RELIANCE STANDARD LIFE INSURANCE COMPANY

GROUP LIMITED WEEKLY INCOME INSURANCE

OUTLINE OF COVERAGE

(1) Read This Policy Carefully -- This outline of coverage provides a very brief description of the important features of this policy. This is not the insurance contract and only the actual policy provisions will control. This policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ THIS POLICY CAREFULLY!**

(2) Group Limited Weekly Income Insurance -- Policies of this category are designed to provide, to persons insured, limited or supplemental coverage.

(3) Please refer to the Schedule of Benefits for a specific description of the benefits, including dollar amounts, and the contributions required, if any, contained in this policy.

(4) Please refer to the Limited Weekly Income Coverage page for a description of exclusions and the Limitation page for limitations on the benefits in this policy.

(5) Please refer to the Individual Eligibility provisions for a description of the reinstatement provisions and the Premium provisions for a description of when we have the right to change premiums.

RELIANCE STANDARD
LIFE INSURANCE COMPANY

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

POLICYHOLDER: Simon Pearce (US) Inc. **POLICY NUMBER:** STD 166463

EFFECTIVE DATE: October 1, 2018

ANNIVERSARY DATES: January 1, 2019 and each January 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 Vermont 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. The Policy provides benefits for loss of time due to disability from sickness or injury. It insures those eligible persons for the benefits shown on the Schedule of Benefits. The insurance is subject to the terms and conditions of the Policy.

The effective date of the 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 "TERMINATION OF THE POLICY" section of the GENERAL PROVISIONS explains when the insurance can be ended.

The Policy is signed by the President and Secretary.

Secretary

President

GROUP LIMITED WEEKLY INCOME INSURANCE
NON-PARTICIPATING
CONTRIBUTORY

RELIANCE STANDARD LIFE INSURANCE COMPANY
Philadelphia, Pennsylvania

GROUP POLICY NUMBER:	STD 166463	**POLICY EFFECTIVE DATE:**	October 1, 2018
POLICY DELIVERED IN:	Vermont	**ANNIVERSARY DATE:**	January 1st in each year

Application is made to us by: Simon Pearce (US) Inc.

This Application is completed in duplicate, one copy to be 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.

Signed at _____ this _____ day of _____

Policyholder: _____

By: _____
(Signature)

_____
(Title)

Please sign and return.

*BC1COAPSTD 16646310/01/2018*RSL
*BC2COAPSimon Pearce (US) Inc.

RELIANCE STANDARD LIFE INSURANCE COMPANY
Philadelphia, Pennsylvania

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TABLE OF CONTENTS

Page

SCHEDULE OF BENEFITS 1.0

DEFINITIONS 2.0

CERTAIN RESPONSIBILITIES OF THE POLICYHOLDER 3.0

GENERAL PROVISIONS 4.0
- Entire Contract
- Changes
- Incontestability
- Records Maintained
- Clerical Error
- Misstatement of Age
- Not in Lieu of Workers' Compensation
- Conformity With State Laws
- Certificate of Insurance
- Termination of the Policy

CLAIMS PROVISIONS 5.0
- Notice of Claim
- Claim Forms
- Written Proof of Loss
- Payment of Claims
- Physical Examination
- Legal Actions

INDIVIDUAL ELIGIBILITY, EFFECTIVE DATE AND TERMINATION 6.0
- General Group
- Eligible Classes
- Effective Date of Individual Insurance
- Termination of Individual Insurance
- Individual Reinstatement

LIMITED WEEKLY INCOME INSURANCE 7.0
- Benefits Payable
- Period of Disability
- Exclusions

PARTIAL DISABILITY BENEFIT 8.0

TRANSFER OF INSURANCE COVERAGE 9.0

PREMIUMS 10.0
- Premium Payment
- Premium Rate
- Grace Period

LIMITATION 11.0

EXTENSION OF COVERAGE UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA) 12.0

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.

INDIVIDUAL EFFECTIVE DATE: The first of the month following the day the person becomes eligible.

INDIVIDUAL REINSTATEMENT: 6 months

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

LIMITED WEEKLY INCOME BENEFIT

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

INJURY: We will pay benefits from the first day of disability.

SICKNESS: We will pay benefits from the eighth consecutive day of disability.

MAXIMUM BENEFIT PERIOD: Benefits, for one period of disability, will be paid up to a maximum of thirteen (13) weeks.

LIMITED WEEKLY INCOME BENEFIT: The Limited Weekly Income Benefit for each Insured will be 60% of Earnings to a maximum benefit of $750.

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

CHANGES IN LIMITED WEEKLY INCOME BENEFIT: Increases in the benefit amount are effective on 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 on that date, the effective date of the increase in the benefit amount will be deferred until the date the Insured returns to active work. Decreases in the benefit amount are effective on the date the change occurs. However, changes in the benefit amount because of a change in Earnings are effective as explained in the definition of Earnings.

Premium changes due to an Insured's age will occur on the January 1st 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 Weekly Income Benefit amount is due to a life event change (such as marriage, birth or specific changes in employment status), proof of good health will not be required for amounts up to the guaranteed issue amount, provided the Eligible Person applies within thirty-one (31) days of such life event.

APPROVED ENROLLMENT PERIODS

It is your responsibility to provide us with written notice at least thirty-one (31) days prior to conducting an Annual Enrollment Period of the beginning and end dates of such enrollment period. The terms of the Approved Enrollment Period will be as follows:

During an Approved Enrollment Period, applications for employees who were previously eligible and are now applying for initial insurance coverage or for employees who are insured and applying for additional insurance coverage will not require proof of good health, provided:

(1) the application is complete, signed, and received by you during the Approved Enrollment Period;
(2) the employee was not previously declined for group disability insurance coverage by us; and
(3) the employee did not have an application withdrawn or marked as incomplete for any reason.

Insurance coverage applied for during this Approved Enrollment Period will be effective on the January 1st following the Approved Enrollment Period, provided the employee is Actively at work and applicable premium is paid.

CONTRIBUTIONS: Person: 100%

Contributions for the Insured are being made on a post-tax basis. For purposes of filing the Insured's Federal Income Tax Return, this means that under the law as of the date this Policy was issued, the Insured's Limited Weekly Income Benefit might be treated as non-taxable. It is recommended that the Insured contact his/her personal tax advisor.

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.

"Eligible Person" means a person who meets the eligibility requirements of this Policy.

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

"Actively at work" and "active work" means the person 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 such as vacation, jury duty and funeral leave, but does not include time off as a result of Injury or Sickness.

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

"Full-time" means working for you for a minimum of 30 hours during a person's regular work week.

"Disabled" means the Insured is:

(1) unable to do the material duties of his/her job; and

(2) not doing any work for payment; and

(3) under the regular care of a physician.

"Injury" means bodily injury resulting directly from an accident. The injury must cause disability which begins while an Insured is covered under this Policy.

"Earnings" means 1/52 of the amount of wages you paid to the Insured as reported on his/her W-2 form as "Medicare wages and tips" (box 5) for the year just before the date disability began. W-2 earnings includes base pay, commissions, bonuses, overtime pay, 401(k) deferrals, 403(b) deferrals and Section 125 deferrals received from you, but excludes group term life imputed income; allowances, such as, but not limited to, disturbance allowances, relocation allowances, leased car and car allowances; and other special forms of compensation. If the W-2 is for less than a full calendar year, W-2 earnings, as defined above, will be annualized and divided by fifty-two (52).

However, if the Insured was not employed by you in the calendar year just before the date disability began, "Earnings" means the Insured’s basic weekly salary received from you just before the date disability began.

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

"Regular Care" means Treatment that is administered as frequently as is medically required according to guidelines established by nationally recognized authorities, medical research, healthcare organizations, governmental agencies or rehabilitative organizations. Care must be rendered personally by the Insured's Physician according to generally accepted medical standards in the Insured's locality and be necessary to meet his/her basic health needs.

"Retirement" means the effective date of an Insured’s:

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

(2) retirement pension benefits under any plan which you sponsor, or make or have made contributions;

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

Retirement Benefits do not include:

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

"Sickness" means illness or disease causing disability which begins while an Insured is covered under this Policy. Sickness includes pregnancy, childbirth, miscarriage or abortion, or any complications therefrom.

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

CERTAIN RESPONSIBILITIES OF THE POLICYHOLDER

For the purposes of this Policy, you 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 31 days prior to conducting an annual enrollment period.

Compliance With Americans With Disabilities Act (ADA)

It is your responsibility to establish and maintain procedures which comply with the employer responsibilities of the Americans With Disabilities Act of 1990, as amended.

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

A Certificate of Insurance will be provided to you for each Insured 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 and salary 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.

GENERAL PROVISIONS

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

CHANGES: No agent has the authority to change or waive any part of this 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 this 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 on behalf of any Insured 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 is covered. The following rules apply to each statement:

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

   (a) it is in written form signed by the Insured, or on behalf of the Insured; and

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

(2) If the statement relates to an Insured'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 the lifetime of the Insured.

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 an Insured's age is misstated, the premium will be adjusted. If the Insured's insurance is affected by the misstated age, it will also be adjusted. The insurance will be changed to the amount the Insured is entitled to at his/her correct age.

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

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: We will send to you an individual certificate for each Insured. The certificate will outline the insurance coverage and to whom benefits are payable.

TERMINATION OF THE POLICY: 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 if:

(1) the premium is not paid at the end of the grace period; or

(2) the number of Insureds is less than the Minimum Participation Number on the Schedule of Benefits; or

(3) the percentage of eligible persons insured is less than the Minimum Participation Percentage 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) or (3) above, 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, pro-rata, any part of the premium paid beyond the date this Policy is cancelled.

Termination of this Policy will not affect any claim which began prior to termination.

CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice must be given to us within thirty-one (31) days after the loss occurs, or as soon as reasonably possible. The notice should be sent to us at our Administrative Office or to our authorized agent. The notice should include the Insured's name and the Policy Number.

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

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

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

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

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

LEGAL ACTIONS: No legal action may be brought against us to recover on 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 (Kansas, five (5) years; South Carolina, six (6) years) from the time written proof of loss is required to be given.

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.

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 in writing for the insurance to go into effect. He/she will become insured on the date stated on the Schedule of Benefits, except that the insurance will go into effect on the later of:

(1) the first of the month following the date he/she applies, if he/she applies within thirty-one (31) days of the date he/she is first eligible; 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 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 remained in a class eligible for the insurance; or

   (c) after being eligible for coverage under a prior 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 an Insured's amount of insurance are effective as shown on the Schedule of Benefits.

If the 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 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 for the Insured; or

(4) the date the Insured enters military service (not including Reserve or National Guard).

INDIVIDUAL REINSTATEMENT: The insurance of a terminated person may be reinstated if he/she is:

(1) on an approved leave of absence; or

(2) on a temporary lay-off.

The Person 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 Person 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. If a Person returns after having resigned or having been discharged, he/she will be required to fulfill the eligibility requirements of this Policy again.

If a Person returns after terminating at his/her request or for failure to pay premium when due, proof of good health must be approved by us before he/she may be reinstated.

LIMITED WEEKLY INCOME INSURANCE

BENEFITS PAYABLE: We will pay Limited Weekly Income Benefits if an Insured:

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

(2) becomes disabled while insured by this Policy.

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

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

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

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

(1) the Insured is no longer disabled;

(2) all benefits due have been paid; or

(3) the Insured has retired from employment with you.

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

(1) the same or related causes and are not separated by two (2) weeks of active work; or

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

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

(1) an intentionally self-inflicted Injury; or

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

(3) the Insured committing a felony; or

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

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

PARTIAL DISABILITY BENEFIT

We will pay Partial Disability Benefits if:

(1) an Insured is Totally Disabled; and
(2) an Insured accepts Rehabilitative Employment.

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

Partial Disability Benefits will equal the Limited Weekly Income Benefits payable under this Policy but in no event will the sum of:

(1) the Partial Disability Benefit;
(2) income from Rehabilitative Employment; and
(3) income from all Other Sources;

exceed 100% of the Insured's Earnings. If it does, the Partial Disability Benefit will be reduced by one dollar for every dollar the sum exceeds 100%. The Partial Disability Benefit is subject to the Maximum Benefit Period shown in the Schedule of Benefits for any one period of disability.

"Rehabilitative Employment" means working in any gainful occupation for which the Insured's training, education or experience will reasonably allow. The Rehabilitative Employment and a plan of rehabilitation must be supervised by a Physician or licensed rehabilitation specialist, and both must be approved by us. Rehabilitative Employment includes the Insured performing all of the material duties of his/her regular occupation on a part-time basis or some of the material duties on a full-time basis. It does not include performing all of the material duties of his/her regular occupation on a full-time basis.

"Totally Disabled", for the purpose of this Partial Disability Benefit only, means that the Insured is unable to perform the material duties of his/her own job and is under the regular care of a Physician.

"Other Sources" include benefits resulting from the same disability for which benefits are payable under this Policy, other than Retirement benefits. These Other Sources include:

(1) disability income benefits an Insured is eligible to receive under any group insurance plan;
(2) disability income benefits an Insured is eligible to receive under any governmental retirement system, except benefits payable under a federal government employee pension benefit;
(3) all permanent as well as temporary disability benefits, including any damages or settlement made in place of such benefits (whether or not liability is admitted), an Insured is eligible to receive under:
    (a) Workers' Compensation Laws;
    (b) occupational disease laws;
    (c) any other laws of like intent as (a) or (b) above; and
    (d) any compulsory benefit law;
(4) any of the following that the Insured is eligible to receive:
    (a) any formal salary continuance plan;
    (b) wages, excluding the amount allowed under this Partial Disability Benefit; and
    (c) commissions or monies, including vested renewal commission, but excluding commissions or monies that the Insured earned prior to disability which are paid after disability has begun;
(5) that part of disability or Retirement benefits paid for by you that an Insured is eligible to receive under a group retirement plan; and
(6) disability or Retirement benefits under the United States Social Security Act, the Canadian pension plans, federal or provincial plans, or any similar law which:
    (a) an Insured is eligible to receive because of his/her disability or eligibility for Retirement benefits; and
    (b) an Insured's dependents are eligible to receive due to (a) above.

TRANSFER OF INSURANCE COVERAGE

If an employee was covered under any group limited weekly income insurance plan maintained by you prior to this Policy's effective date, that employee will be insured under this Policy, provided that he/she is Actively At Work and meets all of the requirements for being an Eligible Person under this Policy on its effective date.

If an employee was covered under the prior group limited weekly income disability plan maintained by you prior to this Policy's Effective Date, but was not Actively at Work due to Injury or Sickness on the Effective Date of this Policy and would otherwise qualify as an Eligible Person, coverage will be allowed under the following conditions:

(1) The employee must have been insured with the prior carrier on the date of the transfer;
(2) Premiums must be paid; and
(3) Disability must begin on or after this Policy's Effective Date.

If an employee is receiving limited weekly income benefits, becomes eligible for coverage under another group limited weekly income disability insurance plan, or has a period of recurrent disability under the prior group limited weekly income insurance plan, that employee will not be covered under this Policy. If premiums have been paid on the employee's behalf under this Policy, those premiums will be refunded.

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 RATE: The Premium due will be the rate per $10.00 of benefit multiplied by the entire amount of benefit then in force. We will furnish to you the premium rate on the Policy effective date and when it is changed. We have the right to change the premium rate:

(1) on any premium due date after this Policy is in force for twenty-seven (27) month(s);

(2) when the extent of coverage is changed by amendment; or

(3) on any Premium Due Date on or after the first Policy Anniversary if your entire group's benefit changes by 15% or more from such group's benefit on the last Policy Anniversary.

We will not change the premium rate due to (1) or (3) 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 (1) or (3) above.

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.

LIMITATION

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

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

a Pre-existing Condition unless the Insured has been actively at work for one (1) full day following the end of twelve (12) consecutive months from the date of the increase.

"Pre-existing Condition" means any Sickness or Injury for which the Insured received medical treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines, during the three (3) months immediately prior to the effective date of the increase.

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

Military Services Leave of Absence:

We will continue the Insured's coverage in accordance with your policies regarding Military Services Leave of Absence under USERRA if the premium for such Insured 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.

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 Military Services Leave of Absence he or she 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 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 USERRA will run concurrently with any other applicable continuation of insurance provision in this Policy.

The Insured's coverage 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 Military Services Leave of Absence in compliance with USERRA. Coverage will not be terminated for an Insured who becomes Disabled during the period of the leave and who is eligible for benefits according to the terms of this Policy. Any Weekly Benefit which becomes payable will be based on the Insured's Earnings immediately prior to the date of Disability.

Should you choose not to continue the Insured's coverage during a Military Services Leave of Absence, the Insured's coverage will be reinstated.

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

CLAIMS FOR BENEFITS

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

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

Claim forms are available from your benefits representative or may be requested by writing to the above address or by calling 1-800-866-2301.

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

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION

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

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

extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

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

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

Disability Benefit Claims
A claimant shall be provided with written notification of any Adverse Benefit Determination. The notification shall be set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an Adverse Benefit Determination on review; and
5. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
   a) The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
   b) The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination; and
   c) A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;
6. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist;
7. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant (defined below) to a claim for benefits; and
8. The notification shall be provided in a Culturally and Linguistically Appropriate (defined below) manner.

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

Appeals of Adverse Benefit Determinations may be submitted in accordance with the following procedures to:

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

Non-Disability Benefit Claims
1. Claimants (or their authorized representatives) must appeal within 60 days following their receipt of a notification of an Adverse Benefit Determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant (defined below) to the claimant's claim for benefits;
4. The review on (timely) appeal shall take into account all comments, documents, records, and other information

submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
5. No deference to the initial Adverse Benefit Determination shall be afforded upon appeal;
6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual; and
7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant's Adverse Benefit Determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination.

Disability Benefit Claims
1. Claimants (or their authorized representatives) must appeal within 180 days following their receipt of a notification of an Adverse Benefit Determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant (defined below) to the claimant's claim for benefits;
4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
5. No deference to the initial Adverse Benefit Determination shall be afforded upon appeal;
6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant's Adverse Benefit Determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination; 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 (define below) to the claimant's claim for benefits; and
4. A statement of the claimant's right to bring an action under section 502(a) of ERISA (where applicable).

Disability Benefit Claims

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

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant (defined below) to the claimant's claim for benefits;
4. A statement of the claimant's right to bring an action under section 502(a) of ERISA (where applicable) as well as a description of any applicable contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim;
5. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
    a) The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
    b) The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination; and
    c) A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;
6. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist;
7. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant (defined below) to a claim for benefits; and
8. The notification shall be provided in a Culturally and Linguistically Appropriate (defined above) manner.

REQUESTS CONCERNING ALLEGED VIOLATION OF THESE PROCEDURES

In the event that a claimant requests a written explanation of any alleged violation of these procedures, such explanation should be provided within 10 days, including a specific description of any basis for asserting that any violation should not cause any administrative remedies available under the plan to be exhausted (where applicable).

DEFINITIONS

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

The term "Culturally and Linguistically Appropriate Manner" means:

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

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

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

The term “Relevant” means:

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

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

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

ERISA STATEMENT OF RIGHTS

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

Receive Information About Your Plan and Benefits

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and

updated summary plan description. The Administrator may make a reasonable charge for the copies.

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

Prudent Actions by Plan Fiduciaries

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

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

Enforce Your Rights

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

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

Assistance with Your Questions

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