reliancestandard
LIFE INSURANCE COMPANY

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

**TABLE OF CONTENTS**



**CERTIFICATE OF INSURANCE**

We certify that you (provided you belong to a class described on the Schedule of Benefits) are insured, for the benefits which apply to your class, under Group Policy No. GL 166103 issued to Central Washington Public Utilities Unified Insurance Program Trust, the Policyholder.

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

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

Secretary

President

GROUP LIFE INSURANCE CERTIFICATE

This Group Life Certificate amends all previous Group Life Certificates and is dated October 20, 2023.

## SCHEDULE OF BENEFITS

**EFFECTIVE DATE:** January 1, 2023, as amended in the Policy through October 1, 2023

**ELIGIBLE CLASSES:** Each Active, Benefit Eligible Employee defined by the Public Utility District to work a minimum of 1,000 hours per year; and a job assignment of at least 6 months per year, except any person employed on a temporary or seasonal basis.

* Covered Public Utilities Districts:

(1) Public Utility District No. 1 of Benton County
(2) Public Utility District No. 1 of Douglas County
(3) Public Utility District No. 1 of Ferry County
(4) Public Utility District No. 1 of Franklin County
(5) Public Utility District No. 2 of Grant County
(6) Public Utility District No. 1 of Okanogan County
(7) Public Utility District No. 1 of Pend Oreille County

**INDIVIDUAL EFFECTIVE DATE:** The day you become eligible.

**AMOUNT OF INSURANCE:**

**Basic Life and Accidental Death and Dismemberment:** One (1) times Earnings, rounded to the next higher $1,000, subject to a minimum Amount of Insurance of $22,000 and a maximum Amount of Insurance of $200,000.

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

| Age | Percentage of available or in force amount at age 69 |
|---|---|
| 70+ | 67% |

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

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

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

**CONTRIBUTIONS:** You are not required to contribute toward the cost of the Basic Insurance.

## DEFINITIONS

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

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

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

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

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

"Earnings", as used in the SCHEDULE OF BENEFITS section, means your annual salary received from a Public Utilities District on the January 1st just before the date of loss. Earnings does not include commissions, overtime pay, bonuses, incentive pay or any other special compensation not received as basic salary.

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

If you were not employed by a Public Utilities District on the January 1st just before the date of loss, Earnings, as defined above, will be as received from a Public Utilities District on your Individual Effective Date just before the date of loss.

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

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

(1) hand or foot, means the complete severance through or above the wrist or ankle joint;

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

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

## GENERAL PROVISIONS

### INCONTESTABILITY

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

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

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

   (a) it is in a written form signed by you, or on your behalf; and

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

(2) If the statement relates to your insurability, it will not be used to contest the validity of insurance which has been in force, before the contest, for at least two (2) years during your lifetime.

### ASSIGNMENT

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

## EFFECTIVE DATE AND TERMINATION

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

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

(1) the Individual Effective Date stated on the Schedule of Benefits, if you apply on or before that date; or

(2) the date you apply, if you apply within thirty-one (31) days from the date you first met the eligibility requirements; or

(3) the date we approve any required proof of good health. We require proof of good health if you apply:

- (a) after thirty-one (31) days from the date you first become eligible; or
- (b) after you terminated this insurance but you remained in a class eligible for this insurance; or
- (c) for an Amount of Insurance greater than the guaranteed issue Amount of Insurance shown on the Schedule of Benefits, if applicable; or
- (d) for an Amount of Insurance greater than you were insured for under the prior group life insurance plan carrier, if applicable; or
- (e) after being eligible for coverage under a prior group life insurance plan for more than thirty-one (31) days but did not elect to be covered under that prior plan; or

(4) the date premium is remitted.

Proof of good health forms are available from us upon request. It is a Public Utilities District's responsibility to provide proof of good health forms to you when required.

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

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

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

(1) the date the Policy terminates; or

(2) the date you cease to be in a class eligible for this insurance; or

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

(4) six (6) months from the date you enter military service on active duty (not including Reserve or National Guard).

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

(1) the date you retire, if due to illness or injury; or
(2) two (2) months, if due to temporary lay-off; or
(3) six (6) months, if due to approved leave of absence.

## CONVERSION PRIVILEGE

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

A. If the insurance ceases due to termination of employment or membership in any of the Policy's classes, an individual Life Insurance Policy may be issued. You are entitled to a policy without disability or supplemental benefits. You must make written application for the policy within thirty-one (31) days after you terminate. The first premium must also be paid within that time. The issuance of the policy is subject to the following conditions:

   (1) The policy will, at your option, be on any one of our forms, except for term life insurance. It will be the standard type issued by us for the age and amount applied for;

   (2) The policy issued will be for an amount not over what you had before you terminated;

   (3) The premium due for the policy will be at our usual rate. This rate will be based on the amount of insurance, class of risk and your age at date of policy issue; and

   (4) Proof of good health is not required.

B. If the insurance ceases due to the termination or amendment of the Policy, an individual Life Insurance Policy can be issued. You must have been insured for at least five (5) years under the Policy and/or the prior carrier. The same rules as in A above will be used, except that the face amount will be the lesser of:

   (1) The amount of your Group Life benefit under the Policy. This amount will be less any amount you are entitled to under any group life policy issued by us or another insurance company; or

   (2) $5,000.

C. If the insurance reduces, as may be provided in the Policy, an individual Life Insurance Policy can be issued. The same rules as in A above will be used, except that the face amount will not be greater than the amount which ceased due to the reduction.

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

E. Any policy issued with respect to A, B or C above will be put in force at the end of the thirty-one (31) day period in which application must be made.

## BENEFICIARY AND FACILITY OF PAYMENT

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

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

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

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

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

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

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

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

If you have not named a beneficiary, or the named beneficiary is not surviving at your death, we may pay up to an amount not exceeding the greater of 10% or $1,000 of the benefit to the person(s) who, in our opinion, have incurred expenses in connection with your last illness, death or burial.

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

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

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

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

## SETTLEMENT OPTIONS

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

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

Settlement Options are described in the Policy.

## WAIVER OF PREMIUM IN EVENT OF TOTAL DISABILITY

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

(1) you become totally disabled prior to age 65;
(2) the Total Disability begins while you are insured;
(3) the Total Disability begins while the Policy is in force;
(4) the Total Disability lasts for at least 6 months;
(5) the premium continues to be paid; and
(6) we receive proof of Total Disability within one (1) year from the date it began.

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

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

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

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

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

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

## ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

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

If you suffer any one of the losses listed below, as a result of an injury, we will pay the benefit shown. The loss must be caused solely by an accident which occurs while you are insured, and must occur within one (1) year of the accident. Only one benefit (the larger) will be paid for more than one loss resulting from any one accident. The Amount of Insurance can be found on the Schedule of Benefits.

| **LOSS OF:** | **AMOUNT OF INSURANCE:** |
|---|---|
| Life | The Full Amount |
| Both Hands | The Full Amount |
| Both Feet | The Full Amount |
| The Sight of Both Eyes | The Full Amount |
| Speech and Hearing | The Full Amount |
| One Hand and One Foot | The Full Amount |
| One Hand and the Sight of One Eye | The Full Amount |
| One Foot and the Sight of One Eye | The Full Amount |
| One Hand | One-Half of the Amount |
| One Foot | One-Half of the Amount |
| Speech or Hearing | One-Half of the Amount |
| The Sight of One Eye | One-Half of the Amount |

**EXCLUSIONS**

A benefit will not be payable for a loss:

(1) caused by suicide or intentionally self-inflicted injuries; or

(2) caused by or resulting from war or any act of war, declared or undeclared; or

(3) to which sickness, disease or myocardial infarction, including medical or surgical treatment thereof, is a contributing factor; or

(4) sustained during your commission or attempted commission of an assault or felony; or

(5) to which your acute or chronic alcoholic intoxication is a contributing factor; or

(6) to which your voluntary consumption of an illegal or controlled substance or a non-prescribed narcotic or drug is a contributing factor.

## EDUCATION BENEFIT

We will pay an additional Education Benefit to your Eligible Dependent Spouse and Eligible Dependent Child(ren) if, due to an Injury sustained while insured under the Policy, you suffer loss of life for which an Accidental Death Benefit is payable under the Policy.

- Benefit Amount For Each Eligible Dependent Child

  5% of your Full Amount of Accidental Death and Dismemberment Benefits shown in the Schedule of Benefits to a maximum benefit of $6,000 per Academic Year.

  If the child does not remain enrolled for an entire Academic Year, the benefit payable will be the lesser of:

  (1) 5% of your Full Amount of Accidental Death and Dismemberment Benefits shown in the Schedule of Benefits to a maximum benefit of $6,000; or
  (2) actual tuition incurred.

- Benefit Amount For Eligible Dependent Spouse

  Actual tuition incurred to a maximum benefit of $5,000. Tuition must be incurred within 30 months following the date of your death.

- Maximum Benefit Period:
  Each Eligible Dependent Child: 4 consecutive years of enrollment.
  Eligible Dependent Spouse: 30 months following the date of your death.

- Maximum Lifetime Benefit:
  Each Eligible Dependent Child: $20,000
  Eligible Dependent Spouse: $5,000

The benefit will be payable once we receive proof of enrollment, active attendance and actual tuition incurred.

**Definitions**

"Eligible Dependent Child(ren)" means your unmarried child(ren) who are under age 26 and financially dependent upon you for support. Such child(ren) must be enrolled: (1) as a full-time student in any post-high school Educational Institution on the date of your death; or (2) in the 12th grade on the date of your death and subsequently enrolls as a full-time student in a post-high school Educational Institution within one (1) year of your death.

"Eligible Dependent Spouse" means your legal spouse who is not legally separated or divorced from you or your civil union/domestic partner who is legally recognized under applicable state law on the date of your death and attends any post-high school Educational Institution for the purpose of obtaining a source of support.

"Educational Institution" includes, but is not limited to, any accredited university, college, trade school, vocational school or professional school.

"Academic Year" means the annual period of sessions of an Educational Institution, usually beginning in September and ending in June.

**Termination of the Education Benefit** - The Education Benefit will terminate for each Eligible Dependent on the earlier of:

(1) the end of the Maximum Benefit Period shown above; or
(2) the date any child no longer meets the definition of Eligible Dependent Child(ren) shown above.

**Minimum Benefit**

If there are no dependents who qualify for the Education Benefit, we will pay a minimum benefit of $1,000 to your Survivor.

"Survivor" means your legal spouse, who is not legally separated or divorced from you or your civil union/domestic partner who is legally recognized under applicable state law. If your spouse or civil union/domestic partner who is legally recognized under applicable state law is not living, then "Survivor" means your unmarried child(ren) under age 20, who is financially dependent upon you for support, including adoptive, foster and step-child(ren), who are in your custody, and your unmarried child(ren) under age 26 who is attending a college or other school on a full-time basis and is financially dependent upon you for support.

If there is more than one eligible surviving child, the benefit will be payable to each child in equal amounts.

If there are no eligible Survivors, no benefit will be payable.

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 the adult that has, in our opinion, assumed the custody and main support of the minor. We will not be held liable for any payment we have made in good faith.

## TOTAL LOSS OF USE

We will pay a Total Loss of Use Benefit according to the Schedule of Losses below if, due to an Injury sustained while insured under the Policy, you suffer such a loss within 1 year of the date the Injury occurred provided:

(1) we receive proof that you have experienced a permanent Total Loss of Use for 12 consecutive months from the date the Injury occurred; and
(2) no benefit is payable under the Policy for the same loss under the Accidental Death and Dismemberment Benefit.

"Total Loss of Use" means the permanent inability to use an entire arm, leg or combination of arms and legs, starting at the shoulder or hip and including the hand or foot, due to incurable paralysis, stiffening of joints, or any other Injury that may cause the limb(s) to become permanently non-functional.

## SCHEDULE OF LOSSES

| **For Total Loss of Use of**: | **Benefit Amount**: |
|---|---|
| Both Arms and Both Legs | The Full Amount |
| Both Arms and One Leg or Both Legs and One Arm | 3/4 of the Full Amount |
| Both Arms | 2/3 of the Full Amount |
| Both Legs | 2/3 of the Full Amount |
| One Arm and One Leg | 2/3 of the Full Amount |
| One Arm or One Leg | 1/2 of the Full Amount |

The Full Amount can be found in the Schedule of Benefits. Only one benefit (the larger) will be paid for more than one loss resulting from any one accident. In no event will the total of all benefits paid under the Policy to you for any one accident, under this benefit and the Accidental Death and Dismemberment Benefit exceed your Amount of Accidental Death and Dismemberment Benefit shown in the Schedule of Benefits.

A benefit will not be payable for a loss:

(1) caused by suicide or intentionally self-inflicted injuries; or

(2) caused by or resulting from war or any act of war, declared or undeclared; or

(3) to which sickness, disease or myocardial infarction, including medical or surgical treatment thereof, is a contributing factor; or

(4) sustained during your commission or attempted commission of an assault or felony; or

(5) to which your acute or chronic alcoholic intoxication is a contributing factor; or

(6) to which your voluntary consumption of an illegal or controlled substance or a non-prescribed narcotic or drug is a contributing factor.

## SEAT BELT AND AIR BAG BENEFIT

**Seat Belt Benefit**

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

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

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

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

**Air Bag Benefit**

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

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

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

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

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

**EXCLUSIONS**

No benefit is payable for any loss sustained by you:

(1) if you were driving or riding in any private passenger Four-Wheel Vehicle which was being used in a race, speed or endurance test, or for acrobatic or stunt driving at the time of the accident;

(2) if you were not wearing a Seat Belt for any reason;

(3) while you were sharing a Seat Belt; or

(4) due to a defect in the Air Bag diagnostic system.

## SURVIVOR BENEFIT

We will pay an additional monthly benefit for up to 6 months to your eligible Survivor(s) if, due to an Injury sustained while insured under the Policy, you suffer loss of life for which an Accidental Death Benefit is payable under the Policy.

The monthly benefit payable will be equal to 1% of your Accidental Death Benefit payable, subject to a maximum monthly benefit of $1,000.

The monthly benefit will terminate on the date 6 monthly benefit payments have been paid.

"Survivor" means your legal spouse, civil union/domestic partner who is legally recognized under applicable state law. If your spouse or legally recognized civil union partner/domestic partner is not living, then "Survivor" means your unmarried child(ren) under age 20, who is financially dependent upon you for support, including adoptive, foster and step-child(ren) who are in your custody, and your unmarried child(ren) under age 26 who is attending a college or other school on a full-time basis and is financially dependent upon you for support.

If there is more than one eligible surviving child, benefits will be payable to each child in equal amounts. Any accrued benefits, unpaid at the death of the last Survivor specified above, will be paid to such Survivor's estate.

If you and your surviving spouse, legally recognized civil union/domestic partner and child(ren) all die at the same time, the benefit will be paid to your estate.

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 the adult that has, in our opinion, assumed the custody and main support of the minor. We will not be held liable for any payment we have made in good faith.

## CLAIMS PROVISIONS

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

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

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

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

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

**LEGAL ACTION:** No legal action may be brought against us to recover on the Policy within 60 days after written proof of loss has been given as required by the Policy. No action may be brought after three (3) years 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 your coverage and that of any Insured Dependent, if applicable, in accordance with a Public Utilities District policies regarding leave under the Family and Medical Leave Act of 1993, as amended, or any similar state law, as amended, if:

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

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

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

**Military Services Leave of Absence:**

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

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

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

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

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

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

(1) the date the Policy terminates; or
(2) the end of the period for which premium has been paid for you; or
(3) the date such leave should end in accordance with a Public Utilities District 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 a Public Utilities District choose not to continue your coverage during a Family and Medical Leave of Absence and/or Military Services Leave of Absence, your coverage as well as any dependent coverage, if applicable, will be reinstated.

## PORTABILITY

You may continue insurance coverage under the Policy and that of your insured Dependents, if any, if coverage would otherwise terminate because you cease to be an Eligible Person, for reasons other than the termination of the Policy, your retirement, or the insured Dependent having reached the maximum age for benefits, provided you:

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

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

(1) the highest amount of life insurance available to Eligible Persons; or
(2) a total of $500,000 from all RSL group life and accidental death and dismemberment insurance combined, whichever is less.

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

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

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

(1) the end of the period for which premium has been paid; or
(2) the date you are covered under another group term life insurance policy; or
(3) the date you reach age 65; or
(4) at any time coverage would normally terminate according to the terms of the Policy had you continued to be an Eligible Person.

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

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

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

## CONTINUATION OF INSURANCE DURING LABOR DISPUTES

If your employer is paying all or some of the premium for your insurance, under the terms of a collective bargaining agreement, and if you cease to work or pay union dues because of a labor dispute, you may continue your insurance, under the following conditions:

(1) your employer must notify you at once, by mail; and
(2) a monthly premium must be paid to your union; and
(3) your union must collect the premium from you, if you cease working because of a labor dispute; and
(4) the premium must be paid by the union to us on a timely basis. Payment should be made in accordance with the Premium provision in the Policy.

Insurance shall not be continued when you cease work, unless all unpaid premium is paid before the next premium due date.

Your premium shall be the same as the rate in effect for your class on the date you stop working, except as provided below.

The Policy will not be changed. We have the right to increase premium rates before, during or after cessation of work if we had that right under the Policy terms had there been no cessation of work. We will determine the effective date of premium increases, in accordance with the Policy terms.

Insurance under this provision shall end on the earliest of:

(1) the end of the period for which the last premium payment was made by the union(s) on your behalf; or
(2) the premium due date that coincides with or follows the date you start to work full-time for another employer; or
(3) the premium due date that coincides with or follows the end of a six-month period from the date you ceased working because of the labor dispute; or
(4) the premium due date that coincides with or follows the date the labor dispute ends.

You may convert to an individual policy, according to Conversion Privilege in the Policy.

If you insured your dependents under this Policy, you must continue to insure them, in order to continue your own insurance. Your monthly contribution for insurance must include premium for your dependents.

The continuation of insurance provision does not apply to any Accident and Sickness benefits (loss of time) that may be provided by the Policy.

Insurance will not be continued unless the union responsible for collecting premium contributions agrees to:

(1) keep adequate books and records; and
(2) allow us to audit the books and records; and
(3) furnish sufficient information to us so claims can be paid properly.

If we receive premiums for a period during which we are not obligated to continue coverage, we shall return it to the union who collected it. That union must return the money to the persons from whom it was collected. However, we are not responsible for the proper refund to you.

## GROUP TERM LIFE INSURANCE ACCELERATED BENEFIT RIDER

**THIS RIDER ADDS AN ACCELERATED BENEFIT PROVISION. THIS ACCELERATED LIFE BENEFIT DOES NOT AND IS NOT INTENDED TO QUALIFY AS LONG TERM CARE UNDER WASHINGTON STATE LAW. IT MAY NOT PROVIDE ALL OF THE BENEFITS OR MEET ALL OF THE STANDARDS REQUIRED OF LONG TERM CARE UNDER WASHINGTON LAW AND REGULATIONS. WASHINGTON STATE LAW PREVENTS THIS ACCELERATED LIFE BENEFIT FROM BEING MARKETED OR SOLD AS LONG TERM CARE. FOR THE PURPOSES OF FEDERAL TAX LAW ONLY, IT IS INTENDED TO BE A 'QUALIFIED LONG TERM CARE PRODUCT'.**

**THIS ACCELERATED BENEFIT IS INTENDED TO QUALIFY UNDER SECTION 7702B (26 U.S.C. 7702B) OF THE INTERNAL REVENUE CODE OF 1986 AS AMENDED BY PUBLIC LAW 104-191. RECEIPT OF THIS ACCELERATED BENEFIT WILL REDUCE THE DEATH BENEFIT AND MAY BE TAXABLE. INSUREDS SHOULD SEEK ASSISTANCE FROM THEIR PERSONAL TAX ADVISOR. BENEFIT PAYMENTS MAY EFFECT QUALIFICATIONS FOR GOVERNMENT ENTITLEMENT PROGRAMS SUCH AS MEDICAID, MEDICARE, SOCIAL SECURITY, OR OTHER SOURCES OF PUBLIC FUNDING.**

**THIS RIDER DOES NOT CONTAIN ITS OWN WAIVER OF PREMIUM PROVISION. THE WAIVER OF PREMIUM PROVISION, IF ANY, OF THE GROUP LIFE POLICY WILL APPLY.**

Attached to Group Policy Number: GL 166103
Issued to Group Policyholder: Central Washington Public Utilities Unified Insurance Program Trust

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

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

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

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

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

"Insured" means the primary Insured and his/her insured Dependents, if any.

"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 24 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 coverage under this rider is in force and the Insured is Certified as Terminally Ill: (a) at any time due to accidental injury; or (b) after the insured has been covered under this Rider for 30 days in the case of sickness. In order for this benefit to be paid:

(1) the Insured must make a Written Request; and

(2) we must receive from any assignee or irrevocable beneficiary their signed acknowledgment and agreement to payment of this benefit.

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

event the Insured's health care provider and a health care provider appointed by us (Reliance Standard Life Insurance Company) disagree on whether the Insured is Terminally Ill, the opinion of the health care provider appointed by the insurer is not binding on the Insured. The parties shall attempt to resolve the matter promptly and amicably. If the disagreement is not so resolved, the Insured has the right to mediation or binding arbitration conducted by a disinterested third party who has no ongoing relationship with either party. Any such arbitration will be conducted in accordance with Chapter 7.04 of Title 7 of the Washington Statutes.

**AMOUNT OF THE ACCELERATED BENEFIT:** The Accelerated Benefit will be an amount equal to 100% of the Death Benefit applicable to the Insured under the Policy on the date of the Certification of Terminal Illness, subject to a maximum benefit of $500,000. This benefit may be paid as a single lump sum or in installment payments mutually agreed to by us and the Insured. The Accelerated 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 Accelerated Benefit paid to such Insured. The amount of the Accelerated Benefit plus the corresponding Death Benefit will not exceed the amount that would have been paid as the Death Benefit in the absence of this Rider.

(2) Any amount of insurance that would otherwise be continued under a Waiver of Premium provision will be reduced proportionately, as will the maximum Face Amount available under the Conversion Privilege.

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

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

(1) the date his coverage under the Policy terminates;

(2) the date of payment of the Accelerated Benefit for his Terminal Illness; or

(3) the date he attains age 75.

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

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

Secretary

**ACCELERATED BENEFIT RIDER DISCLOSURE**
**FOR RIDER LRS-8596-001-1298-WA**

THIS ACCELERATED LIFE BENEFIT DOES NOT AND IS NOT INTENDED TO QUALIFY AS LONG TERM CARE UNDER WASHINGTON STATE LAW. IT MAY NOT PROVIDE ALL OF THE BENEFITS OR MEET ALL OF THE STANDARDS REQUIRED OF LONG TERM CARE UNDER WASHINGTON LAW AND REGULATIONS. WASHINGTON STATE LAW PREVENTS THIS ACCELERATED LIFE BENEFIT FROM BEING MARKETED OR SOLD AS LONG TERM CARE. FOR THE PURPOSES OF FEDERAL TAX LAW ONLY, IT IS INTENDED TO BE A 'QUALIFIED LONG TERM CARE PRODUCT.'

THIS ACCELERATED BENEFIT IS INTENDED TO QUALIFY UNDER SECTION 7702B (26 U.S.C. 7702B) OF THE INTERNAL REVIEW CODE OF 1986 AS AMENDED BY PUBLIC LAW 104-191.

The Accelerated Benefit option is an advance payment of life insurance proceeds under our group term life insurance program. This option allows the Insured to access the face amount of his insurance coverage prior to death if he is diagnosed as having less than 24 months to live. There are no restrictions placed on how the proceeds may be used.

**ELIGIBILITY:** The Insured is eligible to exercise the Accelerated Benefit option if coverage under this rider is in force and the Insured is diagnosed as having a drastically limited life-span: (a) anytime due to accidental injury, or (b) after the insured has been covered under this rider for thirty (30) days in the case of sickness, and his doctor certifies that death will occur within 24 months. We reserve the right to investigate further to verify eligibility.

**THE BENEFIT:** The Accelerated Benefit Option pays 100% of the death benefit, to a maximum of $500,000, in a single lump sum or in installment payments mutually agreed to by us and the Insured. The portion of the death benefit which is not accelerated is payable to the Insured's beneficiary at his death.

There is no additional premium charge for the Accelerated Benefit Rider. There is no reduction in the premium for the group term life insurance coverage if benefits become payable under the Rider.

If the group Policy and/or the Insured's life insurance benefits under the Group Policy terminate, all of the Insured's rights under the Accelerated Benefit Rider also terminate.

**EFFECT OF BENEFIT:** Receipt of the Accelerated Benefit will reduce the death benefit and may be taxable. Therefore, it is recommended that the Insured consult his personal tax advisor for clarification of the current tax law with respect to accelerated death benefits. Benefit payments may effect qualifications for government entitlement programs such as Medicaid, medicare, social security or other sources of public funding.

# Claim Procedures and ERISA Statement of Rights

**CLAIM PROCEDURES FOR CLAIMS FILED WITH**
**RELIANCE STANDARD LIFE INSURANCE COMPANY**
**ON OR AFTER APRIL 1, 2018**

## 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.

In the event of any *Adverse Benefit Determination* (defined below), the claimant (or their authorized representative) may appeal that *Adverse Benefit Determination* in accordance with the following procedures. This opportunity to appeal exists without regard to the applicability of the Employee Retirement Income Security Act of 1974 as amended ("ERISA"), 29 U.S.C. 1001 *et seq.*

## 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. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
   a) The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
   b) The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination; and
   c) A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;
6. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist;
7. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant (defined below) to a claim for benefits; and
8. The notification shall be provided in a Culturally and Linguistically Appropriate (defined below) manner.

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

**REQUESTS CONCERNING ALLEGED VIOLATION OF THESE PROCEDURES**

In the event that a claimant requests a written explanation of any alleged violation of these procedures, such explanation should be provided within 10 days, including a specific description of any basis for asserting that any violation should not cause any administrative remedies available under the plan to be exhausted (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 "Culturally and Linguistically Appropriate Manner" means:

- Oral language services (such as telephone customer assistance hotline) that includes answering questions in any Applicable Non-English Language and providing assistance with filing claims and appeals in any Applicable Non-English Language must be provided;
- A notice in any Applicable Non-English Language must be provided upon request; and
- A statement prominently displayed in any Applicable Non-English Language clearly indicating how to access the language services provided must be included in the English versions of all notices.

The term "Applicable Non-English Language" means:
With respect to an address in any United States county to which a notice is sent, a non-English language is an Applicable Non-English Language if ten percent or more of the population residing in the county is literate only in the same non-English language as determined in guidance published by the United States Secretary of Health and Human Services.

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.