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**GROUP LIFE AND ACCIDENTAL DEATH  
AND DISMEMBERMENT INSURANCE  
PROGRAM**

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**University of California Regents**



# **GROUP LIFE INSURANCE**



## CERTIFICATE OF INSURANCE

We certify that you (provided you belong to a class described on the Schedule of Benefits) are insured, for the benefits which apply to your class, under Group Policy No. GL 96,000 issued to The RSL Group and Blanket Insurance Trust, the Policyholder, covering eligible persons of University of California Regents (herein called the Participating Unit), under Participating Unit No. GL 140685.

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

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

  
Secretary

  
President

### GROUP LIFE INSURANCE CERTIFICATE

This Group Life Certificate amends all previous Group Life Certificates and is dated April 25, 2007.

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## SCHEDULE OF BENEFITS

**EFFECTIVE DATE:** July 1, 2006

**ELIGIBLE CLASSES:** Each active, Full-time resident or clinical fellow enrolled in the Graduate Medical Education Training Program, or a fellow enrolled in UCSF Title Code 3370 at the University of California, San Francisco, except any person employed on a temporary or seasonal basis.

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

**INDIVIDUAL REINSTATEMENT:** 6 months

### **AMOUNT OF INSURANCE:**

**Basic Life:** \$50,000.

The Amount of Basic Life Insurance will be: (1) reduced to 65% of the pre-age 65 amount at age 65; (2) further reduced to 45% of the pre-age 65 amount at age 70; and (3) further reduced to 35% of the pre-age 65 amount at age 75.

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

**CHANGES IN AMOUNT OF INSURANCE:** Changes in the Amount of Insurance because of changes in age, class or earnings (if applicable) are effective on the first of the Policy month coinciding with or next following the date of the change, provided you are 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.

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

## DEFINITIONS

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

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

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

"Full-time" means working for the Participating Unit for a minimum of 20 hours during your regularly scheduled work week.

"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 Participating Unit;
- (2) retirement pension benefits under any plan which the Participating Unit 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.

"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.

## **GENERAL PROVISIONS**

### **INCONTESTABILITY**

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

- (1) No statement will be used in a contest unless:
  - (a) it is in a written form signed by you, or on your behalf; and
  - (b) a copy of such written instrument is or has been furnished to you, your beneficiary or legal representative.
- (2) If the statement relates to your insurability, it will not be used to contest the validity of insurance which has been in force, before the contest, for at least two (2) years during your lifetime.

### **ASSIGNMENT**

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

## EFFECTIVE DATE AND TERMINATION

**EFFECTIVE DATE OF INSURANCE:** Your insurance will go into effect on the date stated on the Schedule of Benefits.

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 last day of the Policy month in which you cease to be in a class eligible for this insurance; or
- (3) the date the Participating Unit's coverage terminates under the Policy; or
- (4) the end of the period for which premium has been paid for you; or
- (5) 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.

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 return after having resigned or having been discharged, you will be required to fulfill the eligibility requirements of the Policy again.

If you return after terminating at your 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 Participating Unit'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 with respect to the Participating Unit, 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) \$5,000.
  
- C. If the insurance reduces, as may be provided in the Policy, an individual Life Insurance Policy can be issued. The same rules as in A above will be used, except that the face amount will not be greater than the amount which ceased due to the reduction.
  
- D. If you die during the time 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 \$2,500 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, with respect to the Participating Unit;
- (4) the Total Disability lasts for at least 6 months;
- (5) the premium continues to be paid; and
- (6) we receive proof of Total Disability within one (1) year from the date it began.

After proof of Total Disability is approved by us, neither you or the Participating Unit 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 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 70; 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.

If you qualify for benefits in accordance with the Waiver of Premium in Event of Total Disability provision because you have been diagnosed by a Physician as totally disabled due to the following Condition(s) or Procedure(s), as later defined;

- (1) Life Threatening Cancer; or
- (2) Heart Attack (Myocardial Infarction); or
- (3) Kidney (Renal) Failure; or
- (4) Receipt of Major Organ Transplant; or
- (5) Stroke,

we will pay you an additional, one time, lump sum benefit in an amount equal to 10% of the death benefit under the basic life portion of this Policy up to a maximum of \$100,000.

This lump sum benefit applies only to the first Condition or Procedure to occur among those hereinafter defined which qualifies you for waiver of premium benefits. No further lump sum benefits will be payable under this provision during the same or any subsequent periods of Total Disability, or as a result of the occurrence of any other Condition or Procedure.

Definition(s):

“Condition(s) or Procedure(s)” mean only the following:

“Life Threatening Cancer” means a malignant neoplasm (including hematologic malignancy), as diagnosed by a Physician who is a board certified oncologist, and which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue, and which is not specifically excluded. The following types of cancer are not considered a Life Threatening Cancer: (1) early prostate cancer diagnosed as T2c or less according to the TNM scale; (2) colorectal cancer diagnosed as T2, N1, M0 or less according to the TNM scale; (3) breast cancer diagnosed as T3, N2, M0 or less according to the TNM scale; (4) First Carcinoma in Situ; (5) pre-malignant lesions (such as intraepithelial neoplasia); (6) brain glioma; (7) benign tumors or polyps; (8) tumors in the presence of the Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS); or (9) any skin cancer other than invasive malignant melanoma in the dermis or deeper, or skin

malignancies that have become Life Threatening Cancers.

“First Carcinoma in Situ” means the first diagnosis of cancer in which the tumor cells still lie within the tissue of the site of origin without having invaded neighboring tissue. First Carcinoma in Situ must be diagnosed pursuant to a pathological diagnosis or clinical diagnosis.

“Heart Attack (Myocardial Infarction)” means the death of a segment of the heart muscle as a result of a blockage of one or more coronary arteries. In order to be covered under this provision, the diagnosis by a Physician of Heart Attack (Myocardial Infarction) must be based on:

- (1) new electrocardiographic changes consistent with and supporting a diagnosis of Heart Attack (Myocardial Infarction); and
- (2) a concurrent diagnostic elevation of cardiac enzymes; and
- (3) therapeutic and functional classifications, 3 or above and C or above respectively, according to the New York Heart Association.

“Kidney (Renal) Failure” means the chronic irreversible failure of both of the kidneys (end stage renal disease), which requires treatment with dialysis on a regular basis. Kidney Failure is covered under this provision only if the diagnosis has been made by a Physician who is a board certified nephrologist.

“Physician” means a duly licensed practitioner who is recognized by the law of the jurisdiction in which treatment is received as qualified to treat the type of condition for which claim is made. The Physician may not be you or a member of your immediate family and must be approved by us.

“Receipt of Major Organ Transplant” means that you have been the recipient of a major organ transplant and that there is clinical evidence of major organ(s) failure which, according to the diagnosis of a Physician, required your failing organ(s) or tissue to be replaced with organ(s) or tissue from a suitable donor under generally accepted medical procedures. Organs or tissues covered by this definition are limited to liver, kidney, lung, entire heart, pancreas, or pancreas-kidney.

“Stroke” means a cerebrovascular accident or infarction (death) of brain tissue, as diagnosed by a Physician, which is caused by hemorrhage, embolism, or thrombosis producing measurable, neurological deficit persisting for at least one hundred eighty (180) days following the occurrence of the Stroke. Stroke does not include Transient Ischemic

Attack (TIA) or other cerebral vascular events.

Receipt of this additional lump sum payment may be taxable. You should seek assistance from your own personal tax advisor.

## CLAIM 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 Participating Unit 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.

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

**PHYSICAL EXAMINATION:** 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, six (6) years) from the time written proof of loss is required to be submitted.

## **FAMILY AND MEDICAL LEAVE OF ABSENCE EXTENSION**

We will allow your coverage to continue for up to 12 weeks in a 12 month period, if you are eligible for, and the Participating Unit has approved, a Family and Medical Leave of Absence under the terms of the Family and Medical Leave Act of 1993 for any of the following reasons:

- (1) To provide care after the birth of a son or daughter; or
- (2) To provide care for a son or daughter upon legal adoption; or
- (3) To provide care after the placement of a foster child in your home; or
- (4) To provide care to a spouse, son, daughter, or parent due to serious illness; or
- (5) To take care of your own serious health condition as explained below.

If you, due to your own serious health condition, meet the definition of Total Disability in the Policy, you will be considered Totally Disabled and eligible for Waiver of Premium benefits according to the Waiver of Premium in Event of Total Disability provision. If you, due to your own serious health condition, are on a Family and Medical Leave of Absence, but not eligible for Waiver of Premium benefits under the Policy, insurance coverage will be continued under this extension.

You will not qualify for the Family and Medical Leave of Absence Extension unless we have received proof from the Participating Unit, in a form satisfactory to us, that you have been granted a leave under the terms of the Family and Medical Leave Act of 1993. Such proof: (1) must outline the terms of your leave; and (2) give the date the leave began; and (3) the date it is expected to end; and (4) must be received by us within thirty-one (31) days after a claim for benefits has been filed with us.

If the Participating Unit grants you a Family and Medical Leave of Absence, the following applies to you:

- (1) While you are on an approved Family and Medical Leave of Absence, the required premium must be paid according to the terms specified in the Policy to keep the insurance in force.
- (2) Coverage will terminate for you if you do not return to work as scheduled according to the terms of your agreement with the Participating Unit; however, you are eligible to convert your coverage under the Conversion Privilege. In no case will

coverage be extended under this benefit beyond 12 weeks in a 12 month period. Insurance will not be terminated for you if you become Totally Disabled during the period of the leave and are eligible for Waiver of Premium benefits, if any, according to the terms of the Policy.

- (3) This extension is not available if you convert your coverage under the Conversion Privilege.
- (4) While you are on an approved Family and Medical Leave of Absence, you will be considered Actively at Work in all instances unless such leave is due to your own illness, injury, or disability. Changes such as revisions to coverage because of age, class or salary changes will apply during the leave except that increases in amount of insurance, whether automatic or subject to election, are not effective for you while you are not Actively at Work until such time you return to Active Work for one full day.

All other terms and conditions of the Policy will remain in force while you are on an approved Family and Medical Leave of Absence.

## **MILITARY SERVICES LEAVE OF ABSENCE COVERAGE**

We will allow your coverage to continue for up to twelve (12) weeks in a twelve (12) month period, if you enter the military service of the United States. While you are on a Military Services Leave of Absence, the required premium must be paid according to the terms specified in the Policy to keep the insurance in force. Changes such as revisions to coverage because of age, class or salary changes will apply during the leave except that increases in amount of insurance, whether automatic or subject to election, are not effective for you until you have returned to work from Military Services Leave of Absence for one full day. All other terms and conditions of the Policy will remain in force during this continuation period. Your continued coverage will cease on the earliest of the following dates:

- (1) the date the Policy, with respect to the Participating Unit, terminates; or
- (2) the date ending the last period for which any required premium was paid; or
- (3) twelve (12) weeks from the date your continued coverage began.

The Policy, however, does not cover any loss which occurs while you are on active duty in the military service if such loss is caused by or arises out of such military service, including but not limited to war or act of war (whether declared or undeclared).

## PORTABILITY

You may continue insurance coverage under the Policy if coverage would otherwise terminate because you cease to be an Eligible Person, for reasons other than the termination of the Participating Unit, or your retirement, 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 considered Totally Disabled under the Waiver of Premium in Event of Total Disability provision, if applicable; and
- (4) have been covered for twelve (12) months under the Policy.

Such coverage may be continued for a period of 2 years beginning on the date you are no longer an Eligible Person.

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

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

whichever is less.

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

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

Insurance coverage continued under this provision for you will terminate on the first of the following to occur:

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

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

If insurance coverage terminates due to (1) or (4) 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 LIVING BENEFIT RIDER

**THIS RIDER ADDS AN ACCELERATED BENEFIT PROVISION. RECEIPT OF THIS ACCELERATED BENEFIT WILL REDUCE THE DEATH BENEFIT AND MAY BE TAXABLE. INSUREDS SHOULD SEEK ASSISTANCE FROM THEIR PERSONAL TAX ADVISOR.**

Attached to Group Policy Number: GL 96,000

Issued to Group Policyholder: The RSL Group and Blanket Insurance Trust

Participating Unit: University of California Regents

Participating Unit Number: GL 140685

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. 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 Living 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 less than 12 months.

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

All pronouns include either gender unless the context indicates otherwise.

**DESCRIPTION OF COVERAGE:** This benefit is payable to the Insured if, 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.

**AMOUNT OF THE LIVING BENEFIT:** The Living 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 Living 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 Living Benefit paid to such Insured. The amount of the Living Benefit plus the corresponding Death Benefit will not exceed the amount that would have been paid as the Death Benefit in the absence of this Rider.
- (2) Any amount of insurance that would otherwise be continued under a Waiver of Premium provision will be reduced proportionately, as will the maximum Face Amount available under the Conversion Privilege.


**MISSTATEMENT OF AGE OR SEX:** The Living 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 Living 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, with respect to the Participating Unit, 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

**GROUP ACCIDENTAL DEATH AND  
DISMEMBERMENT INSURANCE**



## CERTIFICATE OF INSURANCE

**POLICYHOLDER:** The RSL Group and Blanket Insurance Trust

**GROUP POLICY NUMBER:** VAR 55,000

**POLICY EFFECTIVE DATE:** January 1, 1993

**PARTICIPATING UNIT:** University of California Regents

**PARTICIPATING UNIT NUMBER:** VAR 203620

**PARTICIPATING UNIT EFFECTIVE DATE:** July 1, 2006

Subject to the terms of the Group Policy, we certify that you are insured for the benefits which apply to your class as described on the Schedule of Benefits, provided you are an Insured Person, as defined. The Group Policy and Participating Unit Numbers, Policyholder, Participating Unit Name, and Policy and Participating Unit Effective Dates are listed above.

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.

This Certificate is signed by our President and Secretary.

  
Secretary

  
President

## GROUP ACCIDENT CERTIFICATE

This Group Accident Certificate amends the previous Group Accident Certificates and is dated April 25, 2007.

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## SCHEDULE OF BENEFITS

**ELIGIBILITY:** Each active, Full-time resident or clinical fellow enrolled in the Graduate Medical Education Training Program, or a fellow enrolled in UCSF Title Code 3370 at the University of California, San Francisco, except any person employed on a temporary or seasonal basis.

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

**INDIVIDUAL REINSTATEMENT:** 6 months

**AMOUNT OF INSURANCE:      PRINCIPAL SUM:**

INSURED PERSONS:

\$50,000

The Amount of Principal Sum will be:

- (1) reduced to 65% of the pre-age 65 amount at age 65;
- (2) further reduced to 45% of the pre-age 65 amount at age 70; and
- (3) further reduced to 35% of the pre-age 65 amount at age 75.

**CHANGES IN AMOUNT OF INSURANCE:** Changes in the Amount of Insurance because of a change in age or class are effective on the first of the Policy month coinciding with or next following the date of the change, provided that if you are not Actively at Work on the date an increase would otherwise take effect for you, such increase will not take effect until the date you return to active work.

**CONTRIBUTIONS:** You are not required to contribute toward the cost of your insurance coverage.

## DEFINITIONS

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

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

"Full-time" means working for the Participating Unit for a minimum of 20 hours during a person's regularly scheduled work week.

"Insured Person" means a person who meets the Eligibility requirements of the Policy and is enrolled for this insurance, and whose insurance under the Policy is in effect.

"Insured" means an Insured Person unless the context indicates otherwise.

"Injury" means accidental bodily injury to an Insured which is caused directly and independently of all other causes by accidental means and which occurs while the Insured's coverage under the Policy is in force.

"Participating Unit", shall also include an associated or affiliated company, when referring to premium payments; Active Work; Full-time work.

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

"You", "your", and "yours" means the Insured Person.

## GENERAL PROVISIONS

**CHANGES:** No agent has authority to change or waive any part of the Policy. To be valid, any change or waiver must be in writing, signed by a President, Vice President or Secretary and attached to the Policy.

**INCONTESTABILITY:** Any statements made by the Participating Unit, any Insured Person, or on behalf of any Insured Person 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 a contest unless:
  - (a) it is in a written form signed by you, or on your behalf; and
  - (b) a copy of such written instrument is or has been furnished to you, or your beneficiary or legal representative.
- (2) If the statement relates to your insurability, it will not be used to contest the validity of insurance which has been in force, before the contest, for at least two years during your lifetime.

**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.

**CLERICAL ERROR:** Clerical errors in connection with the Policy or delays in keeping records for the Policy, whether by the Participating Unit, 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 has been misstated, benefits will be those that apply to his correct age.

**NOT IN LIEU OF WORKER'S COMPENSATION:** The Policy is not a Worker's Compensation Policy. It does not provide Worker's Compensation benefits.

**PRONOUNS:** All pronouns include either gender unless the context indicates otherwise.

## **INDIVIDUAL ELIGIBILITY, EFFECTIVE DATE AND TERMINATION**

**EFFECTIVE DATE OF INDIVIDUAL INSURANCE:** Your insurance will go into effect on the Individual Effective Date as shown on the Schedule of Benefits.

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

Changes in your amount of insurance are effective as shown on the Schedule of Benefits.

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

- (1) the date the Policy terminates; or
- (2) the date the Participating Unit ceases to be a Participating Unit under the Policy; or
- (3) the last day of the Policy month in which you cease to be in a class eligible for this insurance; or
- (4) the end of the period for which premium has been paid for your coverage.

Any loss which occurs prior to the termination of this insurance coverage will not be affected.

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

- (1) 12 months, if you cease to be eligible due to illness or Injury; or
- (2) 1 month, if you cease to be eligible due to temporary lay-off or approved leave of absence.

**INDIVIDUAL REINSTATEMENT:** If your coverage is terminated, it may be reinstated if you are:

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

You must return to Active Work with the Participating Unit within the period of time shown on the Schedule of Benefits (INDIVIDUAL REINSTATEMENT). You must also be a member of a class eligible for this insurance.

Unless you are returning after having resigned or having been discharged, you will not be required to fulfill the eligibility requirements of the Policy again. The insurance will go into effect on the date you return to Active Work.

## CONVERSION PRIVILEGE

You can use this privilege when your Accidental Death and Dismemberment insurance coverage is no longer in force for any reason, except termination of the group Policy or termination of a Participating Unit's coverage under the Policy. Written application for the converted policy must be made within 31 days after coverage ends. The first premium must also be paid within that time. The issuance of the converted policy is subject to the following conditions:

- (1) the converted policy will take effect on the date of the termination of this insurance, or on the date of application for the converted policy, whichever is later;
- (2) proof of health will not be required; and
- (3) the premium will be applicable to the class of risk to which the Insured belongs, at his attained age, and to the form and amount of insurance provided.

The converted policy's Principal Sum will be the lower of:

- (1) the Amount of Principal Sum applicable to the Insured under the Policy; or
- (2) \$250,000.

The converted policy may provide that it will be renewable on any anniversary with our consent, subject to a maximum age limit.

The converted policy may exclude any condition or hazard which applied to the Insured at the time coverage terminated. Benefits will not be paid under the converted policy for a claim originating under the Policy.

The Insured may convert to any individual Accidental Death and Dismemberment policy we offer in the state where he lives.

## **BENEFICIARY AND FACILITY OF PAYMENT**

**BENEFICIARY:** If you die, any death benefit payable and any other accrued benefits will be paid to the beneficiary named in records maintained by the Participating Unit, or if none, to the beneficiary named to receive the proceeds of the basic Group Life policy issued to the Participating Unit. Benefits will not be paid to the Participating Unit or an officer of the Participating Unit. A beneficiary designation will be effective as of the date you signed it. Any payment made by us before receiving the designation shall fully discharge us to the extent of that payment.

You can change the beneficiary by telling us in writing on our form. The consent of a revocable beneficiary is not needed. The change will take effect only when it is received and approved by us or an authorized Plan Administrator. We cannot attest to the validity of such a change.

If an Insured's beneficiary dies at the same time as the Insured, or within 15 days after his death but before we receive written proof of the Insured's death, payment will be made as if the Insured survived the beneficiary, unless noted otherwise in another provision of this Certificate.

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

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

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

If the Insured has not named a beneficiary or the beneficiary is not surviving at the Insured's death, we may pay up to \$2,500 of the benefit to the person(s) who, in our opinion, has incurred expenses in connection with the Insured's last illness, death or burial. Payment may also be made to the executor or administrator of the Insured's estate, or to any relative of the Insured by blood or marriage.

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.

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

## CLAIMS PROVISIONS

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

**TIME 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 accordingly.

**PAYMENT OF CLAIMS:** If you die, we will pay any death benefit and any other accrued benefits in accordance with the Beneficiary and Facility of Payment provisions. All other benefits will be paid to you.

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

**PHYSICAL EXAMINATION AND AUTOPSY:** We have the right to have a doctor of our choice examine the Insured as often as we think necessary. This section applies while a claim is pending or while we are paying benefits. We also have the right to make an autopsy in case of death, unless the law forbids it. We will pay for the cost of both the examination and the autopsy.

**LEGAL ACTION:** No lawsuit or action in equity can be brought to recover on the Policy:

- (1) before 60 days following the date written proof of loss was furnished to us; or
- (2) after 3 years following the date written proof of loss is required (6 years in South Carolina and 5 years in Kansas).

## SETTLEMENT OPTIONS

You may elect a single sum payment or a different way in which the beneficiary will receive payment of the Principal Sum. If other than a single sum payment is desired, 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 each are not allowed.

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

If a beneficiary dies while receiving payments under one of these options and there is no contingent beneficiary, the balance will be paid in one sum to the beneficiary's estate, unless otherwise agreed to in the instructions for settlement.

Requests for settlement options other than the 3 set out in the Policy may be made. A mutual agreement must be reached between the individual entitled to elect and us.

**OPTION A - FIXED TIME PAYMENT OPTION:** Equal monthly payments will be made for any period chosen, up to 30 years. The amount of each payment depends on the amount applied, the period selected and the payment rates we are using when the first payment is due. The rate of any monthly payment will not be less than shown in the table below. We reserve the right to change the minimum monthly payment. These changes will apply only to requests for settlement elected after the change.

**Option A Table**  
**Minimum Monthly Payment Rates for each \$1,000 Applied**

<u>Years</u>		<u>Years</u>		<u>Years</u>		<u>Years</u>		<u>Years</u>	
1	\$84.47	7	\$13.16	13	\$7.71	19	\$5.73	25	\$4.71
2	42.86	8	11.68	14	7.26	20	5.51	26	4.59
3	28.99	9	10.53	15	6.87	21	5.32	27	4.47
4	22.06	10	9.61	16	6.53	22	5.15	28	4.37
5	17.91	11	8.86	17	6.23	23	4.99	29	4.27
6	15.14	12	8.24	18	5.96	24	4.84	30	4.18

**OPTION B - FIXED AMOUNT PAYMENT OPTION:** Each payment will be for an agreed fixed amount. The amount of each payment will not be less than \$20 for each \$2000 applied. Interest will be credited and added each month on the unpaid balance. This interest will be at a rate set by us, but not less than the equivalent of 3% per year. Payments continue until the amount we hold runs out. The last payment will be for the balance only.

**OPTION C - INTEREST PAYMENT OPTION:** We will hold any amount applied under this section. Interest on the unpaid balance will be paid each month at a rate set by us. This rate will not be less than the equivalent of 3% per year.

# ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

## DESCRIPTION OF COVERAGE

**LOSS OF LIFE, LIMB, SIGHT, SPEECH OR HEARING:** If, due to Injury, an Insured suffers any one of the following specific Losses within 365 days from the date of the accident we will pay the Benefit Amount listed below. However, if more than one listed loss results from any one accident, we will only pay the one largest applicable benefit as listed below.

### LOSS

### BENEFIT AMOUNT:

Loss of Life .....	the Insured's Principal Sum
Loss of Two or More Members .....	the Insured's Principal Sum
Loss of Speech and Hearing .....	the Insured's Principal Sum
Loss of One Member .....	3/4 of the Insured's Principal Sum
Loss of Speech or Hearing .....	1/2 of the Insured's Principal Sum
Loss of Thumb and Index Finger of the Same Hand .....	1/4 of the Insured's Principal Sum
Brain Damage .....	the Insured's Principal Sum

### **DEFINITIONS:**

"Member(s)" means: hand, foot or eye.

"Loss(es)" must result directly and independently from Injury, with no other contributing cause. As used in this benefit with respect to:

- (1) a hand or foot, Loss means the complete severance through or above the wrist or ankle joints;
- (2) an eye, Loss means the total and irrecoverable loss of sight;
- (3) speech, Loss means the total and irrecoverable loss of the function;
- (4) hearing, Loss means the total and irrecoverable loss of the hearing in both ears;
- (5) a thumb and index finger, Loss means the complete severance through or above the metacarpophalangeal joint.

“Brain Damage” means permanent and irreversible physical damage to the brain causing the complete inability to perform all of the substantial and material functions and activities normal to everyday life. Such damage must manifest itself within thirty (30) days of the Injury, require hospitalization of at least five (5) days and persist for twelve (12) consecutive months after the date of the Injury.

## DAY CARE BENEFIT

**DESCRIPTION OF COVERAGE:** We will pay the additional benefit shown below if:

- (1) at your death due to Injury, Loss of Life benefits are payable hereunder;
- (2) you have at least one Dependent child, born or unborn and in any event under 14 years of age on the date of the Injury; and
- (3) such child is in day care within twelve (12) months from the date of death.

**BENEFITS:** Benefits will be paid as follows:

- (1) We will pay an additional monthly benefit equal to actual Day Care charges incurred up to 2% of your Principal Sum, not to exceed \$5,000 in any one calendar year for each Insured Dependent child who is under 14 years of age.
- (2) The benefit with respect to each child will terminate on the earlier of:
  - (a) the date he turns 14 years of age; or
  - (b) the end of a period of four (4) consecutive years from your death.

A prorated benefit will be payable for partial months.

"Dependents" means:

- (1) your legal spouse who is not legally separated or divorced from you; and
- (2) your unmarried child(ren) age 14 days to 20 years, who is financially dependent on you for support. Adoptive, foster and step-children are considered Dependents if they are in your custody; and
- (3) your unmarried child(ren), attending a college or other school on a full-time basis, who is financially dependent on you for support, up to age 26.

Additionally, with respect to an Insured Person whose domestic partnership is formally recognized by applicable state law or for whom an Affidavit of Domestic Partnership is on file with the Policyholder and is in effect, such Insured Person's:

- (1) domestic partner; and
- (2) child(ren), provided he/she otherwise meets the definition of Dependent,

of such domestic partnership formally recognized under applicable state law or named on such Affidavit will be considered a "Dependent" of such Insured Person.

## **COVERAGE FOR MEMBERS OF RESERVE-NATIONAL GUARD**

**DESCRIPTION OF COVERAGE:** We will pay plan benefits for a loss due to Injury of any Insured which is sustained while such Insured is a member of an organized Reserve Corps or National Guard Unit and is:

- (1) attending any regularly scheduled or routine training of less than 60 days, or is enroute to or from such training;
- (2) attending a Service School no matter how long it is, or is enroute to or from that school;
- (3) taking part in any authorized inactive duty training; or
- (4) taking part as a unit member in a parade or exhibition authorized by official orders.

No benefit is payable for any loss that occurs during active duty.

### **DEFINITION:**

"Service School" means one operated by or on behalf of the United States of America.

## **COVERAGE OF EXPOSURE AND DISAPPEARANCE**

### **DESCRIPTION OF COVERAGE**

**EXPOSURE:** Any loss that is due to exposure will be covered as if it were due to Injury, provided such loss results directly and independently of all other causes from accidental exposure to the elements which occurs while the Insured's coverage under the Policy is in force.

**DISAPPEARANCE:** We will presume an Insured suffered loss of life due to an Injury, if:

- (1) while covered under the Policy, such Insured is riding in a conveyance that is involved in an accident, not excluded from coverage;
- (2) the conveyance is wrecked, sinks or disappears as a result of such accident; and
- (3) the Insured's body is not found within 1 year of the accident.

## EDUCATION BENEFIT

**DESCRIPTION OF COVERAGE:** We will pay the additional benefit stated below if at your death due to Injury, Loss of Life benefits are payable hereunder.

**BENEFITS:** Benefits will be paid as follows:

- (1) We will pay 5% of your Principal Sum, subject to a minimum of \$1,000 and a maximum of \$5,000, annually for each of your Dependent children who is:
  - (a) enrolled as a full-time student in any Institute of Higher Learning beyond the 12th grade level on the date of your accident; or
  - (b) in the 12th grade on the date of your accident and subsequently enrolls as a full-time student in an Institute of Higher Learning within 1 year of the date of your death;

provided the child remains so enrolled for the school year. Benefits will be paid for up to 4 consecutive years of enrollment.

- (2) We will pay the actual tuition expense incurred by your Dependent spouse, up to \$3,000 annually, if:
  - (a) such spouse attends an Institute of Higher Learning for the purpose of obtaining a source of support and maintenance; and
  - (b) the tuition expense is incurred within 30 months of the date of your death.

### DEFINITION:

"Institute of Higher Learning" includes but is not limited to: any university; college; trade school; or professional school.

"Dependents" means:

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

- (2) your unmarried child(ren) age 14 days to 20 years, who is financially dependent on you for support. Adoptive, foster and step-children are considered Dependents if they are in your custody; and
- (3) your unmarried child(ren), attending a college or other school on a full-time basis, who is financially dependent on you for support, up to age 26.

Additionally, with respect to an Insured Person whose domestic partnership is formally recognized by applicable state law or for whom an Affidavit of Domestic Partnership is on file with the Policyholder and is in effect, such Insured Person's:

- (1) domestic partner; and
- (2) child(ren), provided he/she otherwise meets the definition of Dependent,

of such domestic partnership formally recognized under applicable state law or named on such Affidavit will be considered a "Dependent" of such Insured Person.

## **SEAT BELT AND AIR BAG BENEFIT**

**DESCRIPTION OF COVERAGE:** We will pay a sum equal to 10% of the Insured Person's Principal Sum if:

- (1) the Insured Person dies as the result of a bodily Injury sustained while riding in or operating a Four-Wheel Vehicle;
- (2) a police report establishes that the Insured Person was properly strapped in a Seat Belt at the time;
- (3) Loss of Life benefits are payable for the Insured Person's death hereunder.

We will pay an additional 5% if the Insured Person is driving in or riding in a Four-Wheel Vehicle which is equipped with a factory-installed Supplemental Restraint System. The Insured Person must be positioned in a seat which is designed to be protected by an air bag and must be properly strapped in the Seat Belt when the air bag inflates. In addition to the above requirements, the police report must establish that the air bag inflated properly upon impact.

The total maximum benefit payable is \$25,000.00.

No benefit will be paid for any loss sustained:

- (1) while driving or riding in any Four-Wheel Vehicle used: in a race; in a speed or endurance test; or for acrobatic or stunt driving; or
- (2) if the Insured Person is not wearing a Seat Belt for any reason; or
- (3) while the Insured Person is sharing a Seat Belt; or
- (4) due to a defect in the Supplemental Restraint System's diagnostic system.

If the police report does not clearly establish that the Insured Person was or was not wearing a Seat Belt at the time of the accident causing the Insured Person's death, we will pay a sum equal to \$1,000 in lieu of the benefit described above.

**DEFINITIONS:**

"Seat Belt" means an unaltered Seat Belt or lap and shoulder restraint.

An air bag is not considered a Seat Belt.

"Supplemental Restraint System" means an air bag which inflates for added protection to the head and chest areas.

"Four-Wheel Vehicle" means a vehicle listed below provided it is: duly licensed for passenger use; and designated primarily for use on public streets and highways:

- (1) a private passenger automobile; or
- (2) a station wagon; or
- (3) a van, jeep, or truck-type vehicle which has a manufacturer's rated load capacity of 2,000 pounds or less; or
- (4) a self-propelled motor home.

## **COMA BENEFIT**

**DESCRIPTION OF COVERAGE:** We will pay the benefit shown below if, as the result of an Injury, an Insured Person lapses into a Coma which lasts for more than 30 days. In order for this benefit to be payable the Coma does not need to be continuous, as long as recurrences are not due to an unrelated cause.

### **DEFINITION:**

"Coma" means a state of profound unconsciousness, from which one cannot be aroused, which results from Injury. The Insured Person must be:

- (1) confined in a hospital or other medical facility; and
- (2) diagnosed as being in a Coma by a licensed physician.

**BENEFIT:** We will pay a monthly benefit equal to 1% of the Insured Person's Principal Sum. The monthly benefits will start on the 31st day of the Coma. Benefits will continue until:

- (1) the Coma ends;
- (2) the Insured Person dies; or
- (3) the end of a period of 100 consecutive months;

whichever is the first to occur.

A prorated benefit will be payable for partial months.

The Insured Person is only eligible for one Coma benefit for each eligible accident.

**TOTAL LOSS OF USE BENEFIT**

**DESCRIPTION OF COVERAGE:** We will pay the benefit shown below if, due to Injury, the Insured Person suffers a Total Loss of Use that is listed below, provided:

- (1) the Insured Person suffers such Total Loss of Use within 1 year of the Injury;
- (2) the Total Loss of Use continues for a period of 12 consecutive months after the onset;
- (3) it is shown by proper medical authority at the end of these 12 months that the Total Loss of Use has been continuous and will be permanent; and
- (4) no benefit is payable for such loss under the Accidental Death and Dismemberment Benefit of this Certificate.

**BENEFITS:** Only one benefit (the larger) will be paid for more than one Total Loss of Use resulting from any one accident.

**For Total Loss of Use of:**

**Benefit Amount:**

Both Arms and Both Legs .....	the Insured Person's Principal Sum
Both Arms .....	2/3 of the Insured Person's Principal Sum
Both Legs .....	2/3 of the Insured Person's Principal Sum
One Arm and One Leg .....	2/3 of the Insured Person's Principal Sum
Both Arms and One Leg or	
Both Legs and One Arm .....	3/4 of the Insured Person's Principal Sum
One Arm or One Leg .....	1/2 of the Insured Person's Principal Sum

In no event will the total of all benefits paid for any one Insured Person for any one accident, under this benefit, the Accidental Death and Dismemberment Benefit and the Coma Benefit, exceed that Insured Person's Principal Sum.

**DEFINITION:**

"Total Loss of Use" means loss of the ability to function because of:

- (1) incurable paralysis; or

(2) stiffening.

In addition, "Total Loss of Use" must affect the entire arm or leg from the shoulder or hip, including the hand or foot attached to it.

## **COMMON CARRIER BENEFIT**

**DESCRIPTION OF COVERAGE:** We will pay an additional benefit equal to the amount paid under the ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT if:

- (1) an Insured Person sustains such a loss due to Injury; and
- (2) such Injury occurs while the Insured Person is riding as a passenger (not as an operator or crew member) in a Common Carrier.

### **DEFINITION:**

"Common Carrier" means any:

- (1) aircraft operated under a license for hire for the transportation of passengers;
- (2) transport aircraft operated by the Military Aircraft Command (MAC) of the United States or by the similar air transport service of any country; or
- (3) land or water conveyance licensed for hire for the transportation of passengers.

## HOSPITAL INDEMNITY BENEFIT

**DESCRIPTION OF COVERAGE:** We will pay the benefit set forth below if, as the result of an Injury an Insured Person is confined in a Hospital as an Inpatient. The confinement must be at the direction of and under the supervision of a Physician, and must commence within 1 year from the date of the Injury. We must be given proof of such Hospital confinement.

**BENEFITS:** The Monthly Benefit shown below will be payable for each full month the Insured Person is Hospital confined as an Inpatient starting with the day Benefits Become Payable as shown below. The benefit payable for partial months will be pro-rated, assuming a 30 day month. In no event will this benefit be payable beyond the Maximum Benefit Period shown for any one Period of Hospital Confinement.

### BENEFIT SCHEDULE

Monthly Benefit	1% of the Insured Person's Principal Sum but not less than \$10 nor more than \$1,000
Benefits Become Payable	after eighth day of Hospital confinement
Maximum Benefit Period	12 months

### DEFINITIONS:

"Hospital" means an institution which meets the following requirements:

- (1) it is operated in accordance with the laws of the jurisdiction in which it is located, pertaining to institutions identified as Hospitals;
- (2) it is primarily engaged in providing the following on an Inpatient basis to injured or sick persons:
  - (a) diagnosis, care and treatment, by or under the supervision of a staff of Physicians or surgeons;
  - (b) continuous 24 hour nursing service by or under the supervision of Registered Nurses (R.N.); and

- (c) facilities for major operative surgery, either in its premises or in facilities available to the Hospital on a prearranged basis; and

(3) it is a Hospital accredited by the American Hospital Association.

A Hospital is not, other than incidentally: (1) a place for rest; (2) a place for the aged; (3) a place for the care of drug addicts or alcoholics; (4) a place for the treatment of mental or nervous disorders; (5) a nursing home; or (6) a facility primarily for rehabilitation or custodial care.

"Inpatient" means a person confined in a Hospital, for whom at least one day's room and board charge is made by the Hospital as a result of an Injury.

"Period of Hospital Confinement" means the duration of time that the Insured Person is confined as an Inpatient. Successive periods of confinement will be treated as one Period of Hospital Confinement if they are:

- (1) due to the same or related cause(s); and
- (2) separated by less than 6 months.

"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 for which claim is made. The Physician may not be the Insured Person or a member of the Insured Person's immediate family.

## **FAMILY AND MEDICAL LEAVE OF ABSENCE EXTENSION**

We will allow your coverage to continue for up to twelve (12) weeks in a twelve (12) month period, if you are eligible for, and the Participating Unit has approved, a Family and Medical Leave of Absence under the terms of the Family and Medical Leave Act of 1993 for any of the following reasons:

- (1) To provide care after the birth of a son or daughter; or
- (2) To provide care for a son or daughter upon legal adoption; or
- (3) To provide care after the placement of a foster child in your home; or
- (4) To provide care to a spouse, son, daughter, or parent due to serious illness; or
- (5) To take care of your own serious health condition.

You will not qualify for the Family and Medical Leave of Absence Extension unless we have received proof from the Participating Unit, in a form satisfactory to us, that you have been granted a leave under the terms of the Family and Medical leave Act of 1993. Such proof: (1) must outline the terms of your leave; and (2) give the date the leave is to begin; and (3) the date it is expected to end; and (4) must be received by us within thirty-one (31) days after a claim for benefits has been filed with us.

If you are granted a Family and Medical Leave of Absence, the following applies to you:

- (1) While you are on an approved Family and Medical Leave of Absence, the required premium must be paid according to the terms specified in the Policy to keep the insurance in force.
- (2) Coverage will terminate for you if you do not return to work as scheduled according to the terms of your agreement with the Participating Unit; however, you are eligible to convert your coverage under the Conversion Privilege. In no case will coverage be extended under this benefit beyond twelve (12) weeks in a twelve (12) month period. Insurance will not be terminated for an Insured who becomes Totally Disabled during the period of the leave and who is eligible for benefits according to the terms of the Policy.

- (3) This extension is not available if you convert your coverage under the Conversion Privilege.
- (4) While you are on an approved Family and Medical Leave of Absence, you will be considered Actively At Work in all instances unless such leave is due to your own illness, injury or disability. Changes such as revisions to coverage because of age, class, or salary changes will apply during the leave except that increases in amount of insurance, whether automatic or subject to election, are not effective if you are not Actively at Work until such time as you return to Active Work for one full day.

All other terms and conditions of the Policy will remain in force while you are on an approved Family and Medical Leave of Absence.

## **MILITARY SERVICES LEAVE OF ABSENCE COVERAGE**

We will allow your coverage to continue for up to twelve (12) weeks in a twelve (12) month period, if you enter the military service of the United States. While you are on Military Services Leave of Absence, the required premium must be paid according to the terms specified in the Policy to keep the insurance in force. Changes such as revisions to coverage because of age, class or salary changes will apply during the leave except that increases in amount of insurance, whether automatic or subject to election, are not effective until you have returned to work from a Military Services Leave of Absence for one full day. All other terms and conditions of the Policy will remain in force during the continuation period. Your continued coverage will cease on the earliest of the following dates:

- (1) the date the Policy terminates; or
- (2) the end of the period for which premium has been paid for your coverage; or
- (3) twelve (12) weeks from the date your continued coverage began.

The Policy, however, does not cover any loss which occurs on active duty in the military service if such loss is caused by or arises out of such military service, including but not limited to war or act of war (whether declared or undeclared) and is also subject to any other exclusions listed in the Exclusions provision.

## EXCLUSIONS

The Policy does not cover any loss:

- (1) to which sickness, disease, or myocardial infarction, including medical or surgical treatment thereof, is a contributing factor; or
- (2) caused by suicide, or intentionally self-inflicted injuries; or
- (3) caused by or resulting from war or any act of war, declared or undeclared; or
- (4) caused by an accident that occurs while in the armed forces of any country, except as shown under the Reserve-National Guard Benefit (any premium paid to us for any period not covered by the Policy while the Insured is in such service will be returned pro rata); or
- (5) caused by or resulting from riding in, getting into or out of any aircraft, unless:
  - (a) the Insured Person is a passenger (not a pilot or crew member) in a tested and approved civilian aircraft being operated as passenger transport in compliance with the then current rules of the authority having jurisdiction over its operation; and
  - (b) the aircraft is not owned, leased or operated by or on behalf of the Participating Unit, the Insured Person, or any other employer of the Insured Person, unless a specific written agreement has been obtained from us; or
- (6) sustained during the Insured Person's commission or attempted commission of an assault or felony.

# **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 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.

## **MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION**

### Non-Disability Benefit Claims

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

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for

the claimant to perfect the claim and an explanation of why such material or information is necessary; and

4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an adverse benefit determination on review.

#### Disability Benefit Claims

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

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

## **APPEALS OF ADVERSE BENEFIT DETERMINATIONS**

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

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

### Non-Disability Benefit Claims

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

### Disability Benefit Claims

1. Claimants (or their authorized representatives) must appeal within 180 days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and

- other information relevant to the claimant's claim for benefits;
4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
  5. No deference to the initial adverse benefit determination shall be afforded upon appeal;
  6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
  7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant's adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination; and
  8. In deciding the appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, the individual conducting the appeal shall consult with a health care professional:
    - (a) who has appropriate training and experience in the field of medicine involved in the medical judgment; and
    - (b) who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal; nor the subordinate of any such individual.

## **TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW**

### Non-Disability Benefit Claims

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

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information

necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

### Disability Benefit Claims

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

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

## **MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW**

### Non-Disability Benefit Claims

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

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;

3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and
4. A statement of the claimant's right to bring an action under section 502(a) of ERISA (where applicable).

### Disability Benefit Claims

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

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

## DEFINITIONS

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

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

The term “relevant” means:

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

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

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

# **RELIANCE STANDARD**

Life Insurance Company

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a **DELPHI** company

Home Office: Chicago, Illinois

Administrative Office: Philadelphia, Pennsylvania

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VAR 203620  
Ed. 4/2007

CLASS 1  
CLASS 1