RELIANCE STANDARD
Life Insurance Company

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

TABLE OF CONTENTS

CERTIFICATE OF INSURANCE

We certify that the Person whose name appears on the enrollment card attached to this Certificate is insured for the benefits which apply to his/her class, under Group Policy No. VPS 325814 issued to United Cerebral Palsy Association of Greater Cleveland, Inc., the Policyholder.

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

Secretary

President

GROUP WEEKLY INCOME INSURANCE CERTIFICATE

This Weekly Income Certificate amends the previous Weekly Income Certificates and is dated June 29, 2012.

SCHEDULE OF BENEFITS

EFFECTIVE DATE: July 1, 2011, as amended in the Policy through June 1, 2012

ELIGIBLE CLASSES: Each active, Full-time employee earning an annual salary of at least $9,000, except any person employed on a temporary or seasonal basis.

WAITING PERIOD:

employees hired prior to January 1, 2012:	30 days of continuous employment
employees hired on or after January 1, 2012:	90 days of continuous employment

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

YOUR REINSTATEMENT: 6 months

WEEKLY INCOME BENEFIT

DAY BENEFITS BEGIN: Benefits, for one period of disability, will be paid as follows:

INJURY AND SICKNESS: We will pay benefits from the later of:

(1) the exhaustion of your accrued banked days; or
(2) the fifteenth consecutive day of disability.

MAXIMUM BENEFIT PERIOD: Benefits, for one period of disability, will be paid up to a maximum of eleven (11) weeks.

WEEKLY INCOME BENEFIT: If an Eligible Person, you may elect an amount of insurance in increments of $25 from a minimum of $100 to a maximum of $1,250 per week up to 60% of your Earnings (rounded to the next lower increment), payable in accordance with the section entitled Weekly Income Insurance.

MINIMUM WEEKLY BENEFIT: In no event will the Weekly Income Benefit be less than $25.00.

In the event that you are covered under any state statutory disability benefit plan, our Benefit will be reduced by any benefit payable under such plan, including but not limited to the following: California Unemployment Compensation Disability Insurance, the Hawaii Temporary Disability Insurance Law, the New Jersey Temporary Disability Benefits Law, the New York Disability Benefits Law, Puerto Rico Disability Benefit Act or Rhode Island disability benefit.

The Weekly Income Benefit will be reduced by any benefit payable to you under the United States Social Security Act. This reduction will include any benefits you are eligible to receive for your spouse or children due to your disability. If there is an increase in Social Security Benefits, the Weekly Income Benefit will not be further reduced.

Weekly Income Benefits terminate at Retirement.

CHANGES IN WEEKLY INCOME BENEFIT: Increases in the benefit amount are effective on the date of the change, provided you are actively at work on the effective date of the change. If you are not actively at work on that date, the effective date of the increase in the benefit amount will be deferred until the date you return to active work. Decreases in the benefit amount are effective on the date the change occurs.

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

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

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

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

taxable. It is recommended that you contact your personal tax advisor.

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 on a full-time basis 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 Sickness.

"Claimant" means you or a duly authorized representative who makes a claim for benefits under the Policy for a loss covered by the Policy as a result of your Injury or Sickness.

"Full-time" means working for the Policyholder for a minimum of 20 hours during your regular work week.

"Disabled" means you are:

(1) unable to do the material duties of your job; and

(2) not doing any work for payment; and

(3) under the regular care of a physician.

"Injury" means bodily injury resulting directly from an accident, independent of all other causes. The injury must cause disability which begins while you are insured under the Policy.

"Earnings", as used in the SCHEDULE OF BENEFITS section, means your weekly salary received from the Policyholder on the day just before the date of disability, prior to any deductions to a 403(b) and Section 125 plan. Earnings does not include commissions, overtime pay, bonuses or any other special compensation not received as basic salary.

If hourly employees are insured, the number of hours worked during a regular work week, not to exceed forty (40) hours per week, will be used to determine weekly earnings.

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

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

"Retirement" means the effective date of your:

(1) retirement pension benefits under any plan of a state, county or municipal retirement system, if such pension benefits include any credit for employment with the Policyholder;

(2) retirement pension benefits under any plan which the Policyholder sponsors, 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.

Retirement Benefits do not include:

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

"Sickness" means illness or disease causing disability which begins while you are insured under the Policy. Sickness includes pregnancy, childbirth, miscarriage or abortion, or any complications therefrom.

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

GENERAL PROVISIONS

INCONTESTABILITY: 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 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 years during your lifetime.

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

CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice must be given to us within thirty-one (31) 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 agent. The notice should include your name and the Policy Number.

CLAIM FORMS: When we receive notice of claim, we will send the claimant the forms to file the proof of loss. If we do not send them within fifteen (15) days after we receive notice, then the proof of loss requirements will be met by giving us a written statement of the nature and extent of the loss within ninety (90) days after the loss began.

WRITTEN 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 reasonably possible. In any event, proof must be given within one (1) year unless the claimant is legally incapable of doing so.

PAYMENT OF CLAIMS: When we receive written proof of loss, we will pay any benefits due. Benefits that provide for periodic payment will be paid for each period as we become liable. We will pay benefits to you, if living, or else to your estate.

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

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

EFFECTIVE DATE AND TERMINATION

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

(1) on the first of the month following the date you apply, if you apply within thirty-one (31) days of the date you are first eligible; or

(2) on the first of the month following 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 remained in a class eligible for this insurance; or

(3) the date premium is remitted.

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 for one full day.

TERMINATION OF INDIVIDUAL 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) the date you enter military service (not including Reserve or National Guard).

CONTINUATION OF INDIVIDUAL INSURANCE: The insurance of an Insured who works within a school system that contracts with the Policyholder to supply therapy services may be continued, by payment of premium, beyond the date the Insured ceases to be eligible for this insurance, but not longer than (3) months, if due to the school system's summer closure.

In the event of a loss which occurs during a period of Continuation of Individual Insurance, Earnings as defined will be determined as of the last day worked prior to the date the Insured ceased to be eligible for this insurance.

YOUR REINSTATEMENT: If you are terminated, your insurance may be reinstated if you return to Active Work with the Policyholder within the period of time as shown on the Schedule of Benefits page. You must also be a member of an Eligible Class, as shown on the Schedule of Benefits page, and have been:
(1) on a leave of absence approved by the Policyholder; or
(2) on temporary lay-off.

You will not be required to fulfill the eligibility requirements of the Policy again. The insurance will go into effect on the day you return to Active Work. If you return after having resigned or having been discharged, you will be required to fulfill the eligibility requirements of the Policy again. If you return after terminating at your request or for failure to pay premium when due, proof of good health must be approved by us before you may be reinstated.

WEEKLY INCOME INSURANCE

BENEFITS PAYABLE: We will pay Weekly Income Benefits if you:

(1) are disabled due to Sickness or Injury; and

(2) become disabled while insured by the Policy.

Weekly Income Benefits are paid from the Day Benefits Begin as shown on the Schedule of Benefits. Benefits are paid up to the Maximum Benefit Period as shown on the Schedule of Benefits, for one period of disability.

The Weekly Income Benefit is shown on the Schedule of Benefits.

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

PERIOD OF DISABILITY: Each period of disability starts from the first day benefits are due. It will end when:

(1) you are no longer disabled; or

(2) all benefits due have been paid.

Two or more disabilities will be deemed the same period of disability if they are from:

(1) the same or related causes and are not separated by one (1) week of active work; or

(2) a different cause and are not separated by one (1) full day of active work.

EXCLUSIONS: Weekly Income Benefits are not paid for any period of disability caused by:

(1) an intentionally self-inflicted Injury; or

(2) an act of war, declared or undeclared; or

(3) your committing a felony; or

(4) Sickness which is covered by a Workers' Compensation Act, or other worker's disability law; or

(5) Injury which occurs out of or in the course of work for wage or profit.

LIMITATION

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

(1) the disability begins in the first twelve (12) months after your effective date; and
(2) you have received medical Treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines for the Sickness or Injury, whether specifically diagnosed or not, causing such disability, during the three (3) months immediately prior to your effective date of insurance.

Weekly Income Benefits will not be paid for a disability:

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

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

With respect to persons electing a benefit increase (whether an increase from coverage under a prior plan, if applicable or under the Policy), any benefit increase will not be paid for a disability:

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

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

You will be considered to have a Pre-existing Condition and will be subject to the Pre-existing Conditions Limitation due to a benefit increase if:

(1) the disability begins in the first twelve (12) months after the effective date of the increase; and
(2) you have received medical Treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines for the Sickness or Injury, whether specifically diagnosed or not, causing such disability, during the three (3) months immediately prior to the effective date of the increase.

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

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

a Pre-existing Condition unless you have been Actively at Work for one (1) full day following the end of twelve (12) consecutive months from the effective date of the increase. A Pre-existing Condition means any Sickness or Injury for which you received medical Treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines for the Sickness or Injury, whether specifically diagnosed or not, causing such disability, during the three (3) months immediately prior to the effective date of the increase (with respect to any increase in benefits).

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

Military Services Leave of Absence:

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

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

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

While you are on a 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 USERRA will run concurrently with any other applicable continuation of insurance provision in the Policy.

Your coverage will cease under this extension on the earliest of:

(1) the date the Policy terminates; or
(2) the end of the period for which premium has been paid for you; or
(3) the date such leave should end in accordance with the Policyholder's policies regarding Military Services Leave of Absence in compliance with USERRA. Coverage will not be terminated if you become Disabled during the period of the leave and are eligible for benefits according to the terms of the Policy. Any Weekly Benefit which becomes payable will be based on your Earnings immediately prior to the date of Disability.

Should the Policyholder choose not to continue your coverage during a Military Services Leave of Absence, your coverage will be reinstated.

Claim Procedures and ERISA Statement of Rights

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

CLAIMS FOR BENEFITS

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

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

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

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION

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

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

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

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

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

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

1. The specific reason or reasons for the adverse determination;

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

Disability Benefit Claims

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

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an adverse benefit determination on review; and
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

Appeals of adverse benefit determinations may be submitted in accordance with the following procedures to:

Reliance Standard Life Insurance Company
Quality Review Unit
P.O. Box 8330
Philadelphia, PA 19101-8330

Non-Disability Benefit Claims

1. Claimants (or their authorized representatives) must appeal within 60 days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
5. No deference to the initial adverse benefit determination shall be afforded upon appeal;
6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and
7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant's adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination.

Disability Benefit Claims

1. Claimants (or their authorized representatives) must appeal within 180 days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
5. No deference to the initial adverse benefit determination shall be afforded upon appeal;

6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant's adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination; and
8. In deciding the appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, the individual conducting the appeal shall consult with a health care professional:

   (a) who has appropriate training and experience in the field of medicine involved in the medical judgment; and
   (b) who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal; nor the subordinate of any such individual.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

Non-Disability Benefit Claims

The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

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

Disability Benefit Claims

The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 45 days after receipt of the claimant's timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

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

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

Non-Disability Benefit Claims

A claimant shall be provided with written notification of the benefit determination on review. In the case of an adverse benefit determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and
4. A statement of the claimant's right to bring an action under section 502(a) of ERISA (where applicable).

Disability Benefit Claims

A claimant must be provided with written notification of the determination on review. In the case of adverse benefit determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
4. A statement of the claimant's right to bring an action under section 502(a) of ERISA (where applicable);
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; and
6. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency" (where applicable).

DEFINITIONS

The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan.

The term "us" or "our" refers to Reliance Standard Life Insurance Company.

The term "relevant" means:

A document, record, or other information shall be considered relevant to a claimant's claim if such document, record or other information:

- Was relied upon in making the benefit determination;
- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
- Demonstrates compliance with administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants; or
- In the case of a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit of the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The term "Reliance Standard Life Insurance Company" means Reliance Standard Life Insurance Company and/or its authorized claim administrators.

ERISA STATEMENT OF RIGHTS

As a participant in the Group Insurance Plan, you may be entitled to certain rights and protections in the event that the Employee Retirement Income Security Act of 1974 (ERISA) applies. ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefits plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interests of you and other Plan Participants and Beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Reliance Standard Life Insurance Company shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal Court. If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.