



reliancestandard

LIFE INSURANCE COMPANY

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

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CERTIFICATE OF INSURANCE

We certify that you (provided you belong to a class described on the Schedule of Benefits and your completed enrollment card is attached) are insured, for the benefits which apply to your class, under Group Policy No. GL 147868 issued to Central Garden & Pet, the Policyholder.

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

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


Secretary


President

GROUP LIFE INSURANCE CERTIFICATE

This Group Life Certificate amends all previous Group Life Certificates and is dated October 23, 2024.

CHANGES IN AMOUNT OF INSURANCE: Increases and decreases in the Amount of Insurance because of changes in age, class or earnings (if applicable) are effective on the January 1st coinciding with or next following the date of the change.

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

Premium changes due to your age will occur on the January 1st coinciding with or next following the birthday that causes you to enter the next age bracket.

If an increase in, or initial application for, the Amount of Insurance is due to a life event change (such as marriage, birth or specific changes in employment status), proof of good health will not be required for amounts up to the guaranteed issue amount, provided you: (a) apply within thirty-one (31) days of such life event; and (b) were not previously declined for group life insurance coverage with us; and (c) did not have a prior application withdrawn or marked incomplete for any reason.

APPROVED ENROLLMENT PERIODS: It is the Policyholder's 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, beginning October 15 and ending on November 15, applications for employees and spouses who were previously eligible and are now applying for initial insurance coverage or are insured and are applying for additional coverage will not require proof of good health for an incremental increase up to \$10,000 in insurance coverage for employees and for an incremental increase up to \$5,000 in insurance coverage for spouses, provided:

- (1) the application is complete, signed, and received by the Policyholder during the "Enrollment Period";
- (2) you and/or your spouse were not previously declined for group life insurance with us; and
- (3) you and/or your spouse did not have an application withdrawn or marked as incomplete for any reason.

Insurance coverage applied for during this "Enrollment Period" will be effective on the January 1st following the Approved Enrollment Period, provided the employee is Actively at Work, the spouse is not confined in a hospital or at home, applicable premium is paid and any applicable service waiting period has been satisfied.

Employees who exceed an incremental increase of more than \$10,000 in insurance coverage, spouses who exceed an incremental increase of more than \$5,000 in insurance coverage, and all amounts in excess of the guarantee issue limits stated in the Policy, are subject to our approval of proof of good health and such amounts of insurance will not be effective until approved by us.

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

DEFINITIONS

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

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

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

"Full-time" means working for the Policyholder for a minimum of 30 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 Policyholder;
- (2) retirement pension benefits under any plan which the Policyholder sponsors, or makes or has made contributions;
- (3) retirement benefits under the United States Social Security Act of 1935, as amended, or under any similar plan or act.

"Earnings", as used in the SCHEDULE OF BENEFITS section, means your annual salary received from the Policyholder on the January 1st just before the date of loss. Earnings does not include overtime pay, bonuses, incentive pay or any other special compensation not received as basic salary. However, Earnings will include commissions received from the Policyholder averaged over the lesser of:

- (1) the number of months worked; or
- (2) the 12 months;

as of the January 1st just prior to the date of loss.

If hourly employees are insured, the number of hours worked during a regularly scheduled work week, not to exceed forty (40) hours per week, times fifty-two (52) weeks, will be used to determine annual earnings.

If you were not employed by the Policyholder on the January 1st just before the date of loss, Earnings, as defined above, will be as received from the Policyholder on your Individual Effective Date just before the date of loss.

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

- (1) your legal spouse who is not legally separated or divorced from you; and
- (2) your child(ren), from birth to 26 years. Adoptive, foster and step-children are considered Dependents if they are in your custody; and
- (3) your child(ren) beyond the limiting age who is both: (a) incapable of self-sustaining employment by reason of intellectual disability or physical handicap; and (b) chiefly dependent upon you for support and maintenance, provided proof of such incapacity and dependency is furnished to us by you within 31 days of the child's attainment of the limiting age and subsequently as may be required by us, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Additionally, if you have a domestic partnership or civil union that is legally recognized under applicable state law or an Affidavit of Domestic Partnership is in effect and on file with the Policyholder, your:

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

of such legally recognized domestic partnership or civil union or named on an Affidavit will be considered your "Dependent".

When your domestic partner or civil union partner is covered under the Policy, the word "spouse" as it appears in the Policy will be deemed to include "domestic partner" and "civil union partner" unless the context indicates otherwise.

GENERAL PROVISIONS

INCONTESTABILITY

Any statement made in the Policyholder's application will be deemed a representation, not a warranty. We cannot contest the validity of the Policy after it has been in force for two (2) years from the date of issue, except for non-payment of premium. All other Policy terms will remain applicable.

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

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

ASSIGNMENT

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

EFFECTIVE DATE AND TERMINATION

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

- (1) on the first of the month coinciding with or next following the date you apply, if you apply within thirty-one (31) days of the date you are first eligible; or
- (2) on the first of the month coinciding with or next following the date we approve any required proof of good health. We require proof of good health if you apply:
 - (a) after thirty-one (31) days from the date you first become eligible; or
 - (b) after you terminated this insurance but remained in a class eligible for this insurance.

Proof of good health forms are available from us upon request. It is the Policyholder's responsibility to provide proof of good health forms to you when required.

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 in an Eligible Class for one full day.

TERMINATION OF INSURANCE: Your insurance will terminate on the first of the following to occur:

- (1) the date the Policy terminates; or
- (2) the date you cease to be in a class eligible for this insurance; or
- (3) the end of the period for which premium has been paid for you; or
- (4) the date you enter military service on active duty (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: Insurance may be reinstated if you were:

- (1) on an approved leave of absence, or
- (2) on a temporary lay-off; or
- (3) rehired after employment had been terminated.

You must return to Active Work with the Policyholder 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 Waiting Period of the Policy again.

If you return after an approved leave of absence or temporary lay-off, the insurance will go into effect on the day you return to Active Work for one full day. If you return after being rehired, the insurance will go into effect on the first of the month following the day you return to Active Work for one full day.

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

CONVERSION PRIVILEGE

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

- A. If the insurance ceases due to termination of employment or membership in any of the Policy's classes, an individual Life Insurance Policy may be issued. You are entitled to a policy without disability or supplemental benefits. You must make written application for the policy within thirty-one (31) days after you terminate. The first premium must also be paid within that time. The issuance of the policy is subject to the following conditions:
 - (1) The policy will, at your option, be on any one of our forms, except for term life insurance. It will be the standard type issued by us for the age and amount applied for;
 - (2) The policy issued will be for an amount not over what you had before you terminated;
 - (3) The premium due for the policy will be at our usual rate. This rate will be based on the amount of insurance, class of risk and your age at date of policy issue; and
 - (4) Proof of good health is not required.
- B. If the insurance ceases due to the termination or amendment of the Policy, an individual Life Insurance Policy can be issued. You must have been insured for at least five (5) years under the Policy and/or the prior carrier. 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 provided in A above 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.
- F. If you are entitled to have an individual policy issued to you without proof of health, then you must be given notice of this right at least fifteen (15) days before the end of the period specified above. Such notice must be: (1) in writing; and (2) presented or mailed to you by the Policyholder. If not, you will have an additional period in order to do so. This additional period will end twenty-five (25) days after you are given notice. This period will not extend beyond sixty (60) days after the expiration date of the period provided above. This insurance will not be continued beyond the period provided in A above.

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, legally recognized civil union/domestic partner or domestic partner named on an Affidavit of Domestic Partnership;
- (2) your surviving child(ren) (including legally adopted child(ren)), 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 the death of an Insured, the beneficiary may make the election, with our consent.

Settlement Options are described in the Policy.

CLAIMS PROVISIONS

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

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

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

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

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

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

DEPENDENT LIFE INSURANCE

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

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

A person may not have coverage both as an Insured and as an insured Dependent. Only one eligible spouse may cover the eligible children as Insured Dependents. The spouse may be covered as a dependent if not covered as an Insured.

EFFECTIVE DATE OF DEPENDENT INSURANCE

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

- (1) the first of the month coinciding with or next following the date you become eligible for Dependent Life Insurance;
or
- (2) the first of the month coinciding with or next following the date the dependent meets the definition of Dependent.

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

- (1) the first of the month coinciding with or next following the date you become eligible for Dependent Life Insurance;
or
- (2) the first of the month coinciding with or next following the date the dependent meets the definition of Dependent, if application is made on or before that date; or
- (3) the first of the month coinciding with or next following the date of application, if application is made within thirty-one (31) days from the date the Dependent first becomes eligible for this insurance; or
- (4) the first of the month coinciding with or next following the date we approve any required proof of good health. Proof of good health forms are available from us upon request. It is the Policyholder's responsibility to provide proof of good health forms to you when required. We require proof of good health if you make application for dependent insurance on your spouse:
 - (a) after thirty-one (31) days from the date the Dependent first becomes eligible for this insurance; or
 - (b) after a prior termination of insurance as long as you remained in a class eligible for dependent insurance; or
 - (c) for an Amount of Insurance greater than the guaranteed issue Amount of Insurance shown on the Schedule of Benefits, if applicable; or
- (5) the date premium is remitted.

After this insurance is in force for one Dependent child, application is not required for added Dependent children.

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

TERMINATION OF DEPENDENT LIFE INSURANCE

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

- (1) the date this Section terminates; or
- (2) the date the dependent is no longer a Dependent as defined; or
- (3) the end of the period for which premium has been paid by you or the Policyholder; or
- (4) the date your insurance terminates; or
- (5) the date you retire from employment with the Policyholder.

CONVERSION OF DEPENDENT LIFE INSURANCE

If the insurance of an insured Dependent terminates because:

- (1) you terminate employment or membership in the classes eligible for this insurance; or
- (2) you die; or
- (3) the Dependent ceases to be eligible for this insurance;

then you may convert the Dependent's insurance to an individual policy. The conversion is subject to the following rules:

- (1) a written application for the conversion policy must be received by us within thirty-one (31) days after the Dependent's insurance terminates. The first premium must be sent in with the application; and
- (2) the premium due for the policy will be at our usual rates. This rate will be based on the Amount of Insurance, class of risk and the age of the Dependent on the date the policy is issued; and
- (3) the policy may be any life plan we currently issue, except term insurance; and
- (4) proof of good health is not required; and
- (5) the policy issued will be for an amount not over what the Dependent had before termination under the Policy; and
- (6) the policy issued will not have disability or supplemental benefits.

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

- (1) the amount of Dependent life insurance under the Policy. This amount will be less any amount of group life insurance the Dependent receives or becomes eligible for within thirty-one (31) days after the Policy terminates; or
- (2) \$5,000.

If an insured Dependent should die within thirty-one (31) days of the date his/her insurance ceased, we will pay the benefit he/she had under the Policy. This will be done whether or not you applied for the individual policy on behalf of the insured Dependent.

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

If an insured Dependent is entitled to have an individual policy issued to him/her without proof of health, then you must be given notice of this right at least twenty-five (25) days before the end of the period specified above. Such notice must be: (1) in writing; and (2) presented or mailed to you by the Policyholder. If not, you will have an additional period in order to do so. This additional period will end twenty-five (25) days after you are given notice. This period will not extend beyond sixty (60) days after the expiration date of the period provided above. This insurance will not be continued beyond the period provided in (1) above.

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 Policy, 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 approved for extension of coverage under the Waiver of Premium in Event of Total Disability provision, if applicable; and
- (4) have not been terminated under the Waiver of Premium in Event of Total Disability provision, if applicable; and
- (5) have been covered for twelve (12) months under the Policy and/or the prior group life insurance policy.

Such coverage may be continued for a period of two (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 Policy 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 two (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.

NOTICE TO POLICYHOLDERS/INSUREDS

We are here to serve you...

As our policyholder/insured, your satisfaction is very important to us. Should you have a valid claim, we fully expect to provide a fair settlement in a timely fashion.

If you are not satisfied...

If you have any questions or complaints about your insurance, please write to our Director of Claims or Department of Consumer Relations at the following address, or call us using our toll-free telephone number.

**Reliance Standard Life Insurance Company
1700 Market Street, Suite 1200
Philadelphia, PA 19103-3938**

Toll-free telephone number: 1-800-644-1103

If, after contacting us, you feel that your problem is not resolved or you are not being treated fairly, you may contact the California Department of Insurance by writing to them at the following address or using their toll-free telephone number.

**Consumer Services Division
State of California
Department of Insurance
300 South Spring Street
South Tower, Suite 201
Los Angeles, CA 90013
www.insurance.ca.gov**

**Toll-free Consumer Hotline in California: 1-800-927-HELP
Area codes 213, 310, and 818 and out-of-state: 1-213-897-8921**

SUMMARY PLAN DESCRIPTION

The following section entitled Summary Plan Description was prepared by Reliance Standard Life Insurance Company at the request of and on behalf of the Plan Sponsor. Reliance Standard Life Insurance Company assumes no responsibility for the accuracy or sufficiency of the information in this section.

SUMMARY PLAN DESCRIPTION

The following information and the description of benefits provided in this booklet constitute the Summary Plan Description.

PLAN NAME: Group Life Insurance

PLAN SPONSOR: Central Garden & Pet
1340 Treal Blvd
Suite 600
Walnut Creek, CA 94597
(925) 948-3625

SPONSOR'S EMPLOYER IDENTIFICATION NUMBER: 68-0275553

PLAN NUMBER: 520

TYPE OF PLAN: Death Benefit Plan

PLAN BENEFITS: Fully Insured - Group Life Insurance Benefits

TYPE OF ADMINISTRATION: The plan is administered in accordance with the terms of the Group Policy issued by the Reliance Standard Life Insurance Company, 1700 Market Street, Suite 1200, Philadelphia, PA 19103-3938.

PLAN ADMINISTRATOR: The Plan Sponsor named above.

AGENT FOR SERVICE OF LEGAL PROCESS: The Plan Sponsor named above.

PLAN YEAR: The plan's fiscal records are kept on a plan year basis beginning January 1st.

PLAN COSTS: The cost of the benefits provided under the plan are paid for by the employee.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) DETERMINATIONS: A plan participant or beneficiary can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order (QMCSO) determinations from the Plan Administrator named above.

AMENDMENT AND TERMINATION: The Plan Sponsor reserves the right, at any time, to amend or terminate the Plan or amend or eliminate benefits under the Plan for any reason.

**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 1-800-644-1103.

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 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. 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 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;
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 (defined 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 below) 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.