

RELIANCE STANDARD

LIFE INSURANCE COMPANY

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

POLICYHOLDER: United Cerebral Palsy Association of Greater Cleveland, Inc.

POLICY NUMBER: VCI 800884

EFFECTIVE DATE: May 1, 2017

ANNIVERSARY DATES: May 1, 2018 and each May 1st thereafter.


PREMIUM DUE DATES: The first premium is due on the effective date. Further premiums are due monthly, in advance, on the first day of each month.


This Policy is delivered in Ohio and is governed by its laws and/or the Employee Retirement Income Security Act of 1974 ("ERISA") as amended, where applicable.

We agree to provide insurance to you in exchange for the payment of premium and a signed Application. This Policy provides benefits if an Insured or Insured Dependent suffers from a Critical Illness as defined herein, subject to any limitations set forth. It insures the eligible persons for the Amount of Insurance shown on the Schedule of Benefits. The insurance is subject to the terms and conditions of this Policy. In the event of a conflict between this Policy and the Certificate, the terms of the Policy control.

The Effective Date of this Policy is shown above. Insurance starts and ends at 12:01 A.M., Local Time, at your main address. It stays in effect as long as premium is paid when due. The "POLICY TERMINATION" section of the GENERAL PROVISIONS explains when the insurance can be ended.

This Policy is signed by our President and Secretary.


Secretary


President

READ THIS POLICY CAREFULLY. PRE-EXISTING CONDITIONS LIMITATIONS APPLY.

THIS POLICY PROVIDES A LIMITED BENEFIT FOR CERTAIN CRITICAL ILLNESSES. THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY OR MEDICAL INSURANCE POLICY. RECEIPT OF BENEFITS UNDER THIS POLICY MAY AFFECT ELIGIBILITY FOR MEDICAID OR OTHER GOVERNMENT BENEFITS AND/OR ENTITLEMENTS.

THIS POLICY IS OPTIONALLY RENEWABLE.

**GROUP CRITICAL ILLNESS POLICY
NON-PARTICIPATING**

RELIANCE STANDARD LIFE INSURANCE COMPANY

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

GROUP POLICY NUMBER: VCI 800884

POLICY EFFECTIVE DATE: May 1, 2017

POLICY DELIVERED IN: Ohio

ANNIVERSARY DATE: May 1st in each year

Application is made to us by: United Cerebral Palsy Association of Greater Cleveland, Inc.

This Application is completed in duplicate, one copy is attached to your Policy and the other returned to us.

It is agreed that this Application takes the place of any previous application for your Policy.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Signed at _____ this _____ day of _____.

Policyholder: _____

By: _____
(Signature)

(Title)

Please sign and return.





*BC1COAPVCI 80088405/01/2017*RSL

*BC2COAPUnited Cerebral Palsy Association of Greater Cleveland, Inc.

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SCHEDULE OF BENEFITS

NAME OF SUBSIDIARIES, DIVISIONS OR AFFILIATES TO BE COVERED: NONE

ELIGIBLE CLASSES: Each active, Full-time employee, except any person employed on a temporary or seasonal basis.

SERVICE WAITING PERIOD:

Exempt* Employees: 30 days of continuous employment.
Non-exempt* Employees: 60 days of continuous employment.

* as defined by the Fair Labor Standards Act, as amended.

INDIVIDUAL EFFECTIVE DATE: The first day of the month coinciding with or next following the date an Eligible Person completes his/her enrollment form.

INDIVIDUAL REINSTATEMENT: 6 months

MINIMUM PARTICIPATION REQUIREMENTS: Percentage: 10% Number of Insureds: 10

AMOUNT OF INSURANCE:

Employee Coverage: Each Eligible Person may elect an Amount of Insurance in increments of \$1,000 from a minimum of \$5,000 to a maximum of \$50,000 which will apply to all Categories.

Any Employee Amount of Insurance over the guaranteed issue amount of \$15,000 is subject to our approval of such person's good health.

For Insureds age 70 and over, the Amount of Insurance is subject to automatic reduction. Upon the Insured's attainment of the specified age below, the Amount of 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+	50%

Dependent Coverage:

Spouse Amount of Insurance: Each eligible Dependent spouse, who is under the age of 70 is eligible for coverage in increments of \$1,000 from a minimum of \$5,000 to a maximum of \$50,000 not to exceed 100% of the Insured Employee's approved Amount of Insurance which will apply to all Categories. The 100% cap based on the Insured Employee's approved Amount of Insurance does not apply when such Insured's Amount of Insurance is reduced due to age.

Any Dependent spouse Amount of Insurance over the guaranteed issue amount of \$15,000 is subject to our approval of the Dependent spouse's good health.

The Dependent spouse Amount of Insurance will reduce in the same manner as the Insured's Amount of Insurance upon the Dependent spouse's attainment of the reducing age(s).

Child Amount of Insurance: 25% of the Insured Employee's approved Amount of Insurance, up to \$12,500. Child coverage is all guaranteed issue and is not subject to proof of good health.

The Child Amount of Insurance will continue at 25% of the Insured's Amount of Insurance prior to any reductions due to age.

CHANGES IN AMOUNT OF INSURANCE: Increases in the Amount of Insurance for any reason are effective on the Policy Anniversary Date coinciding with or next following the date of the change, provided the Insured is Actively at Work on the effective date of the change. If the Insured is not Actively at Work when the change would otherwise take effect, the change will take effect on the day after the Insured has returned to Active Work for one (1) full day.

Decreases in the Amount of Insurance are effective on the Policy Anniversary Date coinciding with or next following the date of the change.

Premium changes due to an Insured's age will occur on the Policy Anniversary Date coinciding with or next following the birthday that causes the Insured to enter the next age bracket.

If an increase in, or initial application for, the Amount of Insurance is due to a life event change (such as marriage, birth or specific changes in employment status), proof of good health will not be required for amounts up to the guaranteed issue amount, provided the Eligible Person applies within thirty-one (31) days of such life event.

CONTRIBUTIONS:

Insured: 100%
Dependent: Insured 100%

Receipt of benefits under this Policy may be taxable. It is recommended that the Insured contact his/her personal tax advisor.

BENEFITS FOR CRITICAL ILLNESSES DIAGNOSED UNDER THIS POLICY

CATEGORY 1

Carcinoma in Situ-Partial Benefit	25% of the Amount of Insurance
Life Threatening Cancer	100% of the Amount of Insurance

CATEGORY 2

Coronary Artery Bypass - Partial Benefit	25% of the Amount of Insurance
Heart Attack (myocardial infarction)	100% of the Amount of Insurance
Stroke	100% of the Amount of Insurance

CATEGORY 3

Kidney (Renal) Failure	100% of the Amount of Insurance
Major Organ Transplant	100% of the Amount of Insurance

ALL CATEGORIES:

Recurrence(s) in the Same Category	50% of the Amount of Insurance except Carcinoma in situ and Coronary By-Pass which is 12.5%.
Subsequent Occurrence(s) in a Different Category	100% of the Amount of Insurance except Carcinoma in situ and Coronary By-Pass which is 25%.
Lifetime Maximum Benefit Per Category	200% of the Amount of Insurance.
Wellness Benefit:	\$50

DEFINITIONS

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

"You," "your" and "yours" means the employer, union or other entity to which this Policy is issued and which is deemed the Policyholder.

"Actively at Work" and "Active Work" means the Insured actually performing on a Full-time basis each and every duty pertaining to his/her job in the place where and the manner in which the job is normally performed. This includes approved time off for vacation, jury duty and funeral leave, but does not include time off as a result of injury or sickness.

"Breslow method" means a method for determining the prognosis for the Insured or Insured Dependent with melanoma by measuring the thickness of such melanoma.

"CIN Grading System" means a system used to determine the severity of Cervical intraepithelial neoplasia (CIN) and refers to new abnormal cell growth. The CIN Grading System grades the degree of cell abnormality numerically, with CIN I being the lowest and CIN III the highest.

"Critical Illness" means a serious sickness or medical procedure required to treat a serious sickness or injury as defined in the Benefit Provisions of this Policy.

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

- (1) the Insured's legal spouse; and
- (2) the Insured's child(ren), from 14 days to 26 years, including natural children, legally adopted children, children who are dependent on the Insured during the waiting period before adoption, stepchildren, and foster children. Foster children must be in the Insured's custody to be considered a Dependent; and
- (3) the Insured's child(ren) beyond the limiting age who is incapable of self-sustaining employment by reason of intellectual disability or physical handicap and who is chiefly dependent on the Insured for support and maintenance.

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

"Diagnosis/Diagnosed" means the diagnosis by a Physician that must be:

- (1) made while the Insured's or Insured Dependent's coverage is in force under this Policy; and
- (2) in writing; and
- (3) based on objective clinical findings or laboratory tests that are supported by medical records and any other diagnostic requirements defined in this Policy.

"Full-time" means working for you for a minimum of 20 hours during a person's regular scheduled work week.

"Gleason score" means a system of grading prostate cancer tissue based on how it looks under a microscope. Gleason scores range from 2 to 10 and indicate how likely it is that a tumor will spread. A low Gleason score means the cancer tissue is similar to normal prostate tissue and the tumor is less likely to spread. A high Gleason score means the cancer tissue is very different from normal and the tumor is more likely to spread.

"Hospital or Medical Facility" means a legally operated, accredited facility licensed to provide full-time care and Treatment for the condition for which benefits are payable under this Policy. It is operated with a full-time staff of licensed Physicians and registered nurses. It does not include facilities that primarily provide custodial or rehabilitative care, education or long-term institutional care on a residential basis.

"Immediate Family" means the parents, siblings, spouse or children of the Insured or Insured Dependent.

"Injury" means bodily injury to the Insured or Insured Dependent resulting directly from an accident, independent of all other causes.

"Insured" means a person who meets the eligibility requirements of this Policy and is enrolled for this insurance.

"Modified Rankin Scale" means a commonly used scale for measuring the degree of disability or dependence in the daily activities of people who have suffered a stroke. The Modified Rankin Scale runs from 0 to 6 with 0 indicating no symptoms and 6 indicating that the patient has passed away. A score of 5 indicates severe disability causing the Insured

or Insured Dependent to be bedridden, incontinent and in need of constant nursing care.

"Physician" means a duly licensed medical or osteopathic doctor who is recognized by the law of the state in which Treatment is provided as qualified to treat the type of Critical Illness for which claim is made. The Physician may not be the Insured or a member of his/her Immediate Family.

"Recurrence" means the Diagnosis by a Physician of a Critical Illness in the same Category as a Critical Illness Diagnosed for which a Critical Illness Benefit has been paid.

"Sickness" means illness, disease, pregnancy or complications from pregnancy requiring the care of a Physician.

"Subsequent Occurrence" means the Diagnosis by a Physician of a Critical Illness Diagnosed in a different Category from a Critical Illness Diagnosed for which a Critical Illness Benefit has been paid under this Policy.

"TNM scale" means the cancer staging system developed and maintained by The American Joint Committee on Cancer (AJCC) and the International Union Against Cancer (IUAC).

"Transplant List" means the list maintained by the United Network of Organ Sharing (UNOS) or its medically recognized successor organization, acting as the administrator for the Organ Procurement and Transplantation Network (OPTN).

"Treatment" means care consistent with the Diagnosis of the Insured's or Insured Dependent's Critical Illness that has the purpose of maximizing the Insured's or Insured Dependent's medical improvement. It must be provided by a Physician whose specialty or experience is most appropriate for such Critical Illness and conforms to generally accepted medical standards to effectively manage and treat the Insured's or Insured Dependent's condition.

CERTAIN RESPONSIBILITIES OF THE POLICYHOLDER

For the purposes of this Policy, you, as Policyholder, act on your behalf or as the employee's agent. Under no circumstances will you be deemed our agent.

Annual Enrollment Periods

It is your responsibility to provide us with written notice and obtain our written approval at least thirty-one (31) days prior to conducting an annual enrollment period.

Compliance with the Employee Retirement Income Security Act (ERISA)

It is your responsibility to establish and maintain procedures which comply with the employer and/or Plan Administrator responsibilities of ERISA and the accompanying regulations, where applicable.

Distribution Of Certificates Of Insurance

Certificates of Insurance will be provided to you for Insureds covered under this Policy. The Certificate will outline the insurance coverage, and explain the provisions, benefits and limitations of this Policy. It is your responsibility to distribute the appropriate Certificates and any updates or other notices from us to each Insured.

Maintenance Of Records

It is your responsibility to maintain sufficient records of each Insured's insurance, including additions, terminations and changes. We reserve the right to examine these records at the place where they are kept during normal business hours or at a place mutually agreeable to you and us. Such records must be maintained by you for at least 3 years after this Policy terminates.

Reporting Of Eligibility And Coverage Amounts

It is your responsibility to notify us on a timely basis of all individuals eligible for coverage under this Policy, of all individuals whose eligibility for coverage ends and of all changes in individual coverage amounts.

It is your responsibility to provide accurate census information on all Insureds on or before each Anniversary Date, if we request such information.

Timely Payment of Premiums

It is your responsibility to pay all premiums required under this Policy when due. Any change in the premium contribution basis must be approved by us.

Premium Rate Changes

It is your responsibility to provide advance notice to Insureds in the event of any applicable rate change that would impact their premium contribution.

GENERAL PROVISIONS

ENTIRE CONTRACT: The entire contract between you and us is the Policy, your application (a copy of which is attached at issue) and any endorsements and amendments.

CHANGES: No agent has authority to change or waive any part of the Policy. To be valid, any change or waiver must be in writing. It must also be signed by one of our executive officers and attached to the Policy.

INCONTESTABILITY: Any statement made in your application will be deemed a representation, not a warranty. We cannot contest this Policy after it has been in force for two (2) years from the date of issue, except for non-payment of premium.

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

- (1) No statement will be used in a contest unless:
 - (a) it is in a written form signed by the Insured or any Insured Dependent, or on behalf of the Insured or any Insured Dependent; and
 - (b) a copy of such written instrument is or has been furnished to the Insured or any Insured Dependent, the Insured's or any Insured Dependent's beneficiary or legal representative.
- (2) If the statement relates to an Insured's or any Insured Dependent's insurability, it will not be used to contest the validity of insurance which has been in force, before the contest, for at least two years during the lifetime of the Insured or Insured Dependent. Also, we will not use such statements to contest a benefit increase after such benefit increase has been in force for two (2) years during the lifetime of the Insured or Insured Dependent.

RECORDS MAINTAINED: You must maintain records of all Insureds. Such records must show the essential data of the insurance, including new persons, terminations, changes, etc. This information must be reported to us regularly. We reserve the right to examine the insurance records maintained at the place where they are kept. This review will only take place during normal business hours.

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

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

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

MISSTATEMENT OF AGE: If the Insured's or the Insured Dependent's age is misstated, the premium will be adjusted if necessary. If the Insured's or the Insured Dependent's insurance is affected by the misstated age, it will also be adjusted. The insurance coverage will be changed to the amount the Insured or the Insured Dependent is entitled to at his/her correct age.

ASSIGNMENT: The benefits under this Policy may not be assigned, except as required by law.

CONFORMITY WITH STATE LAWS: Any section of this Policy, which on its effective date, conflicts with the laws of the state in which this Policy is issued, is amended by this provision. This Policy is amended to meet the minimum requirements of those laws.

CERTIFICATE OF INSURANCE: Certificates of insurance will be provided to you for Insureds covered under this Policy. The certificate will outline the insurance coverage and to whom benefits are payable.

POLICY TERMINATION: You may cancel this Policy at any time. This Policy will be cancelled on the date we receive your letter or, if later, the date requested in your letter.

We may cancel this Policy:

- (1) if the premium is not paid at the end of the grace period; or
- (2) if the number of Insureds (excluding Dependents) covered is less than the Minimum Participation Requirements on the Schedule of Benefits; or
- (3) on any Policy Anniversary after coverage has been in force for twelve (12) months; or
- (4) if the percentage of Eligible Persons insured is less than the Minimum Participation Requirements on the Schedule of Benefits.

If we cancel because of (1) above, this Policy will be cancelled at the end of the grace period. If we cancel because of (2), (3) or (4) we will give you thirty-one (31) days written notice prior to the date of cancellation.

You will still owe us any premium that is not paid up to the date this Policy is cancelled. We will return any part of the premium paid beyond the date this Policy is cancelled.

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

INDIVIDUAL ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

GENERAL GROUP: The general group will be your employees and employees of any subsidiaries, divisions or affiliates named on the Schedule of Benefits.

ELIGIBLE CLASSES: The eligible classes will be those persons described on the Schedule of Benefits.

ELIGIBILITY REQUIREMENTS: A person is eligible for insurance under this Policy if he/she:

- (1) is a member of an Eligible Class, as shown on the Schedule of Benefits page; and
- (2) has completed the Service Waiting Period, as shown on the Schedule of Benefits page.

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

EFFECTIVE DATE OF INDIVIDUAL INSURANCE: If you pay the entire premium, the insurance for an Eligible Person will go into effect on the date stated on the Schedule of Benefits.

If an Eligible Person pays a part of the premium, he/she must apply within thirty-one (31) days of the date he/she is first eligible for insurance coverage and in writing on a form provided by us for the insurance to go into effect. He/she will become insured on the later of:

- (1) the Individual Effective Date as shown on the Schedule of Benefits, if he/she applies on or before that date; or
- (2) on the first day of the month coinciding with or next following the date he/she applies, if he/she applies within thirty-one (31) days from the date he/she first met the eligibility requirements; or
- (3) on the first day of the month coinciding with or next following the date we approve any required proof of good health. We require proof of good health if a person applies:
 - (a) after thirty-one (31) days from the date he/she first becomes eligible; or
 - (b) after he/she terminated this insurance but he/she remained in a class eligible for this insurance; or
 - (c) for an Amount of Insurance greater than the guaranteed issue amount shown on the Schedule of Benefits; or
 - (d) for an Amount of Insurance greater than he/she was insured for with the prior group critical illness carrier, if applicable; or
 - (e) after being eligible for coverage under a prior group critical illness 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.

Changes in the Insured's Amount of Insurance are effective as shown on the Schedule of Benefits.

If the Eligible Person is not Actively at Work on the day his/her insurance is to go into effect, the insurance will go into effect on the day he/she returns to Active Work for one (1) full day.

TERMINATION OF INDIVIDUAL INSURANCE: The insurance of an Insured will terminate on the first of the following to occur:

- (1) the date this Policy terminates; or
- (2) the date the Insured ceases to be in a class eligible for this insurance; or
- (3) the end of the period for which premium has been paid; or
- (4) the date when all Critical Illness benefits applicable to the Insured under this Policy have been paid; or
- (5) the date the Insured enters military service (not including Reserve or National Guard).

CONTINUATION OF INDIVIDUAL INSURANCE: The insurance of the Insured and any Insured Dependents may be continued, by payment of premium, beyond the date the Insured ceases to be eligible for this insurance, but not longer than:

- (1) twelve (12) months, if due to Sickness or Injury; or
- (2) one (1) month, if due to temporary lay-off or approved leave of absence.

INDIVIDUAL REINSTATEMENT: Insurance may be reinstated if a former Insured has been:

- (1) on an approved leave of absence; or
- (2) on temporary lay-off.

The former Insured must return to Active Work with you within the period of time shown on the Schedule of Benefits. He/she must also be a member of a class eligible for this insurance.

The former Insured will not be required to fulfill the eligibility requirements of this Policy again. The insurance will go into effect on the day he/she returns to Active Work. However, if the former Insured returns after having resigned or having been discharged, he/she will be required to fulfill the eligibility requirements of this Policy again.

If an Eligible Person requests insurance after previously terminating insurance at his/her request or for failure to pay premium when due, proof of good health must be approved by us before his/her insurance coverage may be reinstated.

BENEFIT PROVISIONS

CRITICAL ILLNESS BENEFIT: We will pay a lump sum benefit in the amount shown in the Schedule of Benefits to the Insured if the Insured or any Insured Dependent is Diagnosed by a Physician with a Critical Illness within any category as defined below. Payment of the benefit is subject to all of the following:

- (1) the Diagnosis must have been made within the United States or its territories; and
- (2) the Insured's and the Insured Dependents' coverage must be in force under this Policy at the time of Diagnosis of a Critical Illness; and
- (3) any exclusions, limitations or conditions expressed in this Policy; and
- (4) any age reductions shown on the Schedule of Benefits.

Critical Illnesses are separated by categories as follows:

CATEGORY 1 – Cancer Related Critical Illnesses:

"Carcinoma in situ" means the Diagnosis of cancer in which the tumor cells still lie within the tissue of the site of origin without having invaded neighboring tissue.

The term "Carcinoma in situ" does not mean:

- (1) pre-malignant lesions such as intraepithelial neoplasia;
- (2) malignant melanoma of less than .75 mm. maximum thickness as determined by histological examination using the Breslow method; or
- (3) benign tumors or polyps.

Carcinoma in situ must be Diagnosed by a Physician pursuant to a pathological diagnosis. We will, however, pay benefits based on a clinical diagnosis if pathological diagnosis is impossible because it is life threatening or medically inappropriate.

Benefits will not be paid under Carcinoma in situ and Life Threatening Cancer if the Insured or Insured Dependent is eligible for benefits under both Critical Illnesses. We will, however, pay the highest benefit.

"Life Threatening Cancer" means a malignant neoplasm (including hematologic malignancy), as Diagnosed by a Physician who is a board certified oncologist, which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue, and which is not specifically excluded. Leukemias and lymphomas are included.

The following types of cancer are not considered a Life Threatening Cancer:

- (1) Prostate cancer diagnosed as less than T2NOMO according to the TNM scale or classified as less than Gleason score seven (7);
- (2) Carcinoma in situ, including cervical dysplasia, CIN-1, CIN-2 and CIN-3, according to the CIN Grading System;
- (3) Pre-malignant lesions (such as intraepithelial neoplasia);
- (4) All tumors histologically described as:
 - (a) benign;
 - (b) pre-malignant;
 - (c) non-invasive;
 - (d) low-malignancy potential; or
 - (e) borderline malignant;
- (5) All skin cancers, unless there is evidence of metastasis or the tumor is malignant melanoma of greater than .75 mm. maximum thickness as determined by histological examination using the Breslow method;
- (6) Chronic lymphocytic leukemia which has not progressed to a) Rai Stage II; or b) Binet Stage B;
- (7) Papillary carcinoma of the thyroid which does not exceed 1 cm in diameter and is limited to the thyroid; or
- (8) Non-invasive papillary cancer of the bladder, which does not exceed TaNOMO according to the TNM scale.

A positive diagnosis of Life Threatening Cancer must be confirmed by pathological confirmation. We will, however, pay benefits based on a clinical diagnosis if pathological diagnosis is impossible because it is life threatening or medically inappropriate.

Benefits will not be paid under Carcinoma in situ and Life Threatening Cancer if the Insured or Insured Dependent is eligible for benefits under both Critical Illnesses. We will, however, pay the highest benefit.

CATEGORY 2 – Cardiovascular Related Critical Illnesses:

"Coronary Artery Bypass" means the use of a non-coronary blood vessel or blood vessels (either artery or vein) to surgically bypass obstructions in a native coronary artery or arteries supplying blood to the heart.

The term "Coronary Artery Bypass" does not mean any other procedure such as, but not limited to, balloon or laser angioplasty, stent procedures or other minimally invasive procedures performed to increase blood flow.

"Heart Attack (acute myocardial infarction)" means the death of a segment of the heart muscle resulting from blockage of one or more coronary arteries.

In order to be covered under this provision, the Diagnosis by a Physician of Heart Attack (acute myocardial infarction) must be based on:

- (1) typical symptoms of Heart Attack such as, but not limited to, chest pain, shortness of breath, or pain or discomfort in one or both arms; and
- (2) new electrocardiographic changes consistent with and supporting diagnosis of Heart Attack (acute myocardial infarction); and
- (3) a concurrent diagnostic elevation of cardiac enzymes above generally accepted laboratory levels of normal.

Benefits will not be payable for a Heart Attack that occurs within twenty-four (24) hours of a medical procedure.

The death of the heart muscle coincidental with death of the Insured or Insured Dependent from other causes will not be considered a Heart Attack.

"Stroke" means a cerebrovascular event resulting in infarction (death) of brain tissue as Diagnosed by a Physician who is board certified in neurology, which is caused by hemorrhage, embolism or thrombosis evident from neuroimaging (CT, MRI, MRA, PET Tomography or similar imaging technique). Such event must produce measurable, neurological deficit(s) in accordance with a score of three (3) or greater on the Modified Rankin Scale persisting for at least thirty (30) consecutive days following the occurrence of the stroke.

Stroke does not include Transient Ischemic Attack (TIA), attacks of vertebrobasilar ischemia, transient global amnesia, chronic cerebrovascular insufficiency or any other cerebrovascular events such as migraine, hypoxia, traumatic Injury to the brain or blood vessels or vascular disease affecting the eye, optic nerve or vestibular functions.

CATEGORY 3 – Other Critical Illnesses:

"Kidney (Renal) Failure" means the chronic irreversible failure of both of the kidneys (end stage renal disease), which requires Treatment with renal dialysis administered on a regular basis (at least weekly). Kidney Failure is covered under this provision only if the Diagnosis has been made by a Physician who is a board certified nephrologist.

If a Critical Illness benefit has been paid under Kidney (Renal) Failure, we will not pay a benefit under Major Organ Transplant for a kidney transplant.

"Major Organ Transplant" means that the Insured or Insured Dependent has been Diagnosed by a Physician as requiring the replacement of a irreversibly failing organ with an organ transplanted from a suitable human donor and the Insured or Insured Dependent has either been placed on the Transplant List or been the recipient of such major organ transplant performed under generally accepted medical procedures. Organs covered by this definition are limited to the entire liver, kidney, lung, heart, pancreas or pancreas-kidney.

If a Critical Illness benefit has been paid under Kidney (Renal) Failure, we will not pay a benefit under Major Organ Transplant for a kidney transplant.

BENEFIT AMOUNT: Benefits for the Diagnosis of a Critical Illness defined above will be payable at the Amount of Insurance as specified on the Schedule of Benefits.

CONCURRENT DIAGNOSIS OF MORE THAN ONE CRITICAL ILLNESS: If the Insured or Insured Dependent can qualify for benefits for more than one Critical Illness at the same time, we will only pay for one (1) Critical Illness with the highest benefit.

RECURRENCE(S) OF A CRITICAL ILLNESS IN THE SAME CATEGORY: Once an Insured or Insured Dependent has been Diagnosed with a Critical Illness and a Critical Illness Benefit has become payable, Recurrences of a Critical Illness in the same Category will be covered up to the Lifetime Maximum Benefit shown on the Schedule of Benefits provided the Recurrence is diagnosed at least eighteen (18) months after the previous Critical Illness was Diagnosed.

If the Recurrence is diagnosed less than eighteen (18) months after the Diagnosis, no benefit will be payable for that Recurrence. However, a later Recurrence, if any, may be covered.

The benefit payable for a Recurrence will be as shown on the Schedule of Benefits.

SUBSEQUENT OCCURRENCE(S) OF A CRITICAL ILLNESS IN A DIFFERENT CATEGORY: Once a Critical Illness has been Diagnosed in a particular Category under this Policy, coverage will continue and benefits will be payable for subsequent and unrelated Critical Illnesses in a different Category if the Critical Illness is Diagnosed at least six (6) months after the date of the Diagnosis of the prior Critical Illness.

The benefit payable for Subsequent Occurrence(s) will be as shown on the Schedule of Benefits.

DEATH OF THE INSURED OR INSURED DEPENDENT: If the Insured or the Insured Dependent is Diagnosed with a Critical Illness and is eligible for a benefit but dies before a benefit is paid, we will pay the lump sum amount the Insured or Insured Dependent would have been entitled to in accordance with the Beneficiary and Facility of Payment provisions in this Policy.

LIMITATIONS

PRE-EXISTING CONDITIONS: The Insured or Insured Dependent will be considered to have a Pre-existing Condition and will be subject to a Pre-existing Conditions Limitation if:

- (1) a Critical Illness is diagnosed in the first twelve (12) months after the Insured's or Insured Dependent's effective date; and
- (2) he/she has received medical Treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines for a Sickness or Injury, whether specifically diagnosed or not, causing or contributing to such Critical Illness, during the twelve (12) months immediately prior to the Insured's or Insured Dependent's effective date of insurance.

Benefits will not be paid for a Critical Illness:

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

a Pre-existing Condition unless the Critical Illness is diagnosed after twelve (12) consecutive months from the Insured's or Insured Dependent's 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 this Policy) any benefit increase will not be paid for a Critical Illness:

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

a Pre-existing Condition unless the Critical Illness is diagnosed after twelve (12) consecutive months from the effective date of the benefit increase.

The Insured or Insured Dependent 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 Critical Illness is diagnosed in the first twelve (12) months after the effective date of the benefit increase; and
- (2) he/she has received medical Treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines for a Sickness or Injury, whether specifically diagnosed or not, causing or contributing to such Critical Illness, during the twelve (12) months immediately prior to the effective date of the benefit increase.

"Pre-existing Condition" means any Sickness or Injury whether specifically diagnosed or not, for which the Insured or Insured Dependent received medical Treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines, during the twelve (12) months immediately prior to such Insured's or Insured Dependent's effective date of insurance.

A Pre-existing Conditions Limitation will not apply to a Recurrence of a Critical Illness.

EXCLUSIONS

EXCLUSIONS: A Critical Illness benefit will not be paid:

- (1) if caused by or contributed to by one of the following:
 - (a) an act of war, declared or undeclared;
 - (b) intentionally self-inflicted Injury;
 - (c) the Insured's or the Insured Dependent's commission or attempted commission of a felony;
 - (d) the Insured's or the Insured Dependent's use of alcohol or drugs unless taken as prescribed by a Physician;
 - (e) a Sickness or Injury that occurs while the Insured or the Insured Dependent is confined in a penal or correctional institution;
 - (f) cosmetic or elective surgery that is not medically necessary;
 - (g) committing or attempting to commit suicide while sane or insane;
 - (h) the Insured's or Insured Dependent's participation in a riot or insurrection;
- (2) for a Critical Illness Diagnosed outside of the United States unless such Diagnosis is confirmed within the United States. If such Diagnosis is confirmed within the United States, the Critical Illness will be deemed to have occurred on the date Diagnosis was made outside the United States;
- (3) for a Critical Illness Diagnosed in one Category that follows by less than six (6) months a Critical Illness Diagnosed in another Category for which benefits have been paid;
- (4) for a Critical Illness in the same Category as a Critical Illness Diagnosed for which a benefit has been paid if it is Diagnosed less than eighteen (18) months after the previous Critical Illness was Diagnosed;
- (5) for a Heart Attack that occurs within twenty-four (24) hours of a medical procedure.

WELLNESS BENEFIT

We will pay the Insured the amount shown on the Schedule of Benefits for one (1) health screening test performed during a twelve (12) month period for the Insured and his/her Insured Dependents* provided he/she:

- (1) supplies written proof satisfactory to us that such a health screening test has been performed; and
- (2) was covered under this Policy at the time the test was performed; and
- (3) has not already had one of the following health screening tests performed at any time during the same twelve (12) month period.

Health screening tests covered under this Policy are:

- (1) Stress test on a bicycle or treadmill;
- (2) Fasting blood glucose test;
- (3) Blood test for triglycerides;
- (4) Serum cholesterol test to determine level of HDL and LDL;
- (5) Bone marrow testing;
- (6) Breast ultrasound;
- (7) CA 15-3 (blood test for breast cancer);
- (8) CA 125 (blood test for ovarian cancer);
- (9) CEA;
- (10) Chest X-ray;
- (11) Colonoscopy;
- (12) Flexible sigmoidoscopy;
- (13) Hemoccult stool analysis;
- (14) Mammography;
- (15) Pap smear;
- (16) PSA (blood test for prostate cancer); and
- (17) Serum Protein Electrophoresis (blood test for myeloma).

*Only one (1) Wellness Benefit will be paid in a twelve (12) month period for all Insured Dependent children as a group.

The Wellness Benefit is paid in addition to any other payments the Insured or Insured Dependent may receive under this Policy.

PREMIUMS

PREMIUM PAYMENT: All premiums are to be paid by you to us, or to an authorized agent, on or before the due date. The premium due dates are stated on the Policy face page.

PREMIUM RATES: The premium due is based on the coverage requested. Premium rates are based on the age attained on the Premium due date. We have the right to change the premium rates:

- (1) on any premium due date after the Policy is in force for twenty-four (24) months; or
- (2) when the extent of coverage is changed by amendment; or
- (3) on any premium due date on or after the Policy has been in force of twelve (12) months if the entire group's Amount of Insurance or number of Insureds, (excluding Dependents) changes by 25% or more from such group's entire Amount of Insurance or number of Insureds on the Policy's Effective Date.

We will not change the premium rates due to (1) above more than once in any twelve (12) month period. We will tell you in writing at least thirty-one (31) days before the date of a change due to one (1) or three (3) above.

Premium increases due to the Insured or Insured Dependent spouse entering into a higher age bracket will occur on the Policy Anniversary Date coinciding with or next following the Insured's last birthday.

The Insured Dependent spouse age, for purposes of determining Premium under this Policy, is equivalent to the Insured's age.

GRACE PERIOD: You may pay the premium up to thirty-one (31) days after the date it is due. The Policy stays in force during this time. If the premium is not paid during the grace period, the Policy will be cancelled at the end of the grace period. You will still owe us the premium up to the date the Policy is cancelled.

BENEFICIARY AND FACILITY OF PAYMENT

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

If the Insured names more than one beneficiary to share the benefit, he/she 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 the Insured wishes to change the designation. His/her consent is also not needed to make any changes in this Policy.

If the beneficiary dies at the same time as the Insured, or within 15 days after his/her death but before we received written proof of the Insured's death, payment will be made as if the Insured survived the beneficiary, unless noted otherwise.

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

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

Benefits payable at the death of an Insured Dependent will be paid to the Insured unless another individual has been designated as beneficiary.

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 the Insured has not named a beneficiary, or the named beneficiary is not surviving at the Insured's death, we may pay up to \$2,500 of the benefit to the person(s) who, in our opinion, have incurred expenses in connection with Insured's 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.

With respect to the Facility of Payment provision, the benefit will be held with interest at a rate set by us.

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 thirty-one (31) days after the date of the Diagnosis of a Critical Illness, or as soon as reasonably possible. The notice should be sent to us at our Administrative Offices or to our authorized agent. The notice should include the Insured's or Insured Dependent's name and the Policy Number.

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

PROOF OF LOSS: For any covered Critical Illness or health screening test, 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.

Proof of Loss for a covered Critical Illness must include, at the Insured's expense, all of the following information:

- (1) the date of Diagnosis;
- (2) a completed claim form signed by the Insured or Insured Dependent and the Insured's or Insured Dependent's Physician(s);
- (3) supporting documentation from the Physician, including but not limited to, clinical, radiological, pathological, histological or laboratory evidence of Critical Illness; and
- (4) the name and address of any Hospital or Medical Facility, as well as the Physician, providing Treatment prior to the Diagnosis.

Proof of Loss for a covered health screening test must include, at the Insured's expense, all of the following information:

- (1) a completed claim form signed by the Insured or Insured Dependent and the Insured's or Insured Dependent's Physician(s); and
- (2) supporting documentation from the Physician, including but not limited to laboratory evidence that a health screening test from the list of covered health screening tests in this Policy has been performed and the date on which such test was performed.

TIME OF PAYMENT OF CLAIMS: When we receive satisfactory written proof of loss, we will immediately pay any benefits due within thirty (30) days. Benefits that provide for periodic payment will be paid accordingly.

PAYMENT OF CLAIMS: All benefits will be paid to the Insured, if living. Any benefits unpaid at the time of death will be paid to the beneficiary.

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

PHYSICAL EXAMINATION AND AUTOPSY: At our own expense, we will have the right to have the Insured or Insured Dependent examined as often as reasonably necessary when a claim is pending. We can also have an autopsy performed unless prohibited by law.

LEGAL ACTION: No legal action may be brought against us to recover on this Policy within sixty (60) days after written proof of loss has been given as required by this Policy. No action may be brought after three (3) years from the time written proof of loss is required to be submitted.

DEPENDENT CRITICAL ILLNESS INSURANCE

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

When an Insured Dependent is Diagnosed with a Critical Illness in accordance with the Critical Illness Benefit provision we will pay the applicable benefit shown on the Schedule of Benefits. Only dependents that meet the definition of Dependent can be insured for this benefit.

Any benefit payable for an Insured Dependent will be paid to the Insured unless another individual has been designated as beneficiary.

A person may not have coverage under this Policy both as an Insured and as an Insured Dependent. Only one eligible spouse may cover the eligible children as Insured Dependents. The spouse may be covered as a Dependent if not covered as an Insured. If insurance is in force for an Insured Dependent child, any newly eligible Dependent child(ren) will be automatically covered.

ELIGIBILITY: An Eligible Person is eligible to enroll his/her eligible Dependents on the date he/she becomes an Insured.

EFFECTIVE DATE OF DEPENDENT INSURANCE: If you pay the entire premium, the insurance for a Dependent will become effective on the later of:

- (1) the first day of the month coinciding with or next following the date the Insured becomes eligible for Dependent insurance; or
- (2) the first day of the month coinciding with or next following the date the dependent meets the definition of Dependent.

If you require an Insured to pay a portion of the Dependent premium, he/she may insure his/her Dependents by making written application. In this case, the insurance for Dependents will take effect on the later of:

- (1) the first day of the month coinciding with or next following the date the Insured becomes eligible for Dependent insurance; or
- (2) the first day of the month coinciding with or next following the date the dependent meets the definition of Dependent, if application is made on or before that date; or
- (3) the first day of the month coinciding with or next following the date of application, if application is made within thirty-one (31) days from the date the Dependent first becomes eligible for this insurance, or
- (4) the first day of the month coinciding with or next following the date we approve any required proof of good health. We require proof of good health if an Insured makes application for Dependent spouse insurance:
 - (a) after thirty-one (31) days from the date the Dependent spouse first becomes eligible for this insurance; or
 - (b) after a prior termination of insurance as long as the Dependent spouse remained in a class eligible for Dependent insurance; or
 - (c) for an Amount of Insurance greater than the guaranteed issue amount shown on the Schedule of Benefits; or
 - (d) for an Amount of Insurance greater than he/she was insured for with the prior group critical illness carrier, if applicable; or
 - (e) after the Dependent spouse was eligible for coverage under a prior group critical illness plan for more than thirty-one (31) days but did not elect to be covered under that prior plan; or
- (5) the date premium is remitted.

For a Dependent who is confined in a Hospital or Medical Facility or at home on the date on which he/she would otherwise become insured, insurance will be effective as of the date the confinement ends.

Changes in the Insured Dependent's Amount of Insurance are effective as shown on the Schedule of Benefits.

TERMINATION OF DEPENDENT INSURANCE: The insurance for an Insured Dependent will terminate on the first of the following dates:

- (1) the date this Section terminates; or
- (2) the date the dependent is no longer a Dependent as defined; or
- (3) the date the Insured Dependent spouse reaches age 75; or
- (4) the end of the period for which premium has been paid by you or the Insured; or

- (5) the date all benefits available under this Policy have been paid on behalf of all Insured Dependents; or
- (6) the date the Insured's insurance terminates; or
- (7) the date the Insured retires.

NEWLYWED PROVISION: At the marriage of an Insured who had not previously elected Dependent coverage, his/her new spouse shall automatically become an Insured Dependent.

Such spouse shall be an Insured Dependent for thirty-one (31) days. He/she shall then cease to be an Insured Dependent unless:

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

NEWBORN CHILDREN: If a child is born to an Insured who has not elected Dependent coverage, such child shall be an Insured Dependent from the moment of birth.

The newborn child shall be an Insured Dependent for thirty-one (31) days. He/she shall then cease to be an Insured Dependent unless:

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

The above coverage will also be extended to newly adoptive (or child(ren) placed for adoption), foster or step children, as of the date they become financially dependent on an Insured for support, provided they otherwise meet the definition of Dependent.

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

Family and Medical Leave of Absence:

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

- (1) the premium for such Insured and his/her Dependents, if applicable, continues to be paid during the leave; and
- (2) you have approved the Insured's leave in writing and provide 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.

Military Services Leave of Absence:

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

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

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

While the Insured is on a Family and Medical Leave of Absence for any reason other than his or her own illness, injury or disability or Military Services Leave of Absence he or she will be considered Actively at Work. Any changes such as revisions to coverage due to age or class, 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 for an Insured who is not considered Actively at Work until the Insured has returned to Active Work for one (1) full day.

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

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

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

PORTABILITY

The Insured may continue Critical Illness insurance coverage under this Policy and that of his/her Insured Dependents if coverage would otherwise terminate because he/she ceases to be an Eligible Person, for reasons other than the termination of this Policy, the Insured's retirement or termination of spouse coverage provided he/she:

- (1) notifies us in writing within thirty-one (31) days from the date insurance coverage is terminated under this Policy; and
- (2) remits the necessary premiums when due; and
- (3) has been covered for twelve (12) months under this Policy and/or the prior group critical illness insurance policy.

The Amount of Insurance available under the Portability provision will be the current Amount of Insurance the Insured and Insured Dependents are insured for under this Policy on the last day the Insured was Actively at Work.

The premium charged to continue coverage will be based on the prevailing rate charged to all insureds who choose to continue coverage under the Portability provision. The premium will be billed directly to the Insured on a quarterly basis.

If an Insured's and Insured Dependent's Critical Illness coverage under this Policy includes the Wellness Benefit then such benefits may be continued under this Policy.

Insurance coverage continued under this provision for the Insured or his/her Insured Dependents will terminate on the first of the following to occur:

- (1) the end of the period for which premium has been paid;
- (2) the date the Insured reaches age seventy (70);
- (3) at any time coverage would normally terminate according to the terms of this Policy had the Insured continued to be an Eligible Person; or
- (4) the date the Insured Dependent spouse attains age seventy-five (75) with respect to Insured Dependent spouse coverage continued under this provision.

In addition, coverage will reduce at any time it would normally reduce according to the terms of this Policy had the Insured and Insured Dependent spouse continued to be eligible.

If this Policy terminates subsequent to the Insured's election to continue his/her coverage, and that of his/her Insured Dependents in accordance with the Portability provision, such coverage will be continued in accordance with the provisions of the Insured's certificate.

RELIANCE STANDARD LIFE INSURANCE COMPANY

**NOTICE CONCERNING COVERAGE
LIMITATIONS AND EXCLUSIONS UNDER THE OHIO LIFE AND
HEALTH INSURANCE GUARANTY ASSOCIATION ACT**

Residents of Ohio who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Ohio Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Ohio Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Ohio. You should not rely on coverage by the Ohio Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. You should check with your insurance company representative to determine if you are only covered in part or not covered at all.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

**Ohio Life and Health Insurance Guaranty Association
1840 MacKenzie Drive
Columbus, Ohio 43220**

**Ohio Department of Insurance
50 W. Town Street
Third Floor, Suite 300
Columbus, Ohio 43215**

The state law that provides for this safety-net coverage is called the Ohio Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

(please refer to next page)

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in Ohio and hold a life or health insurance contract, annuity contract, unallocated annuity contract; if they are insured under a group insurance contract, issued by a member insurer; or if they are the payee or beneficiary of a structured settlement annuity contract. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a medical, health or dental care corporation, an HMO, a fraternal benefit society, a mutual protective association or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does **not** provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out: The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of \$300,000, except as specified below, no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. The association will not pay more than \$100,000 in cash surrender values, \$500,000 in major medical insurance benefits, \$300,000 in disability or long-term care insurance benefits, \$100,000 in other health insurance benefits, \$250,000 in present value of annuities, or \$300,000 in life insurance death benefits. Again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages, the association will pay a maximum of \$300,000, except for coverage involving major medical insurance benefits, for which the maximum of all coverages is \$500,000.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the act: For unallocated annuities that fund governmental retirement plans under Sections 401(k), 403(b) or 457 of the Internal Revenue Code, the limit is \$250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the association be liable to spend more than \$300,000 in the aggregate per individual, except as noted above. For covered unallocated annuities that fund other plans, a special limit of \$1,000,000 applies to each contractholder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

For more information about the Ohio Life & Health Insurance Guaranty Association, visit our website at:
www.olhiga.org