RELIANCE STANDARD
Life Insurance Company

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

PARTICIPATING UNIT: Gray Hunter Stenn, LLP

EFFECTIVE DATE: July 1, 2011

We certify that you are insured for the benefits set forth under Policy number VL 600, the Policy, issued to the RSL Employer Trust, the Policyholder. A copy of the trust agreement and the Policy are on file with us. They can be reviewed upon request at any time during normal business hours. This Certificate of Insurance 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 delivered earlier to you.

10 DAY RIGHT TO EXAMINE CERTIFICATE: If you are not satisfied with this Certificate of Insurance, you may return it to us or to our authorized representative within ten (10) days of receipt. We will then make a full refund of any premiums paid. If this Certificate of Insurance is returned, insurance coverage will never have been in force.

Secretary

President

VOLUNTARY GROUP TERM LIFE INSURANCE
CERTIFICATE OF INSURANCE

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*BC1VGC2VG 18281407/01/2011*RSL
*BC2VGC2Gray Hunter Stenn, LLP

SCHEDULE OF BENEFITS AND PREMIUMS

An eligible employee is not insured for any amount or type of insurance not specifically applied for on his application. There are circumstances when a benefit amount applied for will be subject to medical evidence of insurability and approval by Reliance Standard.

OWNER: The eligible employee, unless the employee has named someone else in writing and filed the change with us.

INSURED: The named Insured is any eligible employee for whom insurance coverage is in effect for himself.

If an eligible employee elects this coverage for his spouse and not for himself, then the named insured is the spouse for whom insurance coverage is in effect.

ISSUE AGE: As of the Individual Effective Date, the Insured's age in relation to the Anniversary Date.

ANNIVERSARY DATE: July 1

PARTICIPATING UNIT NUMBER: VG 182814

ELIGIBLE PERSONS:

All Actively-at-Work, Full-time Employees of the Participating Unit who have completed 60 days of continuous employment, except any person employed on a temporary or seasonal basis, and their Dependents.

"Actively-at-Work" means: a person actually performing on a Full-time basis each and every duty pertaining to his job in the place where and 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.

"Full-time" means: working for the Participating Unit for a minimum of 32 hours during a person's regularly scheduled work week.

"Dependent" means:

(a) the employee's legal spouse;

(b) the employee's unmarried child(ren), including any foster child, adopted child or stepchild who resides in the employee's home, who is age 14 days but under 20 years of age and who is financially dependent on the employee for support;

(c) the employee's unmarried child(ren), including any foster child, adopted child or stepchild, who is attending a college or other school on a full-time basis, and is financially dependent on the employee for support and under age 26; and

(d) the employee's 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 the employee for support and maintenance.

Additionally, with respect to an employee who is a partner in a civil union or for whom an Affidavit of Domestic Partnership is on file with the Participating Unit and is in effect, such employee's:

(a) civil union partner or domestic partner; and

(b) children, provided he/she otherwise meets the definition of Dependent,

of the civil union or as named on such Affidavit will be considered a "Dependent" of such employee. When the employee's civil union partner or domestic partner is covered under the Policy, the word "spouse" as it appears in the Policy will be deemed to mean "civil union partner" or "domestic partner", unless the context indicates otherwise.

Additionally, with respect to an employee for whom an Affidavit of Domestic Partnership is on file with the Participating Unit and is in effect, such employee’s (1) domestic partner and (2) children, provided he/she otherwise

meets the definition of Dependent, named on such Affidavit will be considered a "Dependent" of such employee. When the employee's domestic partner is covered under the Policy, the word "spouse" as it appears herein and in the Policy, and any applicable Riders to the Policy, will be deemed to mean "domestic partner", unless the context indicates otherwise.

A person may not have coverage both as an employee and as a Dependent. Only one insured spouse may cover the eligible children as insured Dependents. The employee or spouse must be insured in order for children to be insured.

Spouse Maximum Age: 75

On the date of application, the spouse must be under age 70.

AMOUNT OF INSURANCE (eligible employee): This is the amount the eligible employee is insured for under this insurance plan.

Each eligible employee may elect a benefit amount from a minimum of $10,000 to a maximum of $500,000 (in $10,000 increments). The benefit amount elected is subject to evidence of insurability and age requirements as follows:

(a) Any benefit amount subject to medical evidence of insurability will become effective only upon our approval.

(b) The Amount of Insurance in effect on the insured employee is subject to automatic reduction beginning at age 75 as shown in the following Table. The reduction applies equally to those eligible employees initiating insurance coverage at age 75 or over.

AT AGE	FACE AMOUNT REDUCES TO:
75-79	60.0% of available or in force amount at age 74
80-84	35.0% of available or in force amount at age 74
85-89	27.5% of available or in force amount at age 74
90-94	20.0% of available or in force amount at age 74
95-99	7.5% of available or in force amount at age 74
100 +	5.0% of available or in force amount at age 74

The Amount of Insurance will be reduced by an amount equal to the Living Benefit paid for the insured employee.

DEPENDENT INSURANCE:

This section is applicable only to the extent an eligible employee makes written application for and pays applicable premium for spouse and/or children coverage.

AMOUNT OF INSURANCE: This is the amount an eligible Dependent is insured for under this insurance plan.

Each eligible employee may elect a benefit amount for his spouse from a minimum of $10,000 to a maximum of $500,000 (in $10,000 increments). The amount elected is subject to age and evidence of insurability requirements, as follows:

(a) On the date of application, the spouse must be under age 70.

(b) Any benefit amount subject to medical evidence of insurability will become effective only upon our approval.

Insurance on a spouse terminates at age 75.

Each eligible employee may elect a benefit amount for his Dependent children as follows:

ATTAINED AGE	AMOUNT OF INSURANCE
Less than 14 days	None
14 days but less than 6 months	$1,000
6 months but less than 26 years	$5,000, $10,000, $15,000 or $20,000,

as elected on the individual application.

One benefit amount is applicable to all eligible children. Newly acquired eligible children automatically become insured if the eligible employee insures other Dependent children.

The Amount of Insurance will be reduced by an amount equal to the Living Benefit paid for the insured Dependent.

EFFECTIVE DATE OF INDIVIDUAL INSURANCE:

An eligible employee must apply in writing for this insurance. Those employees eligible before or upon the Participating Unit's Effective Date must complete, sign and return the application during the initial enrollment period. All other employees must apply during their initial eligibility period (within thirty-one (31) days of first becoming eligible). If insurance is applied for beyond the initial enrollment period or beyond the initial eligibility period, medical evidence of insurability will always be required; the only exceptions are life event changes (see CHANGES section) and any annual enrollment approved by us.

GUARANTEED ISSUE AMOUNTS

EMPLOYEE: If an eligible employee is under age 60 and applies for coverage on himself in accordance with all requirements for making application, up to $100,000 of insurance will be issued on the Individual Effective Date. If an eligible employee is age 60 but less than 70 and applies for coverage on himself in accordance with all requirements for making application, $10,000 of insurance will be issued on the Individual Effective Date.

DEPENDENT SPOUSE: If an eligible employee applies for coverage on his spouse in accordance with all requirements for making application, $10,000 of insurance will be issued on the Individual Effective Date, provided the spouse is under age 60.

DEPENDENT CHILDREN: If an eligible employee applies for coverage on his dependent children in accordance with all requirements for making application, the benefit amount elected by the employee will be issued on the Individual Effective Date, provided the employee or spouse is insured.

AMOUNTS SUBJECT TO EVIDENCE OF INSURABILITY

Any benefit amount subject to medical evidence of insurability will become effective on the Individual Effective Date, but only after approval by us. If we do not approve such an amount, the eligible employee will be notified in writing and any premium paid for coverage not issued will be returned. If payroll deduction of premiums should begin prior to our approval, it does not mean coverage is in effect.

CHANGES

Automatic decreases in the Amount of Insurance due to an insured employee's age are effective on the Anniversary Date coinciding with or next following the date the change occurs.

If a change in the insured employee's Amount of Insurance is received that would alter the calculation of a benefit reduction based on age, the benefit reduction will be recalculated using the new benefit amount. The recalculated benefit amount will become effective as described above.

If an increase in, or initial application for, an Amount of Insurance is due to a life event change (such as marriage, birth or specific changes in employment status), medical evidence of insurability will not be required, provided the eligible employee completes, signs and returns the application within thirty-one (31) days of such life event. A change due to a life event will become effective on the Individual Effective Date.

INDIVIDUAL EFFECTIVE DATE

The Participating Unit has chosen the following Individual Effective Date for insurance elected by eligible employees: the first day of the month following the date the employee signs his application, for guaranteed issue amounts; and the first day of the month following the date the employee's application is approved by us, for amounts subject to evidence of insurability, provided the employee has satisfied any service waiting period and any premium has been paid, as applicable.

The Individual Effective Date cannot predate either: (a) the Participating Unit Effective Date; or (b) the date the employee first becomes eligible for this insurance. Any application dated prior to the date the employee first becomes eligible will be considered to be dated on the first day of eligibility.

The Individual Effective Date may be deferred for an employee not Actively-at-Work and for any enrolled dependent confined in a hospital or at home.

Insurance applied for during a Reliance Standard-approved annual enrollment that takes place beyond the eligible employee's initial enrollment period or beyond the employee's initial eligibility period will become effective according to the specific rules for such enrollment.

PREMIUMS:

This insurance coverage is 100% employee paid via payroll deduction.

PREMIUM MODE: Monthly PREMIUM: See TABLE OF RENEWAL PREMIUMS

An Eligible Person will be covered under this insurance plan only when: (1) the eligible employee has applied for this insurance in accordance with all requirements for making application; (2) Reliance Standard has approved any amount(s) of insurance subject to medical evidence of insurability; (3) premium has been paid as applicable; and (4) insurance is in effect in accordance with all requirements regarding Individual Effective Date and termination provisions.

DEFINITIONS

"Insured" means: an eligible employee as defined in the Participating Unit Application who is actively working and for whom insurance coverage is in effect. If the employee does not elect this coverage, then Insured means the insured spouse for whom insurance coverage is in effect. Except, as stated herein, “Insured” does not refer to your insured Dependents.

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

"You", "your" and "yours" means: the Insured named in the Schedule of Benefits and Premiums.

GENERAL PROVISIONS

INCONTESTABILITY

Any statement made by you, on behalf of you, any insured Dependent, or on behalf of any insured Dependent, the Participating Unit, or the Policyholder 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 life insurance for which you and any insured Dependent are covered. The following rules apply to each statement.

A. No statement will be used in a contest unless:

   (1) it is in written form signed by you, any insured Dependent, or on behalf of you or any insured Dependent; and

   (2) a copy of such written statement is or has been furnished to you or any insured Dependent, or your or an insured Dependent's beneficiary or legal representative.

B. 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 2 years during your or any insured Dependent's lifetime.

CLERICAL ERROR

Clerical errors in connection with the Policy or delays in keeping records for the Policy, whether by the Policyholder, the Participating Unit, 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.

MISSTATEMENT OF AGE

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

CONFORMITY WITH STATE LAWS

Any provision in the Policy which is in conflict with the laws in the state where it is issued or in a state that otherwise has jurisdiction over such provision, is amended to conform with the minimum requirements of such laws of that state.

PRONOUNS

All pronouns include either gender unless the context indicates otherwise.

DEFERRED EFFECTIVE DATE, TERMINATION AND CONTINUATION

DEFERRED EFFECTIVE DATE

If, on the Effective Date, you are employed and not regularly performing the duties of your occupation, or are unemployed and not engaged in normal activities for a person of like age or sex, then your insurance coverage will be effective on the date you return to:

(1) the regular performance of your job duties; or

(2) the normal activities for a person of like age and sex, for those not employed.

TERMINATION OF INDIVIDUAL INSURANCE

Your insurance coverage will terminate on the first of the following to occur:

(1) the premium due date coinciding with or next following the date the Participating Unit terminates;

(2) the premium due date coinciding with or next following the date you cease to be eligible for this insurance (except as described under the provision entitled "Portability");

(3) the end of the period for which your premium has been paid;

(4) the premium due date coinciding with or next following the date you convert to an individual plan of insurance according to the terms of the Policy;

(5) the date you enter military service (not including the Reserves or National Guard); or

(6) in the case where an insured spouse is the Insured, the Anniversary Date (shown in the Schedule of Benefits and Premiums) coinciding with or next following his 75th birthday.

CONTINUATION OF INDIVIDUAL INSURANCE

Your insurance coverage may be continued, by payment of premium, beyond the premium due date coinciding with or next following the date you are no longer eligible for this insurance, but not longer than:

(1) twelve (12) months, if due to illness or injury; or

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

CONVERSION PRIVILEGE

You can use this privilege when your insurance under the Policy terminates. Conversion is subject to the following:

A. If the insurance ceases, except as described in B. below or for non-payment of premium, an individual life insurance policy may be issued. You must make written application for the policy within thirty-one (31) days after your insurance terminates. 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 our option, be on any one of our forms, except term life insurance and it will be the standard type issued by us for the age and amount applied for;

   (2) the face amount of the policy cannot exceed the Amount of Insurance you had under the Policy immediately before your insurance terminated; and

   (3) the premium for the policy will be at our usual rate and it will be based on the amount of insurance, class of risk and your age at date of conversion.

   Proof of good health is not required.

B. If the insurance ceases due to the termination or amendment of the Policy or termination of the Participating Unit, an individual life insurance policy may be issued. You must have been insured for at least five (5) years under the Policy. The same rules as in A. above will apply, except that the face amount will be the lesser of:

   (1) the Amount of Insurance you had under the Policy immediately before your insurance terminated, reduced by any amount you are entitled to under any other group life policy issued by us or another insurance company; or

   (2) $10,000.

C. If you die during the time in which you are entitled to apply for an individual policy, we will pay the benefit to which you were entitled under the Policy. This will be done whether or not you applied for the individual policy.

D. Conversion will not be allowed while any premium is in default, or if you are Totally Disabled and entitled to a waiver of premiums.

E. Any policy issued in accordance with A. or B. above will be effective on the day following the day insurance coverage under the Policy terminates.

F. If your coverage under the Policy includes Waiver of Premium, Accidental Death and/or other supplemental benefits, then such benefits may be included under the individual policy.

G. If Waiver of Premium, Accidental Death and/or other supplemental benefits are not effective on the date of conversion, such benefits may be added on the conversion date. However, proof of good health will be required for such additional benefits.

PORTABILITY

You may continue your insurance coverage under the Policy, and that of your insured Dependents, if coverage would otherwise terminate because you cease to be eligible, for reasons other than the termination of the Participating Unit, provided you:

(1) notify us in writing within thirty-one (31) days from the date you cease to be eligible;

(2) remit the necessary premiums when due; and

(3) are not considered Totally Disabled under the Waiver of Premium in Event of Total Disability provision, if applicable.

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 Waiver of Premium, Accidental Death and/or other supplemental benefits, then such benefits may be continued under the Policy.

Your insured spouse, if applicable, may not continue this insurance coverage after the anniversary date (shown in the Schedule of Benefits and Premiums) coinciding with or next following his 75th birthday.

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

(1) the premium due date coinciding with or next following the date the Policy ends; or

(2) the end of the period for which premium has been paid.

If your insurance coverage terminates due to (1) above, it can be converted to an individual life insurance policy. The conversion will be subject to the terms and conditions set forth under the Conversion Privilege.

OWNERSHIP, BENEFICIARY AND ASSIGNMENT

OWNERSHIP

The Owner is the person who is entitled to all rights, privileges and options of individual insurance contained in the Policy. This includes the right to change the Beneficiary (unless irrevocably named) or name any contingent Owner. The Owner is the employee unless the individual application or enrollment form states otherwise, or is later changed in writing and filed with us.

If the employee is not the Owner and the Owner dies before you without naming a successor, then all rights of the Owner shall pass to the executors or administrators of the deceased Owner's estate.

BENEFICIARY

"Beneficiary" means: the person(s) who will receive the Death Benefit of the Policy. Such Beneficiary is named in writing as the Beneficiary in your application or enrollment form, unless later changed in accordance with the applicable provisions of the Policy.

The Beneficiary designation must be recorded with us or our authorized plan administrator and will be effective on the date it is recorded. Any payment made by us to a Beneficiary before receiving a change in the designation will fully discharge us to the extent of that payment.

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

CHANGE OF OWNERSHIP AND BENEFICIARY

During your lifetime, the Owner or Beneficiary may be changed as often as desired while the Policy is in force. The change must be made in writing by the Owner on a form satisfactory to us. An irrevocable Beneficiary may be changed with the written consent of that Beneficiary.

A change of ownership will not affect the interest of any Beneficiary. Such changes are subject to the rights of any assignee on record with us. The change will take effect only when we receive it and will then become effective as of the date of the application for change, whether or not you are living at that time. However, such change will be subject to any payment made or action taken by us before the request is recorded.

ASSIGNMENT

Assignment of your coverage, or any interest in it, must be made in duplicate and sent to us at our Administrative Office. When we record it, the assignment will take effect as of the date it is signed. We are not liable for any action we take before we record it. We are not responsible for the validity of the assignment. We may rely solely on the assignee's statement as to the amount of his interest.

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 a Beneficiary is not named or the Beneficiary is not surviving at your or your insured Dependent's death, we may pay up to $2,000 to the person(s) who, in our opinion, has incurred expenses in connection with your or your insured Dependent's last illness, death, or burial. This payment may also be made to the executor or administrator of your or your insured Dependent's estate, or to any relative of yours or your insured Dependent 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.

The benefit will be held with interest at a rate set by us but not less than such rate required by law.

Any payment we have made in good faith will fully discharge us to the extent of that payment.

LIMITATIONS

If you or your insured Dependent(s) die by suicide while sane or insane, within two (2) years from the Effective Date of your/his insurance coverage, our payment will be limited to a refund of all premiums paid prior to the date of death.

The maximum amount of insurance you or your insured Dependent spouse may have under the Policy is $500,000. Insurance over $500,000 will be void and premiums paid therefore will be refunded.

The Amount of Insurance in effect is subject to automatic reduction beginning at age 75. This reduction applies equally if you are initiating insurance coverage at age 75 or over. (Refer to Table of Insurance Amounts below.) An insured Dependent spouse's insurance will automatically terminate at age 75, subject to all other Policy provisions.

TABLE OF INSURANCE AMOUNTS

AGES	FACE AMOUNT REDUCES TO:
75-79	60.0% OF THE AMOUNT AVAILABLE OR IN FORCE AT AGE 74
80-84	35.0% OF THE AMOUNT AVAILABLE OR IN FORCE AT AGE 74
85-89	27.5% OF THE AMOUNT AVAILABLE OR IN FORCE AT AGE 74
90-94	20.0% OF THE AMOUNT AVAILABLE OR IN FORCE AT AGE 74
95-99	7.5% OF THE AMOUNT AVAILABLE OR IN FORCE AT AGE 74
100 +	5.0% OF THE AMOUNT AVAILABLE OR IN FORCE AT AGE 74

PREMIUMS

Premiums that apply to the coverage outlined on your Schedule of Benefits and Premiums are payable on or before the premium due date.

Premium increases, resulting from you or an insured Dependent entering into a higher age bracket, occur on the Anniversary Date (shown in the Schedule of Benefits and Premiums) coinciding with or next following your/his last birthday.

We reserve the right to adjust the premium rate on any premium due date:

(1) after coverage has been in force twenty-four (24) months; or

(2) if the coverage is changed by amendment.

PREMIUM DUE DATES

The first premium is due on the Effective Date. Further premiums are due as stated on the Schedule of Benefits and Premiums.

GRACE PERIOD

After the first premium, a premium is payable up to thirty-one (31) days after the date it is due. Insurance coverage will stay in force during this time. If the premium is not paid during this grace period, insurance coverage will terminate at the end of the grace period. The premium will still be owed to us up to the date the insurance coverage terminated.

TABLE OF RENEWAL PREMIUMS
PER $10,000 FACE AMOUNT PER MONTH

Age at Renewal	Premium Rate
Under 30	$ .65
30-34	.64
35-39	.92
40-44	1.52
45-49	2.56
50-54	4.20
55-59	7.14
60-64	8.74
65-69	13.09
70 and Over	25.16

To determine the premium for other than a monthly basis, multiply the premium rates above by three (3) for quarterly, by six (6) for semi-annually, or by twelve (12) for annually and then multiply the Amount of Insurance by the appropriate modal premium.

Premiums for Dependent children will be:

Amount of Insurance	Age	Monthly Premium Rate
$1,000 $5,000	14 days but less than 6 months 6 months but less than age 26	$.82
$1,000 $10,000	14 days but less than 6 months 6 months but less than age 26	$1.62
$1,000 $15,000	14 days but less than 6 months 6 months but less than age 26	$2.42
$1,000 $20,000	14 days but less than 6 months 6 months but less than age 26	$3.22

To determine the premium for other than a monthly basis, multiply the premium rates above by three (3) for quarterly, by six (6) for semi-annually, or by twelve (12) for annually.

Premiums charged to continue coverage under the Portability provision will be based on the prevailing rate charged to all insureds who choose to continue coverage under this provision.

When coverage begins, premiums are based on the Issue Age shown in the Schedule of Benefits and Premiums.

Premium increases resulting from you or an insured Dependent entering into a higher age bracket occur on the Anniversary Date (shown in the Schedule of Benefits and Premiums) coinciding with or next following your/his last birthday.

We reserve the right to change the rates. The change will be determined upon the experience for the class of risk insured under the Policy. We will give written notice of our intention to change such rates at least thirty-one (31) days prior to any Policy anniversary date.

SETTLEMENT OPTIONS

The Owner may elect a single sum payment or a different way in which the Beneficiary will receive payment of the Death Benefit. If other than a single sum payment is desired, he 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 eligible.

If no instructions for a settlement option are in effect at your or your insured Dependent's death, the Beneficiary may make the election, with our consent.

DEATH BENEFIT

The Death Benefit is the amount we will pay upon our receipt of written proof of your or your insured Dependent's death which occurs while the Policy is in force. Such benefit is the Amount of Insurance shown in the Schedule of Benefits and Premiums and will be paid to the named Beneficiary.

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) the employee becomes Totally Disabled prior to age 60;

(2) the Total Disability lasts for at least six (6) months in a row;

(3) we receive proof of Total Disability within one (1) year from the date it began; and

(4) the premium continues to be paid during the six (6) month period.

"Total Disability/Totally Disabled" means: an employee's complete inability to engage in any type of work for wage or profit for which such employee is suited by education, training or experience.

After proof of Total Disability is approved by us, premium payment for you and your insured Dependents is not required for one (1) year. Also any premiums paid from the start of the Total Disability will be returned.

The employee must submit annual proof of continued Total Disability to have insurance extended for additional one (1) year periods. The employee may be required to be examined by a doctor approved by us, at our expense as part of the proof. We will not require the employee to be examined more than once a year after the insurance has been extended to two (2) full years.

The Amount of Insurance continued will be the amount that was in force at the time that Total Disability began. This amount will not increase. This amount will reduce or cease at any time it would reduce or cease if the employee had not been Totally Disabled. If an employee dies, we will be liable under this extension only if written proof of death is received by us within one (1) year from the date of death.

The insurance extended will cease on the earliest of:

(1) the date the employee is no longer Totally Disabled;

(2) the date the employee refuses to be examined;

(3) the date the employee fails to furnish the required proof of Total Disability;

(4) the date the employee attains age 70; or

(5) the Date The Employee Retires.

The "Date The Employee Retires" means the effective date of an employee's:

(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 Participating Unit;

(2) retirement pension benefits under any plan which the Participating Unit sponsors, or to which the Participating Unit makes or has made contributions; or

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

This benefit will not be provided if Total Disability is from: intentionally self-inflicted injury; or results from an act of war, declared or undeclared.

The Conversion Privilege or Portability may be available when this extension ceases.

DEPENDENT LIFE INSURANCE

When an insured Dependent dies, we will pay the applicable benefit shown in the Schedule of Benefits and Premiums. Payment will be made to you unless another Beneficiary has been designated. If such designation is made, benefits will be paid in accordance with the Beneficiary provisions. In such case, "you", "your" and "yours" will include your insured Dependent in such Beneficiary provisions.

“Dependent” means:

(1) the employee's legal spouse;

(2) your unmarried child(ren), including any foster child, adopted child or stepchild who resides in your home, who is age 14 days but under 20 years of age and who is financially dependent on you for support;

(3) your unmarried child(ren), including any foster child, adopted child or stepchild, who is attending a college or other school on a full-time basis, and is financially dependent on you for support and under age 26; and

(4) 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.

Additionally, with respect to an employee who is a partner in a civil union or for whom an Affidavit of Domestic Partnership is on file with the Participating Unit and is in effect, such employee's:

(1) civil union partner or domestic partner; and

(2) children, provided he/she otherwise meets the definition of Dependent,

of the civil union or as named on such Affidavit will be considered your "Dependent". When your civil union partner or domestic partner is covered under the Policy, the word "spouse" as it appears in the Policy will be deemed to mean "civil union partner" or "domestic partner" unless the context indicates otherwise.

A person may not have coverage both as an employee and as a Dependent. Only one insured spouse may cover the eligible children as insured Dependents. The employee or spouse must be insured in order for children to be insured.

EFFECTIVE DATE OF DEPENDENT INSURANCE

You may insure your Dependents by making written application, paying the applicable premium, and providing proof of good health, if required by us. You must have insurance coverage under the Policy in order for Dependents to be insured. The insurance for Dependents will take effect on the date:

(1) we approve the application and any required proof of good health; and

(2) the applicable premium is paid.

If insurance is in force for a Dependent child, application is not required to insure any other Dependent children of yours who are born or adopted after the first Dependent child's coverage began.

When the first Dependent child is a newborn, coverage is provided automatically for a period from age 14 days to age 30 days. If application is not made for this child within thirty (30) days of birth, insurance for the child will terminate at the end of this period.

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 to occur:

(1) the premium due date coinciding with or next following the date the Participating Unit terminates;

(2) the premium due date coinciding with or next following the date a Dependent is no longer eligible as a Dependent;

(3) the end of the period for which premium has been paid;

(4) the premium due date coinciding with or next following the date your insurance terminates ;

(5) the premium due date coinciding with or next following the date a Dependent's insurance is converted to an individual plan of insurance according to the terms of the Policy; or

(6) the date an insured Dependent attains the maximum age.

CONVERSION OF DEPENDENT LIFE INSURANCE

A. If the insurance of an insured Dependent ceases, except as described in B. below or for non-payment of premium, then the insured Dependent may convert his insurance to an individual policy. The conversion is subject to the following:

(1) written application and the first premium for the conversion policy must be received by us within thirty-one (31) days after the Dependent's insurance terminates;

(2) the premium due for the conversion policy will be at our usual rates and will be based on the amount of insurance, class of risk and the age of the Dependent on the date the policy is issued;

(3) the policy may be any life plan we currently issue, except term life insurance;

(4) proof of good health is not required;

(5) the face amount of insurance available for conversion cannot exceed the Amount of Insurance in effect on the insured Dependent under the Policy (except as stated in item 6); and

(6) the face amount of insurance available for a Dependent child who has attained the maximum age for coverage may be up to five (5) times the amount which was in force on the insured Dependent child under the Policy.

B. If the insurance of an insured Dependent ceases due to termination or amendment of the Policy or termination of the Participating Unit, then he may convert his insurance to an individual policy. The Dependent must have been insured at least five (5) years under the Policy. The same rules as shown in A. above will apply, except that the face amount will be the lesser of:

(1) the amount of Dependent life insurance under the Policy reduced by any amount of group life insurance the Dependent receives or becomes eligible for within thirty-one (31) days after the Policy terminates; or

(2) $10,000.

The insured Dependent spouse's insurance may not be converted after the Anniversary Date (shown in the Schedule of Benefits and Premiums) coinciding with or next following his 70th birthday.

If an insured Dependent dies during the time in which he is entitled to apply for an individual policy, we will pay the benefit to which he was entitled under the Policy. This will be done whether or not such Dependent applied for the individual policy.

Any individual policy issued in accordance with this section will be effective on the day following the day insurance coverage under the Policy terminates.

CLAIMS PROVISIONS

NOTICE OF CLAIM

Written notice must be given to us within thirty (30) days after the loss occurs, or as soon as reasonably possible. The notice should be sent to us at our Administrative Office or to our authorized representative. The notice should include the Participating Unit's name, the Participating Unit Number (shown on the Schedule of Benefits and Premiums) and your name.

CLAIM FORMS

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

PROOF OF LOSS

For any covered loss, written proof must be sent to us within ninety (90) days. If it is not reasonably possible to give proof within ninety (90) days, the claim is not affected if the proof is sent as soon as possible. In any event, proof must be given within one (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 your death, or due to death, will be paid to your 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 AND AUTOPSY

At our expense, we have the right to have you examined as often as reasonably necessary when 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 from the time written proof of loss is required to be submitted.

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

Family and Medical Leave of Absence:

We will continue the Insured's coverage and that of any insured Dependent, if applicable, in accordance with the Participating Unit'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 such Insured and his Dependents, if applicable, continues to be paid during the leave; and
(2) the Participating Unit has approved the employee's 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 the Insured's coverage and that of any insured Dependent, if applicable, in accordance with the Participating Unit's policies regarding Military Services Leave of Absence under USERRA if the premium for such Insured and his 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 the employee is on a Family and Medical Leave of Absence for any reason other than his own illness, injury or disability or Military Services Leave of Absence he will be considered Actively-at-Work. Any changes such as revisions to coverage due to age will apply during the leave, except that increases in any insured's amount of insurance will not be effective when the employee is not considered Actively-at-Work until he has returned to Active Work for one (1) full day.

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

The Insured's coverage and that of any insured Dependent, if applicable, will cease under this extension on the earliest of:

(1) the date the Participating Unit's coverage under the Policy terminates; or
(2) the end of the period for which premium has been paid for the Insured; or
(3) the date such leave should end in accordance with the Participating Unit'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 Participating Unit choose not to continue the Insured's coverage during a Family and Medical Leave of Absence and/or Military Services Leave of Absence, the Insured's coverage as well as any Dependent coverage, if applicable, will terminate in accordance with the termination of insurance provisions under the Policy. However, we will restore the Insured's coverage and that of any eligible Dependent, if applicable, as of the date the eligible employee returns to active work.

GROUP TERM LIFE INSURANCE LIVING BENEFIT RIDER

THIS RIDER ADDS A LIVING BENEFIT PROVISION. RECEIPT OF THIS LIVING BENEFIT WILL REDUCE THE DEATH BENEFIT AND MAY BE TAXABLE. INSUREDS SHOULD SEEK ASSISTANCE FROM THEIR PERSONAL TAX ADVISOR.

Group Policy Number: VL 600
Issued to Group Policyholder: RSL Employer Trust
Participating Unit Number: VG 182814
Participating Unit: Gray Hunter Stenn, LLP

This Rider is attached to and made a part of the Policy indicated above. The Certificate is hereby amended, in consideration of the Policyholder's 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 Policy at the death of the Insured, subject to all Policy provisions dealing with changes in the amount of insurance and reductions or termination for age or retirement.

"Insured" means the Insured and his insured Dependents.

"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 twelve (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 sixty (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 acknowledgement 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 50% 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 $250,000. This benefit will be paid as a single lump sum. 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.

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 Insured's coverage under the Group Policy terminates. It is subject to all the terms of the Group Policy not inconsistent herewith.

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

Secretary

NOTICE OF
PROTECTION PROVIDED BY
ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** description of the Illinois Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Illinois law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Illinois law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association per insolvency are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits*
  - $300,000 in disability insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

*The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except special rules apply with regard to hospital, medical and surgical insurance benefits for which the maximum amount of protection is $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also residency requirements and other limitations under Illinois law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ilhiga.org or contact:

Illinois Life and Health	*Illinois Department of Insurance*
Insurance Guaranty Association	*4th Floor*
8420 West Bryn Mawr Avenue, Suite 550	*320 West Washington Street*
Chicago, Illinois 60631-3404	*Springfield, Illinois 62767*
(773) 714-8050	*(217) 782-4515*

Insurance companies and agents are not allowed by Illinois law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Illinois law, then Illinois law will control.

Claim Procedures and
ERISA Statement of Rights

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

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed form along with any requested information to:

Reliance Standard Life Insurance Company
Claims Department
P.O. Box 8330
Philadelphia, PA 19101-8330

Claim forms are available from your benefits representative or may be requested by writing to the above address or by calling 1-800-644-1103.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION

Non-Disability Benefit Claims

If a non-disability claim is wholly or partially denied, the claimant shall be notified of the adverse benefit determination within a reasonable period of time, but not later than 90 days after our receipt of the claim, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the benefit determination is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing.

Disability Benefit Claims

In the case of a claim for disability benefits, the claimant shall be notified of the adverse benefit determination within a reasonable period of time, but not later than 45 days after our receipt of the claim. This period may be extended for up to 30 days, provided that it is determined that such an extension is necessary due to matters beyond our control and that notification is provided to the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If, prior to the end of the first 30-day extension period, it is determined that, due to matters beyond our control, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the claimant is notified, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which a decision is expected to be rendered. In the case of any such extension, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

Non-Disability Benefit Claims

A Claimant shall be provided with written notification of any adverse benefit determination. The notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and
4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an adverse benefit determination on review.

Disability Benefit Claims

A claimant shall be provided with written notification of any adverse benefit determination. The notification shall be set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of "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.