ZURICH AMERICAN LIFE INSURANCE COMPANY

1299 Zurich Way
Schaumburg, IL 60196

A Stock Insurance Company

Group Long Term Disability Insurance Policy

Policyholder: [redacted]
("the Policyholder")

Policy Number: [redacted]

Agreement To Insure

This Group Insurance Policy (*"Policy"*) is a legal contract between the *Policyholder* and Zurich American Life Insurance Company. This *Policy* takes effect on the *Policy* effective date shown on the Group Insurance Policy Schedule. All provisions on this and the following pages are part of the *Policy*.

"We", *"us"*, *"our"*, and "the Company" mean Zurich American Life Insurance Company.

We agree to insure eligible *employees* of the *Policyholder*. *We* will pay benefits in accordance with the terms, conditions, limitations, and exclusions set forth in this *Policy*. Eligible *employees* are all the classes of *employees* described in the Group Certificate(s) of Coverage, ("Certificate").

We issue this *Policy* in consideration of the application and payment of the initial premium by the *Policyholder*. The first premium is due and payable on the *Policy* effective date. Subject to the *grace period* provision of the *Policy*, all premiums after the first premium must be paid when or before they are due. No benefits will be paid in the absence of premium.

This *Policy* is governed by the *laws* of the state where it is delivered and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

This Policy is Non- Participating.

David Dietz, President

Patrick Carty, Secretary

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POLICY CONTENTS

SECTION 1

All the provisions set forth in this document as well as the provisions found in the Certificate(s), rider(s), amendment(s), endorsement(s), and benefit schedules, if any, shown on this page and attached to this *Policy* are made part of this Group Insurance Policy. The application of the *Policyholder* and the *employees*, if any are made part of this Group Insurance Policy. A copy of the *Policyholder's* application(s) will be attached to the *Policy* when issued.

Policy Forms	Effective Date
Policyholder Application – Form	01/01/2021
Group Insurance Policy	01/01/2021
Group Long Term Disability Certificate of Coverage and Long Term Disability Insurance Benefits Schedule	01/01/2021

SPECIAL NOTICES

PLEASE READ THIS POLICY CAREFULLY

In the event *you* need to contact someone about this insurance *Policy* for any reason, please contact *your* agent or broker. If no agent or broker was involved in the sale of this insurance, or if *you* have additional questions *you* may contact *us* at the following address and telephone number:

Zurich American Life Insurance Company
1299 Zurich Way
Schaumburg, IL 60196

800-206-8826

Written correspondence is preferable so that a record of the inquiry is maintained. Have the *Policy* number available when contacting *us*.

Fraud Notice

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

GROUP INSURANCE POLICY SCHEDULE

SECTION 2

Policy Effective Date:	January 1, 2021. This *Policy* effective date begins at 12:01 AM at the address of the *Policyholder* where this *Policy* is delivered.
Initial Term of Policy:	From January 1, 2021 through December 31, 2023
Policy Anniversaries:	January 1, of each year, beginning in 2022
Grace Period:	31 Days
Premium Due Dates:	The *Policy* effective date and the 1st day of each succeeding calendar month.
Governing Jurisdiction:	State of Illinois

Minimum Participation Number: 2

Associated Companies:
We extend benefits under this *Policy* to certain *employees* of its Associated Companies, if any.

An *employee* of more than one Associated Company will be considered an *employee* of only one of those *employers*, for the purpose of the *Policy*. That *employee's* service with all other Associated Companies will be treated as service with that one.

On any date when an *employee* ceases to be an Associated Company, the *Policy* will be considered to end for *employees* of that *employer*. This applies to all of those *employees* except those who on the next day, are still within the *eligible classes* of a *Plan* of benefits of the *Policy* as *employees* of another Associated Company. The *Plans* of benefits for *eligible classes* are listed in the *Policy's* Benefit Schedule.

The *Policyholder* must let *us* know, in writing, within 30 days, when an *employer* listed as an Associated Company is no longer one of its subsidiaries or affiliates.

SCHEDULE OF INITIAL PREMIUM RATES

SECTION 3

This schedule lists the initial premium rates on the effective date of the Policy. Rates are subject to change in accordance with the Premium Rate Changes Provision of this Policy.

Effective Date: January 1, 2021

Premium Due Date: January 1, 2021, and the first day of each calendar month thereafter

Classes of Employees to which this Schedule applies:

Class 1: All *active, full-time employees* working 35 hours or more each week. Seasonal, temporary, or part-time *employees* are not eligible.

Applicable Coverage: Monthly Rate

All Coverages The premium rates in effect on the *Policy* effective date are those determined by *us*. Those rates will be shown on the billing notice(s) sent to the *Policyholder* (subject to any subsequent corrections).

Cost of Insurance: The initial premiums for each plan of benefits is based on the initial rate(s) shown below.

Basic Long Term Disability

Initial Rate:

AGE	RATE PER $100 OF COVERED PAYROLL
< 30	$0.3200
30-39	$0.4500
40-49	$0.6000
50-59	$0.7100
60 and over	$0.7700

The premium rates are for a period of one month. Initial rates are subject to change as provided in this *Policy*.

Monthly Premium Rate Guarantee
Initial monthly premium rates are guaranteed as follows:

Insurance Coverage	Rate Guarantee Period
Long Term Disability	36 months

The rate guarantee is subject to the terms and provisions of the "Premium" Section of this *Policy*. *We* may change the initial premium rates during the rate guarantee period in accordance with the Premium Rate Changes provision of this *Policy*.

PREMIUM

SECTION 4

PAYMENT OF PREMIUMS

The *Policyholder* must pay *us* all premiums on or before the date on which they fall due. The initial premium will be due on the *Policyholder's Policy* effective date. The initial premium covers the period from the *Policy* effective date to the first premium due date. The premium due date which begins one month or more after the *Policy* effective date. Premiums thereafter will be due on each succeeding premium due date as stated in the Group Insurance Policy Schedule.

Premiums are to be paid by the *Policyholder* to *us*. Each premium due may be paid at *our Home Office*. If a premium is not paid on or before its due date, the *Policy* subject to the *grace period*, will be cancelled.

We may accept a partial payment of premium due without waiving *our* right to collect the entire amount due. If *we* expressly agree to accept late payment of a premium without terminating this *Policy*, the *Policyholder* remains liable for all premiums and fees during the extended period.

All amounts are to be paid in United States dollars.

COST OF THIS INSURANCE

The initial premium for each *Plan* is based on the initial rate(s) shown in the Schedule of Initial Premium Rates.

PREMIUM AMOUNTS

The premium due under this *Policy* on any premium due date will be the sum of the premium charges for all the insurance coverages provided under this *Policy*. The premium charges will be determined in accordance with the premium rates in effect on the premium due date and the *employees* then insured.

Premiums may be determined by other methods which: (a) yields about the same total amount; and (b) is agreeable to both the *Policyholder* and the Company.

INITIAL RATE GUARANTEE

Refer to the Schedule of Initial Premium Rates for the initial rate guarantee.

The rate guarantee supersedes only those provisions appearing elsewhere in this *Policy* which give *us* the right to change the premium rates, and then, only for the period of time for which the rates are guaranteed. However, *we* may change the premium rates during the rate guarantee period in accordance with the premium rate changes provision below in this *Policy*. The rate guarantee in no way affects, amends, or supersedes any other provision in the *Policy*.

PREMIUM RATE CHANGES

We have the right to change premium rates as follows:

- on any date if *we* and the *Policyholder* mutually agree to change premium; or
- as of any premium due date.

We will notify the *Policyholder* in writing at least 30 days before a premium rate is changed.

Unless the Schedule of Initial Premium Rates or an amendment states otherwise, no change in rates will be made until 36 months after the *Policy* effective date. An increase in

rates will not be made more often than once in a 12-month period. However, *we* reserve the right to change the rates at any time, even during a rate guarantee period if any of the following events takes place:

There is a change in the factors bearing on the risk assumed including the following:

- the terms of the *Policy* change;
- a change occurs in the plan design;.
- a division, subsidiary, associated company, affiliated company, or *eligible class* is added or deleted;
- a new *law* is enacted; a judicial decision, or a change or clarification of any existing *law* by a regulatory agency that affects the costs or administration of this *Policy* or *Plan* of insurance;
- *we* determine the *Policyholder* failed to promptly furnish any necessary information requested by *us*, or has failed to perform any other obligations relating to the *Policy*; or
- a material misrepresentation by the *Policyholder*, including but not limited to:

    - its reported experience during the pre-sale process; or
    - the number of insured persons changes by 15% or more.

INCREASES OR DECREASES IN PREMIUM DUE

Premium increases or decreases which take effect during a policy month are adjusted and due on the next premium due date following the change. Changes will not be prorated daily.

If premiums are payable monthly, any insurance for newly eligible *employees* becoming effective will be charged for from the first day of the policy month on or right after the date the insurance takes effect.

Premium charges for insurance, that terminates for eligible *employees* and their *dependents*, if any will cease as of the first day of the policy month on or right after the date the insurance terminates.

If premiums are payable less often than monthly, premium charges or credits for increases and decreases will result in pro-rated adjustment on the next premium due date for the number of policy months between the date premium charges start or cease and the end of the premium-paying period.

If this *Policy* is changed to provide more coverage to take effect on a date other than the first day of a premium-paying period, a pro rata premium for the coverage will be due and payable on that date. It will cover the period then starting and ending right before the start of the next premium-paying period.

Each premium due will include any adjustment in past premiums which is caused by those changes which have not been taken into account at a prior date.

GRACE PERIOD

We provide a *grace period* of 31 consecutive days for the payment of any premium due after the initial premium. During the *grace period,* the *Policy* will remain in force and will not be terminated for nonpayment of premium if the *Policyholder* pays all premiums due by the last day of the *grace period.* If the *Policyholder* fails to pay all premiums by the last day of the *grace period,* this *Policy* automatically terminates on the date the *grace period* expires

The *Policyholder* is liable to pay premiums to *us* for the time the *Policy* is in force. *We* may recover from the *Policyholder* the costs of collecting any unpaid premiums, including reasonable attorney's fees and costs of suit incurred by *us* in the collection of all overdue amounts.

No benefits will be paid for claims incurred during the *grace period* until and unless *we* receive the premium for that period.

The *Policyholder* may write to *us* in advance and request that the *Policy* be ended at the end of the period for which premiums have been paid or at any time during the *grace period*. Upon notice, *we* will cancel the *Policy* as of the earlier date. The *Policyholder* is liable to *us* for any unpaid premium for the time the *Policy* was in force.

PREMIUM REFUNDS AND ADJUSTMENTS

Retroactive Adjustments.
We may, at *our* discretion, make retroactive adjustments to the *Policyholder* to correct billing errors for overpayments or underpayments. However, the *Policyholder* may only receive a maximum of six month's credit for a correction other than age or sex. Corrections due to a billing error, age or sex are not limited. *We* may reduce any such credits by the amount of any payments *we* may have made on behalf of an *Insured* before the correction was requested. Retroactive additions will be made at *our* discretion based upon eligibility guidelines stated in the Certificate of Coverage and are subject to the payment of all applicable premiums.

Age Or Sex Adjustment
If an age or sex is used to determine the premium charge for a *employee's* insurance and the age is found to be in error, the amount of the *employee's* insurance under any *Plan* affected by the change will then be adjusted to reflect the amount that the premium paid would have provided at the correct age or sex .

Premium Contributions From Employees
The *Policyholder* determines the amount, if any, of each *employee's* contribution toward the cost of the insurance under the *Policy*.

RESPONSIBILITIES OF THE POLICYHOLDER

SECTION 5

RECORDS

Either the *Policyholder* or *us*, upon mutual agreement, will keep a record of the insured *employees*. The record will contain the key facts about their insurance. All records of the *Policyholder* and of the *employee*, which bear on the insurance, must be open to *us* for its inspection at any reasonable time.

The *Policyholder* will furnish to *us*, on a monthly basis (or as otherwise required), such information as *we* may reasonably require to administer this *Policy* and to determine the premium amount. This includes, but is not limited to information about *employees:*

- who are eligible to become insured;
- changes in family status;
- whose amounts of coverage change or terminate;
- occupational information; and
- any other information required to manage a claim and any other information reasonably required.

The *Policyholder* represents that all enrollment and eligibility information that has been or will be supplied to *us* is accurate. The *Policyholder* acknowledges that *we* can and will rely on such enrollment and eligibility information in determining whether a person is eligible for coverage under this *Policy*. To the extent, the *Policyholder* supplies such information to *us* (in electronic or hard copy format), the *Policyholder* agrees to:

- maintain and make available to *us*, a reasonably complete record of such information (in electronic or hard copy format, for at least seven years or until the final rights and duties under this *Policy* have been resolved, and to make such information available to *us* upon request;
- if applicable, obtain from all *employees*, and *late applicants* "*Evidence of Insurability*" authorization in the form currently being used by *us* in the enrollment process (or such other form as *we* may reasonably approve).

We will not be liable to *employees* for the fulfillment of any obligation prior to information being received in a form satisfactory to *us*. The *Policyholder* may correct wrong data given to *us* if *we* have not been harmed by acting on it. Clerical error or omission by *us* or the *Policyholder* will not prevent a *employee* from receiving coverage, affect the amount of a *employee's* coverage or cause a *employee's* coverage to begin or continue when coverage would not have otherwise been effective.

The *Policyholder* must notify *us* of the date in which a *employee's* employment ceases for the purpose of termination of coverage under this *Policy*. Subject to applicable *law*, unless otherwise provided in the Certificate(s) of Coverage, *we* will consider a *employee's* employment to continue until stopped by the *Policyholder*.

The *Policyholder* must notify *employees* of the termination of the *Policy* in compliance with all applicable *laws*. However, *we* reserve the right to notify *employees* of termination of the *Policy* for any reason, including non-payment of premium. The *Policyholder* must provide written notice to *employees* of their rights upon termination of coverage.

ACCESS

The *Policyholder* must make payroll and other records directly related to a *employee's* coverage under this *Policy* available to *us* for inspection, at *our* expense, at the *Policyholder's* office, during regular business hours, upon reasonable advance request. This provision will survive termination of this *Policy*.

NEWLY ELIGIBLE EMPLOYEES

From time to time all new *employees* or newly eligible *employees* for an *eligible class* for insurance and desiring the same shall be added to the group or class originally insured.

FORM DISTRIBUTION

The *Policyholder* agrees to timely distribute materials to *employees* regarding enrollment and coverage features. This includes Certificates of Coverage as described in Certificates Provision of this *Policy*.

POLICIES AND PROCEDURES AND COMPLIANCE VERIFICATION

The *Policyholder* must comply with all policies and procedures established by *us* in administering and interpreting this *Policy*. The *Policyholder* must, upon request, provide a certification of its compliance with *our* participation and contribution requirements. The *Policyholder* must, upon request, submit proof that it continues to meet the definition of an eligible group as provided under applicable *law* or regulation.

RIGHT TO AUDIT

We reserve the right to audit, once every two years, the *Policyholder's* billing records and premium accounting practices. If *we* discover:

- an underpayment of premium by the *Policyholder*, the *Policyholder* will be obligated to remit, in a timely manner, the underpayment amount; or
- an overpayment of premium, *we* will return any overpayment amount in a timely manner.

CONTINUATION RIGHTS AND CONVERSION

The *Policyholder* is responsible to notify all eligible *employees* of their right to continue coverage pursuant to the continuation provisions in the Certificate(s) of Coverage and applicable *law*. The *Policyholder* is responsible to provide notification to each *employee* within 15 days after termination of coverage, of their conversion right, including a description of plans available, premium amounts, and application forms.

GENERAL PROVISIONS

SECTION 6

CERTIFICATES OF COVERAGE

We will issue the *Policyholder*, Certificates of Coverage (referred to as "Certificates"), riders(s), endorsement(s) and amendments, if any, which are evidence of the coverage *we* agree to provide under this *Policy*. *We* may deliver Certificates in electronic or paper form as required by the *Policyholder*. The *Policyholder* must make available or distribute the Certificate(s) to each insured *employee*. The insurance in force will be set forth in the Certificate(s). Certificate values, benefits and all applicable charges are administered separately for each Certificate issued under the *Policy*.

POLICIES AND PROCEDURES

We have the right to adopt reasonable policies, procedures, rules, and interpretations of this *Policy* and the Certificate(s) in order to promote orderly and efficient administration. *Our* failure to implement or insist upon compliance with any provision of this *Policy* at any given time or times does not constitute a waiver of *our* right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of premiums. This applies regardless if the circumstances are the same.

POLICY MODIFICATION AND AMENDMENT

All agreements made by *us* are signed by an authorized executive officer of the Company. Only officers of the Company have authority to:

- waive any conditions or restrictions of the *Policy*;
- extend the time in which a premium may be paid;
- make or change a contract; or
- bind the Company by a promise or a representation or by information given or received.

An agent or a broker is not an officer of the Company and has none of the above listed authority, whether implied or express.

The *Policy* may be amended without the consent of the insured *employees* or of anyone else with a beneficial interest in it. An amendment does not affect a claim incurred before the date of change.

This *Policy* is deemed to be automatically amended to conform with the provisions of applicable *laws* and regulations.

Mutual Consent:
The *Policy* may be amended at any time by mutual written consent of the *Policyholder* and *us*. This can be done through written request made by the *Policyholder* and agreed to by *us*.

All Other Changes:
This *Policy* may also be amended by *us* with 30 days written notice to the *Policyholder*. The *Policyholder* will not have to give written agreement of a change in this *Policy* if:

- the *Policyholder* has asked for the change and *we* have agreed to it;
- the change is needed to correct an error in the *Policy*, including any Certificate of Coverage issued to anyone;

- the change is needed so that this *Policy* will conform to any state or federal *law*, regulation or ruling of a jurisdiction that affects a person covered under this *Policy*; or
- the change has been initiated by *us* and is not resulting in either a reduction or elimination in benefits or coverage, or an increase in premium.

The *Policyholder* will have to give written agreement of a change in this *Policy*:

- that reduces or eliminates benefits or coverage; or
- that increases benefits or coverage with a concurrent increase in premium during the *Policy* term, except if the increased benefits or coverage is required by *law*.

Payment of the applicable premium after notice of the proposed changes will be deemed to constitute the *Policyholder's* written agreement of those changes on behalf of all persons covered under this *Policy*.

PRIOR AGREEMENTS; SEVERABILITY

As of the *Policy* effective date, this *Policy* replaces and supersedes all other prior agreements between the parties as well as any other prior written or oral understandings, negotiations, discussions or arrangements between the *Policyholder* and *us* related to matters covered by this *Policy*. If any provision of this *Policy* is deemed invalid or illegal, that provision is severable, and the remaining provisions of this *Policy* shall continue in full force and effect.

CLERICAL ERRORS

A clerical error in keeping records, or a delay in making an entry, does not alone cause the *Policy* or the coverage for any *employee* under the *Policy* to become invalid. An equitable adjustment in premiums will be made when the error or delay is found. If the clerical error affects the existence or amount of insurance, the facts as determined by *us* will be used to decide if insurance is in force and its amount. *We* may also modify or replace a *Policy*, Certificate of Coverage or other document issued in error.

ERISA CLAIM FIDUCIARY -CLAIM DETERMINATIONS

For the purpose of section 503 of Title I of the Employee Retirement Income Security Act of 1974, as amended (ERISA), *we* are a fiduciary with authority to review all denied claims for benefits under this *Policy*. In exercising this fiduciary responsibility, *we* have authority to determine whether and to what extent eligible *employees* and beneficiaries are entitled to benefits and to construe any disputed or doubtful terms under this *Policy*, the Certificate(s) of Coverage, or any other incorporated document. *We* are deemed to have properly exercised such authority unless *we* abuse it by acting arbitrarily and capriciously. *We* have the right to adopt reasonable policies, procedures, rules, and interpretations of this *Policy* to promote the orderly and efficient administration of the *Policy*.

Determinations made by *us* pursuant to this provision do not prohibit or prevent a claimant from seeking judicial review in federal court of *our* determinations. The reservation made under this provision only establishes the scope of review that a federal court will apply when (a claimant) seeks judicial review of *our* determination of eligibility for benefits, the payment of benefits, or interpretation of the terms and conditions applicable to the benefit plan.

The *Policyholder* is responsible for making reports and disclosures required by ERISA. This includes the creation, the distribution, and the final content of:

- summary plan descriptions;
- summary of material modifications; and
- summary annual reports.

MISSTATEMENTS

If any fact as to the *Policyholder* or any *employee* is found to have been misstated or omitted, a fair change in premiums or benefits may be made.

All statements made by the *Policyholder* or a *employee* shall be deemed representations and not warranties. No written statement made by a *employee* shall be used by *us* in a contest unless a copy of the statement is or has been furnished to the *employee* or his beneficiary, or the person making the claim.

OTHER GOODS AND SERVICES

From time to time, *we* may offer or provide insureds or their beneficiaries certain programs, goods, and services in addition to the insurance coverage provided under this *Policy*. *We* also may arrange for third party vendors to provide programs, goods, and services at a discount (including without limitation beneficiary financial counseling services and *employee* assistance programs) to the *Insured* or their beneficiaries. Though *we* may make the arrangements, the third-party vendors are solely liable for providing the goods and services. *We* are not responsible for providing or failing to provide the goods and services to insureds or their beneficiaries. Further, *we* shall not be liable to insureds or their beneficiaries for the negligent provision of the programs, goods, and services by third party vendors.

DELEGATION AND SUBCONTRACTING

The *Policyholder* acknowledges and agrees that *we* may enter into arrangements with third parties to delegate functions under this *Policy* such as *we* determine appropriate in *our* sole discretion and as consistent with applicable *laws* and regulations. The *Policyholder* also acknowledges that *our* arrangements with third party vendors are subject to change in accordance with applicable *laws* and regulations.

INCONTESTABILITY

As to the *Policy* in general: *we* may not contest the validity of this *Policy*, except for non-payment of premiums, after it has been in force for two years from the *Policy* effective date.

As to Disability Benefits: *we* may not use any statement made by:

- the *Policyholder* or any *employee* as the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing.
- the *Policyholder* as the basis for voiding this *Policy* after it has been in force for two years from the *Policy* effective date.
- an eligible *employee* in a defense of a claim for loss incurred or starting after coverage, as to which claim is made, has been in effect for two years.

CONFORMITY WITH LAW

If the provision of the *Policy* does not conform to the requirements of any state or federal *law* or regulation that applies to the *Policy*, the *Policy* is automatically changed to conform with *our* interpretation of the requirements of that *law* or regulation.

The *Policy* conforms to the minimum requirements of the state where the *Policy* is issued. The state *law* where the *Policy* is issued supersedes any conflicting *laws* of any other state.

ASSIGNMENT

No assignment of the benefits under this *Policy* or any Certificate of Coverage will be binding on *us* until the original assignment or a certified copy of the assignment is given to *us* at *our Home*

Office. The assignment is subject to any action *we* may have taken before receiving it. *We* do not assume responsibility for the validity or sufficiency of an assignment. An assignment of the Certificate operates so long as the assignment remains in force. To the extent provided under the terms of the assignment, an assignment transfers all rights and obligations of the *Insured* or the owner if other than the *Insured*. This insurance may not be levied on, attached garnished, or otherwise taken for a person's debts. This does not apply where it is contrary to *law*.

RELATIONSHIP BETWEEN THE PARTIES

The relationship between the parties is a contractual relationship between independent contractors. Neither party is an agent or *employee* of the other in performing its obligations pursuant to this *Policy*.

NOT IN LIEU OF WORKERS' COMPENSATION

This *Policy* does not satisfy any requirements for Workers' Compensation insurance.

POLICY CANCELLATION AND MODIFICATION

SECTION 7

POLICY CANCELLATION

Either *we* or the *Policyholder* may cancel this *Policy* on any premium due date by giving 30 days advance written notice to the other party. This *Policy* or a *Plan* under this *Policy* can be cancelled by *us* or by the *Policyholder* at any time by the mutual written consent of the *Policyholder* and *us*. When both the *Policyholder* and the Company agree, this *Policy* or a *Plan* can be cancelled on an earlier date. If the Company or the *Policyholder* cancels this *Policy* or a *Plan*, coverage will end at 12:00 midnight on the last day of coverage at the address of the *Policyholder*.

Cancellation By The Policyholder

This *Policy*, or any coverage included may be cancelled by the *Policyholder*. The *Policyholder* may cancel this *Policy* as to all or any class of its *employees*. The *Policyholder* must give *us* written notice at least 30 days in advance of any premium due date. The notice must state when such termination shall occur. It shall not be effective during a period for which a premium has been paid to *us* for the coverage.

The *Policyholder* may cancel this *Policy* or a *Plan* by written notice delivered to *us* at least 30 days prior to the cancellation date.

Cancellation By The Company

We may cancel or modify this Policy upon 30 days advance written notice to the *Policyholder* if:

- there is less than 100% participation of those eligible *employees* for a *Policyholder* paid *Plan;*
- the *Policyholder* does not promptly provide *us* with information that is reasonably required;
- the *Policyholder* fails to perform any of its obligations that relate to this *Policy;*
- fewer than two *employees* are insured under a *Plan* or the *Policy*;
- the premium is not paid in accordance with the provisions of the *Policy* that specify whether the *Policyholder*, the *employee*, or both pays the premiums;
- the *Policyholder* does not promptly report to *us* the names of any *employees* who are added or deleted from the *eligible class;*
- *we* determine that there is a significant change, in the size, occupation, or age of the *eligible class* as a result of a corporate transaction such as a merger, divestiture, acquisition, sale or reorganization of the *Policyholder* and/or its *employees* ;
- the *Policyholder* breaches a provision of this *Policy* and such breach remains uncured at the end of the notice period;
- the *Policyholder* ceases to meet *our* requirements for an *employer* group as defined under applicable state *law* or regulation;
- the *Policyholder* fails to meet *our* contribution or participation requirements applicable to this *Policy*;
- the *Policyholder* fails to provide the certification required by the Policies and Procedures Provision within a reasonable period of time specified by *us*; or
- the *Policyholder* changes its eligibility or participation requirements without *our* consent.

Further, We May Cancel The Policy Immediately:

- upon notice to *Policyholder* if the *Policyholder* has performed any act or practice that constitutes fraud or made any intentional misrepresentation of a material fact relevant to the coverage provided under this *Policy*; or
- The Participating Employer fails to pay any premium within the *grace period*. The *Policy* will be automatically cancelled, and no further notice will be provided.

If *we* modify this *Policy* or a *Plan*, for reasons other than the *Policyholder*'s failure to pay premium, a written notice will be delivered to the *Policyholder* at least 31 days prior to the modification date. The *Policyholder* may cancel this *Policy* or a *Plan* if the modifications are unacceptable.

If this *Policy* or a *Plan* is cancelled, the cancellation will not affect a payable claim.

If the *Policy* terminates for any reason, the *Policyholder* remains liable for all premiums due and unpaid before the termination, including, but not limited to, premium payments for any period of time the *Policy* is in force during the *grace period*. Covered *employees* also remain liable for their cost sharing and other required contributions to coverage for any period of time the *Policy* is in force during the *grace period*. *We* may recover from the *Policyholder* our costs of collecting any unpaid premiums including reasonable attorneys' fees and costs of suit.

Effect Of Cancellation

The cancellation of this *Policy* will not relieve either party from any obligation incurred before the date of cancellation. When cancelled, this *Policy* and all coverage provided hereunder will end at 12:00 midnight on the effective date of termination.

We may, at *our* sole discretion, reinstate cancelled coverage, provided any past due premium and reinstatement fees are paid.

Notice To Employees

It is the responsibility of the *Policyholder* to notify *employees* of the termination of the *Policy* in compliance with all applicable *laws*. However, *we* reserve the right to notify *employees* of termination of the *Policy* for any reason, including non-payment of premium. In accordance with the Certificate, the *Policyholder* shall provide written notice to *employees* of their rights upon termination of coverage.

ZURICH AMERICAN LIFE INSURANCE COMPANY
1299 Zurich Way
Schaumburg, IL 60196

Group Long Term Disability Insurance Policy

Zurich American Life Insurance Company
Long Term Disability Plan
Benefits Schedule

This Long Term Disability Plan provides financial protection for *you* by paying a portion of *your income* if *you* become disabled due to an *illness* or *injury* while covered under this *Plan*. The amount *you* receive is based on the amount *you* earned before *your* disability began. In some cases, *you* can receive disability payments even if *you* work while *you* are disabled.

This Benefits Schedule (hereinafter "Schedule") is a summary of some of the features and benefits of *your employer's* Long Term Disability Plan. It is not a contract. *You* are not necessarily entitled to insurance because *you* received this Schedule. *You* are only entitled to insurance if *you* are eligible in accordance with the terms of the Certificate, *you* have met *your employer's* eligibility requirements and premium has been paid. For a complete description of the terms, conditions, exclusions and limitations of *your employer's Plan*, refer to *your* Certificate. In the event of a discrepancy between this Schedule and the Certificate, the Certificate will control.

Policyholder:	[redacted]
Policy Number:	[redacted]
Policy Effective Date:	January 1, 2021
Plan Year:	January 1, 2021 through December 31, 2021 and each following January 1st.

Eligible Classes: All persons in the following class(es)are eligible for *employee* coverage:

Class 1: All *active, full-time employees* working 35 hours or more each week. Seasonal, temporary, or part-time *employees* are not eligible.

Minimum Hours Requirement For Active Employment:
Employees must be working at least 35 regularly scheduled hours per week.

Service Waiting Period: None.

Who Pays For The Coverage:
You are required to pay the entire cost of *your* coverage.

Premium Waiver:
If *you* become disabled, no premium payments are required for *your* coverage while *you* are receiving benefits under this *plan*, provided the premium was paid during the *elimination period.*

Elimination Period:
Benefits start after the first 180 days of an approved disability.
Benefits begin the day after the *elimination period* is completed.

Accumulation Period:	30 Return-to-Work Days

Monthly Benefit

Monthly Benefit Percentage: 60% of *covered monthly earnings* to the monthly maximum benefit less *deductible sources of income.*

Your* benefit may be reduced by *deductible sources of income* and *disability earnings.* Some disabilities may not be covered or may have limited coverage under this *Plan.

The Maximum Monthly Benefit is:	$15,000 per month
The Minimum Monthly Benefit is:	Greater of $100 or 10% of *your gross disability benefit.* ***You* are not eligible for the minimum monthly benefit during periods of overpayment until the overpayment has been recovered by *us* or offset by *your monthly benefit.***
Survivor Benefit:	3 times the *net disability benefit.*

Rehabilitation Program Benefit:

Ten percent of *your gross disability benefit* to a maximum of $5,000.

Refer to the Certificate for program details.

In addition, *we* will provide a *monthly benefit* to *you* for three months following the date *your* disability ends if *we* determine *you* are no longer disabled while:

- *you* are participating in the *rehabilitation program;* and
- *you* are not able to find employment.

Child Care Expense Benefit:

While *you* are participating in *our rehabilitation program, you* may receive payments to cover certain childcare expenses limited to the following amounts:

Child Care Expense Benefit Amount: $400 per month for child age 13 and under.

Child Care Expense Calendar Year Maximum Benefit Amount: $2,500 per month for all children.

Limited Benefits for Mental Illness, and Mental Disorders:

Benefits for *mental illness*, and mental disorders, are limited to 24 months while insured under the *Policy* unless *you* are *confined* as a resident inpatient in a *hospital* at the end of the 24 month period. The *monthly benefit* will continue to be paid during such *confinement*.

Pre-Existing Condition Limitation	3/12 applies. Refer to the Certificate for a full description.

Maximum Benefit Duration Table

The table below shows the maximum duration for which benefits may be paid. All other limitations of the *Policy* will apply.

Age At Disability	Maximum Benefit Period
Less than age 62	To Social Security Normal Retirement Age
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 or older	12 months
Year of Birth	**Social Security Normal Retirement Age**
1937 or before	65 years
1938	65 years 2 months
1939	65 years 4 months
1940	65 years 6 months
1941	65 years 8 months
1942	65 years 10 months
1943-1954	66 years
1955	66 years 2 months
1956	66 years 4 months
1957	66 years 6 months
1958	66 years 8 months
1959	66 years 10 months
1960 and after	67 years

Limited and Excluded Conditions and Disabilities:

Total Benefit: The total benefit payable to *you* on a monthly basis (including all benefits provided under this *Plan*) will not exceed 100% of *your covered monthly earnings* unless otherwise stated in the Certificate under specific conditions.

Your Plan does not cover disabilities related to all *injuries*, *illness* or disease. Refer to *your* Certificate for a complete list of exclusions and limitations.

The following disabilities have limited benefits under this *Plan*: *mental illness* and mental disorders. Refer to the Certificate for a detailed description of the benefits and the limitations.

IMPORTANT: THIS SCHEDULE SHOULD BE ATTACHED TO YOUR CERTIFICATE. THIS SCHEDULE REPLACES ANY PRIOR SCHEDULES ISSUED TO YOU WITH RESPECT TO THE COVERAGES DESCRIBED IN THE CERTIFICATE.

Zurich American Life Insurance Company

Certificate of Coverage

Long Term Disability Plan

Policyholder: [redacted]
Policy Number: [redacted]

Zurich American Life Insurance Company is pleased to welcome *you* to the *Plan*. This is *your* Certificate of Coverage, hereinafter "Certificate", as long as *you* are eligible for coverage and *you* meet the requirements for becoming insured. *You* will want to read this Certificate carefully and keep it in a safe place. This Certificate may be delivered electronically when agreed to by the *Policyholder* and *us*.

This Long Term Disability Plan provides financial protection for *you* by paying a portion of *your* income if *you* become disabled due to an *illness* or *injury* while covered under this *Plan*. The amount *you* receive is based on the amount *you* earned before *your* disability began. In some cases, *you* can receive disability payments even if *you* work while *you* are disabled.

Throughout this document the words *"we", "our", "us"*, and "the Company" means Zurich American Life Insurance Company. The words *"you"* and *"your"* mean the insured *employee* of the *Policyholder* sponsoring this *Plan*. Some terms and provisions are written as required by insurance *law*. Important terms are defined in the "Glossary" Section of the Certificate. Defined terms appear in italic print. If *you* should have any questions about the content or provisions, please consult *us* electronically through *our* website or at the toll-free number provided below. *We* will assist *you* in any way to help *you* understand *your* benefits.

The benefits described in this Certificate are subject in every way to the entire Group Insurance Policy. If the terms and provisions of the Certificate are different, the *Policy* will govern. The Group Insurance Policy includes this Certificate, the Benefit Schedule(s), and any riders or amendments issued with the Group Insurance Policy. The *Policyholder's* application and any application or *evidence of insurability* completed by *you* or on *your* behalf, when applying for coverage or an increase in coverage, are also considered part of the *Policy*.

Your coverage may be cancelled or changed under the terms and provisions of the *Policy*. The *Policy* is delivered in and is governed by the *laws* of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. When making a benefit determination under the *Policy*, *we* have discretionary authority to determine *your* eligibility for benefits and to interpret the terms and provisions of the *Policy*.

For purposes of effective dates and ending dates under the Group *Policy*, all days begin at 12:01 a.m. and end at 12:00 midnight at the *Policyholder's* address.

Zurich American Life Insurance Company is located at:

1299 Zurich Way
Schaumburg, IL 60196

Our toll-free number is: 800-206-8826.
Our website address is: www.zurichna.com.

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SPECIAL NOTICES

Zurich American Life Insurance Company	
Toll Free Number:	800-206-8826
Social Security Advocacy Program	800-206-8826
Claim Information Toll Free Number	800-206-8826

No benefits are covered under this Certificate in the absence of payment of current premiums subject to the grace period and the "Premium" Section of the Group Insurance Policy. Unless specifically provided for in any applicable termination or continuation of coverage provision, described in this Certificate or under the terms of the Group Insurance Policy, this *Plan* does not pay benefits for a disability incurred before coverage starts under this *Plan*, This *Plan* will not pay any benefits for any losses, claims or expenses that start after coverage ends.

Benefits may be modified during the term of this *Plan* as specifically provided under the terms of the Group Insurance Policy or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply to any losses incurred that start on or after the effective date of the *Plan* modification. There are no vested rights to receive any benefits described in the Group Insurance Policy or in this Certificate beyond the date of termination or renewal including if the loss, *accident* or disability starts on or after the effective date of the *Plan* modification, but prior to *your* receipt of amended *Plan* documents.

Fraud Notice

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

DISCLOSURE NOTICES
For Residents of the Following States:

INDIANA

NOTICE TO EMPLOYEES
Questions regarding *your Policy* or coverage should be directed to:

Zurich American Life Insurance Company
7045 College Blvd, Overland Park, KS 66211-1523
1-888-634-6780

If *you* (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint *you* have been unable to resolve with *your* insurer *you* may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street
Suite 300
Indianapolis, IN 46204

Consumer Hotline:
1-800-622-4461

In the Indianapolis Area:
1-317-232-2395

Complaints can be filed electronically at www.in.gov/idoi

ARKANSAS
QUESTIONS OR PROBLEMS WITH YOUR POLICY?

If *you* have any questions or problems with *your Policy*, *you* may contact *us* at the address below or one of the other organizations listed:

Zurich American Life Insurance Company
7045 College Boulevard
Overland Park, Kansas 66211-1523
Telephone: (877) 678-7534

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
Telephone: (501) 371-2640 or (800) 852-5494

GEORGIA

NOTICE

The *laws* of the State of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

ILLINOIS

NOTICE TO EMPLOYEES - ILLINOIS

This notice is to advise *you* that should any complaints arise regarding this insurance, *you* may contact the following:

Zurich American Life Insurance Company
7045 College Blvd, Overland Park, KS 66211-1523
(888) 634-6780

For *your* information, the following is *your* state's Department of Insurance contact information:

Illinois Department of Insurance
Consumer Division
320 W Washington St
Springfield, IL 62767
(217) 782-4515

WISCONSIN

NOTICE TO EMPLOYEES – WISCONSIN

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? – If *you* are having problems with *your* insurance company or agent, do not hesitate to contact the insurance company or agent to resolve *your* problem.

Zurich American Life Insurance Company
7045 College Blvd, Overland Park, KS 66211-1523
(888) 634-6780

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance *laws*, and file a complaint. *You* can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting :

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
Toll-Free: (800) 236-8517
Telephone: (608) 266-0103

GENERAL PROVISIONS
Your Long Term Disability Plan

This Disability Plan provides *you* with a source of monthly income if *you* should become disabled and unable to work because of an *sickness* or *injury* while covered under this *Plan*.

What Is The Certificate?

This Certificate of Coverage ("Certificate") is a written document prepared by Zurich American Life Insurance Company. It tells *you* important information about *your Plan* such as:

- the coverage to which *you* may be entitled;
- claim processing and administrative procedures;
- to whom *we* will make a payment; and
- the limitations, exclusions and requirements that apply within the *Plan*.

The Certificate may include attachments such as amendments and riders, which describe additional provisions about *your Plan*. Please read the entire document carefully to fully understand *your* Long Term Disability Plan.

Eligibility

Who Is Eligible For Coverage?

To be eligible for coverage under this *Plan*, the following requirements must be met:

- *you* must be employed by the *Policyholder;*
- *you* must be in *active employment;*
- *you* must be in an *eligible class;* and
- *you* must be working inside the United States.

Determining Your Eligible Class

Your employer determines the criteria that are used to define the *eligible class(es)* for insurance coverage under this *Plan*. *Your employer* determines if *you* are in an *eligible class*. Such criteria are based solely upon the conditions related to *your* employment established by *your employer*. *We* will rely upon the representation of the *employer* as to *your* eligibility for coverage under this *Plan* and as to any fact concerning such eligibility.

The criteria describing *eligible classes* of *employees* are listed on the Benefits Schedule attached to this Certificate. Refer to the Benefits Schedule or contact *your employer* to determine if *you* are in an *eligible class*.

When Are You Eligible For Coverage?

If *you* are working for *your employer* in an *eligible class,* the date *you* are eligible for coverage is the *Plan* effective date.

New Hires:
If *you* are in an *eligible class* on the date of hire, *your* eligibility date is the date *you* are hired. If *you* enter an *eligible class* after *your* date of hire, *your eligibility date* is the date *you* enter the *eligible class*.

Effective Date Of Coverage

When Does Your Coverage Begin?

When *you* pay 100% of the cost of *your* coverage, *you* will be covered at 12:01 a.m. on the latest of:

- the date *you* are eligible for coverage, if *you* apply for insurance on or before that date;
- the date *you* apply for insurance, if *you* apply within 31 days after *your eligibility date*; or
- the date *we* approve *your* application, if *evidence of insurability* is required (or subject to the *pre-existing condition* exclusion); or
- the date *your* required premium payment is received by *us*.

What If You Are Absent From Work On The Date Your Coverage Would Normally Begin?

If *you* are absent from work due to *injury*, *sickness*, a *mental illness*, or *leave of absence*, on the date *your* insurance would otherwise become effective, *your* coverage, increase in coverage or a new benefit will be deferred begin until the date *you* return to *active employment*.

Enrollment

How Do You Enroll For Coverage?

You will be provided with *Plan* design and enrollment information when *you* first become eligible to enroll. If *you* must contribute towards the cost of basic coverage or *you* elect to purchase additional coverage at the time of enrollment *you* are required to enroll for coverage. To do so *you* must complete and sign a group insurance enrollment form, satisfactory to *us*, and deliver it to *your employer*.

If an *evidence of insurability* application is required, *you* must complete it in accordance with the instructions below.

When Do You Enroll?

If *you* are required to enroll for *your* insurance, *you* will need to enroll within 31 days of *your eligibility date*. Otherwise, *you* may be considered a *late applicant*. If *you* miss the enrollment period, *you* will not be able to participate in the *Plan* until:

- *you* complete the requirements for a *late applicant* described below; and
- *we* approve *you* as a *late applicant*.

If *you* do not enroll for coverage when *you* first become eligible *you* may be denied coverage if *your evidence of insurability* is not satisfactory.

Late Applicant Enrollment Requirements

If *you* do not enroll for coverage within 31 days after becoming eligible, but wish to do so later, *your employer* will provide *you* with information on when and how *you* can enroll as a *late applicant*.

You must complete an enrollment form and submit *evidence of insurability* to *us*. *We* will

review the information and solely determine *your eligibility date*. *We* will notify *you* and *your employer* of *our* decision.

Late applicants are subject to the pre-existing condition limitation.

When Is Evidence Of Your Insurability Required?

Evidence of insurability means a statement of *your* medical history which *we* will use to determine if *you* are approved for coverage. This requirement will be met when *we* decide the *evidence of insurability* is satisfactory. An *evidence of insurability* form can be obtained from *your employer.*

If *you* are required to submit *evidence of insurability*, *you* must:

- complete and sign a health and medical history form provided by *us*;
- submit to a medical examination, if requested;
- provide any additional information that *we* require including verification of earnings and attending physicians' statements, and
- furnish all such evidence at *your* own expense.

Evidence of Insurability (EOI) is required if:

- *you* enroll for coverage for the first time if not elected upon initial enrollment;
- *you* re-enroll for coverage after *your* coverage ends for any reason;
- *you* are a *late applicant*, which means *you* apply for coverage more than 31 days after the date *you* are eligible for coverage;
- *you* voluntarily cancelled *your* coverage and are reapplying; or
- *your* coverage was cancelled because *you* did not make the required contributions.

The *Policyholder* may not waive the *evidence of insurability* requirement for any reason.

Annual Enrollment Period

During the *annual enrollment period*, *you* will have the opportunity to review *your* coverage needs for the upcoming year. During this period, *you* have the option to apply for insurance. The choices *you* make during this *annual enrollment period* will become effective the following plan year as indicated on the Benefits Schedule.

After Coverage Begins

How Do You Pay For Your Coverage?

Your employer may require *you* to pay for all of the cost of *your* insurance. *Your employer* will determine the amount of *your Plan* contributions, if any. *Your employer* will advise *you* of the required amount of *your* contributions and inform *you* of any required payroll deductions.

Once *you* have satisfied the *elimination period*, *your* premium and contributions, if any, will be waived for any period *you* are eligible to receive monthly benefits.

When Coverage Ends

When Does Your Coverage End?

Your coverage under this *Plan* ends on the earliest of:

- the date the *Policy* or a *Plan* is cancelled;
- the date *you* voluntarily stop *your* coverage;
- the date *you* are no longer in an *eligible class;*
- the date *you* are no longer eligible for coverage;
- the date *your eligible class* is no longer covered;
- the last day of the period for which *you* made any required contributions;
- the last day *you* are in *active employment* except as provided under the *leave of absence* provision;
- the date *your* employment stops for any reason, including job elimination, or being placed on severance. This will be the date *you* stop *active employment*;
- the date on which *you* retire;
- the date on which *you* voluntarily or involuntarily lose *your* professional license; or
- the date on which *you* begin active duty in the armed forces of any country.

When Will Your Coverage Continue If You Are Temporarily Not Working?

If premium payments continue to be made on *your* behalf, *we* may deem *your* employment to continue for purposes of remaining eligible for coverage under this *Plan* as described below.

If *you* are not in *active employment* due to authorized leave as agreed to by *your employer* and *us*, *your* coverage may continue until stopped by *your employer*

Reinstatement Of Coverage

If *your* Long Term Disability coverage ends, *you* may apply to reinstate coverage subject to the rules described in the "When Does Your Coverage Begin?" Section. If *we* approve *your* request, *we* will notify *you* of *your* reinstatement date.

What Happens To My Coverage Under This Policy While I Am On A Family And Medical Leave Of Absence Or A Military Leave Of Absence?

Coverage will be continued until the end of the later of:

- the leave period required by the federal Family and Medical Leave of Absence Act of 1993 and any amendments;
- the leave period required by the Uniformed Services Employment and Reemployment Rights Act of 1994 and any amendments; or
- the leave period required by applicable national, state, or local *law*, or any similar *law*, *plan*, or act.

If the *Policyholder's* policy does not provide for continuation of *your* coverage during a family and medical *leave of absence*, *your* coverage will be reinstated when *you* return to *active employment*.

How Can Statements Made In Your Application For This Coverage Be Used?

We consider any statements *you* or *your employer* makes in a signed application for coverage or an *evidence of insurability* form, or that *your employer* makes in the application process, a representation and not a warranty. If any of the statements *you* or *your employer* make are not complete and/or not true at the time they are made, *we* can:

- reduce or deny any claim; or
- cancel *your* coverage from the original effective date or any the increase in coverage.

We will use only statements made by the *employer* in the application process and statements made by *you* in a signed application as a basis for doing this. If a statement is used in a contest, a copy of that statement will be furnished to *you* or, in the event of *your* death or incapacity, to *your* eligible survivor or personal representative.

If the *Policyholder* gives *us* information about *you* that is incorrect, *we* will:

- use the facts to decide whether *you* have coverage under the *Plan* and in what amounts; and
- make a fair adjustment of the premium.

Our failure to implement or insist upon compliance with any provision of this *Policy* at any given time or times shall not constitute a waiver of *our* right to implement or insist upon compliance with that provision at any other time or times. This applies whether or not the circumstances are the same.

Incontestability

During the first two years that *your* insurance is in force, *we* may use any statement *you* have made in contesting the validity of that coverage. This also applies to any increase in *your* coverage for the two years that follow the effective date of that increase if *evidence of insurability* was required in order for the increase to take effect.

Once coverage, including an increase in coverage has been continuously in effect for two years, the validity of *your* insurance may not be contested by *us* unless *your* statement was in writing on a form signed by *you* and was fraudulently made in order to obtain that coverage or increase.

Subrogation And Right Of Reimbursement

As used herein, the term *"third party,"* means any party that is, or may be, or is claimed to be responsible for *illness* or *injuries* to *you* that caused *your* disability. Such illness or injuries are referred to as *"third party injuries". "Third party"* includes any party responsible for payment of benefits for loss of time or wages as a result of *third party injuries.*

By accepting benefits under this *Plan*, *you* specifically acknowledge *our* right of subrogation.

We are assigned the right to recover from the negligent *third party,* or his or her insurer, to the extent of the benefits *we* paid for that *sickness* or *injury. You* are required to furnish any information or assistance or provide any documents that *we* may reasonably require in order to exercise *our* rights under this provision. This provision applies whether or not the *third party* admits liability. *We* may proceed against any party with or without *your* consent

By accepting benefits under this *Plan*, *you* or *your* representatives further agree to:

- notify *us* within 30 days and in writing when notice is given to any party, including an insurance company or attorney, of the intention to investigate or pursue a claim to recover damages or obtain compensation due to *third party injuries* sustained by *you*;
- cooperate with *us* and do whatever is necessary to secure *our* rights of subrogation and recovery under this Certificate;
- give *us* a first-priority lien on any recovery, settlement, or judgment or other source of compensation which may be had from any party to the extent of the full cost of all benefits associated with *third party injuries* provided by this *Plan* (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement);
- pay, as the first priority, from any recovery, settlement judgment, or other source of compensation, any and all amounts due *us* as recovery of the full cost of all benefits associated with *third party injuries* paid by this *Plan* (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by *us* in writing;
- do nothing to prejudice *our* rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery, which specifically attempts to reduce or exclude the full cost of all benefits paid by the *Plan;* and
- serve as a constructive trustee for the benefits of this *Plan* over any settlement or recovery funds received as a result of *third party injuries.*

We may recover full cost of all benefits paid by this *Plan* under this Certificate without regard to any claim of fault on *your* part, whether by comparative negligence or otherwise.

Does The Coverage Under A Plan Replace Or Affect Any Workers' Compensation Or State Disability Insurance?

The coverage under a *Plan* does not replace or affect the requirements for coverage by Workers' Compensation or state disability insurance. However, any Workers' Compensation benefits are considered a *deductible source of income.*

Recovery Of Overpayments

If payments are made in amounts greater than the benefits that *you* are entitled to receive, *We* have the right to recover any overpayments. Refer to the "Claim Information" Section for the process *we* use to recover overpayments:

How Will We Handle Insurance Fraud?

We shall have the right and promise to use all means available to *us* to detect, investigate, deter, and prosecute those who commit insurance fraud. *We* shall have the right to pursue all legal remedies if *you* and/or *your employer* perpetrate insurance fraud.

Insurance fraud occurs when *you* or *your Policyholder* knowingly and with intent to defraud or deceive *us*, provide *us* with false information or file a claim for benefits that contains any false, incomplete or misleading information, or conceals for the purpose of misleading, information concerning any material fact.

It is a crime if *you* or the *Policyholder* to commit insurance fraud and may subject such person to criminal and civil penalties. Such penalties include, but are not limited to fines, denial or termination of insurance benefits, recovery of any amounts paid, civil damages, criminal prosecution, and penalties.

Does The Policyholder Act As Our Agent?

No. For purposes of the *Policy*, the *Policyholder* acts on their own behalf. Under no circumstances will the *Policyholder* be deemed *our* agent.

LONG TERM DISABILITY BENEFITS

How Do We Define A Long Term Disability?

During the *elimination period* and the first 24 months benefits are payable, *you* are disabled when *we* determine that:

- *you* are unable to perform the *material and substantial duties* of *your regular occupation* due solely to *your sickness* or *injury*;
- *you* are under the *regular care* of a *physician*, and
- *you* have a 20% or more loss in *your indexed monthly earnings* due to the same *sickness* or *injury*.

After monthly payments have been payable for 24 months, *you* are disabled when *we* determine that due to the same *sickness* or *injury*:

- *you* are unable to perform the duties of any *gainful occupation* for which *you* are reasonably fitted by education, training or experience;
- *you* are under the *regular care* of a *physician;* and
- *you* have a 20% or more loss in *your indexed monthly earnings* due to the same *sickness* or *injury*.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

We will assess *your* ability to work and the extent to which *you* are able to work by considering the facts and opinions from *your physicians*, and *physicians* and medical practitioners or vocational experts of *our* choice.

We may require *you* to be examined by a *physician*, other medical practitioner and/or vocational expert of *our* choice. *We* will pay for this examination. *We* can require an examination as often as it is reasonable to do so. *We* may also require *you* to be interviewed by *our* authorized representative. Refusal to be examined or interviewed may result in denial or termination of *your* claim.

How Long Must You Be Disabled Before You Are Eligible To Receive Benefits?

You must be continuously disabled through *your elimination period*. The days that *you* are not disabled will not count toward *your elimination period*. *We* will treat *your* disability as continuous if *your* disability stops for 30 days or less during the *elimination period*. No benefit is payable for or during the *elimination period*.

Your elimination period is described in the Benefits Schedule.

Can You Satisfy Your Elimination Period If You Are Working?

Yes. If *you* are working while *you* are disabled, the days *you* are disabled will count toward *your elimination period*.

When Will You Begin To Receive Benefits?

You will begin to receive *benefits* when *we* approve *your* claim, providing the *elimination*

period has been satisfied and *you* are disabled. *We* will send *you* a *monthly benefit* for any period for which *we* are liable.

What Are Your Covered Monthly Earnings?

"Covered Monthly Earnings" means *your* gross monthly income from *your employer* in effect just prior to *your* date of disability. It includes *your* total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plans, or flexible spending account.

Covered monthly earnings include shift differential, commissions, and bonuses. It does not include any expenses, allowances, and other unusual and non-recurring compensation, such as relocation assistance and event awards. Commissions and bonuses will be averaged for the 12 months just prior to the date disability begins, or the months employed, if less than 12 months.

How Is Your Benefit Determined If You Are Disabled And Not Working?

We will follow this process to calculate *your* benefit amount:

1) Multiply *your covered monthly earnings* by the monthly benefits percentage shown in the Benefits Schedule.
2) The *maximum monthly benefit* is listed in *your* Benefits Schedule.
3) Compare the answer from Item 1) with the maximum *monthly benefit*. The lesser of these two amounts is *your gross disability benefit*.
4) Subtract from *your gross disability benefit* any *deductible sources of income*.

The amount figured in Item 4) is *your monthly benefit*. The *monthly benefit* will be recalculated when *your* income changes or *you* receive any new *deductible sources of income*.

After the *elimination period*, if *you* are disabled for less than 1 month, *we* will send *you* 1/30th of *your* benefit for each day of disability.

Monthly benefit means *your* benefit amount after any *deductible sources of income* have been subtracted from *your gross disability benefit*.

Maximum monthly benefit means the maximum benefit amount for which *you* are insured under this *Plan* as shown in the Benefits Schedule.

Gross disability benefit means the benefit amount before *we* subtract *deductible sources of income* and *disability earnings*.

Deductible sources of income mean other income from deductible sources listed in the *Plan* that *you* receive or are entitled to receive while *you* are disabled. This income will be subtracted from *your gross disability benefit*.

How Is Your Benefit Determined If You Are Disabled And Working?

For the first 12 months of payable benefits:

1. If *you* are disabled and return to work, *we* will not reduce *your monthly benefit* for *disability earnings* if:
   - *your* monthly *disability earnings*, if any, are less than 20% of *your indexed monthly earnings* due to the same *sickness* or *injury*; and
   - *you* have satisfied the *elimination period*.

2. If *you* are disabled and *your* monthly *disability earnings* are 20% or more of *your indexed monthly earnings*, due to the same *sickness* or *injury*, *we* will calculate *your monthly benefit* as follows:

    - During the first 12 months of payable benefits, while working, *your monthly benefit* will not be reduced by *your disability earnings* as long as *disability earnings* plus the *gross disability benefit* does not exceed 100% of *indexed monthly earnings.*

        1) Add *your* monthly *disability earnings* to *your gross disability benefit.*
        2) Compare the answer in item 1) to *your indexed monthly earnings*.

    If the answer from item 1) is less than or equal to 100% of *your indexed monthly earnings*, *we* will not further reduce *your monthly benefit*.
    If the answer from item 1) is more than 100% of *your indexed monthly earnings*, *we* will subtract the amount over 100% from *your monthly benefit.*

After benefits have been payable for 12 months, while working, the amount of *your monthly benefit* will change, and *we* will consider a portion of *your disability earnings* to be a *deductible source of income.* Fifty percent of *your disability earnings* will be added to *your* other *deductible sources of income*, if any. The sum will be deducted from *your gross disability benefit*. This amount will be *your monthly benefit.*

We may require *you* to send proof of *your disability earnings* on a monthly basis. *We* will re-calculate *your* benefit each month and adjust *your* monthly benefit based on *your* monthly *disability earnings.*

As part of *your* proof of *disability earnings*, *we* can require that *you* send *us* appropriate financial records, including copies of *your* IRS federal income tax return, W-2's and 1099's, which *we* believe are necessary to substantiate *your* income.

After the *elimination period*, if *you* are disabled for less than 1 month, *we* will send *you* 1/30th of *your monthly benefit* for each day of disability.

When Will Your Monthly Benefits End If Working While Disabled?

If *your monthly disability earnings* exceed 80% of *your indexed monthly earnings*, *we* will stop *your* benefits and *your* claim will end.

Disability earnings means the earnings which *you* receive while *you* are disabled and working, plus the earnings *you* could receive if *you* were working to *your* greatest extent possible. This would be, based on *your* restrictions and limitation:

- during the first 24 months of disability *benefits*, the greatest extent of work *you* are able to do in *your regular occupation*, that is reasonably available.
- beyond 24 months of disability payments, the greatest extent of work *you* are able to do in any occupation, that is reasonably available, for which *you* are reasonably fitted by education, training, or experience.

Salary continuance paid to supplement *your disability earnings* will not be considered payment for work performed.

We will review *your* status from time to time. *We* will require satisfactory proof of earnings and continued disability. No disability benefits will be paid, and insurance will end if *we* determine *you* are able to work under a transitional work arrangement or other modified work arrangement and *you* refuse to do so without *good cause*.

What Will We Use For Covered Monthly Earnings If You Become Disabled During A Covered Layoff Or Leave Of Absence?

If *you* become disabled while *you* are on a *leave of absence*, *we* will use *your* monthly earnings from *your employer* in effect just prior to the date *your* absence begins.

How Can We Protect You If Your Disability Earnings Fluctuate?

If *your disability earnings* routinely fluctuate widely from month to month, *we* may average *your disability earnings* over the most recent three months to determine if *your* claim should continue.

If *we* average *your disability earnings*, *we* will not terminate *your* claim unless the average of *your disability earnings* from the last three months exceeds 80% of *indexed monthly earnings*. *We* will not pay *you* a benefit for any month during which *disability earnings* exceed 80% of *indexed monthly earnings*.

If *we* average *your disability earnings*, *we* will terminate *your* claim if the average of *your disability earnings* from the last three months exceeds 80% of *indexed monthly earnings*.

We will not pay *you* for any month during which *disability earnings* exceed the above amounts. The *minimum monthly benefit* will not be paid when *disability earnings* exceed the above amounts.

What Are "Deductible Sources Of Income" And How Do They Affect My Benefits?

Deductible sources of income are other income benefits *you*, *your spouse* or *your dependents* may be entitled to receive because of *your* disability or retirement. These benefits are taken into consideration when *your monthly benefit* is calculated and may reduce *your monthly benefit*.

We will subtract from *your gross disability benefit* the following *deductible sources of income*:

1. The amount that *you* receive or are entitled to receive under:

    - a Workers' Compensation *law;*
    - an occupational disease *law; or*
    - any other *plan, act, or law* with similar intent.

2. The amount that *you* receive or are entitled to receive as disability income *benefits* under any:

    - state compulsory benefit act or *law;*
    - automobile liability insurance policy;
    - other group insurance plan; or
    - governmental retirement system as a result of *your* job with *your employer*.

3. The gross amount that *you*, *your spouse*, and children receive or are entitled to receive as disability *benefits* because of *your* disability under:

    - the United States Social Security Act;
    - the Canada Pension Plan;
    - the Quebec Pension Plan;
    - the Railroad Retirement Act; or
    - any similar *plan, act, or law* of any country, state, or province.

Amounts paid to *your* former *spouse* or to *your* children living with such *spouse* will not be included.

4. The gross amount that *you* receive as retirement payments or the amount your *spouse* and children receive as retirement payments because *you* are receiving retirement payments under:

    - the United States Social Security Act;
    - the Canada Pension Plan;
    - the Quebec Pension Plan;
    - the Railroad Retirement Act; or
    - any similar *plan, act, or law* of any country, state, or province.

    This does not include benefits for any month before *you* reach normal retirement age, as defined under the Social Security Act, unless *you* choose to receive these benefits.

    Benefits paid to *your* former *spouse* or *your* children living with such *spouse* will not be included.

5. The amount that *you*:

    - receive as disability benefits under *your employer's retirement plan*;
    - voluntarily elect to receive as retirement *benefits* under *your employer's retirement plan*;
    - receive as retirement benefits when *you* reach the later of age 62 or normal retirement age, as defined in *your employer's retirement plan*.

    Disability payments under a *retirement plan* will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

    Retirement *benefits* will be those benefits that are paid based on *your employer's* contribution to the *retirement plan*. Disability benefits which reduce the retirement benefit under the *Plan* will also be considered as a retirement benefit.

    Regardless of how the retirement funds from the *retirement plan* are distributed, *we* will consider *your* and *your employer's* contributions to be distributed simultaneously throughout *your* lifetime.

    Amounts received do not include amounts rolled over or transferred to any eligible *retirement plan*. *We* will use the definition of eligible *retirement plan* as defined in Section 402 of the Internal Revenue code including any future amendments that affect the definition.

6. 100% of the amount *you* receive under Title 46, United States Code Section 688 (The Jones Act).

7. Third party payments, damages, settlements, or judgments received for *your* disability (after subtracting attorney's fees

8. 100% of the amount *you* receive under the maritime doctrine of maintenance, wages, and cure. This includes only the "wages" part of such benefits.

9. The amount of loss of time benefits that *you* receive or are entitled to receive under any *salary continuation or accumulated sick leave*.

10. Individual disability income benefits paid by *your employer*, that *you* receive or are entitled to receive to the extent that *your* total *monthly benefits*, including any other group and/or individual disability benefits, exceed or would exceed 50%-100% of *your* gross monthly earnings.

11. The amount *you* receive or are entitled to receive under any unemployment income act or *law* due to the end of employment with *your employer* or payable by insured and uninsured plans or as a result of *your* membership or association in any group, union or other organization.

12. The amount that *you* receive from a paid family leave

With the exception of retirement payments, or amounts that *you* receive from a partnership, proprietorship, or any similar draws, *we* will only subtract *deductible sources of income* which are payable as a result of the same disability.

We will not reduce *your* payment by *your* Social Security retirement income if *your* disability begins after age 65 and *you* were already receiving Social Security retirement payments.

What Are Not Deductible Sources Of Income?

We will not subtract from *your gross disability benefit* income *you* receive from, but not limited to, the following:

- 401(k) plans;
- profit sharing plans;
- thrift plans;
- tax sheltered annuities;
- stock ownership plans;
- non-qualified plans of deferred compensation;
- pension plans for partners;
- military pension and disability income plans;
- credit disability insurance;
- franchise disability income plans;
- individual retirement accounts (IRA;)
- individual disability income plans;
- 457 deferred compensation plans;
- 403(b) ax sheltered annuity plans; or
- retirement benefits from a former *employer.*

What If Subtracting Deductible Sources Of Income Results In A Zero Benefit (Minimum Monthly Benefit)?

If *your monthly benefit* is reduced to zero due to subtracting *deductible sources of income*, *you* will receive a *minimum monthly benefit*. *Your minimum monthly benefit* is listed on the Benefits Schedule.

We may apply *your minimum monthly benefit* toward any outstanding overpayment. The *minimum monthly benefit* will not be paid in any month when *disability earnings* exceed 80% of *your indexed monthly earnings*. This includes when *we* average *your disability earnings* as described above.

What Happens When You Receive A Cost Of Living Increase From Deductible Sources of Income?

Once *we* have subtracted any *deductible source of income* from *your gross disability benefit*, *we* will not further reduce *your monthly benefit* due to a cost of living increase from that source.

What If We Determine You May Qualify For Deductible Income Benefits?

When *we* determine that *you* may qualify for benefits in the "Deductible Sources Of Income" Section, *we* will estimate *your* entitlement to these benefits. *We* can reduce *your monthly benefit* by the estimated amounts if such benefits:

- have not been awarded or received; and
- have not been denied; or
- have been denied, and the denial is being appealed, if appeal rights are provided.

Your monthly benefit may **NOT** be reduced by the estimated amount if *you*:

- apply for the disability benefits in the "Deductible Sources Of Income" Section, and appeal *your* denial to all administrative levels *we* feel are necessary; and
- sign *our* reimbursement agreement form. This form states that *you* promise to pay *us* any overpayment caused by an award.

If *your* benefit has been reduced by an estimated amount, *your* benefit will be adjusted when *we* receive proof:

- of the amount awarded; or
- that benefits have been denied and all appeals *we* feel are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to *you*.

What Happens If You Receive A Lump Sum Payment?

If *you* receive a lump sum payment from any *deductible source of income*, the lump sum will be pro-rated on a monthly basis over the time period for which the sum was given. If no time period is stated, *we* will use a reasonable one.

What Is The Maximum Benefit Period?

You will receive a benefit for each month *you* remain disabled up to the *maximum benefit period*. *Your maximum benefit period* is based on *your* age at disability. Refer to the Long Term Disability Benefits Schedule for specific *maximum benefit period* durations.

When Will Benefits Stop?

Your claim will end, and benefits will stop on the earliest of the following:

- the end of the *maximum benefit period*;

- the date *you* are no longer *disabled* under the terms of the *Plan*;
- during the first 24 months of benefits, when *you* are able to work in *your regular occupation* on a part-time basis, but *you* choose not to;
- after 24 months of benefits, when *you* are able to work in any *gainful occupation* on a part-time basis, but *you* choose not to;
- if *you* are working and *your* monthly *disability earnings* exceed 80% of *your indexed monthly earnings*, the date *your* earnings exceed 80%;
- the date *you* fail to submit proof of continuing disability;
- if *you* are incarcerated;
- the date *you* die; or
- the date *your employer* offers *you* another or modified job position, which *physicians* agree *you* are able to perform, at a pay rate that exceeds 80% of *your indexed monthly earnings*.

Disability Benefits Will Not Be Paid For Any Period Of Disability During Which You:

- are not following a plan of *appropriate care* for *your* disability, or complications of *your* disability;
- are not receiving *appropriate care*;
- refuse to participate in *our rehabilitation program*,a Worksite Modification Program, a transitional work arrangement or other modified work arrangement which may be for *your regular occupation* or *any reasonable occupation*.
- *you* fail to cooperate with *us* in the administration of the claim. Such cooperation includes, but is not limited to provding any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

What Disabilities Have A Limited Pay Period Under Your Plan?

We will pay disability benefits on a limited basis for a disability caused by the following condition:

- disabilities, which as determined by *us*, due in whole or in part to *mental illness* have a limited pay period during *your* lifetime.

The lifetime cumulative *maximum benefit period* for all disabilities caused by *mental illness* is 24 months during *your* lifetime. Only 24 months of benefits will be paid for any combination of such disabilities even if the disabilities are not continuous; and/or are not related.

We will not pay beyond the limited pay period as indicated above, or the *maximum benefit period*, whichever occurs first. *We* will not apply any period of confinement to *your* lifetime cumulative maximum.

Exceptions
We will not apply the *mental illness* limitation to dementia if it is a result of:

- stroke;
- trauma;
- viral infection;
- Alzheimer's disease; or
- other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

What Disabilities Are Not Covered Under Your Plan?

Your Plan does not cover any disabilities caused by or resulting from:

- a *pre-existing condition;*
- intentionally self-inflicted injuries or attempted suicide;
- active participation in a riot or an act of insurection, rebellion or civil commotion;
- war, declared or undeclared, or any act of war;
- participation in an illegal activity or illegal act or to which a contributing cause was *your* being engaged in an illegal occupation;
- commission of a crime for which *you* have been convicted, this includes but is not limited to local, state, country, provincial or federal *law*, or the disability results from commison of, or attempting to commit a criminal act;
- intoxication, including driving a motor vehicle while intoxicated. ("Intoxicated" means *your* blood alcohol or drug level meets or exceeds the level at which intoxication would be presumed under the *law* of the state, country, jurisdiction in which the event, activity or accident occurred; or
- influence of a controlled substance, unless administered by a physican, or taken according to a physician's instructions, and within clinical guidelines.

What Is A Pre-Existing Condition?

You have a *pre-existing condition* if both 1 and 2 are true:

1. *you* received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the three months (*look back period)* just prior to *your* effective date of coverage.

2. the disability begins in the first 12 months after *your* effective date of coverage.

What If You Are Not In Active Employment When Your Employer Changes Insurance Carriers To Us (Continuity Of Coverage)?

When the *Plan* becomes effective, *we* will provide coverage for *you* if:

- *you* are not in active employment because of a *sickness* or *injury*; and
- *you* were covered by the prior *Policy.*

Your coverage is subject to payment of premium.

Your monthly benefit will be limited to the amount that would have been paid by the prior carrier. *We* will reduce *your monthly benefit* by any amount for which *your* prior carrier is liable.

How Does The Pre-Existing Condition Work If You Were Covered Under Your Employer's Prior Plan (Continuity Of Coverage)?

You may be eligible for a *monthly benefit* if *your* disability results from a *pre-existing condition* if, *you* were:

- in *active employment* and insured under the *Plan* on its effective date; and
- insured by the prior *Policy* at the time of change.

In order to receive a *monthly benefit*, *you* must satisfy the *pre-existing condition* provision under:

1. *our Plan*; or
2. the prior carrier's plan, if benefits would have been paid had that *Policy* remained in force.

If *you* do not satisfy item 1) or item 2) above, *we* will not pay benefits under *our Plan*.

If *you* satisfy item 1), *we* will determine *your* benefits according to *our Plan* provisions.

If *you* only satisfy item 2), *we* will administer *your* claim according to *our Plan* provisions. However, *your monthly benefit* will be the lesser of:

- the *monthly benefit* that would have been payable under the terms of the prior plan if it had remained in force.
- the *monthly benefit* under *our Plan*.

Your benefits will end on the earlier of the following dates:

- the end of the *maximum benefit period* under the *Plan*; or
- the date benefits would have ended under the *prior plan* if it had remained in force.

What Happens If You Return To Work Full Time With Your Employer And Your Disability Occurs Again?

If *you* have a *recurrent disability*, as determined by *us*, *we* will treat *your* disability as part of *your* prior claim, and *you* will not have to complete another benefit *elimination period* if:

- *you* were continuously insured under the *Plan* for the period between the end of *your* prior claim and *your recurrent disability*; and
- *your* recurrent disability occurs within six months from the end of *your* prior claim.

Your recurrent disability will be subject to the same terms of the *Plan* as *your* prior claim and will be treated as a continuation of that disability.

Any disability, which occurs after six months from the date *your* prior claim ended, will be treated as a new claim. The new claim will be subject to all of the *Policy* provisions, including the *elimination period*.

If *you* become covered under any other group long term disability plan, *you* will not be eligible for benefits under this Disability Plan.

ADDITIONAL LONG TERM DISABILITY BENEFITS AND PROGRAMS

Survivor Benefit

What Benefits Will Be Provided To Your Family If You Die?

When *we* receive proof that *you* have died, while totally disabled, *we* will pay *your eligible survivor* a lump sum benefit equal to three months of *your net monthly benefit* if, on the date of *your* death:

- *your* disability had continued for the greater o 180 days or the expiration of any *employer*-sponsored short term disability or *salary continuation* plan; and
- *you* were receiving or were entitled to receive payments under this *Plan*.

However, *we* will first apply the survivor benefit to any overpayment that may exist on *your* claim.

If *you* have no *eligible survivors*, payment will be made to *your* estate, unless there is none.

Rehabilitation Program

A Program To Help You Return To Work.
We have a vocational *rehabilitation program* available to assist *you* in returning to work. *We* will determine whether *you* are eligible for this program, at *our* sole discretion. In order to be eligible for rehabilitation services and benefits, *you* must be medically able to engage in a return to work program.

Your claim file will be reviewed by one of *our* rehabilitation professionals to determine if a *rehabilitation program* might help *you* return to *gainful employment*. As *your* file is reviewed, medical and vocational information will be analyzed to determine an appropriate return to work program. *We* will make the final determination of *your* eligibility for participation in the program. *We* will provide *you* with a written rehabilitation plan developed specifically for *you*.

The *rehabilitation program* may include at *our* sole discretion, but is not limited to, the following services and benefits:

- coordination with *your employer* to assist *you* to return to work;
- adaptive equipment or job accommodations to allow *you* to work;
- vocational evaluation to determine how *your* disability may impact *your* employment options;
- job placement services;
- resume preparation;
- job seeking skills training; or
- education and retraining expenses for a new occupation.

Additional Benefits While You Participate In Our Rehabilitation Program

We will pay an additional benefit of 10% of *your gross disability benefit* to a maximum benefit of $5,000. This benefit is not subject to *Policy* provisions which would otherwise increase or reduce the benefit amount such as *deductible sources of income*. However, the *maximum benefit* and *maximum benefit period* will apply. In addition, *we* will continue benefits for *you*

for three months following the date *your* disability ends if *we* determine *you* are no longer disabled while:

- *you* are participating in *our rehabilitation program*; and
- *you* are not able to find employment.

This benefit payment may be paid in a lump sum.

When Will The Rehabilitation Program Benefits End?
Benefits for the *rehabilitation program* will end on the earliest of the following dates:

- the date *we* determine that *you* are no longer eligible to participate in *our rehabilitation programs;* or
- any other date on which benefits would stop in accordance with this *Plan.*

Child Care Expense Benefits While You Participate In A Rehabilitation Program

While *you* are participating in *our rehabilitation program, we* will pay a Child Care Expense Benefit when *you* are disabled and *you* are incurring expenses to provide care for a child under the age of 13.

The payment of the Dependent Care Expense Benefit will begin immediately after *you* start *our rehabilitation program. Our* payment of the Child Care Expense Benefit will:

- be $400 per month; and
- not exceed $2,500 per calendar year for all childcare expenses combined.

To receive this benefit, *you* must provide satisfactory proof that *you* are incurring expenses that entitle *you* to the Child Care Expense Benefit.

Child Care Expense Benefits will end on the earlier of the following:

- the date *you* are no longer incurring expenses for *your* dependent;
- the date *you* no longer participate in *our rehabilitation program*; or
- any other date benefits would stop in accordance with this *Plan.*

Worksite Modification Benefit

How Can We Help Your Employer Identify And Provide Worksite Modification?
A worksite modification might be what is needed to allow *you* to perform the *material and substantial duties* of *your regular occupation* with *your employer.* One of *our* designated professionals will assist *you* and *your employer* to identify a modification *we* agree is likely to help *you* remain at work or return to work. This agreement will be in writing and must be signed by *you, your employer* and *us.* When this occurs, *we* will assist *your employer* with the cost of the modification, up to the greater of:

- $1,000, or
- the equivalent of two months of *your monthly benefit.* This benefit is available to *you* on a one-time only basis.

CLAIM INFORMATION

Long Term Disability

Reporting Of Claims

You are required to submit a claim to *us* in writing by mail or fax. Claim forms may be obtained from the *Plan* Administrator, *your employer* or from *us*. Follow the procedure chosen by *your employer* to report a disability claim to *us*. *You* may submit *your* initial claim electronically through *our* website at www.myzurichleave.com. Follow the instructions on the website and submit all requested documents and information.

When Do You Notify Us Of A Claim?

We encourage *you* to notify *us* of *your* disability claim as soon as possible, so that a claim decision will be made in a timely manner. Written notice of a claim should be sent within 90 days after the date *your* disability begins. Failure to give notice within the time prescribed does not invalidate or reduce any claim if it is shown that it was not reasonably possible to give the notice within that time, and notice was given as soon as was reasonably possible. However, *you* must send *us* written proof of *your* claim no later than 90 days after *your* elimination period. If it is not possible to give proof within 90 days, it must be given no later than one year(s) after the time proof is otherwise required except in the absence of legal capacity.

If *you* submit a claim before *you* have been notified of *our* decision on any coverage amount requiring *evidence of insurability*, *your* amount of coverage will be determined as if *our* final underwriting decision had been made prior to the date of claim.

The claim form is available from *your employer*, or *you* can request a claim form from *us*. If *you* do not receive the form from *us* within 15 days of *your* request, send *us* written proof of claim without waiting for the form.

You must notify *us* immediately when *you* return to work in any capacity.

How Do You File A Claim?

You and *your employer* must fill out *your* own sections of the claim form. *You* must then give *your* claim form to *your* attending *physician* for *your* disability. *Your physician* should fill out his or her section of the form and send it directly to *us*.

What Information Is Needed As Proof Of Your Claim?

Your proof of claim must be provided at *your* expense. It must include the following information:

1. that *you* are under the regular care of a licensed *physician;*
2. appropriate documentation of *your* monthly covered income;
3. appropriate documentation that *you* are not working at any job during the *elimination period* for *your* Long Term Disability claim;
4. the date *your* disability began;
5. the cause of *your* disability;
6. the extent of *your* disability, including restrictions and limitations preventing *you* from performing *your regular occupation* or any *gainful occupation*; and
7. the name and address of any inpatient or outpatient facility, *hospital*, or *institution* where *you* received treatment, including all attending *physicians*.

We may request that *you* provide *us* with proof of continuing disability indicating that *you* are under the *regular care* of a *physician*. This proof shall be in writing and satisfactory to *us*.

You will be required to give *us* authorization to obtain additional medical information from *your* medical providers. *You* may also be required to provide *us* with non-medical information such as copies of *your* IRS Federal Income Tax return, W-2's and 1099's, as part of *your* proof of continuing disability.

This proof must be provided at *your* own expense and must be received within 30 days of a request by *us*. *We* will deny *your* claim or stop sending *you* payments if the appropriate information is not submitted.

Who Will We Make Benefit Payment To?

Benefits will be paid to *you*.

Payment Of Claim

We will begin to pay *your* benefit for which *we* are liable under the terms of the *Policy* within 30 days following *our* receipt of satisfactory proof of loss as described above. Any balance remaining unpaid upon the termination of liability, will be paid immediately. *We* will pay interest on any unpaid claim for which *we* are liable at the rate of 9 percent per annum from the 30th day after receipt of such proof of loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid.

You or *your* authorized representative will be notified by *us* of any known failure to provide sufficient documentation for a due proof of loss within 30 days after receipt of the claim. Any required interest payments shall be made within 30 days after the payment.

What Happens If We Overpay Your Claim?

We have the right to recover any overpayments for amounts paid greater than the benefits that *you* are entitled to receive. This includes but is not limited to *our* error, *your* receipt of deductible sources of income or fraud. *We* will not recover more money than the amount *we* paid *you*.

We have the right to do any one or all of the following:

- require *you* to return the overpayment on request;
- stop payment of benefits until the overpayment is recovered;
- take any legal action needed to recover the overpayment; and
- place a lien, if not prohibited by *law*, in the amount of the overpayment on the proceeds of any other income, whether on a periodic or lump sum basis.

If the overpayment occurred as a result of *your* receipt of *deductible sources of income, during the* period for which *you* have received a benefit under this *Plan*, *we* will exclude from the amount to be recovered, any advocate or legal fees incurred by *you* to obtain such *deductible sources of income,* provided *you* return the overpayment to *us* within 30 days of *our* written request. If *you* do not return the overpayment to *us* within 30 days, such fees will not be excluded. *You* will remain responsible for repayment of the total overpaid amount.

Examples of *deductible sources of income* are:

- Workers' Compensation;
- Federal Social Security benefits;
- Disability payments made by, or on behalf of, a third party as a result of any person's
- action or inaction.

All full list of *deductible sources of income* is located in the "Long Term Disability Benefits" Section of the Certificate.

Unpaid Premium Due

Any unpaid premium due for *your* coverage under this *Policy* may be recovered by *us* by offsetting against amounts otherwise payable to *you* under this *Policy*, or by other legally permitted means.

When Will We Require You To Obtain Physical Examinations And Evaluations?

We will have the right and opportunity to have a *physician*, dentist, vocational expert or other medical or vocational professional of *our* choice examine *you* when *you* request benefits for new and ongoing claims under this *Plan*. Multiple exams, evaluations and functional capacity exams may be required during *your* disability for an ongoing claim. This will be done at all reasonable times while a claim for benefits is pending or under review. This will be done at *our* expense at no cost to *you*.

What Are The Time Limits For Legal Proceedings?

You can start legal action regarding *your* claim 60 days after proof of claim has been given to *us* and up to three years from the time proof of claim is required, unless otherwise provided under federal *law*.

CLAIM PROCEDURES AND APPEAL INFORMATION

Applicability Of ERISA

If this *Policy* provides benefits under a plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. Whether a plan is governed by ERISA is determined by a court, however, *your employer* may have information related to ERISA applicability. If ERISA applies, the following items constitute the *Plan*: the additional information contained in this document, the *Policy*, including *your* Certificate of Coverage, the Benefits Schedule and any additional summary plan description information provided by the *Plan Administrator*. Benefit determinations are controlled exclusively by the *Policy*, *your* Certificate of Coverage, and the information in this document.

How To File A Claim

If *you* wish to file a claim for benefits, *you* should follow the claim procedures described in *your* certificate of coverage. To complete *your* claim filing, *we* must receive the claim information it requests from *you* (or *your* authorized representative), *your* attending physician, and *your employer*. If *you* or *your* authorized representative has any questions about what to do, *you* or *your* authorized representative should contact *us* directly.

Claims Procedures

We will give *you* notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if *we* determine that such an extension is necessary due to matters beyond the control of the *Plan* and *we* notify *you* of the circumstances requiring the extension of time and the date by which *we* expect to render a decision. If such an extension is necessary due to *your* failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and *you* will be afforded at least 45 days within which to provide the specified information. If *you* deliver the requested information within the time specified, any 30-day extension period will begin after *you* have provided that information. If *you* fail to deliver the requested information within the time specified, *we* may decide *your* claim without that information.

If *your* claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the *Plan* will:

- state the specific reason(s) for the determination;
- reference specific *Plan* provision(s) on which the determination is based;
- describe additional material or information necessary to complete the claim and why such information is necessary;
- describe *Plan* procedures and time limits for appealing the determination, and *your* right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from *us* on appeal; and
- disclose any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Appeal Procedures

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made no later than 45 days following receipt of the written request for review. If *we* determine that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). *We* will notify *you* in writing if an additional 45-day extension is needed.

If an extension is necessary due to *your* failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and *you* will be afforded at least 45 days to provide the specified information. If *you* deliver the requested information within the time specified, the 45-day extension of the appeal period will begin after *you* have provided that information. If *you* fail to deliver the requested information within the time specified, *we* may decide *your* appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of *your* appeal. *You* will have access to all relevant documents as defined by, applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by *us* and will be made by a person different from the person who made the initial determination, and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, *we* will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the *Plan* in connection with the denial of *your* claim, *we* will provide *you* with the names of each such expert, regardless of whether the advice was relied upon.

A notice that *your* request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;
- a reference to the specific *Plan* provision(s) on which the determination is based;
- a statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
- a statement describing *your* right to bring a lawsuit under Section 502(a) of ERISA if *you* disagree with the decision;
- the statement that *you* are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records, or other information relevant to the determination; and
- the statement that "*You* or *your Plan* may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact *your* local U.S. Department of Labor Office and *your* State insurance regulatory agency".

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before *you* begin any legal action regarding *your* claim.

Other Rights

The Company, for itself and as claims fiduciary for the *Plan*, is entitled to legal and equitable relief to enforce its right to recover any benefit overpayments caused by *your* receipt of *deductible sources of income* from a third party. This right of recovery is enforceable even if the amount *you* receive from the third party is less than the actual loss suffered by *you* but will not exceed the benefits paid *you* under the *Policy*. The Company and the *Plan* have an equitable lien over such sources of income until any benefit overpayments have been recovered in full.

Discretionary Acts

The *Plan*, acting through the *Plan Administrator*, Zurich American Life Insurance Company delegates to and its affiliate's discretionary authority to make benefit determinations under the *Plan*. The Company may act directly or through their employees and agents or further delegate their authority through contracts, letters or other documentation or procedures to other affiliates, persons, or entities. Benefit determinations include determining eligibility for benefits and the amount of any benefits, resolving factual disputes, and interpreting and enforcing the provisions of the *Plan*. All benefit determinations must be reasonable and based on the terms of the *Plan* and the facts and circumstances of each claim.

Once *you* are deemed to have exhausted *your* appeal rights under the *Plan*, *you* have the right to seek court review under Section 502(a) of ERISA of any benefit determinations with which *you* disagree. The court will determine the standard of review it will apply in evaluating those decisions.

GLOSSARY

General definitions used throughout this Certificate include:

Accident means a sudden unforeseeable external event that caused bodily injury to an *Insured* while coverage is in force under the *Policy*.

Accumulation Period means the period of time from the date disability begins during which *you* must satisfy the *elimination period*.

Active Employment means *you* are working for *your employer* for earnings that are paid regularly and that *you* are performing the *material and substantial duties of your regular occupation*. *You* must be working at least the minimum number of hours as described under *eligible class(es)* in each *Plan*.

Your work site must be:

- *your employer's* usual place of business;
- an alternative work site at the direction of *your employer*, other than *your* home unless clear specific expectations and duties are documented;
- a location to which *your* job requires *you* to travel; or
- at a location to which *your employer's* business requires *you* to relocate live for an extended period of time.

Normal vacation is considered *active employment*.

If *your* employment status is being continued under a severance or termination agreement, *you* will not be considered in *active employment*.

Temporary and seasonal workers are excluded from coverage

Administrator means the person(s) or organization(s) that are designated by the *Policyholder* to perform certain functions on behalf of the *Policyholder*.

References to the *Policyholder* mean the *administrator* when the *administrator* is acting on behalf of the *Policyholder*.

Annual Enrollment Period means the period in each calendar year agreed upon by the *employer* and *us* when an eligible *employee* may enroll for or change benefit elections under the *Policy*.

Appropriate Care means the determination of an accurate and medically supported diagnosis of the *Insured's* disability, or ongoing medical treatment and care of the *Insured's* disability by a physician that conforms to generally-accepted medical standards, including frequency of treatment and care.

Civil Union means the legally recognized union of two eligible individuals of the same or opposite sex established pursuant to the Illinois Religious Freedom and Civil Union Act 750 ILCS 75/1. Parties to a civil union shall receive the same benefits and protections and be subject to the same responsibilities as spouses in a marriage. A Civil Union includes Civil Unions formed outside Illinois established in accordance with applicable state *laws* from other jurisdictions which provide substantially has the same rights under marriage.

Civil Union Partner means a person who has established a civil union pursuant to the Illinois Religions Freedom and Civil Union Act 750 ILCS 75/1 or a legally recognized civil union from other jurisdictions.

Confined or Confinement means a hospital stay of at least 8 hours per day.

Covered Monthly Earnings means *your* gross monthly income from *your employer* in effect just prior to *your* date of disability. It includes *your* total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plans, or flexible spending account.

Covered monthly earnings include shift differential, commissions, and bonuses. It does not include any expenses, allowances, and other unusual and non-recurring compensation, such as relocation assistance and event awards. Commissions and bonuses will be averaged for the 12 months just prior to the date disability begins, or the months employed, if less than 12 months.

Deductible Sources of Income means income from the deductible sources listed in the *Plan* that *you* receive or are entitled to receive while *you* are disabled. This income will be subtracted from *your gross disability benefit.*

Disability Benefit when used with the term *retirement plan*, means money which:

- is payable under a *retirement plan* due to a disability, as defined in the *Plan*, and
- does not reduce the amount of money, which would have been paid as retirement benefits which would have been paid as retirement benefits under the *Plan* if the disability had not occurred. (If the payment does cause a reduction, it will be considered a retirement benefit as defined in this certificate.

Disability Earnings are the earnings *you* receive while *you* are disabled and working, plus the earnings *you* would receive if *you* were working to *your maximum capacity*. This would be based on *your* restrictions and limitations:

- during the first 24 months of disability payments, the greatest extent of work *you* are able to do in *your* regular occupation, that is reasonably available;
- beyond 24 months of disability payments, the greatest extent of work *you* are able to do in any occupation, that is reasonably available, for which *you* are reasonably filled by education, training, or experience.

Salary continuation paid to supplement *your disability earnings* will not be considered payment for work performed.

Eligible Classes means the classes of *employees* that *your employer* has selected as being eligible to receive coverage under a *Plan*. *Your employer* alone determines the criteria that are used to define the *eligible class(es)* for insurance coverage under this *Plan*. *We* will rely on the representation(s) of the *employer* as to *your* eligibility for coverage under this *Plan* and as to any fact concerning such eligibility.

Eligibility Date means the date *you* become eligible for insurance.

Eligible Survivor means *your spouse*, if living, otherwise *your* children under age 25 equally.

Elimination Period means a period of continuous disability that must be satisfied before *you* are eligible to receive benefits from this *Plan us*.

Employee means a person who is in *active employment* in the United States with the *employer* and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the *employer* and such affiliated corporations, proprietorships or partnerships is under common control. *Employee* shall exclude in any case, *part-time employees,* temporary *employees,* and *employees* who work for the *employer* less than the number of hours per week indicated in the Benefits Schedule. This term does not include employees who normally work less than 35 hours a week for the *employer.*

Employer means the *Policyholder* and subsidiaries or affiliates of the *Policyholder* that the *Policyholder* has requested in writing to have included under the *Policy,* and *we* have approved such request.

Evidence of Insurability means a statement of *your* medical history that *we* will use to determine if *you* are approved for coverage. *Evidence of insurability* will be at *your* expense.

Full-Time means the number of hours set by the employer as a regular workday for *full-time employees* in the *Insured's eligible class.*

Gainful Occupation means an occupation, including self-employment, that is or can be expected to provide *you* with an income within 12 months of *your* return to work, that exceeds 80% of *your indexed monthly earnings.*

Gainful occupation is used to determine *your* eligibility for benefits following the *regular occupation* period.

Good Cause means a medical reason preventing *your* participation in the rehabilitation program or in a transitional work arrangement. Satisfactory proof of good cause must be provided to *us.*

Grace Period means a period of time following the premium due date during which premium payment may be made.

Gross Disability Benefit means the total benefit amount for which an *employee* is insured under this *Plan* before *we* subtract *deductible sources of income* and *disability earnings* subject to the *maximum benefit.*

Home Office means 1299 Zurich Way, Schaumburg, IL 60196.

Hospital or Institution means an accredited facility licensed to provide care and treatment for the condition causing *your* disability.

Indexed Monthly Earnings means for the first year *you* are disabled *your indexed monthly earnings* will be equal to *your monthly covered earnings.* After *you* have been disabled for one year, *your indexed monthly earning* means *your covered monthly earnings* adjusted on each anniversary of benefit payments, after a 12 month period of disability by the lesser of 1% or the current annual percentage increase in the Consumer Price Index. *Your indexed monthly earnings* may increase or remain the same but will never decrease.

The U.S. Department of Labor publishes the consumer price Index (CPI-W). *We* reserve the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-W. Indexing is only used as a factor in the determination of the percentage of lost earnings while *you* are disabled and working in the determination of any *gainful occupation.*

Income means income *you* earn, while disabled and working, from *your employer* or any other *employer.* However, any *income* earned by working for another *employer* will be considered

income only to the extent that it exceeds the amount of *income you* were earning from such *employer* immediately before *you* became disabled.

Injury means bodily *injury* that is a direct result of an *accident* and independent of disease or bodily infirmity. The *injury* must occur and the disability must begin while *you* are covered under this *Plan*. Exception: any disability that occurs more than 60 days after the *injury* will be considered a *sickness* for the purpose of determining benefits under this *Policy*.

Insured means any person covered under this *Plan* for whom premium has been paid.

Law, Plan or **Act** means the original enactment of the *law, plan* or *act* and all amendments.

Leave of Absence means *you* are temporarily absent from *active employment* for a period of time that has been agreed to in advance in writing by *your employer*. *Your* normal vacation time or any period of disability is not considered a *leave of absence*.

Limited means what *you* cannot or are unable to do.

Material and Substantial Duties means duties that:

- are normally required for the performance of *your* regular occupation; and
- cannot be reasonably omitted or modified, except that if *you* are required to work an average in excess of 40 hours per week, *we* will consider *you* able to perform that requirement if *you* are working or have the capacity to work 40 hours per week.

Maximum Capacity means based on *your* restrictions and limitations:

- during the first 24 months of disability, the greatest extent of work *you* are able to do in *your* regular occupation that is reasonably available, and
- beyond 24 months of disability the greatest extent of work *you* are able to do in any occupation, that is reasonably available, for which *you* are reasonably qualified by education, training, or experience.

Maximum Period of Payment means the longest period of time *we* will make payments to *you* for any one period of disability.

Mental Illness means a psychiatric or psychological condition classified in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM) published by the American Psychiatric Association, most current as of the start of a disability. Such disorders include, but are not limited to, psychotic, emotional or behavioral disorders, schizophrenia, depression, bipolar illness, or disorders relating from stress or to substance abuse or dependency. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of the disability. These conditions are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other methods of treatment as standardly accepted in the practice of medicine.

Monthly Benefit means *your* benefit amount after any *deductible sources of income* and *disability earnings* have been subtracted from *your gross disability benefit*.

Part-Time Basis means the ability to work and earn 20% or more of *your* indexed monthly earnings.

Payable Claim means a claim for which *we* are liable under the terms of the *Policy*.

Physician means a person performing tasks that are within the limits of his or her medical license; and:

- a person who is licensed to practice medicine, and prescribe and administer drugs and medicines, or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the *laws* and regulations of the governing jurisdiction.

We will not recognize *you* or a person related to *you* as a *physician* for a claim that *you* send to *us*. This includes but not limited to *your spouse*, children, parents, siblings, brothers-in-*law*, sisters-in-*law*, or stepchildren.

Plan means a line of coverage under the *Policy*.

Policyholder means an *employer* who as applied for coverage under the *Policy* for eligible *employees* and their dependents.

Pre-Existing Condition means a condition for which *you* received medical treatment, consultation, care, or services including diagnostic measures, or took prescribed drugs or medicines for *your* condition during the given period of time as stated in the *Plan*.

Prior Plan means the plan of insurance providing similar benefits sponsored by the *employer* in effect directly prior to the *Policy* effective date.

Reasonable Occupation means any gainful activity for which *you* are, or may reasonably become fitted by education, training, or experience.

Reasonable Accommodation means modifications or adjustments to a job, an employment practice or the work environment that makes it possible for a disabled person to perform the material duties of their occupation without causing undue hardship to any *employer*. It must meet federal standards of Reasonable Accommodation as detailed in the Americans with Disabilities Act of 1991 and any later amendments.

Recurrent Disability means a disability, which is:

- caused by a worsening in *your* condition; and
- due to the same cause(s) as *your* prior disability for which *we* made a Long Term Disability payment, or
- *you* satisfied *your elimination period*.

Regular Care means:

- *you* personally visit a *physician* as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat *your* disabling condition(s); and
- *you* are receiving the most appropriate treatment and care, which conform with generally accepted, medical standards, for *your* disabling condition(s) by a *physician* whose specialty or experience is the most appropriate for *your* disabling conditions(s) according to generally accepted medical standards.

Regular Occupation means the occupation *you* are routinely performing when *your* disability begins. *We* will look at *your* occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific *employer* or at a specific location.

Rehabilitation Program means a program, approved by *us*, designed to assist *you* to return to work.

Retirement Plan means a defined contribution plan or defined benefit plan. These are plans, which provide retirement benefits to employees and are not funded entirely by *employee* contributions. *Retirement plan* includes but is not limited to any plan that is part of any federal, state, county, municipal or association retirement system.

Salary Continuation or Accumulated Sick Leave means continued payments to *you* by *your employer* of all or part of *your monthly earnings*, after *you* become disabled as defined by the *Policy*. This continued payment must be part of an established plan maintained by *your employer* for the benefit of all *employees* covered under the *Policy*. *Salary continuation* or *accumulated sick leave* does not included compensation paid to *you* by *your employer* for work *you* actually perform after *your* disability begins. Such compensation is considered *disability earnings* and would be taken into account in calculating *your monthly benefit*.

Sickness means an *illness*, disease or disabling pregnancy. The *sickness* must begin while *you* are covered under this *Plan*.

Total Covered Payroll means the total amount of monthly earnings for which *employees* are incurred under this *Plan*.

Spouse means:

- the *Insured's* lawful *spouse*, (not including a *spouse* who is legally separated); or
- the *Insured's Civil Union Partner*; or
- *your Domestic Partner*.

We will not recognize a partner relationship established in any state that does not legally recognize such relationship.

We, Us and **Our** means Zurich American Life Insurance Company.

You, Your means an insured *employee* who is eligible for *our* coverage under this *Plan*.

NOTICE OF PROTECTION PROVIDED BY

ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** description of the Illinois Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Illinois 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 member life, annuity, health maintenance organization or health insurance company becomes financially unable to meet its obligations and is placed into Receivership by the Insurance Department of the state in which the company is domiciled. If this should happen, the Association will typically arrange to continue coverage, pay claims, or otherwise provide protection in accordance with Illinois law, with funding from assessments paid by other insurance companies and health maintenance organizations.

The basic protections provided by the Association per insured in each insolvency are:

- Life Insurance
  - $300,000 for death benefits
  - $100,000 for cash surrender or withdrawal values
- Health Insurance
  - $500,000 for health benefit plans*
  - $300,000 for disability insurance benefits
  - $300,000 for long-term care insurance benefits
  - $100,000 for other types of health insurance benefits
- Annuities
  - $250,000 for withdrawal and cash values

* The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except special rules apply with regard to health benefit plan benefits for which the maximum amount of protection is $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion 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 residency requirements and other limitations under Illinois law.

To learn more about these above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ilhiga.org or contact:

Illinois Life and Health Insurance Guaranty Association 901 Warrenville Road, Suite 400 Lisle, IL 60532-4324	Illinois Department of Insurance 4th Floor 320 West Washington Street Springfield, Illinois 62767

Insurance companies, health maintenance organizations and agents are not allowed by Illinois 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 or health maintenance organization, you should not rely on Association coverage. If there is any inconsistency between this notice and Illinois law, then Illinois law will control.

The Association is not an insurance company or health maintenance organization. If you wish to contact your insurance company or health maintenance organization, please use the phone number found in your policy or contact the Illinois Department of Insurance at DOI.InfoDesk@illinois.gov.

ZURICH

Privacy Notice

We Take Important Steps to Protect the Nonpublic Personal Information We Collect About You

Dear Customer: ***rev. January 2020***

We care about your privacy. That is why we believe in your right to know what nonpublic personal information ("NPI") we collect about you and what we do with that information. This Privacy Notice describes the NPI we collect about you and how we share and protect that information.

Overview	UNDERSTANDING HOW WE USE YOUR PERSONAL INFORMATION
Why are you receiving this Notice?	Financial institutions, which include the Company, choose how they share your NPI. Federal and state law gives consumers the right to limit some but not all sharing of that information. Federal law also requires us to tell you how we collect, share and safeguard your NPI. You are receiving this Privacy Notice because our records show either that you are a customer who is obtaining or has obtained insurance coverage or non-insurance products or services.
What types of information do we collect?	The types of NPI we collect depend on the product or service you have with us. This information can include: • Information about you we receive on applications or other forms, such as your name, address, telephone number, date of birth, your social security number, driver's license number, employment information, information about your income, assets and net worth, and medical information; • Information about your transactions with the Company and its affiliates; • Information about your insurance coverage, premiums, claims history, and payment history; • Data from insurance support organizations, government agencies, insurance information sharing bureaus; • Property information and similar data about you or your property, such as property appraisal reports; and • Information we receive from a consumer reporting agency or insurance information sharing bureau, such as a credit or fraud report. When your relationship with us ends, we may continue to share information about you as described in this Privacy Notice.
What do we do with the NPI we collect?	We share your NPI in the course of supporting your insurance coverage or non-insurance products or services, as authorized by law, or with your consent. This includes sharing, as permitted by law, your NPI with affiliated parties and nonaffiliated third parties, as applicable, in the course of supporting your insurance coverage or non-insurance products. These affiliates and nonaffiliated third parties include: • Financial service providers, such as banks and other insurance companies; • Non-financial companies, such as medical providers and nonaffiliated service providers that perform marketing services on our behalf; and • Others, such as consumer reporting agencies and insurance information sharing bureaus. In the section below, we list the reasons we can share your NPI, whether we actually share your NPI, and whether you can opt out of this sharing (or if you are a resident of Vermont, whether you

	have the right to opt in to allowing this sharing).

Reasons we can share your personal information	Does Company Share?	Can you opt out of this sharing or limit this sharing or is your authorization required for this sharing? [For residents of Vermont: Do you have the right to opt in to allow this sharing?]
For our everyday business purposes – such as to process your transactions, administer insurance coverage, products or services, maintain your account, prevent fraud and report to credit bureaus	Yes	No
For our marketing purposes - to offer our products and services to you	Yes	No
For joint marketing with other financial companies	No	Not Applicable
For our affiliates' everyday business purposes – transaction and experience information	Yes	No
For our affiliates' everyday business purposes – information about your creditworthiness	No	Not Applicable
For our affiliates to market to you	Yes	No
For non-affiliates to market their products to you	No	Not Applicable

Collecting and safeguarding information	
How often do you notify me about your privacy practices?	We must notify you about our sharing practices when you receive your policy, open an account or purchase a service, and each year while you are a customer, or when significant or legal changes require a revision. Please review the privacy policy posted on our website, ZurichNA.com. It contains additional information about our practices.
Why do you collect my NPI?	We collect NPI when you apply for insurance or file an insurance claim to help us provide you with our insurance products and services, and determine your insurability or other eligibility. We may also ask you and others for information to help us verify your identity in order to prevent money laundering and terrorism. Information in a report prepared by an insurance support organization may be retained by that organization and provided to others.
What NPI do we share?	We may provide to affiliates and/or nonaffiliated third parties the same NPI listed above in the section entitled, "What types of information do we collect?"
How do you safeguard my NPI?	Employees who have access to your NPI are required to maintain and protect the confidentiality of that information. Access to your personal information may be needed to conduct business on your behalf or to service your insurance coverage. In addition, we maintain physical, electronic and procedural measures to protect your personal information in compliance with applicable laws and regulatory standards.

FOR RESIDENTS OF ARIZONA, CALIFORNIA, CONNECTICUT, GEORGIA, ILLINOIS, MAINE, MASSACHUSETTS, MINNESOTA, MONTANA, NEW JERSEY, NEVADA, NORTH CAROLINA, OHIO, OREGON, OR VIRGINIA:

You have the following individual rights under state law:

Except for certain documents related to claims and lawsuits, you have the right to access the recorded personal information that we have collected about you which we reasonably can locate and retrieve. To access your recorded personal information, you must submit a request using our online form on our website, ZurichNA.com, or calling our toll-free number at 1-800-382-2150. You may also reasonably describe the information you seek in writing and send your written request to the Privacy Office via mail (Zurich – Privacy Office, 1299 Zurich Way, Schaumburg, IL 60196) or via email at privacy.office@zurichna.com. If you would like a copy of your recorded personal information that we reasonably can locate and retrieve, we may charge you a reasonable fee to cover the costs incurred in providing you a copy of the recorded information if it is permitted by law. If you request medical records, we may elect to supply that information to you through your designated medical professional for security purposes. We may also direct you to a consumer reporting agency to obtain certain consumer report information.

Generally, most of the recorded nonpublic personal information we collect about you and have in our possession is from policy applications or enrollment forms you submit to obtain our products and services, and is reflected in your statements and other documentation you receive from us. If you believe that the personal information we have about you in our records is incomplete or inaccurate, please let us know at once through any of the above methods, and we will investigate and correct any errors we find.

You also have the right to request the correction, amendment, or deletion of recorded personal information about you that we have in our possession. You may make your request using any of the above methods.

Residents of California and Nevada have additional rights over their non-public personal information if it is not governed by the Gramm-Leach-Bliley Act. For more information about these rights, please consult our online privacy policy posted on our website, ZurichNA.com.

FOR RESIDENTS OF MASSACHUSETTS ONLY WHO ARE ZNA P&C CUSTOMERS: You may ask in writing for the specific reasons for an adverse underwriting decision. An adverse underwriting decision is where we decline your application for insurance, offer to insure you at a higher than standard rate or terminate your coverage.

Key words and phrases	TERMS YOU SHOULD KNOW

Definitions	
Everyday business purposes	The actions necessary for financial companies like the Company to conduct business and manage customer accounts, such as: • Processing transactions, mailing and auditing services; • Administering insurance coverage, product, services or claims; • Providing information to credit bureaus; • Protecting against fraud; • Responding to court/governmental orders or subpoenas and legal investigations; and • Responding to insurance regulatory authorities.
Affiliates	Financial or nonfinancial companies related by common ownership or control. • *Company affiliates include insurance and non-insurance companies under common ownership with the Company and that provide insurance and non-insurance products or services.*
Nonaffiliated Third Parties	Financial or nonfinancial companies not related by common ownership or control. We may share your information with companies that we hire to perform marketing and business services for us, such as data processing, computer software maintenance and development, and transaction processing. When we share information with others to perform these services, they are required to take appropriate steps to protect this information and use it only for purposes of performing the services. • *The Company does not share information with nonaffiliates to market their products to you.*

Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. • *The Company does not jointly market.*

Changes to this Privacy Notice; contact us	We may change the policies, standards and procedures described in this Notice at any time to comply with applicable laws and/or to conform to our current business practices. We will notify you of material changes. If you have any questions about your contract with us, you should contact your agent. If you have questions specific to our Privacy Notice, contact our Privacy Office via mail (Zurich – Privacy Office, 1299 Zurich Way, Schaumburg, IL 60196) or via email at privacy.office@zurichna.com.

This Privacy Notice is sent on behalf of the following affiliated companies, which are referred to in this Privacy Notice, in the aggregate, as the "Company:"

American Guarantee and Liability Insurance Company, American Zurich Insurance Company, Colonial American Casualty and Surety Company, Empire Fire & Marine Insurance Company, Empire Indemnity Insurance Company, The Fidelity and Deposit Company of Maryland, Steadfast Insurance Company, Universal Underwriters Insurance Company, Universal Underwriters of Texas Insurance Company, Zurich American Insurance Company, Zurich American Insurance Company of Illinois, The Zurich Services Corporation (together, "the ZNA P&C Companies"), Zurich American Life Insurance Company, and Zurich American Life Insurance Company of New York.