LifeMap Assurance Company®
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GROUP LONG TERM DISABILITY INSURANCE
CERTIFICATE OF COVERAGE

CLASS 01 – Contracted Administrators and Middle Management

POLICYHOLDER: GRANITE SCHOOL DISTRICT

POLICY NUMBER: UT 00511U

POLICY EFFECTIVE DATE: JANUARY 1, 2019

This is to certify that LifeMap Assurance Company has issued and delivered the Group Long Term Disability Insurance Policy to the Policyholder. The Policy insures the employees of the Policyholder who are eligible for the insurance, become insured and continue to be insured according to the terms of the Policy. The terms of the Policy that affect your insurance are contained in the following pages. Your coverage may be terminated or modified in whole or in part 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.

This Certificate of Coverage describes the benefits that an insured employee is entitled to receive and becomes a part of the Policy. **PLEASE READ THIS CERTIFICATE CAREFULLY**.

The coverage offered under the policy is conditionally renewable according to the terms and provisions of the Certificate of Coverage. **Pre-existing limitations or exclusions and other limitations or exclusions may apply.** The maximum benefit duration schedules may limit or reduce benefits or cost of living adjustments based on the attainment of certain ages. A copy of the master policy is available for your inspection at the Policyholder's home office.

This Certificate voids and replaces any prior Certificate issued under the Group Policy Number shown above.

All terms of insurance under the Policy begin and end at 12:01 a.m. Standard time in the place where the Policy is delivered.

Signed for LifeMap Assurance Company at its Home Office in Portland, Oregon.

Assistant Secretary

President

The policy covers disabilities due to an occupational sickness or injury.

The policy does not replace or affect the requirements for coverage by any Workers' Compensation or state disability insurance.

CERTIFICATE OF COVERAGE
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SECTION I
SCHEDULE OF BENEFITS

CLASSES TO BE COVERED

Class 01 – All full-time active Contracted Administrators and Middle Management Employees.

MINIMUM HOURS REQUIREMENT: 20 regularly scheduled hours per week.

WAITING PERIOD

1. If **you** were hired on or before 01/01/2019: The first of the month following date of hire.

2. If **you** were hired after 01/01/2019: The first of the month following date of hire.

ACCUMULATION OF ELIMINATION PERIOD:

Elimination period: 120 days
Accumulation period: 240 consecutive days

The elimination period and the accumulation period begin on the first day of **your** disability. Benefits for a **payable** claim begin the day after the elimination period is completed. The elimination period and the accumulation period are comprised of calendar days.

MONTHLY PAYMENT

60% of **your monthly earnings** not to exceed $5,000 per month.

The minimum monthly benefit is the greater of $100 or 10% of the **gross monthly payment**.

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

MAXIMUM BENEFIT AMOUNT WITHOUT EVIDENCE OF INSURABILITY:

$5,000 per month

MONTHLY EARNINGS

"**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, including any shift differential, and any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include commissions, bonuses, overtime pay or any other extra compensation, or income received from sources other than **your Employer**.

Your monthly salary or wages is based on the average number of hours you worked during the last 12 calendar months (or during your period of employment if fewer than 12 months); but not more than 173 hours per month; or if you are paid on an hourly basis, the calculation of **your** monthly wages is based on **your** hourly pay rate multiplied by the number of hours you are regularly scheduled to work per month; but not more than 173 hours per month.

Earnings, whether for a full year or partial year, will be converted to a monthly amount for the purpose of calculating the **monthly payment**.

WHO PAYS FOR THE COVERAGE: **Your Employer** pays the cost of **your** coverage.

MAXIMUM PERIOD OF PAYMENT

(Social Security Normal Retirement Age duration (SSNRA))

For a disability which begins before **you** reach age 60, the **maximum period of payment** will be until the Social Security Normal Retirement Age (SSNRA) as shown in the following table:

Year of Birth	*Social Security Normal Retirement Age
Before 1938	65 years
1938	65 years and 2 months
1939	65 years and 4 months
1940	65 years and 6 months
1941	65 years and 8 months
1942	65 years and 10 months
1943-1954	66 years
1955	66 years and 2 months
1956	66 years and 4 months
1957	66 years and 6 months
1958	66 years and 8 months
1959	66 years and 10 months
1960 and after	67 years

* Age at which **you** are entitled to unreduced Social Security benefits based on the Social Security Amendments of 1983.

For a disability which starts on or after **you** reach age 60, the **maximum period of payment** will be determined according to the following table:

Your Age When Disability Begins	**Maximum Period of Payment**
Less than age 60	To Social Security Normal Retirement Age (SSNRA)*
Age 60	60 months or to SSNRA*, whichever is greater
Age 61	48 months or to SSNRA*, whichever is greater
Age 62	42 months or to SSNRA*, whichever is greater
Age 63	36 months or to SSNRA*, whichever is greater
Age 64	30 months or to SSNRA*, whichever is greater
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

REGULAR OCCUPATION PERIOD: 60 Months

TOTAL BENEFIT CAP:

If **you** are eligible to receive payments under the policy in addition to **your monthly payment**, the total benefit payable to **you** on a monthly basis (including all benefits provided under the policy) will not exceed 100% of **your monthly earnings**; unless an excess amount is payable as a result of a Cost of Living Adjustment. However, if **you** are participating in a **vocational rehabilitation plan**, the total benefit payable to **you** on a monthly basis (including all benefits provided under this policy) will not exceed 110% of **your monthly earnings**; unless an excess amount is payable as a result of a Cost of Living Adjustment.

The above items are only highlights of the policy. For a full description of your coverage, including any additional benefits, exclusions or limitations that may apply, continue reading your Certificate of Coverage.

SECTION II - DEFINITIONS

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 the MINIMUM HOURS REQUIREMENT in the SCHEDULE OF BENEFITS.

To be in **active employment, your** work site must be:

1. **your Employer's** usual place of business;
2. an alternative work site at the direction of **your Employer**, including **your** home; or
3. a location to which **your** job requires **you** to travel.

Normal vacation is considered **active employment**.

Temporary and seasonal workers are excluded from coverage.

APPROPRIATE CARE means that **you**:

1. regularly visit a **doctor** as frequently as medically required according to standard medical practice to effectively treat and manage **your** disabling condition(s); and
2. receive care or treatment appropriate for the disabling condition(s), conforming with standard medical practice, by a **doctor** whose specialty or experience is most appropriate for the disabling condition(s) according to standard medical practice.

CONTEST means that if **we** determine **you** made a material misrepresentation in **your** application for coverage under the policy, **we** assert in writing that such coverage was therefore never effective. The **contest** is effective on the date **we** mail the letter and refund the premium to **you**.

DEDUCTIBLE SOURCES OF INCOME means income from other sources as listed in the policy which **you** receive while **you** are disabled. This income will be subtracted from **your gross monthly payment.**

DISABILITY EARNINGS means the earnings which **you** receive while **you** are disabled and working.

DOCTOR means:

1. a person performing tasks that are within the limits of his or her medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. a person with a doctoral degree in Psychology (Ph. D. or Psy. D.) whose primary practice is treating patients; or
4. 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 **your** family members, including but not limited to, **spouse**, children, parents, including in-laws, or siblings, including in-laws, a business or professional partner, or any person who has a financial affiliation or business interest with **you** as **a doctor** for a claim that **you** send to **us**.

EMPLOYEE means a person who is a citizen or legal resident of the United States in **active employment** with the **Employer**.

EMPLOYER means the **Policyholder** and includes any division, subsidiary, or affiliated company named in the policy.

ENROLL means **you** have completed the process of applying for coverage under the policy.

ENROLLMENT FORM means the application **you** complete and submit to **us** to apply for coverage under the policy.

EVIDENCE OF INSURABILITY means a statement of **your** medical history that **we** will use to determine if **you** are approved for coverage. Expenses associated with medical underwriting will be provided at **your** own expense.

EVIDENCE OF INSURABILITY FORM means the portion of the **enrollment form** that **you** complete and submit to **us** that contains a statement of **your** medical history.

GAINFUL OCCUPATION means an occupation that is or can be expected to provide **you** with an income within 12 months of **your** return to work, that exceeds:

1. 60% of **your indexed monthly earnings**, if **you** are working; or
2. 60% of **your indexed monthly earnings**, if **you** are not working.

GRACE PERIOD means the 60 day period following the premium due date during which premium payment for the policy may be made by the **Policyholder**.

GROSS MONTHLY PAYMENT means **your** benefit before any reduction for **deductible sources of income** and **disability earnings.**

HOSPITAL, HEALTH FACILITY OR INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing **your** disability.

INDEXED MONTHLY EARNINGS means **your monthly earnings** adjusted on each anniversary of benefit payment by the lesser of 10% 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 Consumer Price Index (CPI-U or CPI-W) is published by the U.S. Department of Labor. **We** reserve the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-U or CPI-W.

Indexing is only used as a factor in the determination of the percentage of lost earnings while **you** are disabled and working and in the determination of **gainful occupation**.

INJURY means a bodily **injury** that is the direct result of an accident and not related to any other cause. The **injury** must occur, and disability resulting from the **injury** must begin while **you** are covered under the policy. An **injury** that occurs before **you** are covered under the policy will be treated as a **sickness**.

INSURED means any person covered under the policy.

LAW or **ACT** means the original enactments of the **law** or **act** and all amendments.

MATERIAL AND SUBSTANTIAL DUTIES means duties that:

1. are normally required for the performance of **your regular Occupation**; and
2. cannot be reasonably omitted or modified.

MAXIMUM BENEFIT means the total monthly benefit amount for which **you** are insured under the policy subject to all policy provisions.

MAXIMUM PERIOD OF PAYMENT means the longest period of time **we** will make payments to **you** for any one period of disability.

MONTHLY EARNINGS means **your** gross monthly income from **your Employer** as stated in the SCHEDULE OF BENEFITS.

MONTHLY PAYMENT means **your** benefit after any **deductible sources of income** and **disability earnings** have been subtracted from **your gross monthly payment**.

OCCUPATIONAL SICKNESS OR INJURY means a **sickness** or **injury** that was caused by or aggravated by any employment for pay or profit.

PART - TIME BASIS means the ability to work and earn from 20% through 80% of **your indexed monthly earnings**. Ability is based on **your** capacity to work and not job availability.

PAYABLE CLAIM means a claim for which **we** are liable under the terms of the policy.

POLICYHOLDER means the **Employer** to whom the policy is issued and who sponsored the coverage for its **employees**.

PRE-EXISTING CONDITION means any condition for which **you** have done any of the following at any time during the 3 months just prior to **your** effective date of coverage, whether or not that condition is diagnosed at all or is misdiagnosed:

1. received medical treatment or consultation;
2. taken or were prescribed drugs or medicine; or
3. received care or services, including diagnostic measures.

RECURRENT DISABILITY means a disability which is:

1. caused by a worsening in **your** condition; and
2. due to the same cause(s) as **your** prior disability for which **we** made a **monthly payment**.

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.

REGULAR OCCUPATION PERIOD is the period of time shown in the SCHEDULE OF BENEFITS that begins after the elimination period.

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 which 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**, and includes **salary continuation**, **accumulated sick leave** or any similar **Employer** sponsored paid time off plan**.**

SICKNESS means illness, disease or physical condition. Disability resulting from the **sickness** must begin while **you** are covered under the policy.

SPOUSE means **your** legal husband, wife as defined by **your** state of residence.

TEMPORARY LAYOFF or **LEAVE OF ABSENCE** means **you** are 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 **temporary layoff** or **leave of absence.**

TREATMENT FREE means **you** have not received medical treatment, consultation, care or services including diagnostic measures, and **you** have not taken or been prescribed drugs or medicines for the **pre-existing condition**.

VOCATIONAL REHABILITATION PLAN means a written plan that a vocational rehabilitation professional, designated by **us**, prepares in accordance with the VOCATIONAL REHABILITATION SERVICES provision of the policy.

WAITING PERIOD means the continuous period of time (shown in the SCHEDULE OF BENEFITS) that **you** must be in **active employment** in an eligible class before **you** are eligible for coverage under the policy.

WE, **US**, and **OUR** means LifeMap Assurance Company.

YOU, YOUR means a person who is eligible for coverage under the policy.

SECTION III - ENROLLMENT AND ELIGIBILITY

ELIGIBILITY DATE

If **you** are working for **your Employer** in an eligible class, the date **you** are eligible for coverage is the later of:

1. the policy effective date; or
2. the day after **you** complete **your waiting period**.

WHEN COVERAGE BEGINS

When **your Employer** pays 100% of the cost of **your** coverage under the policy, **you** will be covered at 12:01 a.m. Standard Time at **your Employer's** address on the date **you** are eligible for coverage.

When **you** and **your Employer** share the cost of **your** coverage under the policy or when **you** pay 100% of the cost yourself, **you** will be covered at 12:01 a.m. Standard Time at the **Policyholder's** address on the latest of:

1. the date **you** are eligible for coverage, if **you enroll** for insurance on or before that date;
2. the first day of the month following the date **you enroll** for insurance, if **you enroll** within 31 days after the date **you** become eligible for coverage; or
3. the first day of the billing period following the date **we** approve **your enrollment form**, if **evidence of insurability** is required.

In order for **your** coverage to begin, **you** must be in **active employment**. **Your** coverage is subject to payment of premium.

WHEN EVIDENCE OF INSURABILITY IS REQUIRED

Evidence of insurability is required if:

1. **you** are a late applicant, which means **you enroll** for coverage more than 31 days after the date **you** are eligible for coverage;
2. **you** voluntarily canceled **your** coverage and are reapplying.

An **evidence of insurability form** can be obtained from **your employer**.

REHIRE

If **you** are a former **employee** rehired within six months of the date **your** employment terminated, **your** previous service in an eligible class will apply toward the **waiting period** to determine **your** eligibility date. All other policy provisions apply.

IF YOU ARE ON A LEAVE OF ABSENCE AFTER YOUR COVERAGE BEGINS

If **you** are on a **leave of absence** written and approved by **your Employer**, and if premium is paid, **your** coverage may be continued beyond the date **you** are no longer in **active employment**, limited to the time periods described below.

If **you** are on a **leave of absence** as described under the Family and Medical Leave **Act** of 1993 ("FMLA") or applicable state family and medical leave **law** ("State FML"), and **your Employer's** Human Resource Policy provides for continuation of disability coverage during an FMLA or State FML **leave of absence**, **your** coverage will be continued until the end of the later of:

1. the leave period permitted by the federal Family and Medical Leave **Act** of 1993 and any amendments; or
2. the leave period permitted by applicable state **law**.

For the purpose of benefit determination should **you** become disabled while on an approved **leave of absence**, **your monthly earnings** will be based on **your** earnings prior to the date the **leave of absence** began.

If **you** are on a **leave of absence** other than an FMLA or State FML **leave of absence**, and if premium is paid, **your** coverage will be continued through the end of the month that immediately follows the month in which **your leave of absence** begins. If **you** are receiving paid sick leave through **your Employer**, coverage will continue for up to 12 months following the month in which the **leave of absence** begins.

If **you** are on a **leave of absence** for active military service as described under the Uniformed Services Employment and Reemployment Rights **Act** of 1994 (USERRA) and applicable state **law, your** coverage may be continued until the end of the later of:

1. the length of time the coverage may be continued under the Certificate of Coverage for an FMLA or State FML **leave of absence**; or
2. the length of time the coverage may be continued under the Certificate of Coverage for a **leave of absence** other than an FMLA or State FML **leave of absence**.

If **your Employer** has approved more than one type of **leave of absence** for **you** during any one period that **you** are not in **active employment**, **we** will consider such leaves to be concurrent for the purpose of determining how long **your** coverage may continue under the policy.

If **your** coverage is not continued during an FMLA or State FML **leave of absence**, and **you** return to **active employment** immediately following the end of **your** FMLA or State FML **leave of absence**, **your** coverage will be reinstated. **We** will not apply a new **waiting period**, require **evidence of insurability**, or apply a new **pre-existing condition** limitation.

If **your** coverage is not continued during a **leave of absence** for active military service, and **you** return to **active employment**, **your** coverage may be reinstated in accordance with USERRA and applicable state **law**.

In no event will **your** coverage under the policy be continued beyond the date **your** coverage would otherwise end according to the terms of the WHEN YOUR COVERAGE ENDS provision.

IF YOU ARE NOT IN ACTIVE EMPLOYMENT DUE TO A TEMPORARY LAYOFF OR LABOR STRIKE

If **you** are not in **active employment** due to a **temporary layoff**, and if premium is paid, **you** will be covered through the end of the month that immediately follows the month in which **your temporary layoff** begins.

If **you** are not in **active employment** due to a labor strike, and if premium is paid, **you** will be covered through the end of the month that immediately follows the month in which the labor strike begins.

WHEN YOUR COVERAGE ENDS

Your coverage under the policy ends on the earliest of:

1. the date the policy is canceled;
2. the date **your** eligible class is no longer covered;
3. the end of the **Policyholder's grace period,** if the **Policyholder** does not remit premium to **us** by the end of such period;
4. the end of the period for which **you** paid premiums, if **you** stop making a required premium contribution;
5. the last day **you** are in **active employment** except as provided under a covered **leave of absence, temporary layoff**, or labor strike; or
6. the date **you** are no longer in an eligible class.

We will provide coverage for a **payable claim** that occurs while **you** are covered under the policy.

CHANGES TO YOUR COVERAGE

Once **your** coverage begins, any increased or additional coverage will take effect on the latest of:

1. the effective date of the change, if **you** are:
    a. in **active employment**;
    b. on a **temporary layoff** or **leave of absence**; or
    c. working reduced hours, for reasons other than disability.
2. the date **we** approve your application, if **evidence of insurability** is required; or
3. the date **you** return to **active employment**, if **you** are not in **active employment** due to **injury** or **sickness**.

If **you** are not in **active employment** due to **injury** or **sickness**, any increased or additional coverage will begin on the date **you** return to **active employment**.

An increase in **your** long term disability coverage due to an amendment of the policy; or your enrollment in another plan option, may be subject to a **pre-existing condition** limitation as described in the policy. If the **pre-existing condition** limitation is applicable to the increase in coverage, **you** will be limited to the benefit **you** had on the day before the increase. An increase in coverage will not affect a **payable claim** that occurs prior to the increase. Any decrease in coverage will take effect immediately but will not affect a **payable claim** that occurs prior to the decrease.

SECTION IV - CONTINUITY OF COVERAGE

IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO LIFEMAP ASSURANCE COMPANY

If **you** are not in **active employment** due to **injury**, **sickness**, **leave of absence** or **temporary layoff** on the date **your Employer** changes insurance carriers to LifeMap Assurance Company and **you** were covered under the prior policy at the time this policy became effective, **we** will provide continuity of coverage under this policy. In order for this provision to apply, the prior policy's coverage must be similar to this policy.

If **you** are not in **active employment** due to **injury**, **sickness**, **leave of absence** or **temporary layoff** on the effective date of this policy, and **you** would otherwise be eligible to become insured under the policy, **we** will provide limited coverage under this policy. Coverage under this provision will begin on this policy's effective date and will continue until the earliest of:

1. the end of the month following the date **you** return to **active employment**; or
2. the end of any period of continuance or extension provided under the prior policy; or
3. the date coverage would otherwise end, according to the provisions of this policy.

Your coverage under this provision is subject to payment of premium.

Any benefits payable under this provision will be paid as if the prior policy had remained in force. **We** will reduce **your** payment by any amount for which the prior carrier is liable.

If coverage ends under this provision, or if **you** were not covered under **your Employer's** prior policy on the date that policy terminated, the WHEN COVERAGE BEGINS provision under this policy will apply.

This provision applies only to **employees** insured under a group long term disability policy through this **Employer** on the day before the effective date of this policy.

IF YOU HAVE A DISABILITY DUE TO A PRE-EXISTING CONDITION AFTER YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO LIFEMAP ASSURANCE COMPANY

We may make payment if **your** disability is caused by, contributed by or results from a **pre-existing condition** if:

1. **you** were insured by the prior policy at the time **your Employer** changed insurance carriers to LifeMap Assurance Company**;** and
2. **you** have been continuously covered under this policy from the effective date of **your Employer's** LifeMap Assurance Company policy through the date **your** disability began.

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

1. this policy; or
2. the prior policy, if benefits would have been paid had that policy remained in force.

If **you** satisfy the **pre-existing condition** provision of this policy, **we** will determine **your** payments according to this policy's provisions.

If **you** do not satisfy the **pre-existing condition** provision of this policy, but **you** do satisfy the prior policy's **pre-existing condition** provision:

1. **your monthly payment** will be the lesser of:
   a. the **monthly payment** that would have been payable under the terms of the prior policy if it had remained in force; or
   b. the **monthly payment** under this policy; and
2. benefits will end on the earlier of:
   a. the date benefits end under this policy, as described under the DURATION OF PAYMENTS provision; or
   b. the date benefits would have ended under the prior policy if it had remained in force.

If **you** do not satisfy either this policy's or the prior policy's **pre-existing condition** provision, **we** will not make any payments.

We will require proof that **you** were insured under the prior policy.

All other provisions of this policy will apply.

SECTION V - BENEFIT INFORMATION

DEFINITION OF DISABILITY

You are considered disabled when **we** review **your** claim and determine that, due to **your sickness** or **injury**:

1. **you** are unable to perform all the **material and substantial duties** of **your regular occupation**; and
2. **you** have a 20% or more loss in **your indexed monthly earnings**.

After 60 months of payments**, you** are considered disabled when **we** review **your** claim and determine that, due to **your sickness** or **injury**, **you** are unable to perform the duties of any **gainful occupation** for which **you** are reasonably qualified based on **your** training, education and experience.

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

You must be under the **appropriate care** of a **doctor** in order to be considered disabled.

We may require **you** to be examined by one or more **doctors**, other medical practitioners, or vocational experts 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. **Your** failure to comply with this request may result in denial or termination of benefits.

ACCUMULATION OF ELIMINATION PERIOD

You must be continuously disabled through **your** elimination period. **Your** elimination period is as stated in the SCHEDULE OF BENEFITS. It is the period of continuous disability **you** must satisfy before **you** are eligible to receive benefits under the policy.

If **you** return to work while satisfying **your** elimination period, **you** may satisfy **your** elimination period within the accumulation period. The accumulation period is as stated in the SCHEDULE OF BENEFITS.

The days that **you** are not disabled will not count toward **your** elimination period.

If **you** do not satisfy the elimination period within the accumulation period, a new period of disability will begin.

The elimination period and the accumulation period begin on the first day of **your** disability.

You do not have to experience a loss of earnings during the elimination period; however, once the elimination period has been satisfied, benefits are payable only if **you** have a 20% or more loss in **your indexed monthly earnings**.

Benefits for a **payable** claim begin the day after the elimination period is completed.

SATISFYING YOUR ELIMINATION PERIOD IF YOU ARE WORKING

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

WHEN YOU RECEIVE PAYMENTS

Benefits for a **payable claim** begin the day after the elimination period is completed. The elimination period is shown in the SCHEDULE OF BENEFITS. **You** will begin to receive payments when **we** approve **your** claim, providing the elimination period has been met and **you** are disabled. **We** will send **you** a **monthly payment** at the end of each month for any period for which **we** are liable.

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

AMOUNT OF PAYMENT

A. ***IF YOU ARE DISABLED AND NOT WORKING, OR DISABLED AND WORKING AND YOUR DISABILITY EARNINGS ARE LESS THAN 20% OF YOUR INDEXED MONTHLY EARNINGS***

We will follow this process to figure **your** payment:

1. Multiply **your monthly earnings** by 60%.
2. The **maximum benefit** is $5,000 per month.
3. Compare the answer from Item 1 with the **maximum benefit**. The lesser of these two amounts is **your gross monthly payment**.
4. Subtract from **your gross monthly payment** any **deductible sources of income**.

The amount figured in Item 4 is **your monthly payment**.

Your monthly payment will never be less than the minimum monthly benefit shown in the SCHEDULE OF BENEFITS.

B. IF YOU ARE DISABLED AND WORKING, AND YOUR DISABILITY EARNINGS ARE AT LEAST 20% BUT LESS THAN OR EQUAL TO 80% OF YOUR INDEXED MONTHLY EARNINGS

During the first 12 months of payments, the sum of **your gross monthly payment** plus **disability earnings** may be less than or equal to, but not more than, 100% of **your indexed monthly earnings.** If the sum exceeds 100% of **your indexed monthly earnings**, **we** will reduce **your** payment under the policy by the excess amount.

To determine whether the sum of **your gross monthly payment** plus **disability earnings** is less than or equal to or exceeds 100% of **your indexed monthly earnings**, **we** will follow this process:

1. Multiply **your monthly earnings** by 60%.
2. The **maximum benefit** is $5,000 per month.
3. Compare the answer from Item 1 with the **maximum benefit**. The lesser of these two amounts is **your gross monthly payment**.
4. Add **your disability earnings** to **your gross monthly payment**.

If the answer in Item 4 above is less than or equal to 100% of **your indexed monthly earnings**, **your monthly payment** will be **your gross monthly payment** minus any **deductible sources of income**.

If the answer in Item 4 above is greater than 100% of **your indexed monthly earnings**, **we** will follow this process to figure **your monthly payment**:

a. Add **your disability earnings** to **your gross monthly payment**.
b. From the answer in Item 1, subtract **your indexed monthly earnings**. If the result is zero or less, record **your** answer as zero.
c. From **your gross monthly payment**, subtract the answer in Item 2 and any **deductible sources of income**.

The amount figured in Item c is **your monthly payment**.

After 12 months of **monthly payments**, **you** will receive payments based on the percentage of income **you** are losing due to **your disability**. **We** will follow this process to determine **your monthly payment**:

1. Subtract **your disability earnings** from **your indexed monthly earnings**.
2. Divide the answer in Item 1 by **your indexed monthly earnings.** The result is **your** percentage of lost earnings.
3. From **your gross monthly payment**, subtract any **deductible sources of income**.
4. Multiply the answer in Item 2 by the answer in Item 3.

The answer in Item 4 is **your monthly payment**.

PROOF OF EARNINGS

We may require **you** to send proof of **your** monthly **disability earnings** each month. **We** will adjust **your** payment based on **your** monthly **disability earnings**.

As part of **your** proof of **disability earnings**, **we** can require that **you** send **us** appropriate financial records that **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 payment** for each day of disability.

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 **your indexed monthly earnings.**

We will not pay **you** for any month during which **your disability earnings** exceed the amount allowable under the policy. In no event will benefits be paid beyond the **maximum period of payment**.

WE WILL NEVER PAY MORE THAN 100% OF MONTHLY EARNINGS

If **you** are eligible to receive benefits under the policy in addition to the **monthly payment**, the total benefit payable to **you** on a monthly basis (including all benefits provided under the policy) will not exceed 100% of **your monthly earnings**; unless an excess amount is payable as a result of a Cost of Living Adjustment. However, if **you** are participating in a **vocational rehabilitation plan**, the total benefit payable to **you** on a monthly basis (including all benefits provided under this policy) will not exceed 110% of **your monthly earnings**; unless an excess amount is payable as a result of a Cost of Living Adjustment.

INCREASES IN THESE OTHER INCOME BENEFITS

After the first deduction for each of the other income benefits, **we** will not further reduce **your monthly payment** due to any cost of living increases payable under these other income benefits. This provision does not apply to increases received from any form of employment.

LUMP SUM PAYMENT

We will prorate other income benefits which are paid in a lump sum on a monthly basis over the time period for which the sum is given. If no time period is stated, the sum will be prorated on a monthly basis over **your** expected lifetime as determined by **us**.

COST OF LIVING ADJUSTMENT

We will make a Cost of Living Adjustment (COLA) after **you** have received one full year of **monthly payments**.

Your payment will increase by 3% of **your gross monthly payment** beginning on the first anniversary of payments and each following anniversary while **you** continue to receive payments for **your** disability.

Each month, **we** will add the Cost of Living Adjustment to **your monthly payment**. When **we** add the adjustment to **your** payment, the increase may cause **your** payment to exceed the **maximum benefit**.

DEDUCTIBLE SOURCES OF INCOME

The following are **deductible sources of income**:

1. The amount that **you** receive as disability income payments under any:
   a. state compulsory benefit **act** or **law**;
   b. military disability benefit plan;
   c. governmental retirement system as a result of **your** job with **your Employer**; or
   d. other group insurance policy.
2. The amount **you** receive as a result of any action brought under Title 46, United States Code Section 688 (The Jones Act).
3. The amount **you** receive under any **salary continuation** or **accumulated sick leave** plan.
4. The amount that **you**:
   a. receive as disability payments under **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.
   b. voluntarily elect to receive as retirement payments under **your Employer's retirement plan**. Retirement payments will be those benefits which 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.
   c. receive as retirement payments when **you** reach the later of age 62 or normal retirement age, as defined in **your Employer's retirement plan.**

   Regardless of how the retirement funds from the **retirement plan** are distributed, **we** will consider the **Employer** and **employee** 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 which affect the definition.
5. The amount that **you**, **your spouse**, and **your** children receive as disability payments because of **your**
   disability under:
   a. the United States Social Security **Act**;
   b. the Canada Pension Plan;
   c. the Quebec Pension Plan; or
   d. any similar plan or **Act**.
6. The amount that **you, your spouse**, and **your** children receive as retirement payments or the amount **your**
   spouse and **your** children receive as retirement payments because **you** are receiving retirement payments
   under:
   a. the United States Social Security **Act**;
   b. the Canada Pension Plan;
   c. the Quebec Pension Plan; or
   d. any similar plan or **Act**.
7. The amount **you** earn or receive from any form of employment.
8. The amount **you** receive from any unemployment compensation **law**.
9. The amount that **you** receive under:
   a. a workers' compensation **law**;
   b. an occupational disease **law**; or
   c. any other **act** or **law** with similar intent.

With the exception of retirement payments, **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.

IF YOU RECEIVE A COST OF LIVING INCREASE FROM DEDUCTIBLE SOURCES OF INCOME

Other than for increases in any income **you** earn from any form of employment, once **we** have subtracted any **deductible source of income** from **your gross monthly payment**, **we** will not further reduce **your** payment due to a cost of living increase from that source.

IF YOU RECEIVE A LUMP SUM PAYMENT FROM DEDUCTIBLE SOURCES OF INCOME

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, the sum will be pro-rated on a monthly basis from the date of the award over **your** expected lifetime as determined by **us**.

YOU MAY QUALIFY FOR DEDUCTIBLE SOURCES OF INCOME

When **we** determine that **you** may qualify for benefits for which **you** are eligible in the **deductible sources of income** section, **we** will estimate **your** entitlement to these benefits. **We** can reduce **your** benefit under the policy by the estimated amounts if such benefits:

1. have not been awarded or denied; or
2. have been denied and the denial is being appealed.

Your gross monthly payment will NOT be reduced by the estimated amount if **you**:

1. apply for the disability payments for which **you** are eligible in the **deductible sources of income** section and appeal **your** denial to all administrative levels **we** determine are necessary; and
2. sign **our** Agreement Concerning Benefits form. This form states that **you** promise to pay **us** any overpayment caused by an award and **we** shall be entitled to impose a constructive trust on any such award.

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

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

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, the sum will be pro-rated on a monthly basis from the date of the award over **your** expected lifetime as determined by **us**.

NON-DEDUCTIBLE SOURCES OF INCOME

We will not subtract from **your gross monthly payment** income **you** receive from, the following:

1. 401(k) plans;
2. profit sharing plans;
3. thrift plans;
4. tax sheltered annuities;
5. stock ownership plans;
6. credit disability insurance;
7. non-qualified plans of deferred compensation;
8. pension plans for partners;
9. military pension plans;
10. franchise disability income plans;
11. “no fault” motor vehicle plans;
12. individual disability plans paid by the **employee**;
13. a **retirement plan** from another employer;
14. individual retirement accounts (IRA).

If **salary continuation** or **accumulated sick leave** plan payments plus the **gross monthly payment** and **disability earnings** exceed 100% of **your monthly earnings**, **we** will subtract the amount in excess of 100% from **your monthly payment**.

MINIMUM MONTHLY BENEFIT

The minimum payment each month for a **payable claim** is the greater of:

1. $100; or
2. 10% of **your gross monthly payment**.

We may apply this amount to recover an outstanding overpayment.

DURATION OF PAYMENTS

We will send **you** a payment each month up to the **maximum period of payment**. **Your maximum period of payment** is stated in the SCHEDULE OF BENEFITS. It will be paid during a continuous period of disability, and will be based on **your** age at disability.

WAIVER OF PREMIUM

We do not require premium payment while **you** are receiving Long Term Disability payments under this policy.

WHEN PAYMENTS END

REGULAR OCCUPATION PERIOD is the period of time shown in the SCHEDULE OF BENEFITS that begins after the elimination period.

REGULAR OCCUPATION PERIOD:

60 Months

We will stop sending **you** payments and **your** claim will end on the earliest of the following:

1. the end of the **maximum period of payment**;
2. the date **you** are no longer disabled under the terms of the policy;
3. the date **you** fail to submit proof of continuing disability;
4. the date **you** die;
5. during the **regular occupation period** when **you** are able to return to work in **your regular occupation** on a part-time basis but **you** do not;
6. after the **regular occupation period**, when **you** are able to work in any **gainful occupation** on a part-time basis but **you** do not; or
7. the date **your disability earnings** exceed 80% of **your indexed monthly earnings.**

We will not pay a benefit for any period of disability during which **you** are incarcerated.

WHEN THE BENEFIT PERIOD IS EXTENDED

The **maximum period of payment** is shown in the SCHEDULE OF BENEFITS. However, benefits will be extended beyond the end of the **maximum period of payment** if **you** are disabled and have attained the age specified in the SCHEDULE OF BENEFITS and have not received twelve **monthly payments**. In this event, the **maximum period of payment** will be extended during the continuance of disability until twelve **monthly payments** have been paid.

RECURRENT DISABILITY

If **you** have a **recurrent disability**, and after **your** prior disability ended, **you** returned to work for **your employer** or any employer for 6 months or less, **we** will treat **your** disability as part of **your** prior claim. **You** do not have to complete another elimination period.

Your monthly payment will be based on **your monthly earnings** as of the date of **your** initial claim.

Your disability, as outlined above, will be subject to the same terms of this policy as **your** prior claim.

Your disability will be treated as a new claim if **your** current disability:

1. is unrelated to **your** prior disability; or
2. after **your** prior disability ended, **you** returned to work for **your Employer** for more than 6 consecutive months.

The new claim will be subject to all of the provisions of the policy and **you** will be required to satisfy a new elimination period.

If this policy terminates and **you** become eligible for payments under any other group disability plan that replaces this policy, **you** will not be eligible for payments under this policy.

VOCATIONAL REHABILITATION SERVICES

We have Vocational Rehabilitation Services available to assist **you** in returning to work to the extent of **your** ability. **We** will review **your** disability claim to determine whether **you** are eligible for these services, at **our** discretion. In order to be eligible for Vocational Rehabilitation Services and benefits, **you** must be medically able to participate in a return to work plan.

VOCATIONAL REHABILITATION PLAN means a written plan that a vocational rehabilitation professional, designated by **us**, prepares in accordance with the Vocational Rehabilitation Services provision of the policy.

Your claim file will be reviewed by a vocational rehabilitation professional to determine if rehabilitation services 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 plan.

We will make the final determination of **your** eligibility for these services.

If **we** determine that Vocational Rehabilitation Services are appropriate, **we** will provide **you** with a written **vocational rehabilitation plan** developed specifically for **you**, and agreed upon by **your doctor**.

The **vocational rehabilitation plan** may include, but is not limited to, the following services:

1. coordination with an employer to assist **you** to return to work;
2. evaluation of adaptive equipment or job accommodations to allow **you** to work;
3. evaluation of possible workplace modifications which might allow **you** to return to work in **your regular occupation** or another job or occupation;
4. vocational evaluation to determine how **your** disability may impact **your** employment options;
5. job placement services, including resume preparation services and training in job-seeking skills;
6. alternative treatment plans such as recommendations for support groups, physical therapy, occupational therapy, or other treatment designed to enhance **your** ability to work.

VOCATIONAL REHABILITATION BENEFIT

If **you** are receiving **monthly payments** under the policy; and **you** are participating in a **vocational rehabilitation plan**, **you** may be eligible for an additional Vocational Rehabilitation Benefit. **We** will pay an additional benefit of 10% of **your gross monthly payment** to a maximum of $1,000 per month.

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 Total Benefit Cap will apply.

WHEN VOCATIONAL REHABILITATION BENEFITS END

Vocational Rehabilitation Benefits will end on the earliest of the following dates:

1. the date **we** determine that **you** are no longer eligible to participate in a **vocational rehabilitation plan**;
2. the date **you** are no longer participating in a **vocational rehabilitation plan**; or
3. any other date on which **monthly payments** would stop in accordance with the policy.

BENEFITS IF YOU DIE - SURVIVOR BENEFIT

When **we** receive proof that **you** have died, **we** will pay **your eligible survivor** a lump sum benefit equal to three (3) times **your gross monthly payment** if, on the date of **your** death:

1. **your** disability had continued for 180 or more consecutive days; and
2. **you** were receiving or were entitled to receive payments under the policy.

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

However, **we** will first apply the Survivor Benefit to recover any overpayments that may exist on **your** claim.

ELIGIBLE SURVIVOR means **your spouse**, if living; otherwise, **your** children under age 26.

SECTION VI - EXCLUSIONS AND LIMITATIONS

DISABILITIES NOT COVERED UNDER THE POLICY

The policy does not cover any disabilities caused by, contributed to by, or resulting from **your**:

1. loss of professional license, occupational license, or certification;
2. participation in a felony;
3. intentionally self-inflicted injuries;
4. attempted suicide, regardless of mental capacity;
5. being legally intoxicated or being under the influence of any narcotic, unless the narcotic is taken under the direction of and as directed by a **doctor**;
6. participation in a war, declared or undeclared, or any act of war;
7. active military duty;
8. active participation in a riot;
9. engaging in any illegal or fraudulent occupation, work, or employment;
10. commission of a crime for which **you** have been convicted;
11. elective surgery except when required for **your appropriate care** as a result of **your injury** or **sickness**; or
12. traveling or flying on any aircraft operated by or under authority of military or any aircraft being used for experimental purposes.

PRE-EXISTING LIMITATIONS

Benefits will not be paid if **your** disability begins in the first 12 months following the effective date of **your** coverage; and **your** disability is caused by, contributed to by; or the result of a condition, whether or not that condition is diagnosed at all or is misdiagnosed, for which **you** received medical treatment, consultation, care or services, including diagnostic measures; or took or were prescribed drugs or medicines in the 3 months just prior to **your** effective date of coverage.

MENTAL ILLNESS LIMITATION

The **maximum period of payment** for disabilities due to **mental illness** is 24 months.

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; or disorders related to 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 a disability.

We will continue to send **you** payments beyond the 24 month period if **you** meet one or both of these conditions:

1. If **you** are confined to a **hospital, health facility or institution** at the end of the 24 month period, **we** will continue to send **you** payment(s) during **your** confinement.

   If **you** are still disabled when **you** are discharged, **we** will send **you** payment(s) for a recovery period of up to [90] days.

   If **you** become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, **we** will send payment(s) during that additional confinement and for one additional recovery period up to 90 more days.

2. In addition to Item 1, if **you** continue to be disabled after the 24 month period, and subsequently become confined to a **hospital, health facility or institution** for at least 14 days in a row, **we** will send payment(s) during the length of the reconfinement.

We will not make payments beyond the limited pay period as indicated above, or the **maximum period of payment**, whichever occurs first.

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

1. stroke;
2. trauma;
3. viral infection; or
4. Alzheimer's disease.

ALCOHOLISM OR DRUG ABUSE LIMITATION

The **maximum period of payment** for disabilities due to alcoholism or drug abuse is 24 months.

We will continue to send **you** payments beyond the 24 month period if **you** meet one or both of these conditions:

1. If **you** are confined to a **hospital, health facility or institution** at the end of the 24 month period, **we** will continue to send **you** payment(s) during **your** confinement.

   If **you** are still disabled when **you** are discharged, **we** will send **you** payment(s) for a recovery period of up to 90 days.

   If **you** become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, **we** will send payment(s) during that additional confinement and for one additional recovery period up to 90 more days.

2. In addition to Item 1, if **you** continue to be disabled after the 24 month period, and subsequently become confined to a **hospital, health facility or institution** for at least 14 days in a row, **we** will send payment(s) during the length of the reconfinement.

We will not make payments beyond the limited pay period as indicated above, or the **maximum period of payment**, whichever occurs first.

SECTION VII - CLAIM INFORMATION

NOTICE OF CLAIM

We encourage **you** to notify **us** of **your** claim as soon as possible so that a claim decision can be made in a timely manner. Written notice of a claim should be given to **us** within 30 days after the date **your** disability begins. The notice may be given to **us** at **our** home office or to **our** authorized agent. Failure to give notice within this timeframe shall not invalidate or reduce any **payable claim** if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

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.

FILING A CLAIM

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

PROOF OF YOUR CLAIM

You must send **us** written proof of **your** claim no later than 90 days after **your** elimination period. Failure to give such proof within this timeframe shall not invalidate or reduce any **payable** claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. Failure to give notice or file proof of loss as required does not bar recovery under the policy if the insurer fails to show it was prejudiced by the failure. **You** must provide proof of claim no later than 1 year after the time proof is otherwise required, except in the absence of legal capacity.

Your proof of claim, provided at **your** expense, must show:

1. that **you** are under the **appropriate care** of a **doctor**;
2. the date **your** disability began;
3. the cause of **your** disability;
4. the appropriate documentation of **your** earnings and **your** activities;
5. the extent of **your** disability, including restrictions and limitations preventing **you** from performing **your regular occupation**;
6. the name and address of any **hospital, health facility** or **institution** where **you** received treatment, including all attending **doctors**; and
7. documentation of prior disability coverage, if applicable.

In some cases, **you** will be required to give **us** authorization to obtain additional medical information, and to provide non-medical information as part of **your** proof of claim, or proof of continuing disability. **We** will deny **your** claim, or stop sending **you** payments, if the appropriate information is not submitted within 45 days of the request.

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

MAKING PAYMENTS

Once **your** claim has been approved, **we** will send **you** a **monthly payment** for any period for which **we** are liable.

OVERPAID CLAIMS

We have the right to recover any overpayments due to:

1. fraud;
2. any administrative error **we** make in processing a claim; or
3. **your** receipt of **deductible sources of income.**

You must reimburse **us** in full. **We** will determine the method by which the repayment is to be made.

We will not recover more money than the amount **we** paid **you**. However, **we** reserve the right to recover any prior or current overpayment from any past, current or new payable disability claim under the policy.

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**.

INSURANCE FRAUD

Any person who knowingly and with intent to defraud any insurance company; or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be subject to prosecution for insurance fraud.

We may terminate **your** coverage if **you** have filed a fraudulent claim or statement with **us**. **We** may terminate the group policy if the **Policyholder** or his administrator has filed or assisted with the filing of a fraudulent claim with **us**.

SECTION VIII - GENERAL PROVISIONS

CERTIFICATE OF COVERAGE

This Certificate of Coverage is a written statement prepared by **us** and may include attachments. It tells **you**:

1. the coverage to which **you** may be entitled;
2. to whom **we** will make a payment; and
3. the limitations, exclusions and requirements that apply within the policy.

CLERICAL ERROR

Clerical error or omission by **us** or **your Employer** will not:

1. prevent **you** from receiving coverage, if **you** are entitled to coverage under the terms of the policy; or
2. cause coverage to begin or continue for **you** when the coverage would not otherwise be effective.

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

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

MISSTATEMENT OF AGE

If premiums applicable to **you** are based on age and **you** have misstated **your** age, there will be a fair adjustment of premiums based on **your** true age. If the benefits applicable to **you** are based on age and **you** have misstated **your** age, there will be an adjustment of said benefits based on **your** true age. **We** may require satisfactory proof of **your** age before paying any claim.

NOTE: A refund will not be made for a period more than 12 months before the date **we** are advised of the error.

TIME LIMIT ON CERTAIN DEFENSES

Except in the case of fraud, no statement made by **you** relating to **your** insurability will be used to **contest** the insurance for which the statement was made after the coverage has been in force for two years.

Beyond the periods stated in the PRE-EXISTING CONDITION LIMITATION provision, no claim for disability with respect to which the claim is made, shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of disability, had existed prior to the effective date of the coverage.

STATEMENTS MADE IN AN APPLICATION FOR COVERAGE

We consider any statements **you** or **your Employer** make in an application representations and not warranties. No statement made by **you** will be used to reduce or deny any claim or to cancel **your** coverage unless:

1. the statement is in writing and signed by **you**; and
2. a copy of that statement is given to **you** or **your** beneficiary.

AGENCY

For purposes of the policy, the **Employer** acts on its own behalf or as **your** agent. Under no circumstances will the **Employer** be deemed **our** agent.

ENTIRE CONTRACT AND CHANGES

This certificate is furnished in accordance with and subject to the terms of the policy. The entire contract consists of the policy; which includes the application, and any attached papers; this certificate; and any riders or endorsements. No change in the policy will be effective until approved by one of **our** officers. This approval can only be in writing. It must be noted on or attached to the policy. No insurance producer has authority to change the policy or certificate or to waive any of their provisions.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE

The policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

CLAIMS APPEAL PROCESS

You will be given written notice if a claim is denied in whole or in part. If you are not satisfied with the decision, you, or your authorized representative, may submit a written appeal request to us for reconsideration. This must be received by our office within 180 days after you receive the claim denial. No special form is required. We will provide a full and fair review of your claim by individuals associated with us but who were not involved in making the initial denial of your claim. You may provide us with additional information that relates to your claim and you may request copies of non-confidential information that we have that pertains to your claim. We will notify you of our decision in writing within 45 days of receiving your appeal. If we determine that an extension of time for processing and determining your appeal is required, written notice of the extension shall be provided to you prior to the termination of the 45-day period. An extension will not exceed an additional period of 45 days provided, however, that if we request additional information from you pertaining to the appeal, our deadline for providing notice of our decision will be extended by the amount of time it takes for you to provide this additional information.

Notice of Protection Provided by
Utah Life and Health Insurance Guaranty Association

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

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

The basic protections provided by the Association are:

Life Insurance
- $500,000 in death benefits
- $200,000 in cash surrender or withdrawal values

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

Annuities
- $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

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. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 31A, Chapter 28.

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

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

Utah Life and Health Insurance Guaranty Assoc.
60 East South Temple, Suite 500
Salt Lake City UT 84111
(801) 320-9955

Utah Insurance Department
3110 State Office Building
Salt Lake City UT 84114-6901
(801) 538-3800

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.