GROUP LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PROGRAM

Lubbock County Hospital dba University Medical Center

RELIANCE STANDARD LIFE INSURANCE COMPANY

2001 Market Street, Suite 1500, Philadelphia, PA 19103-7090

IMPORTANT NOTICE

To obtain information or to make a complaint:

You may call Reliance Standard Life Insurance toll-free telephone number for information or to make a complaint at

1-800-351-7500

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

1-800-252-3439

You may write the Texas Department of Insurance

P.O. Box 149104
Austin, Texas 78714-9104
FAX # (512) 475-1771
Web: http://www.tdi.state.tx.us
E-mail:
ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim, you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de Reliance Standard Life Insurance Company para informacion o para someter una queja al

1-800-351-7500

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas

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Austin, Texas 78714-9104
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ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con la compania primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

LRS 8690-0492

CERTIFICATE OF INSURANCE

We certify that you (provided you belong to a class described on the Schedule of Benefits and your completed enrollment card is attached) are insured, for the benefits which apply to your class, under Group Policy No. GL 668871 issued to Lubbock County Hospital dba University Medical Center, the Policyholder.

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

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

Secretary President

GROUP LIFE INSURANCE CERTIFICATE

This Group Life Certificate replaces any previous Group Life Certificates and is dated April 12, 2011.

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SCHEDULE OF BENEFITS

EFFECTIVE DATE: January 1, 2010

ELIGIBLE CLASSES: Each active, Full-time and Part-time employee, except any person employed on a temporary or seasonal basis, according to the following classifications:

CLASS 1: Employee participating in the health plan

CLASS 2: Employee not participating in the health plan

WAITING PERIOD: 1 calendar month (which begins on the first of the month following the date the enrollment form is received; for Basic and Supplemental coverages)

INDIVIDUAL EFFECTIVE DATE: The first of the month following completion of the Waiting Period.

INDIVIDUAL REINSTATEMENT: 30 days

AMOUNT OF INSURANCE:

Basic Life and Accidental Death and Dismemberment:

CLASS 1: One (1) times Earnings, rounded to the next higher $1,000, subject to a minimum Amount of Insurance of $10,000 and a maximum Amount of Insurance of $50,000.

Supplemental Life (Applicable only to you if you elected Supplemental coverage and are paying the applicable premium):

CLASS 1 & 2: $10,000 to $1,000,000 in increments of $10,000.

Amounts of supplemental insurance over $100,000 are subject to our approval of your proof of good health. However, any proof of good health required due to late application for this insurance (See EFFECTIVE DATE OF INSURANCE) will be at no expense to us.

CLASS 1: For Insureds age 70 and over, the Amount of Basic Life, Accidental Death and Dismemberment and Supplemental Life Insurance is subject to automatic reduction. Upon the Insured's attainment of the specified age below, the Amount of Basic Life, Accidental Death and Dismemberment and Supplemental Life 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**
70-74	65%
75-79	40%
80+	25%

CLASS 2: For Insureds age 70 and over, the Amount of Supplemental Life Insurance is subject to automatic reduction. Upon the Insured's attainment of the specified age below, the Amount of Supplemental Life 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**
70-74	65%
75-79	40%
80+	25%

DEPENDENT LIFE:

Option 1 (Dependent Unit Coverage):

Spouse Amount: $10,000
Child Amount: 14 days and over: $10,000

Option 2 (Spouse and/or Child Coverage) *:

Spouse Amount: $5,000 to $250,000 in increments of $5,000
Child Amount: 14 days and over: $10,000

* Applicable to you only if you elect Supplemental Life coverage and are paying the applicable premiums.

The Option 2 Spouse amount of insurance may not exceed 100% of your amount of Supplemental Life Insurance.

Option 2 Amounts of insurance for spouses over $25,000 are subject to our approval of your spouse's proof of good health. However, any proof of good health required due to late application for this insurance (See EFFECTIVE DATE OF DEPENDENT INSURANCE) will be at no expense to us.

The Option 2 Spouse Amount of Insurance will reduce in the same manner as your Amount of Insurance upon your spouse's attainment of reducing ages.

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

CHANGES IN AMOUNT OF INSURANCE:

CLASS 1: Increases and decreases in the Amount of Insurance because of changes in age are effective on the Policy Anniversary Date coinciding with or next following the date of the change. Increases and decreases in the Amount of Insurance because of changes in class or earnings (if applicable) are effective on the date of the change.

With respect to increases in the Amount of Insurance, you must be Actively At Work on the date of the change. If you are not Actively At Work when the change should take effect, the change will take effect on the day after you have been Actively At Work for one full day. However, if you have the right to choose your amount of Supplemental insurance, proof of good health will be required when you change your selection to increase the amount of your Supplemental insurance. Such proof must be approved by us for the increase to take effect.

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 provided you apply within 31 days of such life event.

CLASS 2: Increases and decreases in the Amount of Insurance because of changes in age are effective on the Policy Anniversary Date coinciding with or next following the date of the change. Increases and decreases in the Amount of Insurance because of changes in class or earnings (if applicable) are effective on the date of the change.

With respect to increases in the Amount of Insurance, you must be Actively At Work on the date of the change. If you are not Actively At Work when the change should take effect, the change will take effect on the day after you have been Actively At Work for one full day. However, if you have the right to choose your amount of Supplemental insurance, proof of good health will be required when you change your selection to increase the amount of your Supplemental insurance. Such proof must be approved by us for the increase to take effect.

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 provided you apply within 31 days of such life event.

CONTRIBUTIONS:

CLASS 1: You are not required to contribute toward the cost of the Basic Insurance. You are required to contribute toward the cost of the Supplemental Insurance. It is applicable to you only if you elected Supplemental coverage and are paying the applicable premium. You are required to contribute toward the cost of Dependent Life Insurance.

CLASS 2: You are required to contribute toward the cost of the Supplemental Insurance. It is applicable to you only if you elected Supplemental coverage and are paying the applicable premium. You are required to contribute toward the cost of Dependent Life Insurance.

DEFINITIONS

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

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

"Actively at work" and "active work" means actually performing on a Full-time or Part-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 illness.

"Full-time" means working for the Policyholder for a minimum of 40 hours per week or 80 hours per pay period.

"Part-time" means working for the Policyholder for a minimum of 20 hours per week or 40 hours per pay period.

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

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

"Earnings", as used in the SCHEDULE OF BENEFITS section, means your annual salary received from the Policyholder on the day just before the date of loss, prior to any deductions to a 401(k) or 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 regularly scheduled work week, not to exceed forty (40) hours per week, times fifty-two (52) weeks, will be used to determine annual earnings.

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

CLASS 1: "Loss" as used in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section, with respect to:

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

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

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

(1) your legal spouse who is not legally separated or divorced from you; and

(2) your unmarried child(ren), under age 25. Adoptive, foster and step-children are considered Dependents if they are in your custody; and

(3) your unmarried child who is physically or mentally disabled and under your supervision; and

(4) your unmarried natural or adopted grandchild(ren), under age 25, who is financially dependent upon you for support.

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

GENERAL PROVISIONS

INCONTESTABILITY

Any statements made by you or any Insured Dependent, or on your behalf or any Insured Dependent's 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 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 you or any Insured Dependent, or on your behalf or any Insured Dependent's behalf; and

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

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

ASSIGNMENT

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

EFFECTIVE DATE AND TERMINATION

EFFECTIVE DATE OF INDIVIDUAL INSURANCE: If the Policyholder pays the entire premium, your insurance will go into effect on the date stated on the Schedule of Benefits. If you pay a part of the premium, you must apply in writing for the insurance to go into effect. You will become insured on the later of:

(1) the Individual Effective Date stated on the Schedule of Benefits; or

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

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

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

REINSTATEMENT: Your insurance may be reinstated if it was terminated while you were:

(1) on an approved leave of absence, or

(2) on a temporary lay-off; or

(3) rehired after employment had been terminated.

You must return to active work within the period of time shown on the Schedule of Benefits. You must also be a member of a class eligible for this insurance.

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 requests insurance after terminating at your own request or for failure to pay premium when due, proof of good health must be approved by us before you may be reinstated.

CONVERSION PRIVILEGE

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

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

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

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

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

   (4) Proof of good health is not required.

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

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

   (2) $2,000.

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

D. If you die during the time in which you are entitled to apply for an

individual policy, we will pay the benefit under the Group Policy that you were entitled to convert. This will be done whether or not you applied for the individual policy.

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

BENEFICIARY AND FACILITY OF PAYMENT

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

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

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

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

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

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

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

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

If you have not named a beneficiary, or the named beneficiary is not surviving at your death, we may pay up to $250 of the benefit to the person(s) who, in our opinion, have incurred expenses in connection with your last illness, death or burial.

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

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

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

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

SETTLEMENT OPTIONS

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

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

Settlement Options are described in the Policy.

WAIVER OF PREMIUM IN EVENT OF TOTAL DISABILITY

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

(1) you become totally disabled prior to age 60;
(2) the Total Disability begins while you are insured;
(3) the Total Disability begins while the Policy is in force;
(4) the Total Disability lasts for at least 9 months;
(5) the premium continues to be paid; and
(6) we receive proof of Total Disability within one (1) year from the date it began.

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

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

The Amount of Insurance extended will be limited to the amount of basic group life coverage, with respect to Class 1 and any applicable supplemental group life coverage on your life that was in force at the time that Total Disability began excluding any additional benefits. This amount will not increase. This amount will reduce or cease at any time it would reduce or cease if you had not been totally disabled. If you die, we will be liable under this extension only if written proof of death is received by us.

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

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

You may use the conversion privilege when this extension ceases. Please refer to the Conversion Privilege section for rules. You are not

entitled to conversion if you return to work and are again eligible for the insurance under the Policy. If you use the conversion privilege, benefits will not be payable under the Waiver of Premium in Event of Total Disability provision unless the converted policy is surrendered to us.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Applicable to Class 1:

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

If you suffer any one of the losses listed below, as a result of an injury, we will pay the benefit shown. The loss must be caused solely by an accident which occurs while you are insured, and must occur within 365 days of the accident. Only one benefit (the larger) will be paid for more than one loss resulting from any one accident. The Amount of Insurance can be found on the Schedule of Benefits.

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

EXCLUSIONS

A benefit will not be payable for a loss:

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

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

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

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

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

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

SEAT BELT AND AIR BAG BENEFIT

Applicable to Class 1:

Seat Belt Benefit

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

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

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

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

Air Bag Benefit

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

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

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

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

public roadways.

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

EXCLUSIONS

No benefit is payable for any loss sustained by you:

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

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

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

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

CLAIMS PROVISIONS

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

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

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

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

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

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

DEPENDENT LIFE INSURANCE

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

When an Insured Dependent dies, we will pay the applicable benefit shown on the Schedule of Benefits to you. If you are deceased, then the benefit will be paid to your beneficiary. Only dependents who meet the definition of Dependents can be insured for this benefit.

Applicable to Option 2: A person may not have coverage both as an Insured Person and as a covered 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 Person.

EFFECTIVE DATE OF DEPENDENT INSURANCE

If the Policyholder pays the entire premium, the insurance for a Dependent will become effective on the later of:

(1) the date you become eligible for Dependent Life Insurance; or

(2) the date the dependent meets the definition of Dependent.

If you pay a portion of the dependent premium, you may insure your dependents by making written application. In this case, the insurance for Dependents will take effect on the later of:

(1) the date you become eligible for Dependent Life Insurance; or

(2) the date the dependent meets the definition of Dependent, if application is made on or before that date; or

(3) 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 date we approve any required proof of good health. We require proof of good health if you make application for dependent insurance:

    (a) after thirty-one (31) days from the date the dependent first becomes eligible for this insurance; and

(b) after a prior termination of insurance as long as you remain in a class eligible for dependent insurance.

Applicable to Option 1: After this Insurance is in force for one dependent, application is not required for added dependents.

For dependents who are confined in a hospital or at home on the date on which they would otherwise become insured, insurance will be effective as of the date the confinement ends.

TERMINATION OF DEPENDENT LIFE INSURANCE

The insurance for an Insured Dependent will terminate on the first of the following dates:

(1) the date this Section terminates; or

(2) the date the dependent is no longer a Dependent as defined; or

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

(4) the date your insurance terminates; or

(5) the date you retire.

CONVERSION OF DEPENDENT LIFE INSURANCE

If the insurance of an Insured Dependent terminates because:

(1) you terminate employment or membership in the classes eligible for this insurance; or

(2) you die; or

(3) the dependent ceases to be eligible for this insurance;

then the dependent may convert his/her insurance to an individual policy. The conversion is subject to the following rules:

(1) a written application for the conversion policy must be received by us within thirty-one (31) days after the dependent's insurance terminates. The first premium must be sent in with the

application; and

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

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

(4) proof of good health is not required; and

(5) the policy issued will be for an amount not over what the dependent had before termination under the Policy; and

(6) the policy issued will not have disability or supplemental benefits.

If the dependent's insurance ceases due to termination or amendment of the Policy, an individual policy can be issued. The dependent must have been insured for at least five (5) years under the Policy. The same rules as shown above will be used, except that the face amount will be the lesser of:

(1) the amount of dependent life insurance under the Policy. This amount will be less any amount of group life insurance the dependent receives or becomes eligible for within thirty-one (31) days after the Policy terminates; or

(2) $2,000.

If an Insured Dependent should die during the time in which he/she is entitled to apply for an individual policy, we will pay the benefit under the Group Policy that he/she was entitled to convert. This will be done whether or not the dependent applied for the individual policy.

Any individual policy issued with respect to this section will be effective at the end of the thirty-one (31) day period in which application must be made.

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

Family and Medical Leave of Absence:

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

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

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

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

Military Services Leave of Absence:

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

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

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

While you are on a Family and Medical Leave of Absence for any reason other than your own illness, injury or disability or Military Services Leave of Absence you will be considered Actively at Work. Any changes such as revisions to coverage due to age, class or salary changes, as

applicable, will apply during the leave except that increases in the amount of insurance, whether automatic or subject to election, will not be effective if you are not considered Actively at Work until you have returned to Active Work for one (1) full day.

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

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

(1) the date the Policy terminates; or
(2) the end of the period for which premium has been paid for you; or
(3) the date such leave should end in accordance with the Policyholder's policies regarding Family and Medical Leave of Absence and Military Services Leave of Absence in compliance with the Family and Medical Leave Act of 1993, as amended and USERRA.

Should the Policyholder choose not to continue your coverage during a Family and Medical Leave of Absence and/or Military Services Leave of Absence, your coverage as well as any dependent coverage, if applicable, will be reinstated.

PORTABILITY

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

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

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

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

whichever is less.

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

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

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

(1) the end of the period for which premium has been paid; or
(2) the date you are covered under another group term life insurance policy; or
(3) the date you reach age 65.

(4) at any time coverage would normally terminate according to the terms of the Policy had the Insured continued to be an eligible Person.

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

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

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

GROUP TERM LIFE INSURANCE ACCELERATED BENEFIT RIDER

THIS RIDER ADDS AN ACCELERATED BENEFIT PROVISION. RECEIPT OF THIS ACCELERATED BENEFIT WILL REDUCE THE DEATH BENEFIT. THE ACCELERATION OF LIFE INSURANCE BENEFITS OFFERED UNDER THIS RIDER IS INTENDED TO QUALIFY FOR FAVORABLE TAX TREATMENT UNDER THE INTERNAL REVENUE CODE OF 1986. IF THE ACCELERATION OF LIFE INSURANCE BENEFITS IS TAX-QUALIFIED UNDER THE INTERNAL REVENUE CODE OF 1986, THE BENEFITS WILL NOT BE TAXABLE. TAX LAWS RELATING TO ACCELERATION OF LIFE INSURANCE BENEFITS ARE COMPLEX. THE INSURED IS ADVISED TO CONSULT WITH A QUALIFIED TAX ADVISOR ABOUT THE TAX CONSEQUENCES OF OBTAINING ACCELERATION OF LIFE INSURANCE BENEFITS.

RECEIPT OF ACCELERATION OF LIFE INSURANCE BENEFITS MAY AFFECT YOUR, YOUR SPOUSE OR YOUR FAMILY'S ELIGIBILITY FOR PUBLIC ASSISTANCE PROGRAMS SUCH AS MEDICAL ASSISTANCE (MEDICAID), AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC), SUPPLEMENTARY SOCIAL SECURITY INCOME (SSI), AND DRUG ASSISTANCE PROGRAMS. YOU ARE ADVISED TO CONSULT WITH A QUALIFIED TAX ADVISOR AND WITH SOCIAL SERVICE AGENCIES CONCERNING HOW RECEIPT OF SUCH A PAYMENT WILL AFFECT YOU, YOUR SPOUSE AND YOUR FAMILY'S ELIGIBILITY FOR PUBLIC ASSISTANCE.

Attached to Group Policy Number: GL 668871
Issued to Group Policyholder: Lubbock County Hospital dba University Medical Center

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

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

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

"Certificate" means the document, issued to each Insured, which explains

the terms of his coverage under the Group Life Insurance Policy.

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

"Insured" means only a primary Insured. Dependents are not eligible for coverage under this Accelerated Benefit Rider.

"Physician" means a duly licensed practitioner, acting within the scope of his license, who is recognized by the law of the state in which diagnosis is received. The Physician may not be the Insured or a member of his immediate family.

"Policy" means the Group Life Insurance Policy issued to the Group Policyholder under which the Insured is covered.

"Terminally Ill" or "Terminal Illness" refers to an Insured's illness or physical condition that is Certified by a Physician to reasonably be expected to result in death in 24 months or less.

"Written Request" means a request made, in writing, by the Insured to us.

All pronouns include either gender unless the context indicates otherwise.

DESCRIPTION OF COVERAGE: This benefit is payable to the Insured if, after having been covered under this Rider for at least 60 days, an Insured is Certified as Terminally Ill. In order for this benefit to be paid:

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

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

We may, at our option, confirm the terminal diagnosis with a second medical exam performed at our own expense. If the second medical exam produces a conflicting diagnosis, we would arrange for a third medical exam to be performed at our own expense. The initial terminal diagnosis would then be honored only if it is confirmed by the third opinion.

AMOUNT OF THE ACCELERATED BENEFIT: The Accelerated Benefit will be an amount equal to 75% of the Death Benefit applicable to the Insured under the Policy on the date of the Certification of Terminal Illness, subject to a maximum benefit of $500,000. This benefit may be paid as a single lump sum. The Accelerated Benefit is payable one time only for any Insured under this Rider.

EFFECT OF BENEFIT: If an Insured becomes eligible for, and elects to receive this benefit, it will have the following effects:

(1) The Death Benefit payable for such Insured will be reduced by an amount equal to the Accelerated Benefit paid to such Insured. The amount of the Accelerated Benefit plus the corresponding Death Benefit will not exceed the amount that would have been paid as the Death Benefit in the absence of this Rider.

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

If the Insured elects to receive the Accelerated Benefit, we will send him (and any irrevocable beneficiary) a statement showing the effect that payment of this benefit will have on the death benefit.

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

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

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

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

(3) the date he attains age 75.

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

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

Secretary

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE, ACCIDENT, HEALTH AND HOSPITAL SERVICE INSURANCE GUARANTY ASSOCIATION
(For insurers declared insolvent or impaired on or after September 1, 2005)

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association (the "Association"), to protect policyholders if their life or health insurance company fails. Only the policyholders of insurance companies which are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

It is possible that the Association may not cover your policy in full or in part due to statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas at the time **(irrespective of the policyholder's residency at policy issue)**
- Residents of other states, ONLY if the following conditions are met:

    1. The policyholder has a policy with a company domiciled in Texas;
    2. The policyholder's state of residence has a similar guaranty association; and
    3. The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, and $200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on any one life; or
- Death benefits up to a total of $300,000 under one or more policies on any one life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of $100,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to $100,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

Insurance companies and agents are prohibited by law from using the existence of the association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on coverage by the Association.

Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association
6504 Bridge Point Parkway, Suite 450
Austin, Texas 78730
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.state.tx.us

LRS-8785-0907

Claim Procedures

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

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. 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

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. 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

5. 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.

RELIANCE STANDARD
Life Insurance Company

a DELPHI company

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

GL 668871
Ed. 4/2011