Benefit if:

(1) you are receiving benefits under the Work Incentive Benefit;

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

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

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

During the twelve (12) month period in which you are eligible for the Work Incentive Benefit, an amount equal to actual expenses incurred for child care, up to a maximum of \$250 per month, will be added to your Covered Monthly Earnings when calculating the Benefit Amount under the Work Incentive Benefit.

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

REHABILITATION BENEFIT

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

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

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

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

**ILLINOIS
LIFE AND HEALTH INSURANCE GUARANTY
ASSOCIATION LAW**

Residents of Illinois who purchase health insurance, life insurance, and annuities should know that the insurance companies licensed in Illinois to write these types of insurance are members of the Illinois Life and Health Insurance Guaranty Association. The purpose of this Guaranty Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its policy obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the covered claims of policyholders that live in Illinois (and their payees, beneficiaries, and assignees) and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, as noted below.

**ILLINOIS LIFE AND HEALTH
INSURANCE GUARANTY ASSOCIATION**

DISCLAIMER

The Illinois Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are substantial limitations and exclusions. Coverage is generally conditioned on continued residence in Illinois. Other conditions may also preclude coverage.

You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association Law when selecting an insurer. Your insurer and agent are prohibited by law from using the existence of the

Association or its coverage to sell you an insurance policy.

The Illinois Life and Health Insurance Guaranty Association or the Illinois Department of Insurance will respond to any questions you may have which are not answered by this document. Policyholders with additional questions may contact:

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

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

SUMMARY OF GENERAL PURPOSES AND CURRENT LIMITATIONS OF COVERAGE

The Illinois law that provides for this safety-net coverage is called the Illinois Life and Health Insurance Guaranty Association Law ("Law") (215 ILCS 5/531.01, et seq.). The following contains a brief summary of the Law's coverages, exclusions, and limits. This summary does not cover all provisions, nor does it in any way change anyone's rights or obligations under the Law or the rights or obligations of the Guaranty Association. If you have obtained this document from an agent in connection with the purchase of a policy, you should be aware that its delivery to you does not guarantee that your policy is covered by the Guaranty Association.

A. Coverage:

The Illinois Life and Health Insurance Guaranty Association provides coverage to policyholders that reside in Illinois for insurance issued by members of the Guaranty Association, including:

- (1) life insurance, health insurance, and annuity contracts;
- (2) life, health or annuity certificates under direct group policies or contracts;

- (3) unallocated annuity contracts; and
- (4) contracts to furnish health care services and subscription certificates for medical or health care services issued by certain licensed entities. The beneficiaries, payees, or assignees of such persons are also protected, even if they live in another state.

B. Exclusions from Coverage:

- (1) The Guaranty Association does not provide coverage for:
 - (a) any policy or portion of a policy for which the individual has assumed the risk;
 - (b) any policy of reinsurance (unless an assumption certificate was issued);
 - (c) interest rate guarantees which exceed certain statutory limitations;
 - (d) certain unallocated annuity contracts issued to an employee benefit plan protected under the Pension Benefit Guaranty Corporation and any portion of a contract which is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery;
 - (e) any portion of a variable life insurance or variable annuity contract not guaranteed by an insurer; or
 - (f) any stop loss insurance.
- (2) In addition, persons are not protected by the Guaranty Association if:
 - (a) the Illinois Director of Insurance determines that, in the case of an insurer which is not domiciled in Illinois, the insurer's home state provides substantially similar protection to Illinois residents which will be provided in a timely manner; or
 - (b) their policy was issued by an organization which is not a member insurer of the Association.

C. Limits on Amount of Coverage:

- (1) The Law also limits the amount the Illinois Life and Health Insurance Guaranty Association is obligated to pay. The Guaranty Association's liability is limited to the lesser of either:
 - (a) the contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer; or
 - (b) with respect to any one life, regardless of the number of policies, contracts, or certificates:
 - (i) in the case of life insurance, \$300,000 in death benefits but not more than \$100,000 in net cash surrender or withdrawal values;

- (ii) in the case of health insurance, \$300,000 in health insurance benefits, including net cash surrender or withdrawal values; and
 - (iii) with respect to annuities, \$100,000 in the present value of annuity benefits, including net cash surrender or withdrawal values, and \$100,000 in the present value of annuity benefits for individuals participating in certain government retirement plans covered by an unallocated annuity contract. The limit for coverage of unallocated annuity contracts other than those issued to certain governmental retirement plans is \$5,000,000 in benefits per contract holder, regardless of the number of contracts.
- (2) However, in no event is the Guaranty Association liable for more than \$300,000 with respect to any one individual.

**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 **DELPHI** company

Home Office: Chicago, Illinois

Administrative Office: Philadelphia, Pennsylvania

VPL 300728
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