TORRANCE COUNTY
STATE OF NEW MEXICO

REQUEST FOR PROPOSALS (RFP)

FULLY INSURED LIFE, DISABILITY and VISION COVERAGES

RFP TC-FY23-01

TORRANCE COUNTY PURCHASING
P.O. Box 48
205 S Ninth Street
Estancia, NM 87016

July 29, 2022

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I. INTRODUCTION

A. PURPOSE OF THIS REQUEST FOR PROPOSALS

The County of Torrance, State of New Mexico, on behalf of the Torrance County Board of County Commissioners, seeks sealed proposals from qualified and approved Insurance Carriers to provide fully insured life, short term disability, long term disability and vision benefits effective January 1, 2023.

B. SUMMARY SCOPE OF WORK

Torrance County (County) has been fully insured with Reliance Standard Life Insurance for its life, long term disability and vision benefits since separating from the State of New Mexico's employee benefit program in 2016. Short term disability benefits are currently available through AFLAC as an unaffiliated offering with no County sponsorship or administrative involvement, and the County wishes to evaluate insured options on both an employee paid and County supported basis, Current census includes 114 eligible and enrolled in life and LTD coverages and 81 enrolled in vision coverage.

The County is soliciting proposals from qualified insurers interested in entering into an agreement for insured benefits coverage as described herein, to ensure they are offering competitive, comprehensive benefits to their employees.

The County has contracted with Gallagher Benefit Services, Inc. (GBS) to provide consulting services including the solicitation and evaluation process, the evaluation and implementation process, as well as ongoing benefits consulting. Proposals should be submitted concurrently to the County and GBS as outlined later in this solicitation.

Offerors shall carefully read all information contained in this Request for Proposal (RFP) and respond accordingly. Offerors must complete exhibits in the format originally provided (i.e., Word and/or Excel). Do NOT alter the forms. You must complete them as provided. Do not convert the exhibits to PDF format.

Offerors must complete and submit all Exhibits as outlined in the RFP.

The County is seeking firms which offer the greatest flexibility regarding network, claim systems, plan designs, and contract terms.

The County wishes to partner with firms who demonstrate a commitment to outstanding customer service.

The County wishes to partner with firms who offer a comprehensive suite of state of the art, online tools for both the Employer and the Employee.

The County wishes to maintain current benefit levels as closely as possible. Benefit deviations from current must be clearly identified.

The County wishes to evaluate an alternate County sponsored life benefit for Fire employees to match the current benefit offering for Officers.

The County intends to maintain current contribution structure:

- Basic life, AD&D and LTD – 100% County paid
- Vision – 80% County paid across all dependent election categories
- Voluntary life – 100% employee paid
- STD (considering as new County sponsored benefit) – seeking options assuming 100% County paid and 100% employee paid

The County is implementing Tyler systems and is seeking administrative efficiencies relating to enrollment and premium remittance. Under current systems/process, monthly blackout dates for enrollment data entry apply, premium checks generate with twice-monthly payrolls for each coverage (life, disability and vision) and remittance is via US Mail to two different addresses. Response exhibits will provide Offerors opportunity to describe potential enrollment process and premium remittance improvements.

Provide your proposal based on your broadest, most comprehensive network.

Plan year – January 1 through December 31

Effective Date of Coverage – January 1, 2023

Commissions – Proposals must include commissions matching levels currently in effect as outlined below:

- Life (including AD&D and Voluntary Life coverages) – Level 20%
- Long Term Disability – Level 20%
- Short Term Disability – Level 20%
- Vision – Level 10%

C. SCOPE OF PROCUREMENT

The duration of the professional services contract resulting from this RFP shall be for one (1) year from the date of award. The County reserves the right, by mutual agreement of the parties, to extend the contract on an annual basis at the same price, terms and conditions for up to an additional seven (7) years. Under no circumstances shall the term of this contract, including all extensions and renewals, exceed eight (8) years. This procurement may result in a multiple source award.

D. PROCUREMENT MANAGER

The County of Torrance has designated a Procurement Manager who is responsible for this procurement and whose name, address, and telephone number are listed below. Any inquiries or requests regarding this procurement should be submitted to the Procurement Manager with electronic copies to Gallagher Benefit Services (GBS) as noted below in writing. Offerors may contact ONLY the Procurement Manager regarding the procurement. Other County employees do not have the authority to respond on behalf of the County of Torrance.

The County has contracted with Gallagher Benefit Services, Inc. (GBS) to provide consulting services including the solicitation and evaluation process, the evaluation and implementation process, as well as ongoing benefits consulting. Proposals should be submitted concurrently to the County and GBS as outlined later in this solicitation.

Noah J. Sedillo
Torrance County Purchasing

Delivery Address (Including proposal delivery):	Mailing Address:
205 S Ninth Street // Estancia, NM 87016	P.O. Box 48 // Estancia, NM 87016

Phone: (505) 554-4730
Fax: (505) 384-5294
E-mail: njsedillo@tcnm.us

NOTE: All deliveries via express carrier (INCLUDING PROPOSAL DELIVERY) should be addressed to Noah J. Sedillo's Delivery Address, above.

Proposals should be submitted concurrently to Michael Rohr, Senior Client Consultant and Courtney Seward Client Manager, Gallagher Benefit Services at mike_rohr@ajg.com and Courtney_Seward@ajg.com respectively. By submitting a proposal for the requested coverages, each Offeror is certifying that it is a qualified firm and its proposal complies with regulations and requirements stated within the Request for Proposals.

E. DEFINITION OF TERMINOLOGY

This section contains definitions that are used throughout this procurement document, including appropriate abbreviations.

Attachments means background materials for Offerors use to help formulate a response.

"Board of County Commissioners" (also "BCC") means the elected board in whom all powers of the County are vested and who are responsible for the proper and efficient administration of County government.

"Close of Business" means 5:00 P.M. Mountain Standard Time (MST) or Mountain Daylight Time (MDT), whichever is in effect on the date specified.

"Contract" or “Agreement” means a written agreement for the procurement of items of tangible personal property or services.

"Contractor" means a successful Offeror who enters into a binding contract.

"County" means the County of Torrance, State of New Mexico.

"Determination" means the written documentation of a decision of the procurement manager including findings of fact required to support a decision. A determination becomes part of the procurement file to which it pertains.

“Desirable" refers to the terms "may", "can", "should", "preferably" or "prefers" which identify a desirable or discretionary item or factor. (As opposed to a “mandatory” item or factor.)

"Evaluation Committee" means a body appointed by the Procurement Manager to perform the evaluation of Offeror proposals.

"Evaluation Committee Report" means a report prepared by the Procurement Manager and the Evaluation Committee for submission to appropriate approval authorities for contract award that contains all written determinations resulting from the conduct of a procurement requiring the evaluation of competitive sealed proposals.

“Exhibit(s)” means materials that are identified within the RFP which Offerors must complete and return as part of their RFP response.

"Finalist" is defined as an Offeror who meets all the mandatory specifications of this Request for Proposal and whose score on evaluation factors is sufficiently high to merit further consideration by the Evaluation Committee.

"Mandatory" refers to the terms "must", "shall", "will", "is required" or "are required" which identify a mandatory item or factor. (As opposed to a “desirable” item or factor.) Failure to meet a mandatory item or factor may result in the rejection of the Offeror's proposal.
"Local public body" means every political subdivision of the State of New Mexico and the agencies, instrumentalities and institutions thereof, including two-year post-secondary educational institutions, school districts and local school boards and municipalities.

"NMAC" means the New Mexico Administrative Code, as administered by the New Mexico Commission of Public Records, State Records Center and Archives, Administrative Law Division.

"Offeror" is any person, corporation, or partnership who chooses to submit a proposal.

"Procurement Manager" means the person or designee authorized by the County to manage or administer a procurement requiring the evaluation of competitive sealed proposals.

"Procuring agency of the County" means the department or other subdivision of the County of Torrance that is requesting the procurement of services or items of tangible personal property.

"Purchase Order" or "PO" means the document which directs a contractor to deliver items of tangible personal property or services pursuant to an existing, valid contract.

"Purchasing" means the County of Torrance Purchasing Office, or the Torrance County Purchasing Agent or the Chief Procurement Officer.

"Purchasing Agent" or "PA" means the Purchasing Agent for the County of Torrance.

"Request for Proposals" or "RFP" means all documents, including those attached or incorporated by reference, used for soliciting proposals.

"Responsible Offeror" means an Offeror who submits a responsive proposal and who has furnished required information and data to prove that their financial resources, production or service facilities, personnel, service reputation and experience are adequate to make satisfactory delivery of the services or items of tangible personal property called for in this proposal.

"Responsive Offer" or "Responsive Proposal" means an offer or proposal which conforms in all material respects to the requirements set forth in the request for proposals. Material respects of a request for proposals include, but are not limited to, price, quality, quantity and delivery requirements.

"Statement of Compliance" and "Statement of Concurrence" mean an express statement, by the Offeror in their proposal, that they agree with and agree to the stated requirement(s). Possible examples of acceptable responses include "The [NAME HERE Company] agrees to comply with this requirement." and "The [NAME HERE Company] concurs with this requirement."

F. RESIDENT/VETERAN BUSINESS PREFERENCE

Resident Business Preference

The New Mexico Procurement Code provides for preference for resident businesses and Contractors under certain conditions. If applicable, the preference will be provided to those Offerors that have provided a valid resident business preference certificate with their proposal, as required by 13-1-22 NMSA 1978.

In order for an Offeror to receive preference as a resident business, that Offeror must submit a copy of their preference certificate with their proposal. The preference certificate must have been issued by the New Mexico Taxation and Revenue Department after January 1, 2012. Providing only a preference number is not acceptable and will not qualify the Offeror for any preference.

For more information, reference Sections 13-1-21 and 13-1-22 of the New Mexico Procurement Code. Preference applications are available for download at:

Resident Business:

http://www.tax.newmexico.gov/Businesses/in-state-veteran-preference-certification.aspx

Resident Veterans Preference

Effective July 1, 2022, certain preferences are available to New Mexico veteran-owned businesses. Please see Section V.D.4 for more information and especially note Appendix F.

G. PROCUREMENT LIBRARY

The Procurement Library consists of the following documents which may be accessed by their associated Internet links:

- New Mexico Procurement Code
https://laws.nmonesource.com/w/nmos/Chapter-13-NMSA-1978#!fragment//BQCwhgziBcwMYgK4DsDWszIQewE4BUBTADwBdoByCgSgBpltTCIBFRQ3AT0otojlzYANkIDCSNNACEyPoTC4EbDtypyFCAMp5SAIW4AlAKIAZIwDUAggDlRR2qTAAjaKWxxq1IA

- Torrance County Procurement Policy
https://www.torrancecountynm.org/uploads/Downloads/Finance%20Department/TC%20Finance%20and%20Purchasing%20Policy.pdf

II. CONDITIONS GOVERNING THE PROCUREMENT

This section of the RFP contains the schedule for the procurement, describes the major procurement events and contains the general requirements governing the procurement.

A. SEQUENCE OF EVENTS

The Procurement Manager will make every effort to adhere to the following schedule:

ACTION	RESPONSIBILITY	DATE
1. Issue RFP	Procurement Manager (PM) and Gallagher	07/29/2022 (Friday)
2. Return of "Acknowledgment of Receipt" Form for Distribution List	**Potential Offerors (PO)**	**08/04/2022 (Thursday)**
3. Pre-Proposal Conference	Not Applicable	Not Applicable
4. Deadline to Submit Additional Questions	PO	08/09/2022 (Tuesday)
5. Response to Written Questions/ RFP Amendments	PM/Gallagher to assist	08/11/2022 (Thursday)
6. Submission of Proposal	**Offerors**	**08/25/2022 (Thursday) 3:00 PM MDT**
7. Proposal Evaluation	Evaluation Committee (EC)/Gallagher to Assist	08/26/2022 (Friday) to 09/06/2022 (Tuesday)
8. Notification of Finalists (If desired)	EC	09/07/2022 (Wednesday)
9. Best & Final Offer (If requested)	Offerors	09/13/2022 (Tuesday)
10. Oral (Teleconference) Presentations (If requested)	Evaluation Committee (EC)/Gallagher to Assist	09/14/2022 (Tuesday)
11. Contract Negotiations (If needed)	Tentative winner/County/Gallagher	09/15/2022 (Thursday) to 09/21/2022 (Wednesday)
12. Contract Award*	Purchasing Agent/BCC*	09/28/2022 (Wednesday)
13. Protest Deadline	Offerors	10/14/2022 (Friday)

*Contract award is subject to approval of the Board of County Commissioners.

B. EXPLANATION OF EVENTS

The following paragraphs further detail the activities listed in the sequence of events shown in Section II, Paragraph A.

1. Issue RFP

This RFP is being issued by the Torrance County Purchasing Agent on behalf of the County of Torrance and the Torrance County Board of County Commissioners.

2. Return of "Acknowledgment of Receipt" Form for Distribution List

Potential Offerors should hand deliver or return by facsimile or e-mail or registered or certified mail the "Acknowledgement of Receipt" form that accompanies this document (See Appendix A) to have their organization placed on the procurement distribution list. The form should be signed by an authorized representative of the organization, dated and returned by the close of business on the date indicated in Section II.A (Sequence of Events), above.

The procurement distribution list will be used to notify those that submitted the form of any written responses to questions and any RFP amendments. Failure to return this form shall constitute a presumption of receipt and rejection of the RFP, and the potential Offeror's organization name shall not appear on the distribution list.

3. Pre-Proposal Conference

Not Applicable

4. Deadline to submit additional written questions

Potential Offerors may submit additional written questions as to the intent or clarity of this RFP until 3:00 PM MDT on the date indicated in Section II.A (Sequence of Events), above. All written questions must be sent by e-mail to the Procurement Manager (See Section I, Paragraph D.)

5. Response to written questions/RFP Amendments

Written responses to written questions and any RFP amendments will be posted to the Torrance County Purchasing Office web sitehttp://www.torrancecountynm.org/rfb-rfp, via the "RFB & RFP" link). Notification of such posting shall be provided to all potential Offerors that have returned the "Acknowledgement of Receipt" Form found at Appendix A. A new "Acknowledgement of Receipt" Form will accompany the posted distribution package. The form should be signed by the Offeror's representative, dated, and hand-delivered or returned by facsimile or e-mail or by registered or certified mail by the date indicated thereon. Failure to return this form shall constitute a presumption of receipt and withdrawal from the procurement process.

6. Submission of Proposal

OFFEROR PROPOSALS MUST BE RECEIVED FOR REVIEW AND EVALUATION BY THE PROCUREMENT MANAGER OR DESIGNEE **NO LATER THAN 3:00 PM MDT ON THE DATE INDICATED** IN SECTION II.A (SEQUENCE OF EVENTS),

ABOVE. **PROPOSALS RECEIVED AFTER THIS DEADLINE FOR ANY REASON WILL NOT BE ACCEPTED OR CONSIDERED.**

The date and time of receipt will be recorded on each proposal. Proposals must be addressed and delivered to the Procurement Manager at the delivery address listed in Section I, Paragraph D. Proposals must be sealed and should be labeled on the outside of the package to clearly indicate that they are in response to the "FULLY INSURED LIFE, SHORT TERM DISABILITY, LONG TERM DISABILITY AND VISION COVERAGE for Torrance County", should reference "RFP TC-FY23-01 and should indicate the deadline for receipt (due date and time.) Proposals submitted by facsimile or other electronic means **WILL NOT BE ACCEPTED.**

A public log will be kept of the names of all Offerors submitting proposals. Pursuant to Section 13-1-116 NMSA 1978, the contents of any proposal shall not be disclosed to competing Offerors prior to contract award.

7. Proposal Evaluation

The evaluation of proposals will be performed by an Evaluation Committee appointed by Purchasing Agent. This process will take place during the time period indicated in Section II.A (Sequence of Events), above. During this time, the Procurement Manager may at his option initiate discussions with Offerors who submit responsive or potentially responsive proposals for the purpose of clarifying aspects of the proposals, but proposals may be accepted and evaluated without such discussion. Discussions SHALL NOT be initiated by the Offerors.

8. Notification of Finalists

The Evaluation Committee may select and the Procurement Manager may notify finalist Offerors on the date indicated in Section II.A (Sequence of Events), above. Only finalists will be invited to participate in the subsequent steps of the procurement. The Evaluation Committee reserves the right not to utilize the finalist process if they deem it in the best interest of the County.

9. Best and Final Offers

Finalists may be asked to submit revisions to their proposals for the purpose of obtaining best and final offers on the date indicated in Section II.A (Sequence of Events), above.

10. Oral (Teleconference) Presentations

Finalist Offerors may be required to make an oral (teleconference) presentation to the Evaluation Committee. If so required, the Procurement Manager will schedule the time for each Offeror's presentation. All presentations will be made in a location to be

specified in Estancia, NM 87016 or via specified teleconference. Each presentation will be limited to a fixed amount of time as designated by the Procurement Manager in the Oral (Teleconference) Presentation requirement notification.

11. Contract Negotiations

If necessary, contract negotiations shall commence with the most advantageous Offeror no later than the date indicated in Section II.A (Sequence of Events), above. In the event that mutually agreeable terms cannot be reached within the time specified, the County reserves the right to finalize a contract with the next most advantageous Offeror without undertaking a new procurement process.

12. Contract Award

After review of the Evaluation Committee Report and the tentative contract, the Purchasing Agent anticipates the Board of County Commissioners will award the contract on the date indicated in Section II.A (Sequence of Events), above. This date is subject to change at the discretion of the Purchasing Agent or the Board of County Commissioners.

Any contract awarded shall be awarded to the Offeror whose proposal is most advantageous to the County, taking into consideration the evaluation factors set forth in this RFP. The most advantageous proposal may or may not have received the most points.

13. Protest Deadline

Any protest by an Offeror must be timely, in conformance with, and will be governed by Sections 13-1-172 through 13-1-176 NMSA 1978. The fifteen (15) day protest period for timely Offerors shall begin on the day following contract award and will end at 5:00 PM MDT on the date indicated in Section II.A (Sequence of Events), above. Protests must be written and must include the name and address of the protestor and the Request for Proposals number. It must also contain a statement of grounds for protest including appropriate supporting exhibits, and it must specify the ruling requested from the Purchasing Agent. The protest must be delivered to the Purchasing Agent.

Torrance County Purchasing
Attn. Noah J. Sedillo
P.O. Box 48
205 S Ninth Street
Estancia, New Mexico 87016

NOTE: Protests received after the deadline will not be accepted.

C. GENERAL REQUIREMENTS

This procurement will be conducted in accordance with the New Mexico Procurement Code (13-1-28 through 13-1-199 NMSA 1978) and Torrance County Procurement Policy (Resolution 2022-26).

1. Acceptance of Conditions Governing the Procurement

Offerors must indicate their acceptance of the Conditions Governing the Procurement in the letter of transmittal form (see Appendix D). Submission of a proposal constitutes acceptance of the Evaluation Factors contained in Section V of this RFP.

2. Incurring Cost

Any cost incurred by the Offeror in preparation, transmittal, presentation of any proposal or material or negotiation associated with their response to this RFP shall be borne solely by the Offeror.

3. Prime Contractor Responsibility

Any contract that may result from this RFP shall specify that the prime contractor is solely responsible for fulfillment of the contract with the County. The County will only make contract payments to the prime contractor.

4. Subcontractors

Use of subcontractors must be clearly explained in the proposal and each must be identified by name. The prime contractor shall be wholly responsible for contract performance whether or not subcontractors are used. Substitution of subcontractors, after contract award, must receive prior written approval of the County Purchasing Office.

5. Amended Proposals

An Offeror may submit an amended proposal before the deadline for receipt of proposals. Such amended proposals must be complete replacements for a previously submitted proposal and must be clearly identified as such in the transmittal letter. County personnel will not merge, collate, or assemble proposal materials.

6. Offeror’s Rights to Withdraw Proposal

Offerors will be allowed to withdraw their proposals at any time prior to the deadline for receipt of proposals. The Offeror must submit a written withdrawal request signed by the Offeror's duly authorized representative addressed to the Procurement Manager. The approval or denial of withdrawal requests received after the deadline for receipt of the proposals is governed by the applicable procurement regulations.

7. Proposal Offer Firm

Responses to this RFP, including proposal prices, will be considered firm for one hundred-fifty (150) days after the due date for receipt of proposals or one hundred-twenty (120) days after the due date for the receipt of a best and final offer, if one is solicited.

8. Disclosure of Proposal Contents

The proposals will be kept confidential until a contract is awarded by the awarding authority. At that time, all proposals and documents pertaining to the proposals will be open to the public, except for material which is proprietary or confidential. The Procurement Manager will not disclose or make public any pages of a proposal on which the Offeror has stamped or imprinted "proprietary" or "confidential" subject to the following requirements.

> Proprietary or confidential data shall be readily separable from the proposal in order to facilitate eventual public inspection of the remaining portions of the proposal. Confidential data is normally restricted to confidential financial information concerning the Offeror's organization and data that qualifies as a trade secret in accordance with the Uniform Trade Secrets Act, 57-3A-I to 57-3A-7 NMSA 1978. The price of products offered or the cost of services proposed shall not be designated as proprietary or confidential information.

If a request is received for disclosure of data for which an Offeror has made a written request for confidentiality, the Purchasing Agent shall examine the Offeror's request and make a written determination that specifies which portions of the proposal should be disclosed. Unless the Offeror takes legal action to prevent the disclosure, the proposal will be so disclosed. The proposal shall be open to public inspection subject to any continued prohibition on the disclosure of confidential data.

9. No Obligation

This procurement in no manner obligates Torrance County or any of its departments or other subdivisions to the eventual lease, purchase, etc., of any tangible personal property offered or services proposed until a valid written contract is approved by the Purchasing Agent and other required approval authorities.

10. Termination

This RFP may be canceled at any time and any and all proposals may be rejected in whole or in part when the County determines such action to be in the best interest of the County.

11. Sufficient Appropriation

Any contract awarded as a result of this RFP process may be terminated if sufficient appropriations or authorizations do not exist. Such termination will be effected by sending written notice to the contractor. The County's decision as to whether sufficient appropriations and authorizations are available will be accepted by the contractor as final.

12. Legal Review

The County requires that all Offerors agree to be bound by the General Requirements contained in this RFP. Any Offeror concerns must be promptly brought to the attention of the Procurement Manager.

13. Governing Law

This procurement and any agreement with Offerors that may result shall be governed by the laws of the State of New Mexico.

14. Basis for Proposal

Only information supplied by the County in writing through the Procurement Manager or in this RFP should be used as the basis for the preparation of Offeror proposals.

15. Contract Terms and Conditions

The contract between the County the contractor will follow the format specified by the County and contain the terms and conditions set forth in Appendix B, Sample Contract. However, the County reserves the right to negotiate with a successful Offeror provisions in addition to those contained in this RFP. The contents of this RFP, as revised or supplemented, and the successful Offeror's proposal will be incorporated into and become part of the contract.

Should an Offeror object to any of the County’s terms and conditions, as contained in this Section or in Appendix B, that Offeror must propose specific alternative language. The County may or may not accept the alternative language, at the County’s sole discretion. General references to the Offeror's terms and conditions or attempts at complete substitutions are not acceptable to the County and could lead to disqualification of the Offeror's proposal.

Offerors must provide a brief discussion of the purpose and impact, if any, of each proposed change followed by the specific proposed alternate wording in order for the proposed alternate wording to be considered.

16. Offeror's Terms and Conditions

Offeror's must submit with their proposal a complete set of any additional terms and conditions which they request be included in a contract negotiated with the County. The County may or may not accept the additional language, at the County's sole discretion.

17. Contract Deviations

Any additional terms and conditions, which may be the subject of negotiation, will be discussed only between the County and the selected Offeror and shall not be deemed an opportunity to amend the Offeror's proposal.

18. Offeror Qualifications

The Evaluation Committee may make such investigations as necessary to determine the ability of the Offeror to adhere to the requirements specified within this RFP. The Evaluation Committee will reject the proposal of any Offeror who is not a responsible Offeror or fails to submit a responsive offer as defined in Sections 13-1-83 and 13-1-85 NMSA 1978.

19. Right to Waive Minor Irregularities

The Evaluation Committee reserves the right to waive minor irregularities. The Evaluation Committee also reserves the right to waive mandatory requirements provided that all of the otherwise responsive proposals failed to meet the same mandatory requirements or doing so does not otherwise materially affect the procurement. This right is at the sole discretion of the Evaluation Committee.

20. Change in Contractor Representatives

The County reserves the right to require a change in contractor representatives if the assigned representatives are not, in the opinion of the County, meeting its needs adequately.

21. Notice

The Procurement Code, Sections 13-1-28 through 13-1-199 NMSA 1978, imposes civil and misdemeanor criminal penalties for its violation. The State of New Mexico criminal statutes also impose felony penalties for bribes, gratuities and kick-backs.

22. County Rights

The County reserves the right to accept all or a portion of an Offeror's proposal.

23. Ownership of Proposals

All documents submitted in response to the RFP shall become the property of the County. However, any technical or user documentation submitted with the proposals of non-selected Offerors may be returned after the expiration of the protest period, by request, at the expense of the Offeror.

24. Ambiguity, Inconsistency or Errors in RFP

Offerors shall promptly notify the Procurement Manager, in writing, of any ambiguity, inconsistency or error which they discover upon examination of the RFP.

25. Competition

By submitting a proposal, Offeror certifies that they have not, either directly or indirectly, entered into any action in restraint of full competition in connection with the proposal submitted to the County.

26. Use by Other Government Entities

By submitting a proposal, Offeror indicates that they understand and agree that other government entities within the State of New Mexico, or as otherwise allowed by their governing directives, may contract for the goods or services included in this procurement document with the awarded contractor(s). Contractual engagements accomplished under this provision shall be solely between the awarded vendor and the contracting government entity with no obligation or liability incurred by Torrance County.

27. Confidentiality

Any confidential information provided to, or developed by, the contractor in the performance of any agreement resulting from this RFP shall be kept confidential and shall not be made available to any individual or organization by the contractor without the prior written approval of the County of Torrance.

28. Electronic mail address required

A large part of the communication regarding this procurement will be conducted by electronic mail (e-mail). Offeror must have a valid e-mail address to receive this correspondence.

29. Use of Electronic Versions of this RFP

This RFP is being made available by electronic means. If accepted by such means, the Offeror acknowledges and accepts full responsibility to ensure that no changes are made to the RFP. In the event of conflict between a version of the RFP in the Offeror's

possession and the version maintained by the County, the version maintained by the County shall govern.

III. RESPONSE FORMAT AND ORGANIZATION

A. NUMBER OF RESPONSES

Offeror's may submit only one (1) response to this RFP.

B. NUMBER OF COPIES

Offerors shall deliver electronic copies of their proposal as specified in Section I, Paragraph D on or before the closing date and time for receipt of proposals. The original copy should be clearly marked "ORIGINAL" on the front cover and shall contain original signatures (to include digitally time-stamped and/or watermarked signature). (The "Cost Response Form" and the "Campaign Contribution Disclosure Form". See Section III.C.1, immediately below.) Shall both be clearly marked "ORIGINAL" and provided in a separate attachment submitted with the proposal.

C. PROPOSAL FORMAT

1. Proposal Organization

The proposal should be organized and indexed in the following format and must contain, as a minimum, all listed items in the sequence shown unless otherwise indicated.

a. Letter of Transmittal Form (See Appendix D)

b. Valid Resident Preference Certificate (Optional at Offeror's discretion. See Section I.F.)

c. Resident Veterans Preference Certificate (If applicable. See Appendix F.)

d. Table of Contents

e. Cost Response Form (See Appendix C) in a separate attached document

f. Campaign Contribution Disclosure Form* (See Appendix E) in a separate attached document

g. Exhibits 1through 11

Within each section of their proposal, Offerors should address the items in the order in which they appear in this RFP. Any forms provided in the RFP must be thoroughly completed and included in the appropriate section of the proposal. Unless otherwise specified in this RFP, all discussion of proposed costs, rates or expenses must occur only on the Cost Response Form*, Appendix C.

Any proposal that does not adhere to these requirements may be deemed non-responsive and rejected on that basis.

A proposal summary may be included by Offerors to provide the Evaluation Committee with an overview of the technical and business features of the proposal; however, this material will not be used in the evaluation process unless specifically referenced from other portions of the Offeror's proposal.

2. Letter of Transmittal Form

The Letter of Transmittal Form at Appendix D **must** be completed, signed and included with the Offeror's proposal.

3. Other Supporting Materials

Offerors may attach other materials which they feel may improve the quality of their responses. However, these materials may not be reviewed by members of the Evaluation Committee and **will not** be scored.

IV. SPECIFICATIONS

A. INFORMATION

1. Resident Business Preference

A valid Resident Preference Certificate issued by the New Mexico Taxation and Revenue Department on or after January 1, 2022 **must** be included with the proposal if the Offeror wishes to receive the additional points available as a qualifying resident business. See Section I.F, above, for more information.

2. Resident Veterans Preference Certificate

A complete and signed Resident Veterans Preference Certificate **must** be included with the proposal if the Offeror wishes to receive the additional points available as a qualifying Resident Veteran. See Section V.D.4 for more information.

3. Response to Requirements

Each mandatory requirement in sections IV.B.1 through IV.B.9, below, requires a vendor response, as indicated. Failure to respond to, or properly comply with, a mandatory requirement may result in the disqualification of the Offeror's proposal.

B. MANDATORY REQUIREMENTS

1. Letter of Transmittal Form (0 Points)

Offeror must complete and submit the "Letter of Transmittal Form", found at Appendix D, with their proposal. The form must be signed and dated by an individual authorized to contractually bind the firm.

2. New Mexico licensed insurer (0 Points)

Offeror must be licensed by the New Mexico Office of the Superintendent of Insurance or equivalent.

3. Insurance Carrier Organizational Strength to include: (200 Points)

Offerors must complete all Exhibits as described within the RFP.

(a) Administration / systems strength
(b) Public sector experience
(c) Support / Educational Tools for Employer and Member
(d) Agreement to offer and quality of Performance Guarantees
(e) References

4. Client Management Team to include (100 Points)

Offerors must complete all Exhibits as described within the RFP.

(a) Local Representative
(b) Dedicated Representative
(c) Public Sector Representative
(d) On Site Renewal Assistance/Meetings

5. Network and Plan Design to include: (325 Points)

Offerors must complete all Exhibits as described within the RFP.:

(a) Size / stability of network
(b) Utilization / cost management
(c) Plan Design Customization
(d) EAP Included
(e) Network Match

6. Capability and Agreement to Perform (0 Points)

Offeror certifies that they are capable and qualified to provide the services required by this RFP and agrees to perform the Scope of Work as specified in the Contract at Appendix B. A statement of concurrence is required.

7. Oral (Teleconference) Presentation (50 Points)

If required by the Evaluation Committee, Offeror must agree to attend and participate in an oral presentation (or teleconference presentation) as specified by the Evaluation Committee. A statement of concurrence is required. If held, the offeror will be required to present their proposal and explain their approach to providing audit services to Torrance County.

8. Campaign Contribution Disclosure Form (0 Points)

Offeror must complete and sign the Appendix E, Campaign Contribution Disclosure Form – whether any applicable contribution has been made or not. This form must be submitted with your proposal whether an applicable contribution has been made or not. Note that there are two (2) different signature sections within the form. (For purposes of this requirement, the applicable elected public officials within the County of Torrance are BCC Chairmen Ryan Schwebach; Commissioners Kevin McCall and LeRoy Candelaria; Assessor Jesse Lucero; Clerk Linda Jaramillo; Probate Judge Josie Chavez; Sheriff Martin Rivera and Treasurer Tracy Sedillo.)

9. Cost (325 Points)

Offeror must complete and submit the Cost Response Form, at Appendix C, providing proposed annual contract cost for accomplishing the scope of work. State gross receipts and local option taxes (if any) shall not be included in the proposed cost. Such taxes shall be separately reimbursed to the contractor by the County. Indicate any rate guarantees, rate caps, wellness funds and implementation credits included as part of your offering.

C. DESIRABLE REQUIREMENTS

There are no desirable requirements associated with this procurement.

V. EVALUATION

A. EVALUATION POINT SUMMARY

The following is a summary of evaluation factors with point value assigned to each or a Pass/Fail evaluation. These, along with the general requirements, will be used in the evaluation of individual Offeror proposals.

REF.	REQUIREMENT	POINTS AVAIL.
IV.B.1	Letter of Transmittal Form	0*
IV.B.2	New Mexico licensed insurer	0*
IV.B.3	Organizational Strength	200
IV.B.4	Client Management Team	100
IV.B.5	Network and Plan Design	325
IV.B.6	Capability and Agreement to Perform	0*
IV.B.7	Oral (Teleconference) Presentation	50
IV.B.8	Campaign Contribution Disclosure Form	0*
IV.B.9	Cost	325
TOTAL		1,000

*Pass/Fail only.

Points will be awarded based on the evaluation factors found in V.B.1 through V.B.9, below, as indicated.

B. EVALUATION FACTORS: MANDATORY REQUIREMENTS

1. Letter of Transmittal Form (0 Points)

Pass/Fail only.

2. New Mexico licensed insurer (0 Points)

Pass/Fail only.

3. Organizational Strength (200 Points)

Points will be awarded based on the strength and convincingness of the offeror's response. Offeror responses will also be compared to submittals from other Offerors under this RFP.

4. Client Management Team (100 Points)

Points will be awarded based on the strength and convincingness of the offeror's response. Offeror responses will also be compared to submittals from other Offerors under this RFP.

5. Network and Plan Design (325 Points)

Points will be awarded based on the strength and convincingness of the offeror's response.

6. Capability and Agreement to Perform (0 Points)

Pass/Fail only.

7. Oral (Teleconference) Presentation (50 Points)

If held, points will be awarded based on the quality, content and logic of the offeror's presentation as well as the strength and convincingness of answers provided to questions posed by the Evaluation Committee. If oral (teleconference) presentations are not held, all finalist offerors will be awarded the full fifty (50) points available.

8. Campaign Contribution Disclosure Form (0 Points)

Pass/Fail only.

9. Cost (325 Points)

Points will be awarded based on the total cost proposed on the Cost Response Form and calculated using the following formula:

$$\text{Offeror's Points} = \frac{\text{Lowest Annual Proposed Cost}}{\text{This Offeror's Annual Proposed Cost}} \times 325$$

C. EVALUATION FACTORS: DESIRABLE REQUIREMENTS

There are no desirable requirements associated with this procurement.

D. EVALUATION PROCESS

1. Initial Review

All Offeror proposals will be reviewed for compliance with the mandatory requirements stated within the RFP. Proposals deemed non-responsive to any mandatory requirement will be eliminated from further consideration.

2. Clarifications

The Procurement Manager may contact the Offeror for clarification of the response as specified in Section II, Paragraph B.7.

3. Other Information Sources

The Evaluation Committee may use other sources of information to perform the evaluation as specified in Section II, Paragraph C.18.

4. New Mexico Business Preference

Points will awarded based on Offerors ability to provide a copy of a current Resident Business Certificate or Resident Veterans Certificate. The preference will be provided to those Offerors that have provided a valid resident business preference certificate or a valid resident contractor certificate (as appropriate) or a Resident Veterans Preference Certificate (or both) with their proposal.

5. Scoring and Contract Award Recommendation

Responsive proposals will be evaluated and assigned a point value based on the factors in Section V. Finalist Offerors who are asked and choose to submit revised proposals for the purpose of obtaining best and final offers will have their points recalculated accordingly. The responsible Offeror whose proposal is most advantageous to the County, taking into consideration the evaluation factors in Section V, will be recommended for contract award to the Purchasing Agent, and any other required approving authorities, as specified in Section II, Paragraph B.12. Please note, however, that a serious deficiency in the response to any one factor may be grounds for rejection regardless of overall score.

APPENDIX A

ACKNOWLEDGEMENT OF RECEIPT FORM

Request for Proposals

FULLY INSURED LIFE, SHORT TERM DISABILITY, LONG TERM DISABILITY AND VISION COVERAGE

Torrance County RFP TC-FY23-01

In acknowledgment of receipt of this Request for Proposals, the undersigned agrees that he/she has received a complete copy, beginning with the title page and table of contents, and ending with Appendix F.

The acknowledgment of receipt should be signed and returned (by fax, e-mail, courier or hand delivery) to the Procurement Manager no later than August 04, 2022. Only potential Offerors who elect to return this form completed with the indicated intention of submitting a proposal will receive Attachments 6 through 10 noted in this RFP, copies of all Offeror written questions and the County's written responses to those questions as well as RFP amendments, if any are issued.

The firm listed below does/does not (circle one) intend to respond to this Request for Proposals.

FIRM: _____

REPRESENTED BY: _____ TITLE:_____

E-MAIL ADDRESS: _____

PHONE NO.:_____ FAX NO.:_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

SIGNATURE: _____ DATE:_____

This name and address will be used for all correspondence related to the Request for Proposals.

Please return to:

Noah J. Sedillo
Torrance County Purchasing
P.O. Box 48
205 S Ninth Street
Estancia, NM 87016

Phone: (505) 544-4730
Fax: (505) 384-5294
E-mail: njsedillo@tcnm.us
With electronic copy to
Michael Rohr
Senior Client Consultant
Gallagher Benefit Services
mike_rohr@ajg

With electronic copy to
Courtney Seward
Client Manager
Gallagher Benefit Services
courtney_seward@ajg.com

APPENDIX B

RFP TC-FY-23-01
Fully Insured LIFE, SHORT TERM DISABILITY, LONG TERM DISABILITY AND VISION Coverages Contract

THIS AGREEMENT is made and entered into by and between the County of Torrance, _____, hereinafter referred to as the "County" and **NAME OF CONTRACTOR**, hereinafter referred to as the "Contractor", and is effective as of the date set forth below upon which it is executed by the Board of County Commissioners.

IT IS AGREED BETWEEN THE PARTIES:

1. Scope of Work.

To be completed as negotiated.

2. Compensation.

A. The County shall pay to the Contractor in full payment for services satisfactorily performed _____ dollars ($_____), to be invoiced according to negotiated milestones, deliverables, and services rendered upon contract award. The New Mexico gross receipts tax levied on the amounts payable under this Agreement totaling (AMOUNT) shall be paid by the County to the Contractor in equal monthly amounts. The total amount payable to the Contractor under this Agreement, including gross receipts tax and expenses, shall not exceed (AMOUNT). In no event will the Contractor be paid any amount in excess of the specified total amount payable without this Agreement being amended in writing.

B. Payment is subject to availability of funds pursuant to the Appropriations Paragraph set forth below and to any negotiations between the parties from year to year pursuant to Paragraph 1, Scope of Work. All invoices MUST BE received by the County no later than fifteen (15) days after the termination of the Fiscal Year in which the services were delivered. Invoices received after such date WILL NOT BE PAID.

C. Contractor must submit a detailed statement accounting for all services performed, specified on a minimum of a quarter hour basis, and expenses incurred. If the County finds that the services are not acceptable, within thirty days after the date of receipt of written notice from the Contractor that payment is requested, it shall provide the Contractor a letter of exception explaining the defect or objection to the services, and outlining steps the Contractor may take to provide remedial action. Upon certification by the County that the services have been received and accepted, payment shall be

tendered to the Contractor within thirty days after the date of acceptance. If payment is made by mail, the payment shall be deemed tendered on the date it is postmarked. However, the County shall not incur late charges, interest, or penalties for failure to make payment within the time specified herein.

D. The payment of taxes due for any money received under this Agreement shall be the Contractor's sole responsibility and shall be reported under the Contractor's Federal and State tax identification number(s).

3. Term.

This agreement is for one (1) year from the date of award. This services contract will automatically renew up to seven (7) additional one (1) year terms.. This procurement may result in a multiple source award.

4. Termination.

A. Termination. This Agreement may be terminated by either of the parties hereto upon written notice delivered to the other party at least sixty (60) days prior to the intended date of termination. Except as otherwise allowed or provided under this Agreement, the County's sole liability upon such termination shall be to pay for acceptable work performed prior to the Contractor's receipt of the notice of termination, if the County is the terminating party, or the Contractor's sending of the notice of termination, if the Contractor is the terminating party; provided, however, that a notice of termination shall not nullify or otherwise affect either party's liability for pre-termination defaults under or breaches of this Agreement. The Contractor shall submit an invoice for such work within thirty (30) days of receiving or sending the notice of termination. Notwithstanding the foregoing, this Agreement may be terminated immediately upon written notice to the Contractor if the Contractor becomes unable to perform the services contracted for, as determined by the County or if, during the term of this Agreement, the Contractor or any of its officers, employees or agents is indicted for fraud, embezzlement or other crime due to misuse of government funds or due to the Appropriations paragraph herein. THIS PROVISION IS NOT EXCLUSIVE AND DOES NOT WAIVE THE COUNTY's OTHER LEGAL RIGHTS AND REMEDIES CAUSED BY THE CONTRACTOR'S DEFAULT/BREACH OF THIS AGREEMENT.

B. Termination Management. Immediately upon receipt by either the County or the Contractor of notice of termination of this Agreement, the Contractor shall: 1) not incur any further obligations for salaries, services or any other expenditure of funds under this Agreement without written approval of the County; 2) comply with all directives issued by the County in the notice of termination as to the performance of work under this Agreement; and 3) take such action as the County shall direct for the protection, preservation, retention or transfer of all property titled to the County and records generated

under this Agreement. Any non-expendable personal property or equipment provided to or purchased by the Contractor with contract funds shall become property of the County upon termination and shall be submitted to the County as soon as practicable.

5. Appropriations.

The terms of this Agreement are contingent upon sufficient appropriations and authorization being made by the Board of County Commissioners for the performance of this Agreement. If sufficient appropriations and authorization are not made by the Board of County Commissioners, this Agreement shall terminate immediately upon written notice being given by the County to the Contractor. The County's decision as to whether sufficient appropriations are available shall be accepted by the Contractor and shall be final. If the County proposes an amendment to the Agreement to unilaterally reduce funding, the Contractor shall have the option to terminate the Agreement or to agree to the reduced funding, within thirty (30) days of receipt of the proposed amendment.

6. Status of Contractor.

The Contractor and its agents and employees are independent contractors performing professional services for the County and are not employees of the County of Torrance. The Contractor and its agents and employees shall not accrue leave, retirement, insurance, bonding, use of county vehicles, or any other benefits afforded to employees of the County of Torrance as a result of this Agreement. The Contractor acknowledges that all sums received hereunder are reportable by the Contractor for tax purposes, including without limitation, self-employment and business income tax. The Contractor agrees not to purport to bind the County of Torrance unless the Contractor has express written authority to do so, and then only within the strict limits of that authority.

7. Assignment.

The Contractor shall not assign or transfer any interest in this Agreement or assign any claims for money due or to become due under this Agreement without the prior written approval of the County.

8. Subcontracting.

The Contractor shall not subcontract any portion of the services to be performed under this Agreement without the prior written approval of the County. No such subcontract shall relieve the primary Contractor from its obligations and liabilities under this Agreement, nor shall any subcontract obligate direct payment from the County. In all cases, the contractor is solely responsible for fulfillment of this Agreement.

9. Release.

Final payment of the amounts due under this Agreement shall operate as a release of the procuring agency of the County, its officers and employees, and the County of

Torrance from all liabilities, claims and obligations whatsoever arising from or under this Agreement.

10. Confidentiality.

Any confidential information provided to or developed by the Contractor in the performance of this Agreement shall be kept confidential and shall not be made available to any individual or organization by the Contractor without the prior written approval of the County.

11. Product of Service -- Copyright.

All materials developed or acquired by the Contractor under this Agreement shall become the property of the County of Torrance and shall be delivered to the County no later than the termination date of this Agreement. Nothing developed or produced, in whole or in part, by the Contractor under this Agreement shall be the subject of an application for copyright or other claim of ownership by or on behalf of the Contractor.

12. Conflict of Interest; Governmental Conduct Act.

A. The Contractor represents and warrants that it presently has no interest and, during the term of this Agreement, shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance or services required under the Agreement.

B. The Contractor further represents and warrants that it has complied with, and, during the term of this Agreement, will continue to comply with, and that this Agreement complies with all applicable provisions of the Governmental Conduct Act, Chapter 10, Article 16 NMSA 1978. Without in anyway limiting the generality of the foregoing, the Contractor specifically represents and warrants that:

1) in accordance with Section 10-16-4.3 NMSA 1978, the Contractor does not employ, has not employed, and will not employ during the term of this Agreement any County employee while such employee was or is employed by the County and participating directly or indirectly in the County's contracting process;

2) this Agreement complies with Section 10-16-7(B) NMSA 1978 because (i) the Contractor is not a public officer or employee of the County; (ii) the Contractor is not a member of the family of a public officer or employee of the County; (iii) the Contractor is not a business in which a public officer or employee or the family of a public officer or employee has a substantial interest; or (iv) if the Contractor is a public officer or employee of the County, a member of the family of a public officer or employee of the County, or a business in which a public officer or employee of the County or the family of a public officer or employee of the County has a substantial interest, public

notice was given as required by Section 10-16-7(B) NMSA 1978 and this Agreement was awarded pursuant to a competitive process;

3) in accordance with Section 10-16-8(C) NMSA 1978, (i) the Contractor is not, and has not been represented by, a person who has been a public officer or employee of the County within the preceding year and whose official act directly resulted in this Agreement and (ii) the Contractor is not, and has not been assisted in any way regarding this transaction by, a former public officer or employee of the County whose official act, while in County employment, directly resulted in the County's making this Agreement;

4) in accordance with Section 10-16-13 NMSA 1978, the Contractor has not directly participated in the preparation of specifications, qualifications or evaluation criteria for this Agreement or any procurement related to this Agreement; and

5) in accordance with Section 10-16-3 and Section 10-16-13.3 NMSA 1978, the Contractor has not contributed, and during the term of this Agreement shall not contribute, anything of value to a public officer or employee of the County.

C. Contractor's representations and warranties in Paragraphs A and B of this Article 12 are material representations of fact upon which the County relied when this Agreement was entered into by the parties. Contractor shall provide immediate written notice to the County if, at any time during the term of this Agreement, Contractor learns that Contractor's representations and warranties in Paragraphs A and B of this Article 12 were erroneous on the effective date of this Agreement or have become erroneous by reason of new or changed circumstances. If it is later determined that Contractor's representations and warranties in Paragraphs A and B of this Article 12 were erroneous on the effective date of this Agreement or have become erroneous by reason of new or changed circumstances, in addition to other remedies available to the County and notwithstanding anything in the Agreement to the contrary, the County may immediately terminate the Agreement.

D. All terms defined in the Governmental Conduct Act have the same meaning in this Article 12(B).

13. Amendment.

This Agreement shall not be altered, changed or amended except by instrument in writing executed by the parties hereto and all other required signatories.

14. Merger.

This Agreement incorporates all the Agreements, covenants and understandings between the parties hereto concerning the subject matter hereof, and all such covenants, Agreements and understandings have been merged into this written

Agreement. No prior Agreement or understanding, oral or otherwise, of the parties or their agents shall be valid or enforceable unless embodied in this Agreement.

15. Penalties for violation of law.

The Procurement Code, Sections 13-1-28 through 13-1-199, NMSA 1978, imposes civil and criminal penalties for its violation. In addition, the New Mexico criminal statutes impose felony penalties for illegal bribes, gratuities and kickbacks.

16. Equal Opportunity Compliance.

The Contractor agrees to abide by all federal, state and county laws and rules and regulations, pertaining to equal employment opportunity. In accordance with all such laws, the Contractor assures that no person in the United States shall, on the grounds of race, religion, color, national origin, ancestry, sex, age, physical or mental handicap, or serious medical condition, spousal affiliation, sexual orientation or gender identity, be excluded from employment with or participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity performed under this Agreement. If Contractor is found not to be in compliance with these requirements during the life of this Agreement, Contractor agrees to take appropriate steps to correct these deficiencies.

17. Applicable Law.

In any action, suit or legal dispute arising from this Agreement, the Contractor agrees that the laws of the State of New Mexico shall govern and that venue will lie in the Seventh Judicial District Court in Torrance County. By execution of this Agreement, Contractor acknowledges and agrees to the jurisdiction of the courts of the State of New Mexico over any and all lawsuits arising under or out of any term of this Agreement.

18. Workers Compensation.

The Contractor agrees to comply with state laws and rules applicable to workers compensation benefits for its employees. If the Contractor fails to comply with the Workers Compensation Act and applicable rules when required to do so, this Agreement may be terminated by the County.

19. Records and Financial Audit.

The Contractor shall maintain detailed time and expenditure records that indicate the date; time, nature and cost of services rendered during the Agreement's term and effect and retain them for a period of three (3) years from the date of final payment under this Agreement. The records shall be subject to inspection by the County, the Department of Finance and Administration and the State Auditor. The County shall have the right to audit billings both before and after payment. Payment under this Agreement shall not foreclose the right of the County to recover excessive or illegal payments

20. Disclaimer and Hold Harmless.

Torrance County shall not be liable to the Contractor, or the Contractor's successors, heirs, administrators, or assigns, for any loss, damage, or injury, whether to Contractor's person or property, occurring in connection with Contractor's performance of Contractor's duties according to this Agreement. Contractor shall hold the Torrance County harmless from all loss, damage, and injury, including court costs and attorney fees, incurred by Torrance County in connection with the performance by Contractor of Contractor's duties according to this Agreement.

21. Indemnification.

The Contractor shall defend, indemnify and hold harmless the County of Torrance from all actions, proceeding, claims, demands, costs, damages, attorneys' fees and all other liabilities and expenses of any kind from any source which may arise out of the performance of this Agreement, caused by the negligent act or failure to act of the Contractor, its officers, employees, servants, subcontractors or agents, or if caused by the actions of any client of the Contractor resulting in injury or damage to persons or property during the time when the Contractor or any officer, agent, employee, servant or subcontractor thereof has or is performing services pursuant to this Agreement. In the event that any action, suit or proceeding related to the services performed by the Contractor or any officer, agent, employee, servant or subcontractor under this Agreement is brought against the Contractor, the Contractor shall, as soon as practicable but no later than two (2) days after it receives notice thereof, notify the legal counsel of the County of Torrance and the New Mexico Association of Counties by certified mail.

22. Invalid Term or Condition.

If any term or condition of this Agreement shall be held invalid or unenforceable, the remainder of this Agreement shall not be affected and shall be valid and enforceable.

23. Enforcement of Agreement.

A party's failure to require strict performance of any provision of this Agreement shall not waive or diminish that party's right thereafter to demand strict compliance with that or any other provision. No waiver by a party of any of its rights under this Agreement shall be effective unless express and in writing, and no effective waiver by a party of any of its rights shall be effective to waive any other rights.

24. Authority.

If Contractor is other than a natural person, the individual(s) signing this Agreement on behalf of Contractor represents and warrants that he or she has the power and authority to bind Contractor, and that no further action, resolution, or approval from Contractor is necessary to enter into a binding contract.

25. Lobbying.

No federal appropriated funds can be paid or will be paid, by or on behalf of the CONTRACTOR, or any person for influencing or attempting to influence an officer or employee of any County, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, or the making of any Federal grant, the making of any federal loan, the entering into of any cooperative agreement, or modification of any Federal contract, grant, loan, or cooperative agreement. If any funds other than federal appropriated funds have been paid or will be paid to any person influencing or attempting to influence an officer or employee of any County, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection of this federal contract, grant, loan, or cooperative agreement, the CONTRACTOR shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

26. Approval of Contractor Personnel.

Personnel proposed in the Contractor's written proposal to the County are considered material to any work performed under this Agreement. No changes of personnel will be made by the Contractor without prior written consent of the procuring agency of the County. Replacement of any Contractor personnel, if approved, shall be with personnel of equal ability, experience and qualifications. The Contractor will be responsible for any expenses incurred in familiarizing the replacement personnel to insure their being productive to the project immediately upon receiving assignments. Approval of replacement personnel shall not be unreasonably withheld. The procuring agency of the County shall retain the right to request the removal of any of the Contractor's personnel at any time.

27. Survival.

The agreement paragraphs titled "Patent, Copyright, Trademark, and Trade Secret Indemnification" and "Indemnification" shall survive the expiration of this agreement. Software licenses, leases, maintenance and any other unexpired agreements that were entered into under the terms and conditions of this agreement shall survive this agreement

28. Succession.

This agreement shall extend to and be binding upon the successors and assigns of the parties.

29. Force Majeure.

A party shall be excused from performance under this agreement for any period that the party is prevented from performing as a result of an act of God, strike, war, civil disturbance, epidemic, or court order, provided that the party has prudently and promptly acted to take any and all steps that are within the party's control to ensure performance. Subject to this provision, such non-performance shall not be deemed a default or a ground for termination.

30. Mediation.

In the event a dispute arises as to the rights and obligations among the parties hereto, the parties agree to attempt to resolve the dispute through mediation as a condition precedent to seeking legal and equitable remedies. The parties agree to evenly split the costs of any such mediation services. The parties shall mutually agree upon the choice of mediator. In the event the parties have not agreed upon a mediator within twenty (20) days of written notice to the other regarding the dispute, then a list of seven potential mediators will be obtained from the New Mexico Association of Counties and the parties shall utilize a striking process until a mediator is agreed upon.

31. Notice to Proceed.

It is expressly understood that this Agreement is not binding upon the County until it is executed by the Board of County Commissioners after voting on the contract at a public meeting. The Contractor is not to proceed with its obligations under the Agreement until the Contractor has received a fully signed copy of the Agreement.

32. Attorney's Fees.

In the event this Agreement results in dispute, mediation, litigation, or settlement between the parties to this Agreement, the prevailing party of such action shall NOT be entitled to an award of attorneys' fees and court costs.

33. Cooperation.

All parties hereto will fully cooperate with the other and their respective counsel, accountant, and agents in connection with any steps required to be taken under this Agreement.

34. Incorporation and Order of Precedence.

Request for Proposals No. TC-FY23-01 and the contractor's proposal are incorporated by reference into this agreement and are made a part of this agreement. In the event of any conflict among these documents, the following order of precedence shall apply:

1. Any contract amendment(s), in reverse chronological order; then
2. this contract itself; then
3. the Request for Proposals; then
4. the Contractors Best and Final Offer(s), in reverse chronological order; then
5. the contractor's proposal; then
6. the contractor's standard agreement terms and conditions (which may or may not have been submitted as part of the contractor's proposal).

35. Patent, Copyright, Trademark and Trade Secret Indemnification.

A. The contractor shall defend, at its own expense, the County of Torrance against any claim that any product or service provided under this agreement infringes any patent, copyright or trademark in the United States or Puerto Rico, and shall pay all costs, damages and attorneys' fees that a court finally awards as a result of any such claim. In addition, if any third party obtains a judgment against the County of Torrance based upon the contractor's trade secret infringement relating to any product or service provided under this agreement, the contractor agrees to reimburse the County of Torrance for all costs, attorneys' fees and the amount of the judgment. To qualify for such defense and/or payment, the County of Torrance shall:

i. give the contractor prompt written notice of any claim;

ii. allow the contractor to control the defense or settlement of the claim; and

iii. cooperate with the contractor in a reasonable way to facilitate the defense or settlement of the claim.

B. If any product or service becomes, or in the contractor's opinion is likely to become the subject of a claim of infringement, the contractor shall at its option and expense:

i. provide a procuring agency of the County the right to continue using the product or service;

ii. replace or modify the product or service so that it becomes non-infringing; or

iii. accept the return of the product or service and refund an amount equal to the depreciated value of the returned product or service, less the unpaid portion of the purchase price and any other amounts which are due to the contractor. The contractor's obligation will be void as to any product or service modified by the procuring agency of the County to the extent such modification is the cause of the claim.

36. Professional Liability Insurance.

Contractor agrees to maintain in full force throughout the duration of the Agreement a professional liability insurance policy with a minimum coverage of $1,000,000.00 per occurrence/ $2,000,000.00 aggregate.

37. Contractor's Payment of Property Taxes.

Contractor acknowledges that County has established a policy of ensuring that all individuals and businesses that benefit financially from County through contract are current in paying their property tax obligations to mitigate the economic burden otherwise imposed upon County and its taxpayers. Contractor warrants and certifies that it is presently not delinquent in the payment of its property tax obligations, and that it will not become delinquent during the term of this Contract.

38. Termination For Failure to Comply with All County Tax Requirements.

Without limiting the rights and remedies available to County under any other provision of this contract, failure of Contractor to cure a tax delinquency within 10 days of notice shall be grounds upon which County may terminate this Contract.

39. Notices.

Any notice required to be given to either party by this Agreement shall be in writing and shall be delivered in person, by courier service or by U.S. mail, either first class or certified, return receipt requested, postage prepaid, as follows:

To the County: Janice Y. Barela, County Manager // PO Box 48// Estancia, NM 87016

To the Contractor: [insert name and address].

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date of signature by the Board of County Commissioners below.

By: _____

Date:_____Contractor

Printed Name: _____

Address:

_____

By: _____ Date:_____

Torrance County Manager

Printed Name: Janice Y. Barela

Address: 205 S Ninth Street
Estancia, NM 87016

BOARD OF COUNTY COMMISSIONERS

APPROVED, ADOPTED AND PASSED on this _____ day of _____, 2022.

_____
Ryan Schwebach
Chairman, District II

_____
Kevin McCall
Commissioner, District I

_____
LeRoy Candelaria
Commissioner, District III

Attest:

_____
Yvonne Otero
Torrance County Clerk

Attachment 1

Scope of Work

To be completed as negotiated.

APPENDIX C

COST RESPONSE FORM

Torrance County RFP TC-FY23-01
FULLY INSURED LIFE, SHORT TERM DISABILITY, LONG TERM DISABILITY AND VISION COVERAGE

State gross receipts and local option taxes (if any) shall not be included in the Total Proposed Annual Cost. Such taxes shall be separately reimbursed by the County.

OFFEROR NAME: _____

Coverage Quoted	Yes	No	Confirm Commission % included in proposed rates
Vision			
Life, AD&D and Voluntary Life			
LTD			
STD			

Propose rates for each coverage, assuming award of that single line of coverage. If rate reductions are available with award of multiple lines of coverage, please indicate impact for all applicable coverages. FOR ALL PROPOSED COVERAGES, RATES MUST BE PROVIDED FOR THREE YEARS AT A MINIMUM, WITH PREFERENCE FOR A FOUR-YEAR GUARANTEE. Years five through eight may be negotiated during year four.

Vision:

Tier Coverage	Assumed Enrollments	Year 1-2	Year 3	Year 4	Year 5-8
Employee Only	34				
Employee + Spouse	19				
Employee + Child(ren)	6				
Employee + Family	22				
Total Annual Cost:	81				

Life and AD&D (Current Plan):

	Year 1-2	Year 3	Year 4	Year 5-8
Employee Life Rate:				
Employee AD&D Rate:				
Assumed Volume: $6,017,500				
Total Annual for Life				
Total Annual for AD&D				
Total for Life and AD&D Coverage:				

Life and AD&D (Option 1 – Enhanced Fire benefit, $75,000 benefit to match Officers):

	Year 1-2	Year 3	Year 4	Year 5-8
Employee Life Rate:				
Employee AD&D Rate:				
Assumed Volume: $6,292,500				
Total Annual for Life:				
Total Annual for AD&D				
Total for Life and AD&D Coverage:				

Voluntary Life-Employee

Age Bands	Year 1-2 Rate per $1,000	Year 3 per $1,000	Year 4 per $1,000	Year 5-8 per $1,000
20-24				
25-29				
30-34				
35-39				
40-44				
45-49				
50-54				
55-59				
60-64				
65-69				
70-74				
75-79				
80-84				
85-89				
90-94				
95-99				

Voluntary Life-Spouse

Age Bands	Year 1-2 Rate per $1,000	Year 3 per $1,000	Year 4 per $1,000	Year 5-8 per $1,000
20-24				
25-29				
30-34				
35-39				
40-44				
45-49				
50-54				
55-59				
60-64				
65-69				
70-74				
75-79				
80-84				
85-89				
90-94				
95-99				

Voluntary Life-Dependent Child

Benefit Amount	Year 1-2 Rate per $5,000	Year 3 per $5,000	Year 4 per $5,000	Year 5-8 per $5,000
$5,000				

LTD:

	Year 1-2	Year 3	Year 4	Year 5-8
LTD Rate (Per $100 of covered payroll):				
Assumed Payroll: $422,078				
Total Annual Costs:				

STD:

	Year 1-2	Year 3	Year 4	Year 5-8
STD Rate (Per $10 Weekly Benefit):				
Assumed Weekly Disability Volume: $5,844				
Total Annual Costs:				

Indicate any rate guarantees, rate caps, wellness funds and implementation credits included as part of your offering below.

APPENDIX D

LETTER OF TRANSMITTAL FORM

Items #1 to 4 **MUST** EACH BE RESPONDED TO. Failure to respond to all four items **WILL** RESULT IN THE DISQUALIFICATION OF THE PROPOSAL!

1. Identity (Name) and Mailing Address of the submitting organization:

_____

_____

_____

2: For the person authorized by the organization to contractually obligate the organization:

Name	
Title	

3. For the person authorized to negotiate the contract on behalf of the organization:

Name	
Title	
E-Mail Address	
Telephone Number	

4. For the person to be contacted for clarifications:

Name	
Title	
E-Mail Address	
Telephone Number	

5. Declarations:

- I certify that I am authorized to contractually bind my company.
- On behalf of the submitting organization named in item #1, above, I accept the Conditions Governing the Procurement as required in Section II, Paragraph C.1.
- I concur that submission of our proposal constitutes acceptance of the Evaluation Factors contained in Section V of this RFP.
- I acknowledge receipt of any and all amendments to this RFP.
- I certify that my company/entity/organization commits to comply and act in accordance with (1) Federal Executive Orders and New Mexico State Statutes relating to the enforcement of civil rights, (2) Federal Code 5 USCA 7201 et. seq., Anti-Discrimination in Employment; (3) Executive Order No. 11246, Equal Opportunity in Federal Employment; (4) Title 6, Civil Rights Act of 1964; and (5) Requirements of the American with Disabilities Act of 1990 for work performed as a result of this RFP.

_____ _____, 2022

Authorized Signature and Date (**Must** be **signed** by the person identified in **item #2**, above.)

APPENDIX E

CAMPAIGN CONTRIBUTION DISCLOSURE FORM

Pursuant to the Procurement Code, Sections 13-1-28, et seq., NMSA 1978 and NMSA 1978, § 13-1-191.1 (2006), as amended by Laws of 2007, Chapter 234, any prospective contractor seeking to enter into a contract with any state agency or local public body **for professional services, a design and build project delivery system, or the design and installation of measures the primary purpose of which is to conserve natural resources** must file this form with that state agency or local public body. This form must be filed even if the contract qualifies as a small purchase or a sole source contract. The prospective contractor must disclose whether they, a family member or a representative of the prospective contractor has made a campaign contribution to an applicable public official of the state or a local public body during the two years prior to the date on which the contractor submits a proposal or, in the case of a sole source or small purchase contract, the two years prior to the date the contractor signs the contract, if the aggregate total of contributions given by the prospective contractor, a family member or a representative of the prospective contractor to the public official exceeds two hundred and fifty dollars ($250) over the two year period.

Furthermore, the state agency or local public body may cancel a solicitation or proposed award for a proposed contract pursuant to Section 13-1-181 NMSA 1978 or a contract that is executed may be ratified or terminated pursuant to Section 13-1-182 NMSA 1978 of the Procurement Code if: 1) a prospective contractor, a family member of the prospective contractor, or a representative of the prospective contractor gives a campaign contribution or other thing of value to an applicable public official or the applicable public official's employees during the pendency of the procurement process or 2) a prospective contractor fails to submit a fully completed disclosure statement pursuant to the law.

The state agency or local public body that procures the services or items of tangible personal property shall indicate on the form the name or names of every applicable public official, if any, for which disclosure is required by a prospective contractor.

THIS FORM MUST BE INCLUDED IN THE REQUEST FOR PROPOSALS AND MUST BE FILED BY ANY PROSPECTIVE CONTRACTOR WHETHER OR NOT THEY, THEIR FAMILY MEMBER, OR THEIR REPRESENTATIVE HAS MADE ANY CONTRIBUTIONS SUBJECT TO DISCLOSURE.

The following definitions apply:

"**Applicable public official**" means a person elected to an office or a person appointed to complete a term of an elected office, who has the authority to award or influence the award of the contract for which the prospective contractor is submitting a competitive sealed proposal or who has the authority to negotiate a sole source or small purchase contract that may be awarded without submission of a sealed competitive proposal.

"**Campaign Contribution**" means a gift, subscription, loan, advance or deposit of money or other thing of value, including the estimated value of an in-kind contribution, that is made to or received by an applicable public official or any person authorized to raise, collect or expend contributions on that official's behalf for the purpose of electing the official to statewide or local office. "Campaign Contribution" includes the payment of a debt incurred in an election campaign, but does not include the value of services provided without compensation or unreimbursed travel or other personal expenses of individuals who volunteer a portion or all of their time on behalf of a candidate or political committee, nor does it include the administrative or solicitation expenses of a political committee that are paid by an organization that sponsors the committee.

"**Family member**" means spouse, father, mother, child, father-in-law, mother-in-law, daughter-in-law or son-in-law of (a) a prospective contractor, if the prospective contractor is a natural person; or (b) an owner of a prospective contractor.

"**Pendency of the procurement proces**s" means the time period commencing with the public notice of the request for proposals and ending with the award of the contract or the cancellation of the request for proposals.

"**Prospective contractor**" means a person or business that is subject to the competitive sealed proposal process set forth in the Procurement Code or is not required to submit a competitive sealed proposal because that person or business qualifies for a sole source or a small purchase contract.

"**Representative of a prospective contractor**" means an officer or director of a corporation, a member or manager of a limited liability corporation, a partner of a partnership or a trustee of a trust of the prospective contractor.

Name(s) of Applicable Public Official(s) if any:_____
(Completed by State Agency or Local Public Body)

DISCLOSURE OF CONTRIBUTIONS BY PROSPECTIVE CONTRACTOR:

Contribution Made By: _____

Relation to Prospective Contractor: _____

Date Contribution(s) Made: _____
_____

Amount(s) of Contribution(s) _____
_____

Nature of Contribution(s) _____
_____

Purpose of Contribution(s) _____
_____

(Attach extra pages if necessary)

_____ _____
Signature Date

_____
Title (position)

--OR—

NO CONTRIBUTIONS IN THE AGGREGATE TOTAL OVER TWO HUNDRED FIFTY DOLLARS ($250) WERE MADE to an applicable public official by me, a family member or representative.

_____ _____
Signature Date

_____
Title (Position)

APPENDIX F

Resident Veterans Preference Certification

_____ (NAME OF CONTRACTOR) hereby certifies the following in regard to application of the resident veterans preference to this procurement:

Please check one box only

☐ I declare under penalty of perjury that my business prior year revenue starting January 1 ending December 31 is less than $1M allowing me the 10% preference discount on this solicitation. I understand that knowingly giving false or misleading information about this fact constitutes a crime.

☐ I declare under penalty of perjury that my business prior year revenue starting January 1 ending December 31 is more than $1M but less than $5M allowing me the 8% preference discount on this bid or proposal. I understand that knowingly giving false or misleading information about this fact constitutes a crime.

☐ I declare under penalty of perjury that my business prior year revenue starting January 1 ending December 31 is more than $5M allowing me the 7% preference discount on this bid or proposal. I understand that knowingly giving false or misleading information about this fact constitutes a crime.

"I agree to submit a report, or reports, to the State Purchasing Division of the General Services Department declaring under penalty of perjury that during the last calendar year starting January 1 and ending on December 31, the following to be true and accurate:

"In conjunction with this procurement and the requirements of this business' application for a Resident Veteran Business Preference/Resident Veteran Contractor Preference under Sections 13-1-21 or 13-1-22 NMSA 1978, when awarded a contract which was on the basis of having such veterans preference, I agree to report to the State Purchasing Division of the General Services Department the awarded amount involved. I will indicate in the report the award amount as a purchase from a public body or as a public works contract from a public body as the case may be.

"I understand that knowingly giving false or misleading information on this report constitutes a crime."

I declare under penalty of perjury that this statement is true to the best of my knowledge. I understand that giving false or misleading statements about material fact regarding this matter constitutes a crime.

_____ _____

(Signature of Business Representative)* (Date)

*Must be an authorized signatory for the Business.

The representations made in checking the boxes constitutes a material representation by the business that is subject to protest and may result in denial of an award or unaward of the procurement involved if the statements are proven to be incorrect.

Torrance County

P.O. Box 48
205 South Ninth Street
Estancia, New Mexico 87016
505-544-4700

Attachment to Campaign Contribution Disclosure Form

Current Torrance County Elected Officials

Commissioner, District 1 – Kevin McCall

Commissioner, District 2 – Ryan Schwebach

Commissioner, District 3 – LeRoy Candelaria

Assessor – Jesse Lucero

Clerk – Yvonne Otero

Probate Judge – Josie Chavez

Sheriff – Marty Rivera

Treasurer – Tracy Sedillo

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

Claim History Report

For the Period: Since Inception

Company Name: Torrance County

Policy Number: GL-154637

Name of Insured	Claim Number	Received	Paid Amount
Claimant 1	2021-12-01-0854-GL-01-02	12/01/2021	$50,000.00
Claimant 2	2018-10-19-0082-GL-01-02	10/19/2018	$10,000.00
Claimant 3	2018-10-18-0274-GL-01-01	10/18/2018	$50,000.00
Claimant 4	2020-01-13-0706-GL-01-03	01/13/2020	$100,852.15
Claimant 4	2020-01-13-0706-GL-01-02	01/13/2020	$50,426.08
Claimant 5	2021-12-01-0191-GL-01-01	12/01/2021	$75,000.00
Claimant 5	2021-12-01-0191-GL-01-02	12/01/2021	$100,000.00
		Total for policy GL-154637 :	**$436,278.23**

Life Paid Amount Figure : $436,278.23

Total Paid Amount Figure : $436,278.23

Total Claim Count: **5** ***Overall Total *:*** **$436,278.23**

**** The overall total DOES NOT reflect any open reserve liability for your accounts. Please contact your Regional Sales Office for additional information.***

RELIANCE STANDARD
LIFE INSURANCE COMPANY

Home Office: Schaumburg, Illinois Administrative Office: Philadelphia, Pennsylvania
A Stock Company
Schaumburg, Illinois

CERTIFICATE
GROUP EYE CARE INSURANCE

The Policyholder **TORRANCE COUNTY**

Policy Number **136-9674** **Insured Person**

Plan Effective Date **January 1, 2016** **Certificate Effective Date**
Refer to Exceptions on 9070

Plan Change Effective Date **January 1, 2021**

Class Number 1

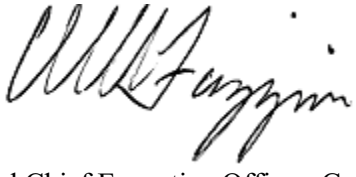
Reliance Standard Life Insurance Company certifies that you will be insured for the benefits described on the following pages, according to all the terms of the group policy numbered above which has been issued to the Policyholder.

Possession of this certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this certificate.

The group policy may be amended or cancelled without the consent of the insured person.

The laws of the state in which the group policy was delivered govern the group policy. The certificate is governed by the law of New Mexico.

This plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty. Please consult your tax advisor.



President and Chief Executive Officer, Group Benefits

9021 NM Rev. 06-17 v ppo

GRIEVANCE AND APPEAL PROCEDURES

If all or part of a claim is denied, You may appeal. You may also request a review of Our benefit decision. You must request a review in writing. This request must be within 180 days after receiving notice of the denial.

You may send Us written comments. You may also send other items to support Your claim. You may review and receive copies of any non-privileged information that is relevant to Your appeal. There will be no charge for such copies. You may request the names of the experts We may have consulted who provided advice to Us about Your claim. You may also request, at no charge, any clinical rationale and/or specific clinical guidelines relied upon by them for any benefit determinations related to dental necessity.

The appeal review will be conducted by someone other than the person who denied the claim. The new reviewer will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. Denials may be based in whole or in part on a medical judgment. This includes determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary. The person conducting the review will consult with a qualified health care professional.

This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items You submit to support Your claim.

If Your appeal is about urgent care, You may call Toll Free at 877-897-4328 and an Expedited Review will be conducted. Verbal notification of Our decision will be made within 72 hours, followed by written notice within 3 calendar days after that.

If Your appeal is about benefit decisions related to clinical or medical necessity, a Standard Consultant Review will be conducted. A written decision will be provided within 30 calendar days of the receipt of the request for appeal.

If Your appeal is about benefit decisions related to coverage, a Standard Administrative Review will be conducted. A written decision will be provided within 60 calendar days of the receipt of the request for appeal.

Any request for review concerning this claim should be sent to:

Quality Control
PO Box 82657
Lincoln, NE 68501-2657
877-897-4328 (Toll Free)
Fax 402-309-2579

You always have the right to contact the Department of Insurance:

Office of the Superintendent of Insurance Consumer Assistance Bureau
PO Box 1689
Santa Fe, NM 87504-1689
Phone: 1-855-4ASK-OSI
(1-855-427-5674)

Non-Insurance Products/Services

From time to time we may arrange, at no additional cost to you or your group, for third-party service providers to provide you access to discounted goods and/or services, such as purchase of eye wear or prescription drugs. These discounted goods or services are not insurance. While we have arranged these discounts, we are not responsible for delivery, failure or negligence issues associated with these goods and services. The third-party service providers would be liable.

To access details about non-insurance discounts and third-party service providers, you may contact our customer connections team or your plan administrator.

These non-insurance goods and services will discontinue upon termination of your insurance or the termination of our arrangements with the providers, whichever comes first.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

The Insurance for each Insured and each Insured Dependent will be based on the Insured's class shown in this Schedule of Benefits. Insured members are responsible for any provider charge over the allowed amount, in addition to any coinsurance, deducible, or other plan limitations.

Benefit Class	Class Description
Class 1	All Eligible Employees

EYE CARE EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

When a Participating Provider is used:	
Exams - Each Benefit Period	$15
Contact Lens Fitting and Evaluation - Each Benefit Period	$60
Frames, Lenses, and Medically Necessary Contacts - Each Benefit Period	$15
When a Non-Participating Provider is used:	
Exams - Each Benefit Period	$15
Frames, Lenses, and Medically Necessary Contacts - Each Benefit Period	$15

Please refer to the EYE CARE EXPENSE BENEFITS page for details regarding frequency, limitations, and exclusions.

DEFINITIONS

COMPANY refers to Reliance Standard Life Insurance Company. The words "we", "us" and "our" refer to Company. Our Home Office address is 2001 Market Street, Suite 1500, Philadelphia, PA 19103.

POLICYHOLDER refers to the Policyholder stated on the face page of the policy.

INSURED refers to a person:

a. who is a Member of the eligible class; and

b. who has qualified for insurance by completing the eligibility period, if any; and

c. for whom the insurance has become effective.

DOMESTIC PARTNER: Refers to two unrelated individuals who share the necessities of life, live together, and have an emotional and financial commitment to one another, similar to that of a spouse.

CHILD. Child means the child of the Insured, a child of the Insured's spouse, if they otherwise meet the definition of Dependent. Eligibility will not be denied on the grounds that the child was born out of wedlock; is not claimed as a dependent on a parent's federal tax return; or does not reside with the parent or in the parent's service area.

When a child is covered as a Dependent of a non-custodial parent, we shall:

a. provide such information to the custodial parent as may be necessary for the child to obtain benefits;

b. permit the custodial parent or the Provider, with the custodial parent's approval, to submit claims for covered services without the approval of the non-custodial parent; and

c. make payments on claims directly to the custodical parent, the Provider or the state Medicaid agency, as appropriate.

When a child is covered as a Dependent as required by a court or administrative order, we shall permit the Insured to enroll the child without regard to any Election Period restrictions. If the Insured fails to enroll the child, we shall accept enrollment upon application by the child's other parent, the state agency administering the Medicaid Program or the state agency administering the child support enforcement program. Coverage for the child will not be terminated unless we receive satisfactory written evidence that the court or administrative order is no longer in effect, or the child has coverage through another carrier that will take effect no later than the effective date of termination.

DEPENDENT refers to:

a. an Insured's spouse or Domestic Partner.

b. each unmarried and married child less than 26 years of age, including natural born children, adopted children from the date of placement for adoption, and children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

c. each unmarried child age 26 or older who is covered under this plan, but only if the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the Insured for support and maintenance. Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the

limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

DEPENDENT UNIT refers to all of the people who are insured as the dependents of any one Insured.

PROVIDER means any person who is licensed by the law of the state in which treatment is provided within the scope of the license. This definition also includes a "practitioner of the healing arts" which means any person holding a license or certificate provided for in Chapter 61, Article 4, 5, 6, 10 or 14A NMSA 1978 authorizing the licensee to offer or undertake to diagnose, treat, operate on or prescribe for any human pain, injury, disease, deformity or physical or mental condition.

PLAN EFFECTIVE DATE refers to the date coverage under the policy becomes effective. The Plan Effective Date for the Policyholder is shown on the policy cover. The effective date of coverage for an Insured is shown in the Policyholder's records.

All insurance will begin at 12:01 A.M. on the Effective Date. It will end after 11:59 P.M. on the Termination Date. All times are stated as Standard Time of the residence of the Insured.

PLAN CHANGE EFFECTIVE DATE refers to the date that the policy provisions originally issued to the Policyholder change as requested by the Policyholder. The Plan Change Effective date for the Policyholder will be shown on the policy cover, if the Policyholder has requested a change. The plan change effective date for an Insured is shown in the Policyholder’s records or on the cover of the certificate.

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

ELIGIBLE CLASS FOR MEMBERS. The members of the eligible class(es) are shown on the Schedule of Benefits. Each member of the eligible class (referred to as "Member") will qualify for such insurance on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Insured."

If employment is the basis for membership, a member of the Eligible Class for Insurance is any full time active employee working at least 20 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

If both spouses are Members, and if either of them insures their dependent children, then the spouse, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the first of the month falling on or first following the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent from the moment of birth.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any full time active employee working at least 20 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

Any spouse who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased employee continued coverage. If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is not required to contribute to the payment of his or her insurance premiums. An insured may or may not be required to contribute to the payment of insurance premiums if he or she is both covered under this policy and also covered under another plan.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, coverage is effective immediately.

For persons who become Members after the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the eligibility period of 30 calendar day(s) of continuous active employment.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be the first of the month falling on or first following:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

EXCEPTIONS. If employment is the basis for membership, a Member must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

A Member will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

If membership is by reason other than employment, a Member must not be totally disabled on the date the insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

But any person who is not in active service or is totally disabled will be insured on the Effective Date if:

1. the person was insured under a policy of group insurance providing like benefits which ended on the day immediately before the Effective Date of the policy providing this coverage; and

2. the person is considered a Member or an eligible Dependent or an eligible Dependent under the policy providing this coverage; and had the prior policy contained the same definition of eligibility, would have been a Member or Dependent or Dependent under the prior policy.

TERMINATION DATES

INSUREDS. The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the end of the month falling on or next following the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

CONTINUATION OF COVERAGE. If coverage ceases according to TERMINATION DATE, some or all of the insurance coverages may be continued. Contact your plan administrator for details.

State Required Continuation

An employee has the right to extend coverage under the group policy upon termination of membership or employment with the group, except as provided below.

The right to extend coverage applies to any spouse or dependent coverages, including a surviving spouse or children whose coverage under the policy terminates by reason of the death of the employee or member or upon the divorce, annulment or dissolution of marriage or legal separation of the spouse from the member or employee of the group.

Notwithstanding the provisions stated above, an employee or dependent does not have the right to continue coverage under the group policy if:

a) the policy or coverage terminates for nonpayment of premium;
b) the policy is not renewed;
c) the policy term has expired; or
d) the individual member or employee is eligible for medicare or any other similar federal or state health program.

On behalf of the insurer, the policyholder shall provide written notification of the right to continue group coverage. The notice shall be sent to the insured's home address at the last known address shown on the records of the policyholder.

The eligible employee or member of the group insured or covered dependent exercising the continuation right shall notify the employer or insurer and make payment of the applicable premium within thirty (30) days following the date of the notification given by the policyholder. There will be no lapse in coverage during the period in which continuation is available.

Coverage shall be provided without additional evidence of insurability and shall not impose any preexisting condition, limitations or other contractual time limitations other than those remaining unexpired under the policy or contract from which continuation is exercised.

EYE CARE EXPENSE BENEFITS

If an Insured has Covered Expenses under this section, we pay benefits as described. The Insured can choose any provider at any time.

COVERED EXPENSES
Covered Expenses include the lesser of:

a. the charge for the covered procedure furnished; or
b. the Maximum Covered Expense for such services or supplies shown in the Schedule of Eye Care Services.

Covered Expenses are the eye care expenses incurred by an Insured for services or supplies. We pay up to the Maximum Covered Expense shown in the Schedule of Eye Care Services.

DEDUCTIBLE AMOUNT
The Deductible Amount is on the Schedule of Benefits. It is an amount of Covered Expenses for which no benefits are payable. It applies separately to each Insured. Benefits are paid only for those Covered Expenses that are over the Deductible Amount.

Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

PARTICIPATING PROVIDERS
A Participating Provider is a provider who has agreed to participate in the VSP network and agrees to provide services and supplies to the Insured at a discounted fee. For questions related to providers or benefit payments, VSP's Customer Care Division is available at (800) 877-7195.

NON-PARTICIPATING PROVIDERS
A Non-Participating Provider is any other provider. Non-Participating providers may be referred to as Affiliate or Open Access Providers. Non-Participating Providers are not subject to our Quality Management Programs. Your out-of-pocket expenses may be greater when you visit a Non-Participating Provider. However, more cost savings or convenience may be available through VSP arrangements with Affiliate Providers. You may contact VSP’s Customer Care Division for details at (800) 877-7195.

EYE CARE SUPPLIES
Eye care supplies are all services listed on the Schedule of Eye Care Services. They exclude services related to Eye Care Exams.

REQUEST FOR SERVICES
When requesting services, the Insured must advise the Participating Provider's office that he or she has coverage under this network plan. If the Insured receives services from a Participating Provider without this notification, the benefits may be limited to those for a Non-Participating Provider.

ASSIGNMENT OF BENEFITS
We pay benefits to the Participating Provider for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, we pay benefits to the Insured unless arranged differently through an Affiliate or Open Access provider, or otherwise required by state regulation.

EXTENSION OF BENEFITS
If your policy terminates, we will pay claims for eye care services and supplies that you received or ordered prior to your policy’s termination. You will have six months following the date of service to submit your claim.

EXPENSES INCURRED
An expense is incurred at the time a service is rendered or a supply item furnished.

PROOF OF LOSS
Written proof of loss must be given to us within 180 days after completion of the service for a claim to be covered. An exception may be made if the Insured shows it was not possible to submit the proof of loss within this period.

LIMITATIONS
This plan has the following limitation:

Some brands of spectacle frames may be unavailable at all locations for purchase as Covered Expenses, or may be subject to additional out-of-pocket expenses. Insureds may obtain details regarding frame brand availability from their treating provider or by calling VSP's Customer Care Division at (800) 877-7195.

EXCLUSIONS
This plan does not cover:

Services and/or materials not specifically included in this Schedule as covered Plan Benefits,

Plano lenses (lenses with refractive correction of less than plus or minus .50 diopter) except as specifically allowed in the frames benefit section below,

Services or materials that are cosmetic, including Plano contact lenses to change eye color and artistically painted Contact Lenses,

Two pairs of glasses in lieu of Bifocals,

Replacement of Spectacle Lenses, Frames, and/or contact lenses furnished under this plan that are lost or damaged, except at the normal intervals when services are otherwise available,

Orthoptics or vision training and any associated supplemental testing,

Medical or surgical treatment of the eyes,

Contact lens modification, polishing or cleaning,

The refitting of Contact Lenses after the initial 90-day fitting period,

Contact Lens insurance policies or service contracts,

Additional office visits associated with contact lens pathology,

Local, state and/or federal taxes, except where law requires us to pay,

Membership fees for any retail center in which an Affiliate or Open Access provider office may be located. Covered persons may be required to purchase a membership in such entities as a condition of accessing Plan Benefits.

SCHEDULE OF EYE CARE SERVICES

The following is a complete list of eye care services for which benefits are payable under this section, You must first pay a Deductible for certain services as indicated on the Schedule of Benefits in the - Eye Care Expense Benefits section.

SERVICE	WHEN COVERED	PLAN MAXIMUM COVERED EXPENSE *Participating Provider*	*Non-Participating Provider**
Vision Examination(s)			
Eye Exam	Once every 12 months	Covered in Full	Up to $ 45.00
Contact Lens Fitting & Evaluation	Once every 12 months	Covered in Full	See Elective Contact Lenses benefit below
Complete Pair of Spectacles			
Lenses (per pair, only one pair of lens type below allowed per covered period)			
Single Vision	Once every 12 months	Covered in Full	Up to $ 30.00
Lined Bifocal	Once every 12 months	Covered in Full	Up to $ 50.00
Lined Trifocal	Once every 12 months	Covered in Full	Up to $ 65.00
Lenticular	Once every 12 months	Covered in Full	Up to $100.00
Frames			
Single Frame	Once every 24 months	Up to $130.00	Up to $ 70.00
Contact Lenses (in lieu of Complete Pair of Spectacles)			
Elective	Once every 12 months	Up to $130.00	Up to $105.00
Medically Necessary**	Once every 12 months	Covered in Full	Up to $210.00

Low Vision (for severe visual problems not correctable with regular lenses, as determined by the treating provider) Insureds can receive professional services for treatment of severe visual problems that are not correctable with regular lenses. The treating provider determines if an Insured's condition meets the criteria for coverage of this benefit. Insureds may contact VSP's Customer Care Division for details at (800-877-7195) for additional information.

*Insureds may receive additional savings and some services may be covered in full by choosing to visit an Affiliate Non-Participating Provider.

**The benefit for Medically Necessary contact lenses is in lieu of the Elective contact lenses benefit listed. The treating provider determines if an Insured meets the coverage criteria for this benefit.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies if an Insured person has eye care coverage under more than one **Plan**. **Plan** is defined below. All benefits provided under this policy are subject to this section.

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total **Allowable expense**.

DEFINITIONS

A. A **Plan** is any of the following that provides benefits or services for medical or eye care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage other than the medical benefits coverage in automobile "no fault" and traditional "fault" type contracts; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

B. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one **COB** provision to certain benefits, such as eye care benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

C. The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health care coverage under more than one **Plan**.

When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is secondary, it determines its benefits after those of another **Plan** and may reduce the benefits it pays so that all **Plan** benefits do not exceed 100% of the total **Allowable expense.**

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and co-payments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

The following are examples of expenses that are not **Allowable expenses**:

(1) If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.

(2) If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.

(3) If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.

(4) The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Closed panel plan** is a **Plan** that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more **Plans**, the rules for determining the order of benefit payments are as follows:

A. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other **Plan**.

B. (1) Except as provided in Paragraph B(2) below, a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

C. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.

D. Each **Plan** determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, policyholder, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or

If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

The **Plan** covering the **Custodial parent**;

The **Plan** covering the spouse of the **Custodial parent**;

The **Plan** covering the **non-custodial parent**; and then

The **Plan** covering the spouse of the **non-custodial parent**.

(c) For a dependent child covered under more than one **Plan** of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

(6) If the preceding rules do not determine the order of benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more **Closed panel** plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give the Company any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A Payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, the Company may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan**. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by the Company is more than it should have paid under this **COB** provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

GENERAL PROVISIONS

ENTIRE CONTRACT: CHANGES. The Company certifies that it has issued to the Policyholder the group policy shown on the certificate cover. The provisions of this certificate, the group policy, and any attached applications and riders constitute the entire contract. Such policy insures certain persons for the benefits described within the certificate. The benefits shown are subject to all the terms of the group policy which has been issued to the Policyholder. All statements made by the Policyholder or an Insured will, in the absence of fraud, be considered representations and not warranties. No statement made to obtain insurance will be used to void the insurance or reduce the benefits of this policy unless it is in a written application signed by the Policyholder or Insured. A copy of this must have been given to the Policyholder or Insured.

No change in this policy will be valid unless approved by one of our officers. No agent may change this policy or waive any of its provisions. Any change in this policy will be valid even though an Insured may not have agreed to it.

NOTICE OF CLAIM. Written notice of a claim must be given to us within 90 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 90 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS. When we receive the notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS. For Eye Care benefits that use either the EyeMed or VSP network, please refer to the limitations section on the Eye Care Expense Benefits page.

TIME OF PAYMENT. We will pay all benefits immediately when we receive due proof. Any balance remaining unpaid at the end of any period for which we are liable will be paid at that time.

PAYMENT OF BENEFITS. All benefits will be paid to the Insured. However, benefits will be paid to the New Mexico Human Services Department provided:

1. the New Mexico Human Services Department has paid or is paying benefits on behalf of the Insured under the state's Medicaid program pursuant to Title XIX of the Federal Social Security Act, 42 U.S.C. 1396, et seq.;

2. payment for the benefits in question has been made by the Human Services Department to the Medicaid provider; and

3. notified that the Insured received benefits under the Medicaid program and that benefits from this plan must be paid directly to the Human Services Department

FACILITY OF PAYMENT. If an Insured or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Insured, then we may, at our option, pay the benefit up to an amount not to exceed $5,000, to any relative by blood or connection by marriage of the Insured who is considered by us to be equitably entitled to the benefit.

Any equitable payment made in good faith will release us from liability to the extent of payment.

PROVIDER-PATIENT RELATIONSHIP. The Insured may choose any Provider who is licensed by the law of the state in which treatment is provided within the scope of their license. We will in no way disturb the provider-patient relationship.

LEGAL PROCEEDINGS. No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than five years after proof of loss is required.

INCONTESTABILITY. Any statement made by the Policyholder to obtain the Policy is a representation and not a warranty. No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Policy unless:

1. The Policy would not have been issued if we had known the truth; and

2. We have given the Policyholder a copy of a written instrument signed by the Policyholder that contains the misrepresentation.

The validity of the Policy will not be contested after it has been in force for one year, except for nonpayment of premiums or fraudulent misrepresentations.

WORKER'S COMPENSATION. The coverage provided under the Policy is not a substitute for coverage under a workmen's compensation or state disability income benefit law and does not relieve the Policyholder of any obligation to provide such coverage.

ERISA INFORMATION AND NOTICE OF YOUR RIGHTS

A. General Plan Information

Name of Plan:	Eye Care Insurance
Name, Address of Plan Sponsor:	TORRANCE COUNTY PO BOX 48 ESTANCIA, NM 87016
Plan Sponsor Tax Id Number:	85-6000257
Plan Number:	502
Type of Plan:	Group Insurance Plan
Name, Address, Phone Number of Plan Administrator:	JOY ANSLEY TORRANCE COUNTY PO BOX 48 ESTANCIA, NM 87016 505-544-4700
Name, Address of Registered Agent for Service of Legal Process:	Plan Sponsor
If Legal Process Involves Claims For Benefits Under The Group Policy, Additional Notification of Legal Process Must Be Sent To:	Reliance Standard Life Insurance Company P.O. Box 82510 Lincoln, NE 68501
Sources of Contributions:	Employer/Member
Funding Method:	Reliance Standard Life Insurance Company--Fully Insured
Plan Fiscal Year End:	December 31
Type of Administration:	
General Administration	Plan Sponsor
Contract & Claim Administration	Reliance Standard Life Insurance Company

B. Notice of Legal Process

Service of legal process may be made upon the plan administrator at the address listed above.

C. Eligibility and Benefits Provided Under the Group Policy

Please refer to the **Conditions for Insurance** within the Group Policy and Certificate of Coverage for a detailed description of the eligibility for participation under the plan as well as the benefits provided. If this plan includes a participating provider (PPO) option, provider lists are furnished without charge, as a separate document.

D. Qualified Medical Child Support Order ("QMCSO")

QMCSO Determinations. A Plan participant or beneficiary can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order determinations from the Plan Administrator.

E. Termination Of The Group Policy

The Group Policy which provides benefits for this plan may be terminated by the Policyholder at any time with prior written notice to Reliance Standard Life Insurance Company It will terminate automatically if the Policyholder fails to pay the required premium. Reliance Standard Life Insurance Company may terminate the Group Policy on any Premium Due Date if the number of persons insured is less than the required minimum, or if Reliance Standard Life Insurance Company believes the Policyholder has failed to perform its obligations relating to the Group Policy.

After the first policy year, Reliance Standard Life Insurance Company may also terminate the Group Policy on any Premium Due Date for any reason by providing a 60-day advance written notice to the Policyholder.

The Group Policy may be changed in whole or in part. No change or amendment will be valid unless it is approved in writing by a Reliance Standard Life Insurance Company executive officer.

F. Claims For Benefits

Claims procedures are furnished automatically, without charge, as a separate document.

G. Continuation of Coverage Provisions (COBRA)

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) gives Qualified Beneficiaries the right to elect COBRA continuation after insurance ends because of a Qualifying Event. The law generally covers group health plans maintained by employers with 20 or more employees in the prior year. The law does not, however, apply to plans sponsored by the Federal government and certain church-related organizations.

i. Definitions For This Section

Qualified Beneficiary means an Insured Person who is covered by the plan on the day before a qualifying event. Any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary.

A Qualifying Event occurs when:

1. The Member dies (hereinafter referred to as Qualifying Event 1);

2. The Member's employment terminates for reasons other than gross misconduct as determined by the Employer (hereinafter referred to as Qualifying Event 2);

3. The Member's work hours fall below the minimum number required to be a Member (hereinafter referred to as Qualifying Event 3);

4. The Member becomes divorced or legally separated from a Spouse (hereinafter referred to as Qualifying Event 4);

5. The Member becomes entitled to receive Medicare benefits under Title XVII of the Social Security Act (hereinafter referred to as Qualifying Event 5);

6. The Child of a Member ceases to be a Dependent (hereinafter referred to as Qualifying Event 6);

7. The Employer files a petition for reorganization under Title 11 of the U.S. Bankruptcy Code, provided the Member is retired from the Employer and is insured on the date the petition is filed (hereinafter referred to as Qualifying Event 7).

ii. Electing COBRA Continuation

A. Each Qualified Beneficiary has the right to elect to continue coverage that was in effect on the day before the Qualifying Event. The Qualified Beneficiary must apply in writing within 60 days of the later of:

1. The date on which Insurance would otherwise end; and

2. The date on which the Employer or Plan Administrator gave the Qualified Beneficiary notice of the right to COBRA continuation.

B. A Qualified Beneficiary who does not elect COBRA Continuation coverage during their original election period may be entitled to a second election period if the following requirements are satisfied:

1. The Member's Insurance ended because of a trade related termination of their employment, which resulted in being certified eligible for trade adjustment assistance;

2. The Member is certified eligible for trade adjustment assistance (as determined by the appropriate governmental agency) within 6 months of the date Insurance ended due to the trade related termination of their employment; and

3. The Qualified Beneficiary must apply in writing within 60 days after the first day of the month in which they are certified eligible for trade adjustment assistance.

iii. Notice Requirements

1. When the Member becomes insured, the Plan Administrator must inform the Member and Spouse in writing of the right to COBRA continuation.

2. The Qualified Beneficiary must notify the Plan Administrator in writing of Qualifying Event 4 or 6 above within 60 days of the later of:

a. The date of the Qualifying Event; or

b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.

3. A Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, must notify the Plan Administrator of the disability in writing within 60 days of the later of:

a. The date of the disability determination;

b. The date of the Qualifying Event; or

c. The date on which the Qualified Beneficiary loses coverage due to the Qualifying Event.

4. Each Qualified Beneficiary who has become entitled to COBRA continuation with a maximum duration of 18 or 29 months must notify the Plan Administrator of the occurrence of a second Qualifying Event within 60 days of the later of:

   a. The date of the Qualifying Event; or

   b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.

5. The Employer must give the Plan Administrator written notice within 30 days of the occurrence of Qualifying Event 1, 2, 3, 5, or 7.

6. Within 14 days of receipt of the Employer's notice, the Plan Administrator must notify each Qualified Beneficiary in writing of the right to elect COBRA continuation.

In order to protect your rights, Members and Qualified Beneficiaries should inform the Plan Administrator in writing of any change of address.

iv. COBRA Continuation Period

1. 18-month COBRA Continuation

   Each Qualified Beneficiary may continue Insurance for up to 18 months after the date of Qualifying Event 2 or 3.

2. 29-month COBRA Continuation

   Each Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, may continue coverage for up to 29 months after the date of the Qualifying Event. All Insured Persons in the Qualified Beneficiary's family may also continue coverage for up to 29 months.

3. 36-Month COBRA Continuation

   If you are a Dependent, you may continue Coverage for up to 36 months after the date of Qualifying Event 1, 4, 5, or 6. Each Qualified Beneficiary who is entitled to continue Insurance for 18 or 29 months may be eligible to continue coverage for up to 36 months after the date of their original Qualifying Event if a second Qualifying Event occurs while they are on continuation coverage.

Note: The total period of COBRA continuation available in 1 through 3 will not exceed 36 months.

4. COBRA Continuation For Certain Bankruptcy Proceedings

   If the Qualifying Event is 7, the COBRA continuation period for a retiree or retiree's Spouse is the lifetime of the retiree. Upon the retiree's death, the COBRA continuation period for the surviving Dependents is 36 months from the date of the retiree's death.

v. Premium Requirements

Insurance continued under this provision will be retroactive to the date insurance would have ended because of a Qualifying Event. The Qualified Beneficiary must pay the initial required premium not later than 45 days after electing COBRA continuation, and monthly premium on or before the Premium Due Date thereafter. The monthly premium is a percentage of the total premium (both the portion paid by the employee and any portion paid by the employer) currently in effect on each Premium Due Date. The premium rate may change after you cease to be Actively at Work. The percentage is as follows:

18 month continuation - 102%

29 month continuation - 102% during the first 18 months, 150% during the next 11 months

36 month continuation - 102%

vi. When COBRA Continuation Ends

COBRA continuation ends on the earliest of:

1. The date the Group Policy terminates;

2. 31 days after the date the last period ends for which a required premium payment was made;

3. The last day of the COBRA continuation period.

4. The date the Qualified Beneficiary first becomes entitled to Medicare coverage under Title XVII of the Social Security Act;

5. The first date on which the Qualified Beneficiary is: (a) covered under another group Eye Care policy and (b) not subject to any preexisting condition limitation in that policy.

H. Your Rights under ERISA

As a participant in this Plan, you are entitled to certain rights and protections under the Employment Retirement Income Security Act of 1974 (ERISA). 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 work-sites 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.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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 benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to operate and administer this plan prudently and in the interest 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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare 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 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 in part, you may file suit in a state or 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 Rights

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 those publications hotline of the Employee Benefits Security Administration

CLAIMS REVIEW PROCEDURES
AS REQUIRED UNDER
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The following provides information regarding the claims review process and your rights to request a review of any part of a claim that is denied. Please note that certain state laws may also require specified claims payment procedures as well as internal appeal procedures and/or independent external review processes. Therefore, in addition to the review procedures defined below, you may also have additional rights provided to you under state law. If your state has specific grievance procedures, an additional notice specific to your state will also be included within the group policy and your certificate.

CLAIMS FOR BENEFITS

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

Vision Service Plan
Attn: Claims Services
P.O. Box 385018
Birmingham, AL 35238-5018

NOTICE OF DECISION OF CLAIM

We will evaluate your claim promptly after we receive it.

We will provide you written notice regarding the payment under the claim within 30 calendar days following receipt of the claim. This period may be extended for an additional 15 days, provided that we have determined that an extension is necessary due to matters beyond our control, and notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision. If the extension is due to your failure to provide information necessary to decide the claim, the notice of extension shall specifically describe the required information we need to decide the claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Policy on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision, along with your right to receive a copy of these guidelines, free of charge, upon request.
d. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Eye Care practice.
e. A description of any additional information needed to support your claim and why such information is necessary.
f. Information concerning your right to a review of our decision.
g. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA following an adverse benefit determination on review.

APPEAL PROCEDURE

If all or part of a claim is denied, you may request a review in writing within 180 days after receiving notice of the benefit denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your appeal. There will be no charge for such copies. You may request the names of the experts we consulted who provided advice to us about your claim.

The appeal review will be conducted by the Plan's named fiduciary and will be someone other than the person who denied the initial claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request.

If your appeal is about urgent care, you may call Toll Free at 877-897-4328, and an Expedited Review will be conducted. Verbal notification of our decision will be made within 72 hours, followed by written notice within 3 calendar days after that.

If your appeal is about benefit decisions related to clinical or medical necessity, a Standard Consultant Review will be conducted. A written decision will be provided within 30 calendar days of the receipt of the request for appeal.

If your appeal is about benefit decisions related to coverage, a Standard Administrative Review will be conducted. A written decision will be provided within 60 calendar days of the receipt of the request for appeal.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Policy on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision along with your right to receive a copy of these guidelines, free of charge, upon request.
d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.
e. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Eye Care practice.
f. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

Certain state laws also require specified internal appeal procedures and/or external review processes. In addition to the review procedures defined above, you may also have additional rights provided to you under state law. Please review your certificate for such information, call us, or contact your state insurance regulatory agency for assistance. In any event, you need not exhaust such state law procedures prior to bringing civil action under Section 502(a) of ERISA.

Any request for appeal should be directed to:
Quality Control, P.O. Box 82657, Lincoln, NE 68501-2657.

Reliance Standard Life Insurance Company
First Reliance Standard Life Insurance Company
Reliance Standard Life Insurance Company of Texas

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice applies to the Group Dental and Eye Care Lines of Business within Reliance Standard Life Insurance Company, First Reliance Life Insurance Company, and Reliance Standard Life Insurance Company of Texas (collectively "Reliance Standard"). We are required to abide by the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new Notice effective for all personal health information maintained by us.

Reliance Standard Office Contact Information: To assert any of your rights with respect to this Notice, or to obtain an authorization form, please call 1-800-487-5553 and request the appropriate form. Please direct any questions about this Notice or requests for further information, or to file a complaint: The Privacy Office, Attn. HIPAA Privacy, 2001 Market Street, Suite 1500, Philadelphia, PA 19130

YOUR RIGHTS
YOU HAVE THE RIGHT TO:

Get a copy of your claims records

You can ask to see or get a copy of your claims records we maintain about you. Ask us how to do this. We will provide a copy or a summary of your claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Correct your claims records

You can ask us to correct your claims records if you think they are incorrect or incomplete. Ask us how to do this.
We may say "no" to your request, but we'll tell you why in writing within 60 days

Request confidential communication

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit the information we share

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect payment for your care.

Get a list of those with whom we've shared your information

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).

We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this Privacy Notice

You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you believe your privacy rights have been violated

You can complain if you feel we have violated your rights by contacting us using the contact information above.
You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/ privacy/hipaa /complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

Answer coverage questions from your family and friends.
At your directions we will share information with your family, close friends, or others involved in payment for your care.
Share information in a disaster relief situation.

I*f you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

We will not share your personal information for marketing purposes or sell your personal information unless you give us your written permission to do so.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Run our organization

We can use and disclose your information to run our organization and contact you when necessary.
We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.

Example: We use health information about you to develop better coverage and service offerings for our insured members, including you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with other health benefit plans that you might also be covered by to coordinate payment for your health services.

Administer your health plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways– usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa /understanding/ consumers/index.html.

Help with public health and safety issues – We can share your health information in certain situations such as to help prevent disease or to report suspected abuse, neglect or domestic violence.

Comply with the law – We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Address workers' compensation, law enforcement, and other government requests – We can share health information about you:

For workers' compensation claims.
For law enforcement purposes or with a law enforcement official.
With health oversight agencies for activities authorized by law.

Respond to lawsuits and legal actions – We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information.
We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
We must follow the duties and privacy practices described in this Notice and give you a copy of it.
We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa /understanding/consumers/noticepp.html.

This Revised Notice is effective 9/23/13.

GROUP LONG TERM DISABILITY INSURANCE PROGRAM

Torrance County

RELIANCE STANDARD LIFE INSURANCE COMPANY

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

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. LTD 126984 issued to Torrance County, the Policyholder.

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 LONG TERM DISABILITY INSURANCE CERTIFICATE

This Group Long Term Disability Certificate amends the previous Group Long Term Disability Certificates and is dated January 29, 2020.

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SCHEDULE OF BENEFITS

EFFECTIVE DATE: January 1, 2016, as amended in the Policy through January 1, 2020

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

"Part-time" means working for the Policyholder for a minimum of 20 hours during your regular work week.

YOUR EFFECTIVE DATE: The first of the month following the day you become eligible.

INDIVIDUAL REINSTATEMENT: 6 months

LONG TERM DISABILITY BENEFIT

ELIMINATION PERIOD: 180 consecutive days of Total Disability.

MONTHLY BENEFIT: The Monthly Benefit is an amount equal to 60% of Covered Monthly Earnings.

To figure this benefit amount payable:

(1) multiply your Covered Monthly Earnings by the benefit percentage(s) shown above;
(2) take the lesser of the amount:
    (a) of step (1) above; or
    (b) the Maximum Monthly Benefit shown below; and
(3) subtract Other Income Benefits, as shown below, from step (2), above.

We will pay at least the Minimum Monthly Benefit as follows.

OTHER INCOME BENEFITS: Other Income Benefits are:

(1) disability income benefits you are eligible to receive because of your Total Disability under any group insurance plan(s);
(2) disability income benefits you are eligible to receive because of your Total Disability under any governmental retirement system, except benefits payable under a federal government employee pension benefit;
(3) all benefits (except medical or death benefits) including any settlement made in place of such benefits (whether or not liability is admitted) you are eligible to receive because of your Total disability under:
    (a) Workers' Compensation Laws;
    (b) occupational disease law;
    (c) any other laws of like intent as (a) or (b) above; and

(d) any compulsory benefit law;

(4) any of the following that you are eligible to receive from the Policyholder:
   (a) any formal salary continuance plan;
   (b) wages, salary or other compensation, excluding the amount allowable when engaged in Rehabilitative Employment; and
   (c) commissions or monies, including vested renewal commissions, but, excluding commissions or monies that you earned prior to Total Disability which are paid after Total Disability has begun;

(5) that part of disability benefits paid for by the Policyholder which you are eligible to receive because of your Total disability under a group retirement plan; and

(6) that part of Retirement Benefits paid for by the Policyholder which you are eligible to receive under a group retirement plan; and

(7) disability or Retirement Benefits under the United States Social Security Act, the Canadian pension plans, or any other government plan for which:
   (a) you are eligible to receive because of your Total Disability or eligibility for Retirement Benefits; and
   (b) your dependents are eligible to receive due to (a) above.

Disability and early Retirement Benefits will be offset only if such benefits are elected by you or if election would not reduce the amount of your accrued normal Retirement Benefits then funded.

Retirement Benefits under number (7) above will not apply to disabilities which begin after age 70 if you are already receiving Social Security Retirement Benefits while continuing to work beyond age 70.

MINIMUM MONTHLY BENEFIT: In no event will the Monthly Benefit payable to you be less than $100.

MAXIMUM MONTHLY BENEFIT: $5,000 (this is equal to a maximum Covered Monthly Earnings of $8,333).

MAXIMUM DURATION OF BENEFITS: Benefits will not accrue beyond the duration specified below:

Age at Disablement	Duration of Benefits (in years)
61 or less	To Age 65
62	3 ½
63	3
64	2 ½
65	2
66	1 ¾
67	1 ½
68	1 ¼
69 or more	1

CHANGES IN MONTHLY BENEFIT: Increases in the Monthly Benefit because of a change in age or class (if applicable) are effective on the Policy Anniversary Date coinciding with or next following the date of the change. Increases in the Monthly Benefit because of a change in earnings are effective the July 1st coinciding with or next following the date of the change.

You must be Actively at Work on the effective date of the change. If you are not Actively at Work on that date, the effective date of the increase in the benefit amount will be deferred until the date you return to Active Work.

Decreases in the Monthly Benefit because of a change in age or class (if applicable) are effective on the Policy Anniversary Date coinciding with or next following the date the change occurs. Decreases in the Monthly Benefit because of a change in earnings are effective on the July 1st coinciding with or next following the date the change occurs.

CONTRIBUTIONS: You are not required to contribute toward the cost of this insurance.

Premium contributions will not be included in your gross income.

For purposes of filing your Federal Income Tax Return, this means that under the law as of the date the Policy was issued, your Monthly Benefit might be treated as taxable. It is recommended that you contact your personal tax advisor.

DEFINITIONS

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

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

"Actively at Work" and "Active Work" mean actually performing on a Full-time or Part-time basis the material duties 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 an Injury or Sickness.

"Any Occupation" means an occupation normally performed in the national economy for which you are reasonably suited based upon your education, training or experience.

"Claimant" means you made a claim for benefits under the Policy for a loss covered by the Policy as a result of your Injury or Sickness.

"Covered Monthly Earnings" means your basic monthly salary received from the Policyholder on the July 1st just before the date of Total Disability. Covered Monthly Earnings does not include commissions, overtime pay, bonuses, incentive pay or any other special compensation not received as Covered Monthly Earnings.

If you are an hourly paid employee, the number of hours worked during a regular work week, not to exceed forty (40) hours per week, times 4.333, will be used to determine Covered Monthly Earnings. If you are paid on an annual basis, then the Covered Monthly Earnings will be determined by dividing the basic annual salary by 12.

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

"Elimination Period" means a period of consecutive days of Total Disability, as shown on the Schedule of Benefits page, for which no benefit is payable. It begins on the first day of Total Disability.

Interruption Period: If, during the Elimination Period, you return to Active Work for less than 30 days, then the same or related Total Disability will be treated as continuous. Days that you are Actively at Work during this interruption period will not count towards the Elimination Period. This interruption of the Elimination Period will not apply to you if you become eligible under any other group long term disability insurance plan.

"Full-time" means working for the Policyholder for a minimum of 30 hours during your regular work week.

"Hospital" or "Institution" means a facility licensed to provide care and Treatment for the condition causing your Total Disability.

"Injury" means bodily Injury resulting directly from an accident, independent of all other causes. The Injury must cause Total Disability which begins while your insurance coverage is in effect.

"Physician" means a duly licensed practitioner of the healing arts who is recognized by the law of the state in which treatment is received as qualified to treat the type of Injury or Sickness for which a claim is made. The Physician may not be you or a member of your immediate family.

"Regular Care" means Treatment that is administered as frequently as is medically required according to guidelines established by nationally recognized authorities, medical research, healthcare organizations, governmental agencies or rehabilitative organizations. Care must be rendered personally by your Physician according to generally accepted medical standards in your locality, be of a demonstrable medical value and be necessary to meet your basic health needs.

"Regular Occupation" means the occupation you are routinely performing when Total Disability begins. We will look at your occupation as it is normally performed in the national economy, and not the unique duties performed for a specific employer or in a specific locale.

"Retirement Benefits" mean money which you are entitled to receive upon early or normal retirement or disability retirement under:

(1) any plan of a state, county or municipal retirement system, if such pension benefits include any credit for employment with the Policyholder;
(2) Retirement Benefits under the United States Social Security Act of 1935, as amended, or under any similar plan or act; or
(3) an employer's retirement plan where payments are made in a lump sum or periodically and do not represent contributions made by you.

Retirement Benefits do not include:

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

"Sickness" means illness or disease causing Total Disability which begins while your insurance coverage is in effect. Sickness includes pregnancy, childbirth, miscarriage or abortion, or any complications therefrom.

"Totally Disabled" and "Total Disability" mean, that as a result of an Injury or Sickness:

(1) during the Elimination Period and for the first 24 months for which a Monthly Benefit is payable, you cannot perform the material duties of your Regular Occupation;
    (a) "Partially Disabled" and "Partial Disability" mean that as a result of an Injury or Sickness you are capable of performing the material duties of your Regular Occupation on a part-time basis or some of the material duties on a full-time basis. If you are Partially Disabled you will be considered Totally Disabled, except during the Elimination Period;
    (b) "Residual Disability" means being Partially Disabled during the Elimination Period. Residual Disability will be considered Total Disability; and
(2) after a Monthly Benefit has been paid for 24 months, you cannot perform the material duties of Any Occupation. We consider you Totally Disabled if due to an Injury or Sickness you are capable of only performing the material duties on a part-time basis or part of the material duties on a full-time basis.

If you are employed by the Policyholder and require a license for such occupation, the loss of such license for any reason does not in and of

itself constitute "Total Disability".

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

TRANSFER OF INSURANCE COVERAGE

If you were covered under any group long term disability insurance plan maintained by the Policyholder prior to the Policy's Effective Date, you will be insured under the Policy, provided that you are Actively At Work and meet all of the requirements for being an Eligible Person under the Policy on its Effective Date.

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

(1) You must have been insured with the prior carrier on the date of the transfer; and

(2) Premiums must be paid; and

(3) Total Disability must begin on or after the Policy's Effective Date.

If you are receiving long term disability benefits, become eligible for coverage under another group long term disability insurance plan, or have a period of recurrent disability under the prior group long term disability insurance plan, you will not be covered under the Policy. If premiums have been paid on your behalf under the Policy, those premiums will be refunded.

Pre-existing Conditions Limitation Credit

If you are an Eligible Person on the Effective Date of the Policy, any time used to satisfy the Pre-existing Conditions Limitation of the prior group long term disability insurance plan will be credited towards the satisfaction of the Pre-existing Conditions Limitation of the Policy.

GENERAL PROVISIONS

TIME LIMIT ON CERTAIN DEFENSES: After the Policy has been in force for two (2) years from its Effective Date, no statement made by you on a written application for insurance shall be used to reduce or deny a claim after your insurance coverage, with respect to which claim has been made, has been in effect for two (2) years.

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

(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.

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

WAIVER OF PREMIUM: No premium is due us while you are receiving Monthly Benefits from us. Once Monthly Benefits cease due to the end of your Total Disability, premium payments must begin again if insurance is to continue.

CLAIMS PROVISIONS

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

CLAIM FORMS: When we receive the notice of claim, we will send you the claim forms to file with us. We will send them within fifteen (15) days after we receive notice. If we do not, then the proof of Total Disability will be met by giving us a written statement of the type and extent of the Total Disability. The statement must be sent within ninety (90) days after the loss began.

WRITTEN PROOF OF TOTAL DISABILITY: For any Total Disability covered by the Policy, written proof must be sent to us within ninety (90) days after the Total Disability occurs. If written proof is not given in that time, the claim will not be invalidated nor reduced if it is shown that written proof was given as soon as was reasonably possible. In any event, proof must be given within one (1) year after the Total Disability occurs, unless you are legally incapable of doing so.

PAYMENT OF CLAIMS: When we receive written proof of Total Disability covered by the Policy, we will pay any benefits due. Benefits that provide for periodic payment will be paid for each period as we become liable.

We will pay benefits to you, if living, or else to your estate.

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

ARBITRATION OF CLAIMS: Any claim or dispute arising from or relating to our determination regarding your Total Disability may be settled by arbitration when agreed to by you and us in accordance with the Rules for Health and Accident Claims of the American Arbitration Association or by any other method agreeable to you and us. In the case of a claim under an Employee Retirement Income Security Act (hereinafter referred to as ERISA) Plan, your ERISA claim appeal remedies, if applicable, must be exhausted before the claim may be submitted to arbitration. Judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction over such awards.

Unless otherwise agreed to by you and us, any such award will be binding on you and us for a period of twelve (12) months after it is rendered assuming that the award is not based on fraudulent information and you continue to be Totally Disabled. At the end of such twelve (12) month period, the issue of Total Disability may again be submitted to arbitration in accordance with this provision.

Any costs of said arbitration proceedings levied by the American Arbitration Association or the organization or person(s) conducting the proceedings will be paid by us.

PHYSICAL EXAMINATION AND AUTOPSY: We will, at our expense, have the right to have you interviewed and/or examined:

(1) physically;
(2) psychologically; and/or
(3) psychiatrically;

to determine the existence of any Total Disability which is the basis for a claim. This right may be used as often as it is reasonably required while a claim is pending.

We can have an autopsy made unless prohibited by law.

LEGAL ACTIONS: No legal action may be brought against us to recover on the Policy within sixty (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 received.

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

ELIGIBILITY REQUIREMENTS: You are eligible for insurance under the Policy if you are a member of an Eligible Class, as shown on the Schedule of Benefits page.

EFFECTIVE DATE OF YOUR INSURANCE: If the Policyholder pays the entire Premium due for you, your insurance will go into effect on Your Effective Date, as shown on the Schedule of Benefits page.

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 latest of:

(1) Your Effective Date, as shown on the Schedule of Benefits page, if you apply on or before that date;
(2) on the first of the month following the date you apply, if you apply within thirty-one (31) days from the date you first met the Eligibility Requirements; or
(3) on the first of the month following the date we approve any required proof of health acceptable to us. We require this proof if you apply:
    (a) after thirty-one (31) days from the date you first met the Eligibility Requirements; or
    (b) after you terminated this insurance but remained in an Eligible Class, as shown on the Schedule of Benefits page.

The insurance for you will not go into effect on a date you are not Actively at Work because of a Sickness or Injury. The insurance will go into effect after you are Actively at Work for one (1) full day in an Eligible Class, as shown on the Schedule of Benefits page.

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

(1) the date the Policy terminates;
(2) the last day of the Policy month in which you cease to meet the Eligibility Requirements;
(3) the end of the period for which Premium has been paid for you; or
(4) the date you enter military service (not including Reserve or National Guard).

YOUR REINSTATEMENT: If you are terminated, your insurance may be reinstated if you return to Active Work with the Policyholder within the period of time as shown on the Schedule of Benefits page. You must also be a member of an Eligible Class, as shown on the Schedule of Benefits page, and have been:

(1) on a leave of absence approved by the Policyholder; or
(2) on temporary lay-off.

You will not be required to fulfill the Eligibility Requirements of the Policy again. The insurance will go into effect after you return to Active Work for one (1) full day. 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 insurance at your request or for failure to pay Premium when due, proof of health acceptable to us must be submitted before you may be reinstated.

BENEFIT PROVISIONS

INSURING CLAUSE: We will pay a Monthly Benefit if you:

(1) are Totally Disabled as the result of a Sickness or Injury covered by the Policy;
(2) are under the regular care of a Physician;
(3) have completed the Elimination Period; and
(4) submit satisfactory proof of Total Disability to us.

Please refer to the Schedule of Benefits for the MONTHLY BENEFIT and OTHER INCOME BENEFITS.

Benefits you are entitled to receive under OTHER INCOME BENEFITS will be estimated if the benefits:

(1) have not been applied for; or
(2) have been applied for and a decision is pending; or
(3) have been denied and the denial may be appealed.

The Monthly Benefit will be reduced by the estimated amount. If benefits have been estimated, the Monthly Benefit will be adjusted when we receive proof:

(1) of the amount awarded; or
(2) that benefits have been denied and the denial cannot be further appealed.

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

For each day of a period of Total Disability less than a full month, the amount payable will be 1/30th of the Monthly Benefit.

COST OF LIVING FREEZE: After the initial deduction for any Other Income Benefits, the Monthly Benefit will not be further reduced due to any cost of living increases payable under these Other Income Benefits.

LUMP SUM PAYMENTS: If Other Income Benefits are paid in a lump sum, the sum will be prorated over the period of time to which the Other Income benefits apply. If no period of time is given, the sum will be prorated over sixty (60) months.

TERMINATION OF MONTHLY BENEFIT: The Monthly Benefit will stop on the earliest of:

(1) the date you cease to be Totally Disabled;
(2) the date you die;
(3) the Maximum Duration of Benefits, as shown on the Schedule of Benefits page, has ended; or
(4) the date you fail to furnish the required proof of Total Disability.

RECURRENT DISABILITY: If, after a period of Total Disability for which benefits are payable, you return to Active Work for at least six (6) consecutive months, any recurrent Total Disability for the same or related cause will be part of a new period of Total Disability. A new Elimination Period must be completed before any further Monthly Benefits are payable.

If you return to Active Work for less than six (6) months, a recurrent Total Disability for the same or related cause will be part of the same Total Disability. A new Elimination Period is not required. Our liability for the entire period will be subject to the terms of the Policy for the original period of Total Disability.

If you become eligible for insurance coverage under any other group long term disability insurance plan, then this Recurrent Disability section will not apply to you.

EXCLUSIONS

We will not pay a Monthly Benefit for any Total Disability caused by:

(1) an act of war, declared or undeclared; or
(2) an intentionally self-inflicted Injury; or
(3) your committing a felony; or
(4) an Injury or Sickness that occurs while you are confined in any penal or correctional institution.

LIMITATIONS

MENTAL OR NERVOUS DISORDERS: Monthly Benefits for Total Disability caused by or contributed to by mental or nervous disorders will not be payable beyond an aggregate lifetime maximum duration of twenty-four (24) months unless you are in a Hospital or Institution at the end of the twenty-four (24) month period. The Monthly Benefit will be payable while so confined, but not beyond the Maximum Duration of Benefits.

If you were confined in a Hospital or Institution and:

(1) Total Disability continues beyond discharge;
(2) the confinement was during a period of Total Disability; and
(3) the period of confinement was for at least fourteen (14) consecutive days;

then upon discharge, Monthly Benefits will be payable for the greater of:

(1) the unused portion of the twenty-four (24) month period; or
(2) ninety (90) days;

but in no event beyond the Maximum Duration of Benefits, as shown on the Schedule of Benefits page.

Mental or Nervous Disorders are defined to include disorders which are diagnosed to include a condition such as:

(1) bipolar disorder (manic depressive syndrome);
(2) schizophrenia;
(3) delusional (paranoid) disorders;
(4) psychotic disorders;
(5) depressive disorders;
(6) anxiety disorders;
(7) somatoform disorders (psychosomatic illness);
(8) eating disorders; or
(9) mental illness.

SUBSTANCE ABUSE: Monthly Benefits for Total Disability due to alcoholism or drug addiction will be payable while you are a participant in a Substance Abuse Rehabilitation Program. The Monthly Benefit will not be payable beyond twenty-four (24) months.

If, during a period of Total Disability due to Substance Abuse for which a Monthly Benefit is payable, you are able to perform Rehabilitative Employment, the Monthly Benefit, less 50% of any of the money received from this Rehabilitative Employment will be paid until: (1) you are performing all the material duties of your Regular Occupation on a full-time basis; or (2) the end of twenty-four (24) consecutive months from the date that the Elimination Period is satisfied, whichever is earlier. All terms and conditions of the Rehabilitation Benefit will apply to Rehabilitative Employment due to Substance Abuse.

"Substance Abuse" means the pattern of pathological use of a Substance which is characterized by:

(1) impairments in social and/or occupational functioning;
(2) debilitating physical condition;
(3) inability to abstain from or reduce consumption of the Substance; or
(4) the need for daily Substance use for adequate functioning.

"Substance" means alcohol and those drugs included on the Department of Health, Retardation and Hospitals' Substance Abuse list of addictive drugs, except tobacco and caffeine are excluded.

A Substance Abuse Rehabilitation Program means a program supervised by a Physician or a licensed rehabilitation specialist approved by us.

PRE-EXISTING CONDITIONS: Benefits will not be paid for a Total Disability:

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

a Pre-existing Condition unless you have been Actively at Work for one (1) full day following the end of twelve (12) consecutive months from the date you became insured.

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

With respect to persons insured prior to January 1, 2016: Benefits above a Maximum Monthly Benefit of $2,000 will not be paid for a Total Disability:

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

a Pre-existing Condition unless you have been Actively at Work for one (1) full day following the end of twelve (12) consecutive months from January 1, 2016.

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

LIMITATIONS - OTHER LIMITED BENEFITS

1. Monthly Benefits will be limited to a total of 24 months in your lifetime for all Total Disabilities caused or contributed to by:

   - Chronic fatigue syndrome; or
   - Environmental Allergic or Reactive Illness; or
   - Self-Reported Conditions.

   No Monthly Benefits are payable beyond the 24 month maximum benefit period or the Maximum Duration of Benefits shown in the Schedule of Benefits, whichever is less.

2. Monthly Benefits will be limited to a total of 24 months in your lifetime for all Total Disabilities contributed to or caused by musculoskeletal and connective tissue disorders of the neck and back, including any disease, disorder, sprain and strain of the joints and adjacent muscles of the cervical, thoracic and lumbosacral regions and their surrounding soft tissue.

   No Monthly Benefits are payable beyond the 24 month maximum benefit period or the Maximum Duration of Benefits shown in the Schedule of Benefits, whichever is less.

Total Disabilities caused by the following musculoskeletal and connective tissue disorders will be treated the same as any other Total Disability and the 24 month maximum benefit period will not apply:

- Arthritis
- Demyelinating diseases
- Myelitis
- Myelopathies
- Osteopathies
- Radiculopathies documented by electromyogram
- Ruptured intervertebral discs
- Scoliosis
- Spinal fractures
- Spinal tumors, malignancy or vascular malformations
- Spondylolisthesis, Grade II or higher
- Traumatic spinal cord necrosis

"Environmental Allergic Or Reactive Illness" means an illness which results from your inability to function due to physical or mental symptoms contributed to or caused by an allergic reaction from physical contact with or exposure to any static or airborne substances.

"Self-Reported Conditions" means those conditions which, when reported by your Physician, cannot be verified using generally accepted standard medical procedures and practices. Examples of such conditions include, but are not limited to, headaches, dizziness, fatigue, loss of energy, or pain.

SPECIFIC INDEMNITY BENEFIT

If you suffer any one of the Losses listed below from an accident resulting in an Injury, we will pay a guaranteed minimum number of Monthly Benefit payments, as shown below. However:

(1) the Loss must occur within one hundred and eighty (180) days; and
(2) you must live past the Elimination Period.

For Loss of:	Number of Monthly Benefit Payments:
Both Hands	46 Months
Both Feet	46 Months
Entire Sight in Both Eyes	46 Months
Hearing in Both Ears	46 Months
Speech	46 Months
One Hand and One Foot	46 Months
One Hand and Entire Sight in One Eye	46 Months
One Foot and Entire Sight in One Eye	46 Months
One Arm	35 Months
One Leg	35 Months
One Hand	23 Months
One Foot	23 Months
Entire Sight in One Eye	15 Months
Hearing in One Ear	15 Months

"Loss(es)" with respect to:
(1) hand or foot, means the complete severance through or above the wrist or ankle joint;
(2) arm or leg, means the complete severance through or above the elbow or knee joint; or
(3) sight, speech or hearing, means total and irrecoverable Loss thereof.

If more than one (1) Loss results from any one accident, payment will be made for the Loss for which the greatest number of Monthly Benefit payments is provided.

The amount payable is the Monthly Benefit, as shown on the Schedule of Benefits page, with no reduction from Other Income Benefits. The number of Monthly Benefit payments will not cease if you return to Active Work. If death occurs after we begin paying Monthly Benefits, but before the Specific Indemnity Benefit has been paid according to the above schedule, the balance remaining at time of death will be paid to your

estate, unless a beneficiary is on record with us under the Policy.

Benefits may be payable longer than shown above as long as you are still Totally Disabled, subject to the Maximum Duration of Benefits, as shown on the Schedule of Benefits page.

SURVIVOR BENEFIT - LUMP SUM

We will pay a benefit to your Survivor when we receive proof that you died while:

(1) you were receiving Monthly Benefits from us; and
(2) you were Totally Disabled for at least one hundred and eighty (180) consecutive days.

The benefit will be an amount equal to 3 times your last Monthly Benefit. The last Monthly Benefit is the benefit you were eligible to receive right before your death. It is not reduced by wages earned while in Rehabilitative Employment.

A benefit payable to a minor may be paid to the minor's legally appointed guardian. If there is no guardian, at our option, we may pay the benefit to an adult that has, in our opinion, assumed the custody and main support of the minor. We will not be liable for any payment we have made in good faith.

"Survivor" means your spouse. If the spouse dies before you or if you were legally separated, then your natural, legally adopted or step-children, who are under age twenty-five (25) will be the Survivors. If there are no eligible Survivors, payment will be made to your estate, unless a beneficiary is on record with us under the Policy.

WORK INCENTIVE AND CHILD CARE BENEFITS

WORK INCENTIVE BENEFIT

During the first twelve (12) months of Rehabilitative Employment during which a Monthly Benefit is payable, we will not offset earnings from such Rehabilitative Employment until the sum of:

(1) the Monthly Benefit prior to offsets with Other Income Benefits; and
(2) earnings from Rehabilitative Employment;

exceed 100% of your Covered Monthly Earnings. If the sum above exceeds 100% of Covered Monthly Earnings, our Benefit Amount will be reduced by such excess amount until the sum of (1) and (2) above equals 100%.

CHILD CARE BENEFIT

We will allow a Child Care Benefit if:

(1) you are receiving benefits under the Work Incentive Benefit;
(2) your Child(ren) is (are) under 14 years of age;
(3) the child care is provided by a non-relative; and
(4) the charges for child care are documented by a receipt from the caregiver, including social security number or taxpayer identification number.

During the twelve (12) month period in which you are eligible for the Work Incentive Benefit, an amount equal to actual expenses incurred for child care, up to a maximum of $250 per month, will be added to your Covered Monthly Earnings when calculating the Benefit Amount under the Work Incentive Benefit.

Child(ren) means: your unmarried child(ren), including any foster child, adopted child or step child who resides in your home and is financially dependent on you for support and maintenance.

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

Family and Medical Leave of Absence:

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

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

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

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

Military Services Leave of Absence:

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

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

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

While you are on a Family and Medical Leave of Absence for any reason other than your own illness, injury or disability or Military Services Leave of Absence you will be considered Actively at Work. Any changes such as revisions to coverage due to age, class or salary changes, as applicable, will apply during the leave except that increases in the amount of insurance, whether automatic or subject to election, will not be effective if you are not considered Actively at Work until you have returned to Active Work for one (1) full day.

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

Your coverage will cease under this extension on the earliest of:

(1) the date the Policy terminates; or
(2) the end of the period for which premium has been paid for you; or
(3) the date such leave should end in accordance with the Policyholder's policies regarding Family and Medical Leave of Absence and Military Services Leave of Absence in compliance with the Family and Medical Leave Act of 1993, as amended and USERRA. Coverage will not be terminated if you become Totally Disabled during the period of the leave and are eligible for benefits according to the terms of the Policy. Any Monthly Benefit which becomes payable will be based on your Covered Monthly Earnings immediately prior to the date of Total Disability.

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

EXTENDED DISABILITY BENEFIT

We will pay an Extended Disability Benefit to you if you:

(1) meet all the requirements of Total Disability of the Policy; and
(2) are receiving a Total Disability Benefit under the Policy that will be exhausted because the Maximum Duration of Benefits has ended; and
(3) are unable to function without another person's Direct Assistance or verbal direction due to:

    (a) an inability to perform at least two Activities of Daily Living (ADL) as defined; or
    (b) Cognitive Impairment as defined; and

(4) are either:

    (a) confined as an Inpatient in a Skilled Nursing Home, Rehabilitation Facility or Rehabilitative Hospital in which patients receive care from licensed medical professionals; or
    (b) receiving Home Health Care or Hospice Care; and

(5) make a Written Request for this benefit within thirty (30) days after the Maximum Duration of Benefits has ended.

The Extended Disability Benefit:

(1) will be an amount equal to 85% of the Monthly Benefit after offsets with Other Income Benefits which was payable prior to you qualifying for the Extended Disability Benefit up to a maximum of $5,000 per month; and
(2) is payable for a maximum of sixty (60) months measured from the date that the Maximum Duration of Benefits has ended.

Definitions:

"Activities of Daily Living (ADL)" means:

(1) Bathing - the ability to wash oneself in the tub or shower or by sponge bath from a basin without Direct Assistance;
(2) Dressing - the ability to change clothes without Direct Assistance, including fastening and unfastening any medically necessary braces or artificial limbs;
(3) Eating/Feeding - the ability to eat without Direct Assistance, once food has been prepared and made available;
(4) Transferring - the ability to move in and out of a chair or bed without

Direct Assistance, except with the aid of equipment (including support and other mechanical devices); and

(5) Toileting - the ability to get to and from and on and off the toilet, to maintain a reasonable level of personal hygiene and to adjust clothing without Direct Assistance.

"Cognitively Impaired" and "Cognitive Impairment" means your confusion or disorientation due to organic changes in the brain resulting in a deterioration or loss in intellectual capacity as confirmed by cognitive or other tests satisfactory to us.

"Direct Assistance" means you require continuous help or oversight to be able to perform the Activity of Daily Living (ADL).

"Home Health Care" means medical and non-medical services, provided in your residence due to Injury or Sickness, including: visiting nurse services; physical, respiratory, occupational or speech therapy; nutritional counseling; and home health aide services. Home Health Care services must be: (1) prescribed by and provided under the supervision of a Physician; and (2) rendered by a licensed home health care provider who is not a member of your immediate family. Home Health Care does not include: homemaker, companion and home delivered meals services; nor informal care services provided by your family members.

"Hospice Care" means a program of care which coordinates the special needs of a person with a Terminal Illness. Hospice Care must be: (1) prescribed by and provided under the supervision of a Physician; and (2) rendered by a licensed hospice care provider who is not a member of your immediate family.

"Inpatient" means a person confined in a Skilled Nursing Home, Rehabilitation Facility or Rehabilitative Hospital, for whom a daily room and board charge is made.

"Pre-existing Condition" means with respect to the Extended Disability Benefit only, any Sickness or Injury for which you received medical treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines, during the three (3) months immediately preceding your effective date of insurance.

"Rehabilitation Facility or Rehabilitative Hospital" means any facility or Hospital that is licensed in the state in which it is operating to provide rehabilitation services, therapy or retraining to you to enable you to walk, communicate, and/or function as a member of society.

"Skilled Nursing Home" means a facility or part of a facility that is licensed or certified in the state in which it is operating to provide Skilled Nursing Care.

"Skilled Nursing Care" means that level of care which:

(1) requires the training and skills of a Registered Nurse;
(2) is prescribed by a Physician;
(3) is based on generally recognized and accepted standards of health care by the American Medical Association; and
(4) is appropriate for the diagnosis and treatment of your Sickness or Injury.

"Terminal Illness" means a Sickness or physical condition that is certified by a Physician in a written statement, on a form prescribed by us, to reasonably be expected to result in death in less than twelve (12) months.

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

Pre-existing Conditions Limitation:

With respect to the Extended Disability Benefit only, benefits will not be paid for a Total Disability:

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

a Pre-existing Condition unless you have been Actively at Work for one (1) full day following the end of twelve (12) consecutive months measured from your effective date of insurance with us.

No benefits will be paid under the Extended Disability Benefit if your Total Disability occurred before your effective date of insurance with us.

The Extended Disability Benefit will cease to be payable on the earliest of the following dates:

(1) the date you die; or
(2) the date you no longer meet the requirements of Total Disability of the Policy; or
(3) the date you:

    (a) are no longer confined as an Inpatient in a Skilled Nursing Home, Rehabilitative Facility or Rehabilitation Hospital; or

(b) are no longer receiving Home Health Care or Hospice Care; or

(4) the date you are no longer considered Cognitively Impaired; or
(5) the date you are no longer unable to perform at least two Activities of Daily Living (ADL); or
(6) the date you receive your 60th monthly Extended Disability Benefit payment.

The Extended Disability Benefit will not be payable for Total Disability which is caused by or results from conditions for which Monthly Benefits are specifically limited by the Policy such as Mental or Nervous Disorders, alcoholism, drug addiction, or other Substance Abuse, musculoskeletal and connective tissue disorders, chronic fatigue syndrome, Environmental Allergic or Reactive Illness, or Self-Reported Conditions.

If the Policy contains a Survivor Benefit, Activities of Daily Living Benefit (ADL), Catastrophic Care Benefit, Supplemental Pension Benefit, Living Benefit, Cost of Living Benefit or a Conversion Privilege, such benefits are not applicable when receiving benefits under the Extended Disability Benefit.

REHABILITATION BENEFIT

"Rehabilitative Employment" means work in Any Occupation for which your training, education or experience will reasonably allow. The work must be approved by a Physician or a licensed or certified rehabilitation specialist approved by us. Rehabilitative Employment includes work performed while Partially Disabled, but does not include performing all the material duties of your Regular Occupation on a full-time basis.

If you are receiving a Monthly Benefit because you are considered Totally Disabled under the terms of the Policy and are able to perform Rehabilitative Employment, we will continue to pay the Monthly Benefit less an amount equal to 50% of earnings received through such Rehabilitative Employment.

If you are able to perform Rehabilitative Employment when Totally Disabled due to Substance Abuse, we will continue to pay the Monthly Benefit less an amount equal to 50% of earnings received through such Rehabilitative Employment. This Monthly Benefit is payable for a maximum of twenty-four (24) consecutive months from the date the Elimination Period is satisfied.

You will be considered able to perform Rehabilitative Employment if a Physician or licensed or certified rehabilitation specialist approved by us determines that you can perform such employment.

RELIANCE STANDARD LIFE INSURANCE COMPANY

AMENDATORY RIDER

It is hereby understood and agreed that the Certificate to which this Rider is attached shall be amended by the addition of the following:

Applicable to Vermont Residents Only

The following sections/provisions of the Certificate are amended to comply with Vermont law:

1. **Schedule of Benefits section, Elimination Period provision.**

   The Elimination Period will be the lesser of the number of days shown on the Schedule of Benefits in the certificate or:

   For Benefit Periods 2 years and greater: 365 days.

   For Benefit Periods greater than 1 year but less than 2 years: 180 days.

2. **Limitations section, Mental or Nervous Disorders and/or Substance Abuse, if such limitations are included in the Certificate.**

   If the Certificate contains limitations in coverage for mental or nervous disorders and/or substance abuse, such limitations will not apply to Vermont residents. Coverage for these conditions will be treated the same as other conditions that may entitle you to full benefits.

3. **Limitations section, Pre-existing Conditions, if such limitation is included in the Certificate.**

   The pre-existing condition provision time period in the definition of Pre-existing Condition shall be the lesser of the time period shown on the Limitations form in the Certificate or twelve (12) months.

   The period of time during which you become Totally Disabled

due to a Pre-existing Condition and a benefit is not payable for such Total Disability is the lesser of the time period as shown in the certificate or twelve (12) months.

All other terms and conditions remain unchanged.

RELIANCE STANDARD LIFE INSURANCE COMPANY

Secretary

NOTICE OF PROTECTION PROVIDED BY NEW MEXICO LIFE INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the New Mexico Life Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under New Mexico law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with New Mexico law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values

- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits

- Annuities
  - $250,000 in present value of annuity benefits

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000 ($500,000 for hospital, medical, and surgical insurance policies).

Note to benefit plan trustees or other holders of unallocated annuities covered under the act: For unallocated annuities that fund certain governmental retirement plans, the limit is $250,000 in present value of annuity benefits per plan participant. For covered unallocated annuities that fund other plans, a special limit of $5,000,000 applies to each contract holder, regardless of the number of contracts held or number of persons covered.

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under New Mexico law.

To learn more about the above protections, please visit the Association's website at www.nmlifega.org, or contact:

New Mexico Life Insurance Guaranty Association P.O. Box 2880 Sante Fe, NM 87504-2880 505-820-7355	Insurance Division Public Regulation Commission P.O. Box 1269 Sante Fe, NM 87504-1269 888-427-5772

Insurance companies and agents are not allowed by New Mexico law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and New Mexico law, then New Mexico law will control.

Claim Procedures and ERISA Statement of Rights

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.

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

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

LTD 126984
Ed. 1/2020

GROUP LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PROGRAM

Torrance County

RELIANCE STANDARD LIFE INSURANCE COMPANY

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

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 154637 issued to Torrance County, 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 January 29, 2020.

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SCHEDULE OF BENEFITS

EFFECTIVE DATE: January 1, 2016, as amended in the Policy through January 1, 2020

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

CLASS 1: Full-time Officer

CLASS 2: Full-time and Part-time Employee, except an Employee included in any other class

INDIVIDUAL EFFECTIVE DATE: The first of the month following the day you become eligible.

INDIVIDUAL REINSTATEMENT: 6 months

AMOUNT OF INSURANCE:

Basic Life and Accidental Death and Dismemberment:

CLASS 1: $75,000.

CLASS 2: $50,000.

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

CLASS 1 & 2: $10,000 to $500,000 in increments of $10,000, not to exceed five (5) times Earnings.

For any class with a combined Basic and Supplemental amount of $150,000 or more, the above Basic and Supplemental amounts cannot exceed a combined maximum of seven (7) times Earnings.

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

For Insureds age 65 and over, the Amount of Basic Life and Accidental Death and Dismemberment Insurance and Supplemental Life Insurance is subject to automatic reduction. Upon the Insured's attainment of the specified age below, the Amount of Basic Life and Accidental Death and Dismemberment Insurance and Supplemental Life Insurance will be reduced to the applicable percentage. This reduction also applies to Insureds who are age 65 or over on their Individual Effective Date.

Age	**Percentage of available or in force amount at age 64**
65-69	65%
70-74	40%
75+	20%

Dependent Life:

Spouse Amount: $10,000 to $500,000 in increments of $10,000
Child Amount:
birth and over: $5,000

The Spouse Amount of Insurance may not exceed 100% of your amount.

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

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

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

CHANGES IN AMOUNT OF INSURANCE: Increases and decreases in the Amount of Insurance because of changes in age are effective on the Policy Anniversary Date coinciding with or next following the date of the change. Increases and decreases in the Amount of Insurance because of changes in class are effective on the first of the month coinciding with or next following the date of the change. Increases and decreases in the Amount of Insurance because of changes in Earnings are effective on the July 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 Policy Anniversary Date 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.

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

DEFINITIONS

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

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

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

"Full-time" means working for the Policyholder for a minimum of 30 hours during your regularly scheduled work week.

CLASS 2: "Part-time" means working for the Policyholder 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 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 July 1st just before the date of loss. Earnings does not include commissions, overtime pay, bonuses, incentive pay or any other special compensation not received as basic salary.

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

If you were not employed by the Policyholder on the July 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.

"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.

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

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

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

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

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

(2) your child(ren), from birth to 26 years, including natural children, legally adopted children, children who are dependent on you during the waiting period before adoption, stepchildren, and foster children. Foster children must be in your custody to be considered a Dependent; and

(3) your child(ren) beyond the limiting age who is incapable of self-sustaining employment by reason of intellectual disability or physical handicap and who is chiefly dependent on you for support and maintenance.

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

GENERAL PROVISIONS

INCONTESTABILITY

Any 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 INDIVIDUAL INSURANCE: If the Policyholder pays the entire premium, the insurance up to the guaranteed issue Amount of Insurance, if applicable, for an Eligible Person will go into effect on the date stated on the Schedule of Benefits.

Amounts of Insurance over the guaranteed issue Amount of Insurance shown on the Schedule of Benefits must be applied for in writing and are subject to proof of good health.

Insurance will be effective on the first of the month following the date we approve such proof of good health.

If you pay a part of the premium, you must apply in writing for the insurance to go into effect. You will become insured on the later of:

(1) the Individual Effective Date stated on the Schedule of Benefits, if you apply on or before that date; or

(2) the first of the month following the date you apply, if you apply within thirty-one (31) days from the date you first met the eligibility requirements; or

(3) the first of the month following the date we approve any required proof of good health. We require proof of good health if you apply:

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

(4) the date premium is remitted.

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.

If you have been previously declined for coverage by us, had an application withdrawn or marked incomplete for any reason, or voluntarily terminated your insurance coverage with us, all future requests for coverage are subject to submission and our approval of proof of good health. However, proof of good health will not be required if after you voluntarily terminated your insurance coverage with us you make a future request due to a life event change or during any approved enrollment period.

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 last day of the Policy month in which 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.

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.

The insurance will go into effect on the day you return to Active Work for one full day. 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 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) $10,000.

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 fifteen (15) 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;
(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 $2,000 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.

WAIVER OF PREMIUM IN EVENT OF TOTAL DISABILITY

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

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

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

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

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

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

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

ACCIDENTAL DEATH AND DISMEMBERMENT 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.

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

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

EXCLUSIONS

A benefit will not be payable for a loss:

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

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

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

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

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

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

SEAT BELT AND AIR BAG BENEFIT

Seat Belt Benefit

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

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

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

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

Air Bag Benefit

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

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

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

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

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

EXCLUSIONS

No benefit is payable for any loss sustained by you:

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

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

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

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

CLAIMS PROVISIONS

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

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

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

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

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 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 up to the guaranteed issue Amount of Insurance for Dependents will become effective on the later of:

(1) the first of the month following the date you become eligible for Dependent Life Insurance; or

(2) the first of the month following the date the dependent meets the definition of Dependent.

Amounts of Insurance over the guaranteed issue Amount of Insurance shown on the Schedule of Benefits for the Dependent spouse must be applied for in writing and are subject to proof of good health. Insurance will be effective the first of the month following the date we approve such proof of good health.

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 following the date you become eligible for Dependent Life Insurance; or

(2) the first of the month 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 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 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.

If the Dependent spouse has been previously declined for coverage by us, had an application withdrawn or marked incomplete for any reason or voluntarily terminated his/her insurance coverage with us, all future requests for coverage, are subject to submission and our approval of proof of good health. However, proof of good health will not be required if the Dependent who voluntarily terminated his/her insurance coverage with us makes a future request for insurance coverage due to a life event change or during any approved enrollment period.

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) $10,000.

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 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 fifteen (15) 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.

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

Family and Medical Leave of Absence:

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

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

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

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

Military Services Leave of Absence:

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

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

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

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

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

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

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

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

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

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 154637
Issued to Group Policyholder: Torrance County

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

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

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

"Certificate" means the document, issued to each Insured, which explains the terms of his coverage under the Group Life Insurance Policy.

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

"Insured" means the primary Insured and his/her insured Dependents, if any.

"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 or in installment payments mutually agreed to by us and the Insured. 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 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

NOTICE OF PROTECTION PROVIDED BY NEW MEXICO LIFE INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the New Mexico Life Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under New Mexico law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with New Mexico law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  $300,000 in death benefits
  $100,000 in cash surrender or withdrawal values

- Health Insurance
  $500,000 in hospital, medical and surgical insurance benefits
  $300,000 in disability income insurance benefits
  $300,000 in long-term care insurance benefits
  $100,000 in other types of health insurance benefits

- Annuities
  $250,000 in present value of annuity benefits

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000 ($500,000 for hospital, medical, and surgical insurance policies).

Note to benefit plan trustees or other holders of unallocated annuities covered under the act: For unallocated annuities that fund certain governmental retirement plans, the limit is $250,000 in present value of annuity benefits per plan participant. For covered unallocated annuities that fund other plans, a special limit of $5,000,000 applies to each contract holder, regardless of the number of contracts held or number of persons covered.

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under New Mexico law.

To learn more about the above protections, please visit the Association's website at www.nmlifega.org, or contact:

New Mexico Life Insurance Guaranty Association P.O. Box 2880 Sante Fe, NM 87504-2880 505-820-7355	Insurance Division Public Regulation Commission P.O. Box 1269 Sante Fe, NM 87504-1269 888-427-5772

Insurance companies and agents are not allowed by New Mexico law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and New Mexico law, then New Mexico law will control.

Claim Procedures and ERISA Statement of Rights

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.

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

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

GL 154637
Ed. 1/2020

Insurance | Risk Management | Consulting

Re: Client Name: Torrance County
Request for Proposal: Basic Life/AD&D, Supplemental Life, LTD coverage, STD coverage and Vision
Proposal Deadline: See RFP
Effective Date: January 1, 2023

On behalf of our client, we are requesting a proposal for Basic Life/A&D, Supplemental Life/AD&D, and LTD and STD coverages. Enclosed, please find the current benefit program material which includes:

- general client information;
- eligibility information;
- current rates;

Thank you very much for your consideration.

Courtney Seward, Client Manager
Gallagher Benefit Services
Courtney_Seward@ajg.com
303-889-2732

GENERAL CLIENT INFORMATION

1. **Client's name and address**

   Torrance County, New Mexico
   205 S. 9th Street
   Estancia, NM 87016

2. **Type of Industry and General Business Background**

   County Government (SIC: 9111)

3. **Eligibility Provisions**

   Employee –

   "Full-time" means working for the Policyholder for a minimum of 30 hours during your regularly scheduled work week.

   CLASS 2: "Part-time" means working for the Policyholder for a minimum of 20 hours during your regularly scheduled work week.

   Coverage begins on the first day of the month following 30 days of continuous employment.

   Police and Fire employees **ARE** included in this coverage.

4. **Number of Eligible Active Employees**

   Approximately 114. See census for complete details.

5. **Reason(s) for soliciting proposals**

   See RFP.

6. **Plans Available for Quotation**

   - Basic Life and AD&D
   - Voluntary Dependent Children Life
   - Voluntary Life
   - Long Term Disability
   - Short Term Disability
   - Vision

   The County is interested in evaluation STD proposals, on a voluntary or county-sponsored basis.

   NOTE: The County is requiring firm rates for a 3-year period, with additional preference for firm rates for a 4-year time-frame. Rates must be equal for at least years one and two.

7. **Plan year**

January 1 through December 31

8. Effective Date of Coverage

January 1, 2023

9. Commission

Include a 10% flat commission level for vision benefits and 20% flat commission for all other lines of coverage to match commissions included in current rates.

10. Proposal Due Date and other proposal requirements

Proposals are due by the end of business on as outlined within the County's official RFP.

In order for your proposal to be considered, do not submit your standard proposal documentation. As mentioned in the RFP, the cost response and campaign contribution shall be submitted separately.

(*Exhibits 1 through 11 MUST be returned in Excel format):*

- Exhibit 1 – Minimum Requirements
- Exhibit 2 – General Questionnaire
- Exhibit 3 – Basic Life/AD&D Questionnaire, Voluntary Life – 2 tabs
- Exhibit 4 – LTD Questionnaire and LTD Contract Questionnaire – 2 tabs
- Exhibit 5 – STD Contact Questionnaire
- Exhibit 6 – Vision General Questionnaire, Vision Network and Coverage Questionnaire and Vision Network New Mexico Specific – 2 tabs
- Exhibit 7 – Basic Life/AD&D, Voluntary Life Benefits– 2 tabs
- Exhibit 8 – LTD Benefits
- Exhibit 9 – STD Benefits
- Exhibit 10 – Vision Benefits
- Exhibit 11 – RFP Signature Page

11. Questions:

A formal vendor Q & A will be conducted. All questions must be submitted via email to Noah as outlined in the County's RFP document.

12. Historical Claims Data:

Life: Included as Attachment 5

Disability: Current carrier has confirmed no disability claims since 1/1/2016 plan inception.

LIST OF PROPOSAL ATTACHMENTS

- Attachment 1 – Background Information
- Attachment 2 – Basic Life and AD&D Certificate of Coverage

- Attachment 3 – LTD Certificate of Coverage
- Attachment 4 – Vision Certificate of Coverage
- Attached 5 – Life Claims Data
- Attachment 6 – Census (To be released when the Acknowledgement of Receipt form is completed by vendor, returned to and approved by County)

Much effort has been made to provide all necessary and accurate information. It is the sole responsibility of the proposers to ensure that they have all information necessary to complete submission of their proposals. If more information is needed, please contact Noah Sedillo, Torrance County Purchasing as outlined in the RFP.

NOTE: ALL INFORMATION IN THIS REQUEST FOR PROPOSAL (RFP) SHOULD BE CONSIDERED PROPRIETARY AND, UNDER NO CIRCUMSTANCES, SHOULD BE RELEASED TO ANY OTHER SOURCE WITHOUT THE PRIOR CONSENT OF GALLAGHER BENEFIT SERVICES, INC.

RFP TIMELINE:

The RFP Timeline can be found in the RFP.

EVALUATION CRITERIA:

The Evaluation Criteria can be found in the RFP.

CURRENT AND PROPOSED PLAN DESIGN(S)

SEE ATTACHED CERTIFICATES FOR COMPLETE DETAILS

BASIC LIFE AND AD&D

CURRENT PLAN –

Carrier:	Reliance Standard Life Insurance
Funding:	Fully Insured
ER / EE Contribution:	Employer paid
Schedule of Benefits:	All Employees: $75,000 for Officers and $50,000 for Regular. The County would like to consider offering $75,000 to Fire Department staff (specifically identified as “Fire” on the census).

Waiver of Premium Included

Rate History:

Life $.17 / 1,000 (1/1/16 to current)
AD&D $.03 / 1,000 (1/1/16 to current)

SUPPLEMENTAL LIFE

CURRENT PLAN –

Carrier: Reliance Standard Life Insurance
Funding: Fully Insured
ER / EE Contribution: Employee paid

Schedule of Benefits: Employee and Spouse: Choose from minimum of $10,000 to a maximum of $500,000 in $10,000 increments (spouse benefit cannot exceed employee benefit elected)
Employee Guarantee Issue: $100,000
Spouse Guarantee Issue: $25,000
Child Life Max and Guarantee Issue: $5,000

Age Reduction: Age 65: 65%
Age 70: 40%
Age 75: 20%

Waiver of Premium Included

Rate History: Rates have remained the same since 1/1/2016.

Voluntary Life:

Age	Rate
18-24	0.07
25-29	0.06
30-34	0.07
35-39	0.09
40-44	0.13
45-49	0.21
50-54	0.33
55-59	0.5
60-64	0.69
65-69	1.16
70-74	2.6
75-79	5.89
80-84	9.91
85-89	26.59
90-94	88.91
95-99	130.07

Spouse Life:

Age	Rate
18-24	0.08
25-29	0.07
30-34	0.08
35-39	0.11
40-44	0.16
45-49	0.25
50-54	0.39
55-59	0.58
60-64	0.86
65-69	1.41
70-74	3.07
75-79	6.38
80-84	9.06
85-89	18.01
90-94	37.22
95-99	79.61

Dependent Life: $1.32 / 5,000 (1/1/16 to current)

LONG TERM DISABILITY

CURRENT PLAN –

Carrier: Reliance Standard Life Insurance
Funding: Fully Insured
ER / EE Contribution: Employer paid

Schedule of Benefits: All Employees:

180 day Elimination period
60% of Pre-disability earnings which is the Insured's monthly salary
Maximum monthly benefit: $5,000
Minimum monthly benefit: $100
Duration: SSNRA
Own Occupation: 2 years

Rate History: $.37 per $100 covered payroll (1/1/16 – current)

VISION

CURRENT PLAN –

Carrier: Reliance Standard Life Insurance
Funding: Fully Insured
ER / EE Contribution: Employer/Employee Contribution

Schedule of Benefits:

Services	In-Network	Out-of-Network Reimbursement
Eye Exam-Once per calendar year		
	$15 exam	$15 exam, up to $35 reimbursement
Lenses – Once per calendar year		
Single Vision Lenses	Covered in full	Up to $30
Lined Bifocal Lenses	Covered in full	Up to $50
Lines Trifocal Lenses	Covered in full	Up to $65
Lenticular Lenses	Covered in full	Up to 100
Frames- Once per two calendar years		
	$130	Up to $70
Contact Lenses-Once per calendar year if you elect contacts instead of frames/ lenses		
Contact Lens Fitting and Exam	Member cost up to $60	Not Covered
Medically Necessary	Covered in Full	Up to $210
Elective Contact Lenses	$130 allowance	Up to $105

$15 Deductible applies to complete pair of glasses or to frames, whichever is selected. Out of Network $15 copay and then 'up to' reimbursement applies.

Rate History:

Coverage Tier	Per month
Employee	$8.24
Employee + Spouse	$16.24
Employee + Child(ren)	$15.40
Employee + Family	$23.40

Rates have been in effect since 1/1/2016.

SHORT TERM DISABILITY

CURRENT PLAN –

Carrier: No current County-sponsored benefit
Funding: Fully Insured requested
ER / EE Contribution: Employer paid with employee paid as an alternative

Schedule of Benefits: All Employees:

Elimination period: 7 day accident / 14 day illness
60% of Pre-disability earnings
Maximum weekly benefit: $1,000
Duration: 180 days

Rate History: N/A – new benefit

PROPOSED PLANS

Please duplicate current benefit structure as closely as possible with the addition of a short-term disability plan offerings (employer paid and employee paid option).

Torrance County
RFP TC-FY-23-01: MINIMUM REQUIREMENTS
EFFECTIVE DATE: JANUARY 1, 2023

ALL VENDORS MUST COMPLETE THIS SECTION. (NOTE, THIS FILE CONTAINS MULTIPLE REQUIRED SECTIONS)

The following are proposal specifications. Please complete the following chart by responding in the right-hand column. If you disagree with any of the criteria, please explain in the DISAGREE column and acknowledge that you may not be considered. If the criteria do not apply to the services you are quoting, please indicate "N/A."

		AGREE	DISAGREE
1	You have reviewed and accept the Plan's eligibility provisions outlined in the RFP.		
2	You must be licensed in New Mexico or willing to obtain a license in New Mexico.		
3	Fully insured premiums must be guaranteed for a minimum of three (3) years from the effective date with additional preference for a fourth year guarantee. Rates must be the same for Years 1 and 2.		
4	Include a 10% flat commission level for vision benefits and 20% flat commission for all other lines of coverage to match commissions included in current rates.		
5	Renewal rates and fees must be submitted 120 days prior to the contract renewal date.		
6	Your proposal assumes that each line of coverage is purchased on a stand-alone basis. Provide information in the Cost Exhibits related to any savings or discounts applicable if your company is awarded multiple lines of coverage.		
7	You have included detailed plan summaries for all quoted plans.		
8	You currently have a Vision provider network in Estancia, New Mexico and surrounding areas.		
9	You may be required to complete a network analysis.		
10	The vendor will be responsible for producing the Booklet/Summary Plan Description . The client reserves the right to review/revise the Booklet/SPD prior to finalization.		
11	Vendor agrees to provide a booklet draft within 60 days of the effective date.		
12	Vendors may be required to attend benefit committee meetings.		
13	Vendors may be required to attend open enrollment meetings.		

14	Vendor agrees to provide all standard reports to the client and its consultant.		
15	The client and its consultant must be able to access reports online.		
16	Insured coverage must be provided on a no-loss/no-gain basis for all covered participants so the current group does not suffer a loss of benefit solely due to the transfer of coverages to your firm.		
17	You must agree to waive the “actively at work” provision for the currently enrolled. The master contract will reflect the elimination of the actively at work restriction or deferred effective date for all initially enrolled active or inactive employees and dependents. This will include only initial eligibles (those eligible on the effective date of the contract) including COBRA continuees.		
18	You are in compliance with all HIPAA Privacy, Electronic Data Interface (EDI) and Security requirements.		
19	Your contract must require no more than a 30-day notice of termination. Your contract cannot prohibit the group from terminating coverage at any time. There must be no penalties for late notification or for termination off anniversary.		
20	Proposals must include performance guarantees outlined in Exhibit 10, if quoting vision.		
21	If your proposal deviates in any respect from the benefits requested, limitations, exclusions, funding methods requested, contract conditions, or any other RFP specifications, you must clearly disclose and describe all such deviations on the RFP Signature Page. You cannot disclose deviations by making a “general” reference to section(s) of the proposal. If the RFP Signature Page does not indicate any deviations, it will be assumed that your proposal exactly matches all RFP requirements.		
22	You completed all questionnaires and exhibits in full and in the format requested (e.g., Word or Excel – not PDF).		
23	By New Mexico State statute(s), insurance premium tax does not apply to public entity employers including, but not limited to, cities, counties, school districts, etc. If selected, premium tax will not be charged.		
24	Confirm that your company will transition existing insureds, at the insurance amounts currently in place, with no Evidence of Insurability requirements.		

25	If awarded Voluntary Life coverage, confirm that upon the initial contract effective date, bidder will allow a one-time open enrollment for all eligible employees to enroll in Voluntary Life with no Evidence of Insurability requirements up to Guarantee Issue limits.		
26	Bidder confirms that in the event the prior carrier does not honor a Long Term Disability claim in the elimination period, solely because the Master Contract is terminated, Bidder agrees to review the claim for benefits without prejudice.		

Torrance County
RFP TC-FY-23-01: GENERAL QUESTIONNAIRE
EFFECTIVE DATE: JANUARY 1, 2023

ALL VENDORS MUST COMPLETE THIS SECTION.

WHEN RESPONDING TO QUESTIONS THAT REQUIRE YOU TO SELECT FROM THE RESPONSES ALREADY PROVIDED, PLEASE PLACE AN " X " IN FRONT OF THE APPLICABLE ANSWER.

	QUESTION	VENDOR RESPONSE			
1	Do you carry an Errors & Omissions policy?		Yes		No
	· Will you hold the client harmless for suits resulting from your actions or omissions?		Yes		No
2	Do you carry a comprehensive general liability policy?		Yes		No
3	Does your company carry a fidelity bond?		Yes		No
4	Please answer the following in regard to the core organization that will provide services requested:				
a	· Who is your parent company?				
b	· Date formed.				
c	· Number of years performing services requested.				
d	· Ratings of company(s):				
e	− A.M. Best				
f	− Moody's				
g	− Standard & Poor's				
h	· Where is your corporate headquarters located?				
i	· Number of employees in your company.				

j	· How many members / insureds are covered by your organization's plan(s)?				
k	− Nationally?				
l	− In New Mexico?				
m	· Have you been acquired within the last 24 months?		Yes		No
n	· Are you currently in discussions to be acquired?		Yes		No
o	· Are you currently involved, or have you recently been involved in, any merger / acquisition affecting the staff or operational areas that will provide services to the client?		Yes		No
5	Has your rating with A.M. Best, Moody's, or Standard & Poor's been downgraded in the last 3 years?		Yes		No
a	If yes, explain reason for downgrade.				
6	Provide company's organization chart, including the team that provides sales and service for New Mexico based clients. Be sure to identify where each team member is based.				
7	Is your organization's current annual financial report, or other documents reflecting financial performance, available online?		Yes		No
a	· If yes, provide website address.				
b	· If no, please provide a paper copy with your proposal.				
8	Do you offshore any services related to the proposed coverages?		Yes		No
a	· If yes, briefly describe services that are off-shored, and to what county.				
9	Please provide the following:				

	Four client references, including one former client, who may be contacted. Municipality/ governmental clients are preferred. ***Please provide the following***:				
a	**Name of Client - Active**				
	Contact Name				
	Address				
	Email Address				
	Telephone number				
	Approximate number of employees covered by each contract.				
b	**Name of Client - Active**				
	Contact Name				
	Address				
	Email Address				
	Telephone number				
	Approximate number of employees covered by each contract.				
c	**Name of Client - Active**				
	Contact Name				
	Address				
	Telephone number				
	Approximate number of employees covered by each contract.				
d	**Name of Client - Terminated**				
	Contact Name				
	Address				
	Email Address				
	Telephone number				
	Reason for termination?				
	Approximate number of employees covered by each contract.				
10	Please describe your premium remittance process and if you have experience working with the ERP system, Tyler.				
a	Does your response vary by coverages proposed? If yes, please explain.				
11	What communications and enrollment materials will you provide for the annual enrollment and/or distribution?				
	· Can this material be customized to meet the client's needs?		Yes		No
	· Is there an additional cost for this service?		Yes		No

Torrance County
RFP TC-FY-23-01: Basic Life and AD&D Questionnaire
EFFECTIVE DATE: January 1, 2023

INSTRUCTIONS: Indicate "Yes" or "No" below if you are proposing above noted coverage(s). If you are not, please indicate "No" below and proceed to the next exhibit. If yes, answer all of the following questions. If a question is not applicable, please indicate "N/A" in the response column. Please do NOT provide any attachments, nor make reference to another document in lieu of providing a response. Please do not add, delete, or re-order any of the questions. If more space is needed to provide an appropriate response, you may add rows directly underneath the question being answered.

WHEN RESPONDING TO QUESTIONS THAT REQUIRE YOU TO SELECT FROM THE RESPONSES ALREADY PROVIDED, PLEASE PLACE AN " X " IN FRONT OF THE APPLICABLE ANSWER.

Above Reference Coverage Quoted?		Yes		No

COVERAGE / SERVICE QUESTIONS

1	Does your basic life insurance plan include a conversion provision?		Yes		No
a	• Are conversion charges included in the renewal financial accounting?		Yes		No
2	Does your basic life insurance plan include a portability provision?		Yes		No
a	If you offer portability, do you deny ported coverage to any insured who is ill or injured at the time of application for Port?		Yes		No
b	If a separate set of portability rates is used, do you apply any underwriting criteria to those individuals?		Yes		No
c	If so, can you deny coverage or rate adjust coverage for ported individuals after underwriting?		Yes		No

d	Can individuals port the entire amount of life insurance?		Yes		No
e	Is portability linked to a coverage limit (e.g., must be covered for a minimum of 2 years)? If yes, please provide details.		Yes		No
f	Do you limit the term of an individual's coverage under a ported contract (e.g., 3 years, to a certain age, etc.)? If yes, please provide details.		Yes		No
g	Should the master contract terminate, are individuals with ported coverage affected (i.e., would their coverage terminate)? Please provide details.		Yes		No
3	Please describe your Accelerated Benefit Option (ABO).				
4	When paying a normal Death Claim (not an Accelerated Benefit Option), does your contract allow you to reduce the total benefit for any Age Reductions that would have occurred within 90 days after the date of death, or do you pay the amount inforce on the date of death?		Reduce for upcoming Age change		Pay amount in force on date of death.
5	If you will not agree to waive the "actively at work" requirement, how do you propose mitigating the risk associated with loss of coverage for employees not "actively at work" as of the effective date?				
6	When your company replaces a prior group life insurance plan, do you require a list of employees not "actively at work" as of the effective date?		Yes		No
a	• If you do require such a list, will you deny a claim for any individual who was not on the "not actively at work" list?		Yes		No
7	Are disabled employees who are not yet eligible for Waiver of Premium under the prior plan transferred to your company's succeeding plan, and is their original Date of Disability applied to your Waiver of Premium requirement?		Yes		No

8	If your company underwrites both the Life and Long Term Disability coverage for the Employer, do you automatically initiate a Life Waiver of Premium claim when LTD claims are received and approved for benefits?		Yes		No
9	You agree that termination of the master contract cannot eliminate your liability (waiver of premium) for an employee whose disability occurred prior to termination of the master contract.		Agree		Disagree
10	Is AD&D coverage provided on a 24-hour basis?		Yes		No
11	Are there limitations to the timeline of injury and date of death for AD&D benefits?				
12	Is the Life benefit payable for death from any cause?		Yes		No
a	If no, what causes are excluded?				
13	Provide a full explanation of how the waiver of premium provision works.				

Torrance County

RFP TC-FY-23-01: Voluntary Life Questionnaire

EFFECTIVE DATE: January 1, 2023

INSTRUCTIONS: Indicate "Yes" or "No" below if you are proposing above noted coverage(s). Note, if you are proposing Basic Life and AD&D, you MUST also propose Voluntary Life. If you are not, please indicate "No" below and proceed to the next exhibit. If yes, answer all of the following questions. If a question is not applicable, please indicate "N/A" in the response column. Please do NOT provide any attachments, nor make reference to another document in lieu of providing a response. Please do not add, delete, or re-order any of the questions. If more space is needed to provide an appropriate response, you may add rows directly underneath the question being answered.

WHEN RESPONDING TO QUESTIONS THAT REQUIRE YOU TO SELECT FROM THE RESPONSES ALREADY PROVIDED, PLEASE PLACE AN " X " IN FRONT OF THE APPLICABLE ANSWER.

Coverage quoted:		Yes		No

1	Is it required that the Employee elect VT life coverage in order for VT Dependent coverage to be elected?		Yes		No
2	Does your VT life insurance plan include a conversion provision?		Yes		No
	• Is conversion offered for VT dependent life coverage?		Yes		No
3	Does your VT life insurance plan include a portability provision?		Yes		No
a	If you offer Portability, do you deny ported coverage to any insured who is ill or injured at the time of application for Port?		Yes		No

b	Can you deny coverage or rate adjust coverage for ported individuals after underwriting?		Yes		No
c	Can individuals port the entire amount of life insurance?		Yes		No
d	Is portability linked to a coverage limit (e.g., must be covered for a minimum of 2 years)? If yes, please provide details.		Yes		No
e	Do you limit the term of an individual's coverage under a ported contract (e.g., 3 years, to a certain age, etc.)? If yes, please provide details.		Yes		No
f	Should the master contract terminate, are individuals with ported coverage affected (i.e., would their coverage terminate)? Please provide details.		Yes		No
4	When your company replaces a prior group life insurance plan, are dependents who were covered under the prior carrier's plan denied immediate coverage if confined in a hospital or medical facility?		Yes		No
5	Please describe your Accelerated Benefit Option (ABO).				
6	When paying a normal Death Claim (not an Accelerated Benefit Option), does your contract allow you to reduce the total benefit for any Age Reductions that would have occurred within 90 days after the date of death, or do you pay the amount inforce on the date of death?		Reduce for upcoming Age change		Pay amount in force on date of death.
7	When your company replaces a prior group life insurance plan, are employees who were covered by the prior carrier required to be actively at work in order to be eligible for coverage on the effective date of the new plan?		Yes		No

8	If you will not agree to waive the "actively at work" requirement, how do you propose mitigating the risk associated with loss of coverage for employees not "actively at work" as of the effective date?				
9	When your company replaces a prior group life insurance plan, do you require a list of employees not "actively at work" as of the effective date?		Yes		No
a	• If you do require such a list, will you deny a claim for any individual who was not on the "not actively at work" list?		Yes		No
10	Are disabled employees who are not yet eligible for Waiver of Premium under the prior plan transferred to your company's succeeding plan, and is their original Date of Disability applied to your Waiver of Premium requirement?		Yes		No
11	You agree that termination of the master contract cannot eliminate your liability (waiver of premium) for an employee whose disability occurred prior to termination of the master contract.		Agree		Disagree
12	Is the VT Life benefit payable for death from any cause?		Yes		No
a	If no, what causes are excluded?				
13	Please provide a full explanation of the procedures / processes, and timetable, for processing and approving EOI.				
a	Do these processes, etc., differ if EOI is due to a Late Enrollment, versus for an amount that exceeds Guarantee Issue?		Yes		No
b	· If yes, explain				
14	Provide a full explanation of how the waiver of premium provision works.				

15	Please describe in detail the enrollment process for employees and their dependents, including any different processes / requirements for initial versus annual enrollment.	
	What are the minimum issue ages for:	
a	· Employees?	
b	· Spouse?	
	What are the maximum issue ages for:	
c	· Employees?	
d	· Spouse?	

Torrance County
RFP TC-FY-23-01: LTD Questionnaire
EFFECTIVE DATE: January 1, 2023

INSTRUCTIONS: Indicate "Yes" or "No" below if you are proposing above noted coverage(s). If you are not, please indicate "No" below and proceed to the next exhibit. If yes, answer all of the following questions. If a question is not applicable, please indicate "N/A" in the response column. Please do NOT provide any attachments, nor make reference to another document in lieu of providing a response. Please do not add, delete, or re-order any of the questions. If more space is needed to provide an appropriate response, you may add rows directly underneath the question being answered.

WHEN RESPONDING TO QUESTIONS THAT REQUIRE YOU TO SELECT FROM THE RESPONSES ALREADY PROVIDED, PLEASE PLACE AN " X " IN FRONT OF THE APPLICABLE ANSWER.

Coverage quoted:		**Yes**		**No**

1	What is your definition of Long Term disability? Please be explicit.				
2	Confirm that the pre-existing condition clause does not apply to those who are currently enrolled, and actively-at-work on the proposed policy effective date, and have satisfied any previous pre-existing condition requirements of the prior policy.		Agree		Disagree
3	Do you require a periodic census report from existing clients?		Yes		No
a	• If so, frequency of report?				
b	• What information is required?				
4	Describe your claim management process, and the types of personnel involved (e.g. nurse case managers, others).				

a	• Describe the qualifications and experience of such personnel.				
b	• Are all registered nurses?				
c	• With whom do these personnel have contact (employee, employer, physician, etc.)?				
5	What determines whether your (carrier's) physician will review the attending physician's statement?				
6	Could your contract be designed to insist upon a third physician's opinion when the claimant's and your company's physicians disagree on the status of a claimant?		Yes		No
7	Once approved for disability benefits, what is the process used to validate continued disability and how frequently is validation required?				
8	What part does your company play in assisting LTD claimants to obtain Social Security disability benefit awards?				
9	Describe how your plan works with Social Security and PERA benefits.				
10	Describe your process and success rate in obtaining refunds of overpayments due to subsequent Social Security awards when full LTD benefits have previously been paid without Social Security offsets (this would be applicable to claimants who previously worked for an employer participating in Social Security.)				
11	Do you typically assign a dedicated claims examiner and/or disability management team to every client's account?		Yes		No

12	Do you have the capability to withhold from disability benefit payments, on behalf of the client, any of the following:				
a	• FICA taxes?		Yes		No
b	• State taxes?		Yes		No
c	• Employee benefit contributions?		Yes		No
13	Does your standard contract contain language to support and administer a plan with provisions outlined in IRS ruling 2004-55?		Yes		No
a	If no, can it be offered as an option if the client requests?		Yes		No
b	If offered as an option, is there an additional cost?		Yes		No
14	Under what circumstances, if ever, would a claim stabilization reserve be required?				
15	Identify the terms and conditions of your contracts should the client terminate their contract with your company (i.e. client liability, responsibility for incurred claims, etc.).				
16	How often do you provide claims activity / experience, and open and closed claims reports?				
17	If the LTD policy contains a Conversion provision, are there additional conversion costs over and beyond the stated premium rate?		Yes		No
18	If the LTD policy contains a Portability provision, are there additional portability costs over and beyond the stated premium rate?		Yes		No

Torrance County
RFP TC-FY-23-01: LTD Contract Questionnaire
EFFECTIVE DATE: January 1, 2023

INSTRUCTIONS: If you are not proposing above noted coverage(s), proceed to the next exhibit. If you are proposing, answer all of the following questions. If a question is not applicable, please indicate "N/A" in the response column. Please do NOT provide any attachments, nor make reference to another document in lieu of providing a response. Please do not add, delete, or re-order any of the questions. If more space is needed to provide an appropriate response, you may add rows directly underneath the question being

CARRIERS: Please complete the following chart to describe the standard benefits included in your LTD group contracts. NOTE: If any benefit mentioned below is not a standard, filed benefit, please note that the benefit varies by quote / proposal.

1	What is the definition of *OWN occupation*?	
a	Does the elimination period count toward the "own occ" period?	
2	What is the definition of *ANY occupation?*	
a	Is "Any Occupation" based on national, regional, or local economy?	
3	Is Earnings Loss *AND* Occupation Loss required to satisfy elimination period or begin benefit payments?	
4	Does your standard LTD policy contain a requirement that total disability must precede partial disability?	
5	Does your definition of disability include a 40-hour work week provision?	
6	Does your definition of disability include a Maximum Capacity provision?	
7	Does your contract include Zero Day Residual?	
a	If yes, what was the increase to rates to include?	

8	Using 80% earnings test, do you index pre-disability earnings so benefit is not offset by future raises?	
9	Describe how separate periods of disability from the same cause are calculated to determine the elimination period.	
10	Describe any C*hildcare benefit included.*	
11	Describe any S*pouse Disability* benefit included.	
12	Describe any *Return to Work* Incentive Program included.	
13	Describe any *Rehabilitation Benefit* included.	
14	Describe any *Survivor Income* Benefit	
15	Does your contract contain any *Long Term Care* benefits?	
16	Describe any *Reasonable Accommodation/Worksite Modification* benefits included.	
17	Does your contract include *CPI indexation?*	
a	How does it work?	
18	Does your contract include a *Cost of Living Adjustment (COLA)* feature?	
a	If yes, what is the impact on the rate?	
19	Is Waiver of Premium included?	
a	If Yes, confirm the following: the premium will be waived after the employee satisfies the elimination period and the WOP is applicable when the employee is approved for the benefit.	
20	Does your LTD policy include a *Portability* privilege?	
21	Does your LTD policy include a *Conversion* privilege?	

22	Describe your Partial Disability Benefit Calculation	
23	Is your LTD coverage provided on a no loss / no gain basis?	
24	Does your standard LTD contract have any of the following exclusions?	
a	Armed conflict, war	
b	Intentionally self-inflicted injury	
c	Sickness, injury occurring while in military services	
d	Committing assault or felony	
e	Participation in riot	
f	Injuries suffered in fight in which EE is aggressor	
g	Loss of professional license / certification	
h	Sickness/injury due to cosmetic or reconstructive surgery, except surgery to correct deformity caused by sickness/injury	
25	List Other Income Offsets	
a	Do you offset against the *actual*, or the *potential / eligible* Social Security benefit amount?	
26	Does your contract limit benefits for Self Reported symptoms?	
27	Does your contract give you Discretionary Authority?	
28	Does the LTD contract typically include an *Employee Assistance Program (EAP) benefit*? If yes, briefly describe benefits such as # telephonic and face-to-face visits, legal and financial assistance, etc.	
a	If included, does the EAP benefit cover ALL employees, or just those who are enrolled in the client's LTD plan?	
b	If not standardly included, do you offer the option to include an EAP benefit?	

Torrance County
RFP TC-FY-23-01: STD Contract Questionnaire
EFFECTIVE DATE: January 1, 2023

INSTRUCTIONS: Indicate "Yes" or "No" below if you are proposing above noted coverage(s). If you are not, please indicate "No" below and proceed to the next exhibit. If yes, answer all of the following questions. If a question is not applicable, please indicate "N/A" in the response column. Please do NOT provide any attachments, nor make reference to another document in lieu of providing a response. Please do not add, delete, or re-order any of the questions. If more space is needed to provide an appropriate response, you may add rows directly underneath the question being answered.

WHEN RESPONDING TO QUESTIONS THAT REQUIRE YOU TO SELECT FROM THE RESPONSES ALREADY PROVIDED, PLEASE PLACE AN " X " IN FRONT OF THE APPLICABLE ANSWER.

Coverage quoted:		Yes		No

1	What is your definition of Short Term disability? Please be explicit.				
2	Confirm that the pre-existing condition clause does not apply to those who are currently enrolled, and actively-at-work on the proposed policy effective date, and have satisfied any previous pre-existing condition requirements of the prior policy.		Agree		Disagree
	Confirm the pre-existing participation requirements.				
3	Do you require a periodic census report from existing clients?		Yes		No
	• If so, frequency of report?				
	• What information is required?				

4	Are benefits payable for any non-occupational illness or injury which results in time away from work?		Yes		No
5	What is your charge to prepare the W-2?		Included		% increase to quoted rate
6	Do you have the capability to withhold from disability benefit payments, on behalf of the client, any of the following:				
	• FICA taxes?		Yes		No
	• State taxes?		Yes		No
	• Employee benefit contributions?		Yes		No
7	Does your standard contract contain language to support and administer a plan with provisions outlined in IRS ruling 2004-55?		Yes		No
	If no, can it be offered as an option if the client requests?		Yes		No
	If offered as an option, is there an additional cost?		Yes		No
8	What are your provisions for successive periods of disability?				
9	Identify the terms and conditions of your contracts should the client terminate their contract with your company (i.e. client liability, responsibility for incurred claims, etc.).				

Torrance County
RFP TC-FY-23-01: Vision General Questionnaire
EFFECTIVE DATE: January 1, 2023

INSTRUCTIONS: Indicate "Yes" or "No" below if you are proposing above noted coverage(s). If you are not, please indicate "No" below and proceed to the next exhibit. If yes, answer all of the following questions. If a question is not applicable, please indicate "N/A" in the response column. Please do NOT provide any attachments, nor make reference to another document in lieu of providing a response. Please do not add, delete, or re-order any of the questions. If more space is needed to provide an appropriate response, you may add rows directly underneath the question being answered.

WHEN RESPONDING TO QUESTIONS THAT REQUIRE YOU TO SELECT FROM THE RESPONSES ALREADY PROVIDED, PLEASE PLACE AN " X " IN FRONT OF THE APPLICABLE ANSWER.

Coverage quoted:		Yes		No

GENERAL QUESTIONNAIRE					
ORGANIZATIONAL QUALIFICATIONS					
1	Please answer the following in regard to the core organization that will provide services requested:				
a	• Who is your parent company?				
b	• Date formed.				
c	• Number of years performing services requested.				
d	• Where is your corporate headquarters located?				
e	• Number of employees in your company.				
2	Show the number of current employer groups you service in each of the size categories below:	Total #		Public Sector #	
a	• Under 500 employees				
b	• 500 to 1,500 employees				
c	• 1,500 to 2,500 employees				
d	• 2,500 or more employees				
3	• Are you currently involved in, or have you recently been involved in, any merger / acquisition affecting the staff or operational areas that will provide services to the client?		Yes		No

4	Is your firm anticipating any major expansion or reorganization in the next year, including any merger / acquisition activity?		Yes		No
5	Audits:				
a	• What is the frequency of your internal audits?				
b	• What is the frequency of your external audits?				
6	Confirm you utilize a claims quality assurance or review process.		Confirmed		Not confirmed
a	• Do you have reviews conducted by an outside agency?		Yes		No
7	Describe your security, backup and disaster recovery procedures.				
8	Attach a sample agreement or policy, similar to the one that would be issued to the County. Indicate where the sample can be found in your proposal.				
9	Briefly describe your firm's financial strength / stability. If rated by the following agencies, provide rating, or indicate you are not rated by that agency.				
a	• If rated by A.M. Best, provide rating or indicate you are not rated by that agency.		RATING		NOT RATED
b	• If rated by Moody's, provide rating or indicate you are not rated by that agency.		RATING		NOT RATED
c	• If rated by Standard & Poor's, provide rating or indicate you are not rated by that agency.		RATING		NOT RATED
CLIENT SERVICE					
10	Provide an organization chart of the team that will provide sales and service for the County. Indicate where in your proposal the organization chart can be found.				
11	What is (are) the location(s) of the Customer Service and Claim payment departments that will service the County?				
12	What are the hours of operation for the Customer Service unit that will service the County?				
13	Do you provide a toll-free telephone number for Customer Service?		Yes		No
14	Indicate all foreign languages offered by the Customer Service center that will be assigned to the County.				
15	On average, how many clients do you service from the Claims and Member Service site(s) that will be assigned to service the County's plan?				
16	Does the same person handle both claims processing and customer service functions?		Yes		No

17	How many trained claim processors do you employ?				
a	• What is their average length of experience?				
b	• What is the average volume of claims paid per day per processor?				
18	What is your average annual employee turnover in Claims and in Customer Service?				
19	What was your average turnaround time for paid claims for the last two-plus years?				
a	2020				
b	2021				
c	2022				
20	Indicate your claims error rate for the last two-plus years:				
a	2020				
b	2021				
c	2022				
ADMINISTRATION					
21	Do you offer a website for the County's benefits and HR staff, and for plan participants?		Yes		No
If yes, answer the following questions. If no, skip to Question # 33.					
22	Briefly describe the information and tools on your website that are available to County benefits and HR staff.				
23	Briefly describe the information and tools on your website that are available to plan participants.				
24	Can participants email questions to your customer service department via the website?		Yes		No
25	Can your customer service representatives respond to member inquiries via the website?		Yes		No
26	Are there any significant changes or enhancements being planned for your website in the next two years?		Yes		No
a	• If yes, describe briefly.				
27	Which of the following tasks can members and plan sponsor representatives perform online? Check all that apply.	Members		Plan Sponsors	
a	Ø Enrollment (New Hires and Open Enrollment)				
b	Ø Changes in Status				
c	Ø Billing (Plan Administrators only)	N/A			
d	Ø Claim inquiry				
e	Ø Physician / provider cost and quality comparison				

Update number when offshore removed

f	Ø ID card request				
g	Ø Terminations				
28	Do you offer online eligibility maintenance for *all* clients?		Yes		No
29	Briefly describe controls in place to maintain a secure environment for communicating and transacting business with plan members, providers, and County benefits and HR staff.				
30	Are you able to provide data that benchmarks the client's experience against the following :				
a	• Your book of business		Yes		No
b	• National norms		Yes		No
c	• Similar sized clients		Yes		No
d	• Similar industry clients		Yes		No
31	Provide a list of all standard reports available: **(List below. Insert lines if needed):**	**Frequency**		**Indicate any cost for report**	**Indicate any limitation on availability due to size of client**
32	What is the lag time on when reports are provided?				
33	Are your reports based on claim INCURRED date, or claim PAID date?		Incurred		Paid
34	What claims adjudication system do you use? (If proprietary, describe the staffing and client response capabilities of your IT staff.)				
a	• Is your system leased/owned?		Own		Lease
b	• When was the system last updated?				
c	• Concisely identify and comment on any major claim / eligibility / reporting system changes or upgrades planned in the next 12 to 24 months, along with the intended outcome.				
35	Can you provide electronic data interface with a client's Disease Management vendor(s) to supply relevant data?		Yes		No
a	• If yes, is there an additional cost?		Yes		No

36	Provide a brief list of services and / or supplies that are not covered or not eligible for reimbursement, but for which discounts are available to members, if any along with the average discount percentage for each category listed.				
37	For services covered but not eligible for reimbursement because member deductible is not satisfied, are network discounts applied to all portions of the claim being paid by the member?		Yes		No
38	Do you coordinate benefits?		Yes		No
a	• If yes, do you outsource this service?		Yes		No
b	• Does your claim system readily identify potential COB opportunities prior to claim payment?		Yes		No
c	• Do you (1) pend and pursue or, (2) pay and pursue these types of claims?		Pend and Pursue		Pay and Pursue
39	Confirm that if you fail to meet timely payment requirements for in-network providers, neither the members nor the Plan will be liable.		Confirmed		Not confirmed
40	Does your claim adjudication system have edits for identification of fraudulent claims?		Yes		No
COST					
41	Will experience be based on actual paid claims (rather than incurred or estimated incurred)?		Yes		No
42	For the renewal year and each subsequent renewal year, what periods of time will be used as the basis for determining renewal recommendations? Specify weightings to be applied to applicable periods.				
43	In the event an account produces a deficit in any one year, will your company seek, in any way, to recoup the deficit?		Yes		No
a	• If yes, please explain in detail.				
44	**Additional Costs:** If there is additional cost for services listed below, the cost must be reflected on RFP Cost Response, Appendix C.				
a	• Is there an additional cost for online / website services and tools?		Yes		No
b	• Is there an additional cost for online eligibility use and maintenance?		Yes		No
c	• Is there an additional charge for hard-copy eligibility / enrollment forms?		Yes		No

Torrance County
RFP TC-FY-23-01: Vision Network and Coverage Questionnaire
EFFECTIVE DATE: January 1, 2023

INSTRUCTIONS: Indicate "Yes" or "No" below if you are proposing above noted coverage(s). If you are not, please indicate "No" below and proceed to the next exhibit. If yes, answer all of the following questions. If a question is not applicable, please indicate "N/A" in the response column. Please do NOT provide any attachments, nor make reference to another document in lieu of providing a response. Please do not add, delete, or re-order any of the questions. If more space is needed to provide an appropriate response, you may add rows directly underneath the question being answered.

WHEN RESPONDING TO QUESTIONS THAT REQUIRE YOU TO SELECT FROM THE RESPONSES ALREADY PROVIDED, PLEASE PLACE AN " X " IN FRONT OF THE APPLICABLE ANSWER.

	Coverage quoted:		Yes		No
	ORGANIZATIONAL QUALIFICATIONS				
1	Briefly describe your network in New Mexico and in particular Estancia, including major locations, and any upcoming plans for expansion of the network.				
2	Briefly describe your national network, including major locations, number of providers, and any upcoming plans for expansion of the network.				
3	Do you own your provider network, or do you subcontract?		Own		Subcontract
a	• If you subcontract, please identify network.				
4	How many providers were added to your network in 2021?				
a	• How many terminated?				
b	• How many chose to terminate participation?				
5	What was your provider retention rate for the following years?:				
a	• 2020				
b	• 2021				
6	During each of the last two years, what percentage of claims processed by your				
a	• 2020				
b	• 2021				
	CLIENT SERVICE				
7	Are you willing to add providers specifically requested by the client?		Yes		No

8	Indicate if the following services are covered in a comprehensive eye exam.				
a	• Case history		Yes		No
b	• Recording corrected and uncorrected visual acuity		Yes		No
c	• Internal exam		Yes		No
d	• External Exam		Yes		No
e	• Pupillary reflexes		Yes		No
f	• Binocular Vision		Yes		No
g	• Objective refraction		Yes		No
h	• Subjective refraction		Yes		No
i	• Test for glaucoma		Yes		No
j	• Slit lamp exam (biomicroscopy)		Yes		No
k	• Dilation (as indicated and permitted)		Yes		No
l	• Color vision		Yes		No
m	• Corneal Topography		Yes		No
n	• Depth perception		Yes		No
o	• Other (describe)				
9	What type of coverage do you offer for contact lenses?				
a	• Does your contact lens coverage include disposables?		Yes		No
10	Do you offer a mail service contact lens program?		Yes		No
11	Do you offer an online frame and lens purchase option?		Yes		No
a	• If yes, please describe.				
12	Describe how the frame allowance works under your plan.				
a	• Are patients limited to a certain selection?		Yes		No
b	• If yes, please describe.				
13	Describe any restrictions on members in accessing providers for materials.				
ADMINISTRATIVE CAPABILITIES					
14	Are ID cards issued and/or required?		Yes		No
15	Describe procedures plan members must follow for any required pre-authorization.				
16	With regard to network directories, please respond to the following items.				
a	• Are your directories available online?		Yes		No
b	• How are members and plan sponsors notified of changes in your network?				
17	How do you monitor provider compliance with policies and protocols?				
COST					

18	Provide your average network allowance for the following services:				
a	• Lasik				
b	• CRT				
c	• PRK				
d	• Conductive Keratoplasty (CK)				
e	• Safety Glasses				
19	Provide your maximum out-of-network allowance for the following services:				
a	• Lasik				
b	• CRT				
c	• PRK				
d	• Conductive Keratoplasty (CK)				
e	• Safety Glasses				
20	What types of lens options are cost-controlled by your organization?				
21	Do members pay up front and submit claims for reimbursement, or are members responsible only for plan copays?		Pay in full, then file for reimbursement		Copays only
22	How often are network provider allowances revised?				
23	Do the network providers have a contractual agreement not to “balance bill” the		Yes		No
24	What is the basis for determining out-of-network reimbursement?				

Torrance County
RFP TC-FY-23-01: Vision Network New Mexico Specific
EFFECTIVE DATE: January 1, 2023

INSTRUCTIONS: If you are not proposing above noted coverage(s), proceed to the next exhibit. If you are proposing, answer all of the following questions. If a question is not applicable, please indicate "N/A" in the response column. Please do NOT provide any attachments, nor make reference to another document in lieu of providing a response. Please do not add, delete, or re-order any of the questions. If more space is needed to provide an appropriate response, you may add rows directly underneath the question being answered.

WHEN RESPONDING TO QUESTIONS THAT REQUIRE YOU TO SELECT FROM THE RESPONSES ALREADY PROVIDED, PLEASE PLACE AN " X " IN FRONT OF THE APPLICABLE ANSWER.

Network Review					
1	Please complete the grids below based on network providers located in the 3-digit Zip Codes indicated. **Note: you may be asked to complete/submit provider match analysis later in the RFP process.**	3 digit Zip Code	Unique Provider Count	Retail Chain Store Location County	
		870			
		871			
		875			
		877			
a	Identify Network Retail Chain Stores Located in Above Zip Codes	Store Name	City	State	Zip

Torrance County
RFP TC-FY-23-01: Basic Life, AD&D and Voluntary Life Benefits
EFFECTIVE DATE: January 1, 2023

CARRIERS: PLEASE COMPLETE THE FOLLOWING CHART TO DESCRIBE THE BENEFITS YOU ARE QUOTING. IF YOU ARE NOT QUOTING THESE LINES OF COVERAGE, INDICATE "No" BELOW AND PROCEED TO THE FOLLOWING EXHIBIT. DO NOT CONVERT TO PDF; USE EXCEL.

Above Reference Coverage Quoted?		**Yes**		**No**

Basic Life Benefits	**Carrier Response?**
Employee Benefit Amount	
All eligible employees	
Guarantee Issue quoted	
Maximum Guarantee Issue amount you will offer	
Age Reduction Schedule, including Termination Age	
Waiver of Premium included?	
Conversion included?	
Portability included?	
Accelerated Benefit Option (ABO) included?	
ABO Percent of Life benefit payable	
ABO Minimum benefit	
ABO Maximum benefit	
AD&D Benefits (please complete separate AD&D tab (exhibit 7B))	

Voluntary Life Benefits	**Carrier Response?**
Employee	
Benefit Increments	
Benefit Maximum	

Guarantee Issue amount quoted	
Maximum Guarantee Issue amount you will offer	
Spouse & Domestic Partner	
Benefit Increments	
Benefit Maximum	
Guarantee Issue amount quoted	
Maximum Guarantee Issue amount you will offer	
Dependent	
Benefit Increments	
Benefit Maximum	
Guarantee Issue amount quoted	
Maximum Guarantee Issue amount you will offer	
Age Reduction Schedule, including Termination Age	
Waiver of Premium included?	
Accelerated Benefit Option (ABO) included?	
ABO Percent of Life benefit payable	
ABO Minimum benefit	
ABO Maximum benefit	
Conversion Included?	
Portability included?	
Participation Requirement	

Torrance County

RFP TC-FY-23-01: Basic Life, AD&D and Voluntary Life Benefits

EFFECTIVE DATE: January 1, 2023

INSTRUCTIONS: Please answer all of the following questions. If you are not quoting these lines of coverage, please proceed to the following exhibit. If a question is not applicable, please indicate "N/A" in the response column. Please do NOT provide any attachments, nor make reference to another document in lieu of providing a response. Please do not add, delete, or re-order any of the questions. If more space is needed to provide an appropriate response, you may add rows directly underneath the question being answered.

NOTE: If any benefit mentioned below is not a standard, filed benefit, please note that the benefit varies by quote / proposal.

Percentage of principal Life amount payable for:	
Loss of Life	
Loss of Both Hands or Both Feet or Both Eyes	
Loss of One Hand and One Foot	
Loss of One Hand or One Foot and One Eye	
Loss of Speech and Hearing in Both Ears	
Quadriplegia	
Paraplegia	
Hemiplegia	
Uniplegia	
Loss of One Hand or One Foot or One Eye	
Loss of Speech or Hearing in Both Ears	
Loss of Thumb and Index Finger of Same Hand	
Loss of All Toes on One Foot	
Other Conditions : Please describe	
Percentage of principal Life amount payable, and any other limits, for the following benefits included in your proposal:	
Seat Belt	

Airbag	
Coma	
Child Day Care	
Education Benefit	
Bereavement	
Repatriation	
Occupational Assault Benefit	
Public Transportation Benefit	
Common Disaster	
Home Alteration Modification	
Exposure and Disappearance	
Other Benefit : Please describe	

Torrance County
RFP TC-FY-23-01: LTD Benefits
EFFECTIVE DATE: January 1, 2023

CARRIERS: PLEASE COMPLETE THE FOLLOWING CHART TO DESCRIBE THE BENEFITS YOU ARE QUOTING. IF YOU ARE NOT QUOTING THIS LINE OF COVERAGE, INDICATE "No" BELOW AND PROCEED TO THE FOLLOWING EXHIBIT. DO NOT CONVERT TO PDF; USE EXCEL.

Above Reference Coverage Quoted?		**Yes**		**No**

LONG TERM DISABILITY	VENDOR RESPONSE
Benefit Percentage	60% Monthly Benefit
Minimum Monthly Benefit	$100
Maximum Monthly Benefit	$5,000
Elimination Period	180 days
Duration of Temporary Recovery During Elim Period	
Definition of Total Disability (include Own Occ, and Income loss requirements)	
Benefit Duration (include schedule of Age Related Benefit Reductions, if applicable).	SSNRA
Pre-existing Condition	
Offsets	

Limitations on Specified Diagnoses (i.e. mental health, musculoskeletal disorders)	
Other Limitations and Exclusions	

Torrance County
RFP TC-FY-23-01: STD Benefits
EFFECTIVE DATE: January 1, 2023

CARRIERS: PLEASE COMPLETE THE FOLLOWING CHART TO DESCRIBE THE BENEFITS YOU ARE QUOTING. IF YOU ARE NOT QUOTING THIS LINE OF COVERAGE, INDICATE "No" BELOW AND PROCEED TO THE FOLLOWING EXHIBIT. DO NOT CONVERT TO PDF; USE EXCEL.

Above Reference Coverage Quoted?		**Yes**		**No**

BENEFITS	**VENDOR QUOTE:**
Benefit Percentage	60% Weekly Benefit
Maximum Weekly Benefit	$1,000
Waiting Period	
Accident	Benefits begin on 8th day
Illness	Benefits begin on 15th day
W-2 preparation included?	Yes
Duration of Disability	26 weeks

Paid Sick Leave Policy for the County is in place,

Torrance County
RFP TC-FY-23-01: Vision Benefits
EFFECTIVE DATE: January 1, 2023

CARRIERS: PLEASE COMPLETE THE FOLLOWING CHART TO DESCRIBE THE BENEFITS YOU ARE QUOTING. IF YOU ARE NOT QUOTING THIS LINE OF COVERAGE, INDICATE "No" BELOW AND PROCEED TO THE FOLLOWING EXHIBIT. DO NOT CONVERT TO PDF; USE EXCEL.

Above Reference Coverage Quoted?		**Yes**		**No**

VISION BENEFIT HIGHLIGHTS	
Please describe the benefit summary of your vision plan offering. This should include in-network versus out-network benefits.	
PERFORMANCE GUARANTEES	
Do you offer vision performance guarantees?	
- If so, provide details in a separate exhibit.	
- If so, what is the maximum amount you are willing to put at risk?	
IMPLEMENTATION ALLOWANCE	
Do you offer an implementation allowance?	
- If so, provide details in a separate exhibit.	
- If so, what is the dollar amount of your allowance?	
PARTICIPATION REQUIREMENT	
What is your participation requirement?	

Torrance County
RFP TC-FY-23-01: Signature Page
EFFECTIVE DATE: January 1, 2023

EXHIBIT 11 RFP Signature Page - TC-FY-23-01

ALL VENDORS MUST COMPLETE THIS EXHIBIT

All deviations from the specifications and other standards included in this RFP TC-FY-23-01 for Torrance County must be clearly defined and outlined by line of coverage below. An Officer of your organization must sign this Signature Page. In the absence of any identified deviations, your organization will be bound to all of the terms and conditions outlined in the RFP.

We certify that our proposal complies with the contents of this Request for Proposal, unless noted in the following list of exceptions.

1
2
3
4
5
6
7

Company Name: _____
Name: _____
Title: _____
Phone Number : _____
E-mail Address: _____
Signature: _____
Date: _____

NOTE: In the case of an electronic proposal submission, your typed name and date above will be considered a valid signature for this RFP.