



**Renaissance**<sup>®</sup>

Life & Health Insurance Company of America

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**GROUP SHORT TERM DISABILITY INSURANCE  
CERTIFICATE OF COVERAGE**

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**Policyholder:** ABC COMPANY  
**Policy Number:** MP0000000000/ 000000  
**Policy Effective Date:** January 1, 2024

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Renaissance Life & Health Insurance Company of America (referred to as "we," "us," or "our") welcomes your Employer as a Policyholder. "You" and "your" as used in this Certificate of Coverage ("Certificate") means an Employee who is eligible for coverage under the Policy.

This is your Certificate as long as you are eligible for coverage and you become insured. We certify that you are insured for the benefits described in this Certificate, subject to the provisions and requirements detailed in this Certificate. THIS CERTIFICATE MAY CONTAIN EXCLUSIONS, LIMITATIONS, REDUCTIONS IN COVERAGE, AND TERMINATION PROVISIONS. PLEASE READ YOUR CERTIFICATE CAREFULLY AND KEEP IT IN A SAFE PLACE.

We have written the Certificate in plain English. There are a few terms and provisions written as required by insurance law. If you have any questions about any of the terms and provisions, please contact us at the toll-free telephone number included above. We will assist you in understanding your benefits.

If the terms and provisions of the Certificate (issued to you) differ from the Policy (issued to the Policyholder), the Policy will govern. Contact the Policyholder if you wish to inspect a copy of the Policy. Your coverage may be canceled or changed 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 Texas and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. The Texas Department of Insurance may be reached at (512) 676-6000. The Policy and this Certificate have been approved under the authority of the Interstate Insurance Product Regulation Commission and issued under the Commission standards. Any provision of the Policy or Certificate that on the provision's effective date is in conflict with Interstate Insurance Product Regulation Commission standards for group disability income insurance in effect on the date of the Commission's approval of the Policy and Certificate is hereby amended to conform to such standards as of the provision's effective date.

For purposes of effective dates and ending dates under the Policy, all days begin at 12:01 A.M. and end at 12:00 midnight, local time, at the Policyholder's place of business in the state where the Policy is issued.

## ABOUT YOUR COVERAGE

Like other disability income coverages, this Plan provides a benefit which replaces a portion of the income you lose if you are out of work due to Sickness or Injury.

We believe the similarities end there.

That's because our Plan gives you more. Besides providing a partial income replacement benefit, our Plan also emphasizes helping you make a successful re-entry into the work force.

Our philosophy is rooted in some key beliefs that have emerged from our experience:

- Most people want to return to work.
- Work itself often plays a valuable therapeutic role in the recovery process.
- Impairments in work capabilities can often be accommodated with special equipment.

Re-employment most often holds the key to a higher standard of living and a better quality of life.

By working with the key people in your life and building on your abilities, we hope to promote results that work for everyone: you, your family, your Employer, and your co-workers.

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## SECTION 1: PLAN HIGHLIGHTS - STD

This is a brief overview of your Short Term Disability (“STD”) benefits. These benefits and other important information about your coverage are described further in the Certificate. We have tried to make the language and format of the Certificate easy to understand. Defined terms and provision titles such as those below are italicized and have initial letters capitalized when used throughout the Certificate.

**Plan Effective Date:** January 1, 2024

**Eligible Class:** Class 3: All Full Time Eligible Employees  
You must be working at least 30 hours per week.

**Benefit Percentage:** 60%

**Maximum Weekly Benefit:** \$3,000\*

\*We will reduce the amount we pay you by Other Income Amounts, as defined in the provision titled WHAT ARE OTHER INCOME AMOUNTS? in Section 4, SHORT TERM DISABILITY BENEFIT SPECIFICS.

**Minimum Weekly Benefit:** \$25

We may apply all payments we owe you toward any outstanding overpayment balances under the Policy.

**Elimination Period:** If Disability is due to an Injury: 14 days.  
If Disability is due to a Sickness: 14 days.

**Maximum Payment Duration:** 11 weeks

**Non-Occupational STD Coverage:** See the provision titled WHEN WILL WE NOT COVER A DISABILITY? in Section 4, SHORT TERM DISABILITY BENEFIT SPECIFICS, for STD exclusions and limitations.

**Pre-existing Conditions Provision:** None

**Waiting Period:**

- If you are in an Eligible Class on or before the Plan Effective Date: None.
- If you are entering an Eligible Class after the Plan Effective Date: 30 days.

**Individual Effective Date:** The first day of the month following completion of the Waiting Period, if applicable.

**Cost of Coverage:**

- The Employer pays the cost of your coverage.

The cost of your coverage must be paid for any period of time during which you are Disabled under this Plan.

For your STD coverage, **Pre-disability Earnings** is defined as shown below:

If you are a partner, **Pre-disability Earnings** means your average weekly earnings as figured:

- From the line showing “self-employment earnings (loss)” from the partner’s Schedule K-1 (Form 1065) of the partnership’s federal income tax return for the two calendar years just prior to the date Disability begins; or
- If you have not been a partner during the two calendar years for which the most recent partnership federal income tax return was filed, then your average weekly earnings will be figured for the employment period during which you have been a partner.

If you are a sole proprietor, **Pre-disability Earnings** means your weekly net profit averaged over:

- The two most recent years; or
- The period you have been a sole proprietor, if you have been a sole proprietor for less than two years.

Annual net profit is figured from Form 1040 Schedule C as the gross income less all deducted expenses (other than depreciation).

If you are a shareholder of a Subchapter S corporation, **Pre-disability Earnings** means your average weekly income from the Employer in effect just prior to the date Disability begins. It includes income from Schedule K-1 (Ordinary business income (loss)), and your W-2 from the S Corporation just prior to the date Disability begins.

Weekly income for K-1 and W-2 income will be averaged over the lesser of:

- The two most recent years; or
- The period of your employment with the Employer if you have been employed for less than two years.

Your W-2 income will include the amount of salary you elected to defer as part of a deferred compensation plan. The deferred compensation plan is defined by a documented, pre-determined formula, as shown on your W-2, and other salary reductions you have agreed to for purposes of funding Employee contributions toward the cost of coverage under employee welfare benefit plans sponsored by the Employer.

If you are a shareholder of a C-Corporation, **Pre-disability Earnings** means your average weekly earnings as figured:

- From the W-2 form (from the box which reflects wages, tips and other compensation) received from the Employer for the two calendar years just prior to the date Disability begins; or
- For the period you were a shareholder, if you have been a shareholder for less than two calendar years.

Your W-2 income will include the amount of salary you elected to defer as part of a deferred compensation plan. The deferred compensation plan is defined by a documented, pre-determined formula, as shown on your W-2, and other salary reductions you have agreed to for purposes of funding Employee contributions toward the cost of coverage under employee welfare benefit plans sponsored by the Employer.

For all other Employees, **Pre-disability Earnings** means your gross weekly rate of earnings from the Employer just prior to the date Disability begins. It does not include commissions, bonuses, overtime, and other extra compensation.

If your Disability begins while you are on a covered Layoff or Leave of Absence, we will use your Pre-disability Earnings from the Employer in effect just before the date your absence begins.

Our payments to you will be based on the amount of your Covered Pre-disability Earnings ; premium payments must be based on the correct definition of Pre-disability Earnings.

## **SECTION 2: GENERAL INFORMATION**

### **WHAT IS THE CERTIFICATE OF COVERAGE?**

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

- The coverage to which you may be entitled;
- To whom we make payments; and
- The limitations, exclusions, and requirements applying to the Plan.

It is the responsibility of the Policyholder to distribute the appropriate Certificate and any updates or other notices from us to each insured individual.

### **TO WHAT INFORMATION DO WE HAVE ACCESS?**

The Employer will give us information about you including:

- If you are eligible for coverage;
- If your amount of coverage changes, including salary change information;
- If your coverage terminates; and
- Other information we may reasonably require.

The Employer's records that we believe have a bearing on coverage under the Plan(s) are open for our inspection at any reasonable time.

Clerical error or omission by the Employer, you, or us will not:

- Terminate coverage which should otherwise be in effect;
- Continue coverage which should otherwise terminate;
- Create coverage which should not be in effect; or
- Change the amount of coverage that should otherwise be in effect.

#### **WHAT IS THE INCONTESTABILITY PERIOD FOR YOUR COVERAGE?**

Any statement you or the Employer makes to obtain coverage or an increase in coverage is a representation and not a warranty. No misrepresentation by you or the Employer will be used to reduce or deny a claim or to deny the validity of your coverage or an increase in coverage unless:

- The misrepresentation is material to the risk accepted;
- our coverage or increase in coverage would not have been approved if the truth had been known;
- Your misrepresentation is contained in a written instrument signed by you; and
- You or your beneficiary, if applicable, have been given a copy of the written instrument containing your misrepresentation.

After your coverage or increase in coverage under the Policy has been in effect for two continuous years during your lifetime, we will not use a misrepresentation by you or by the Employer to:

- Reduce or deny a claim; or
- Deny the validity of your coverage or increase in coverage;

unless it was a fraudulent misrepresentation made with actual intent to deceive, where permitted by applicable law in the state of where the Policy was issued.

However, we have the right at any time to assert as a defense to a claim that you were not eligible to become covered because you did not meet the eligibility requirements in this Certificate, including, but not limited to, the requirements that you: (1) be in an Eligible Class; (2) submit and have approved Evidence of Insurability, if required; and (3) meet the Active Employment requirement.

#### **WHAT CONSTITUTES THE ENTIRE CONTRACT?**

Coverage is provided for eligible Employees under a contract of group insurance between the Policyholder and us. The contract consists of:

- All Policy provisions and any amendments and/or attachments issued;
- The Policyholder's application;
- Employees' signed Evidence of Insurability forms, if any; and
- The Certificate of Coverage.

#### **HOW WILL WE HANDLE INSURANCE FRAUD?**

We promise to focus on all means necessary to support fraud detection, investigation, and prosecution. It is a crime if you or the Employer knowingly, and with intent to injure, defraud or deceive us, file a claim containing any false, incomplete or misleading information. These actions, as well as submission of false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

#### **WHAT IF YOUR AGE OR OTHER DATA IS MISSTATED?**

If your age or other data on you is misstated, we have the right to make an equitable adjustment in the premium or coverage due for you. The true facts will be used to determine if and for what amount coverage should have been provided for you.

**DOES THE EMPLOYER ACT AS YOUR AGENT?**

For all purposes of the Policy, the Employer acts on its own behalf or as your agent. The Employer is not our agent.

**WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?**

You can start legal action regarding your claim 60 days after the date you sent us proof of claim. No action can be brought after the applicable statute of limitations has expired, but in any case, not more than three years after the date of your loss.

**DOES THIS PLAN REPLACE OR AFFECT ANY REQUIREMENT FOR WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?**

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

**SECTION 3: ELIGIBILITY FOR COVERAGE**

**WHEN ARE YOU ELIGIBLE FOR COVERAGE?**

If you are in an Eligible Class, you are eligible for coverage under a Plan on the later of:

- The Plan Effective Date; or
- The date you complete the Waiting Period.

**WHEN DOES YOUR COVERAGE BECOME EFFECTIVE?**

Your coverage will be effective on the date determined as follows:

If you are not required to contribute toward the cost of your coverage: Coverage starts on the 1st day of the month coinciding with or next following the date you have satisfied the Waiting Period.

If you are required to contribute toward the cost of your coverage: Coverage starts on the later of the date you have:

- Applied for coverage and authorized the required payroll deduction for the cost of your coverage;
- Submitted satisfactory Evidence of Insurability which we have approved; and
- Satisfied the Waiting Period.

If you apply for coverage more than 31 days after the date you are first eligible to apply, satisfactory Evidence of Insurability will be required before your coverage will become effective.

**WHEN IS EVIDENCE OF INSURABILITY REQUIRED?**

You will need to provide Evidence of Insurability to us with your application if you:

- Apply for coverage more than 31 days after the date you are first eligible to apply or if required during an Enrollment Period; or
- Voluntarily terminate your coverage and want to reapply for coverage.

You must apply for coverage in writing through the Employer and use an application form that is satisfactory to us. Coverage for amounts of insurance subject to such Evidence of Insurability will become effective on the 1st day of the month coinciding with or next following the date we approve your Evidence of Insurability.

**WHEN CAN YOUR COVERAGE UNDER THIS PLAN CHANGE?**

For changes in the Plan, your Pre-disability Earnings, or your class - Coverage changes become effective on the later of:

- The date of the change; or
- The first of the month coinciding with or next following the date we approve your Evidence of Insurability, if you are required to provide it.

Increases in coverage due to changes in the Plan or your class are also subject to the terms of the Active Employment and Pre-existing Conditions provisions. Increases in coverage due to changes in your Pre-disability Earnings are subject to the terms of the Active Employment provision.

**WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT ON THE DATE YOUR COVERAGE WOULD BE EFFECTIVE?**

If you are not in Active Employment as a result of your Sickness or Injury, then your coverage will be effective on the date you return to Active Employment. This applies to your initial coverage, as well as any increases or additions to coverage occurring after your initial coverage is effective.

**WHEN DOES YOUR COVERAGE UNDER THIS PLAN END?**

Your coverage under this Plan will end on the earliest of the following:

- The date the Policy or Plan terminates;
- The date you are no longer in an Eligible Class;
- The date your class is no longer eligible for coverage;
- The last day for which premium for your coverage has been paid;
- The date you cease Active Employment due to a labor dispute, including but not limited to strike, work slowdown, or lockout; or
- The date you cease Active Employment with the Employer, unless you are Disabled or on a Layoff or Leave of Absence;
- The first day of the month coinciding with or next following the date you enter military service (not including Reserve or National Guard).

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

**WILL YOUR COVERAGE CONTINUE IF YOU ARE ON A LAY-OFF OR LEAVE OF ABSENCE?**

Your Employer may continue your coverage if you are on a Layoff or Leave of Absence. Your coverage may continue through the end of the month following the month in which your Layoff or Leave of Absence begins. The cost of your coverage must be paid during the Layoff or Leave of Absence period. If you return to Active Employment at the end of the Layoff or Leave of Absence, your coverage will continue under the Policy. If you do not return to Active Employment at the end of the Layoff or Leave of Absence, your coverage will end in accordance with WHEN DOES YOUR COVERAGE UNDER THIS PLAN END? provision.

**WHAT IF YOU ARE REHIRED BY THE EMPLOYER WITHIN THE SAME PLAN YEAR DURING WHICH YOUR EMPLOYMENT TERMINATED?**

If you are rehired by the Employer within the same Plan Year that your employment terminated, then:

- You will be insured for the same benefits and class of coverage that were in effect for you on the date your employment terminated; and
- You may not change the plan of benefits or class of coverage during the rest of the Plan Year.

**WHAT HAPPENS TO YOUR COVERAGE IF YOU ARE ON A FAMILY OR MEDICAL LEAVE OF ABSENCE?**

If you are on a Family or Medical Leave of Absence, your coverage will be governed by the Employer's Human Resource policy on Family or Medical Leaves of Absence.

We will continue your coverage if the following conditions are met:

- Premiums for the cost of your continued coverage are paid; and
- Your leave is approved in advance and in writing by the Employer.

Your coverage will continue for up to the greater of:

- The leave period required by the federal Family and Medical Leave Act of 1993, and any amendments; or
- The leave period required by applicable state law.

While you are on an approved Family or Medical Leave of Absence, we will use earnings from your Regular Occupation you were performing just prior to the date your Leave of Absence started to determine our payments to you.



If you return to Active Employment at the end of the approved Family or Medical Leave of Absence, your coverage will continue under the Policy. If you do not return to Active Employment at the end of the Family or Medical Leave of Absence, your coverage will end in accordance with WHEN DOES YOUR COVERAGE UNDER THIS PLAN END? provision.

If your coverage does not continue during a Family or Medical Leave of Absence, then when you return to Active Employment:

- You will not have to meet a new Waiting Period, including a Waiting Period for coverage of a Pre-existing Condition; and
- You will not have to give us Evidence of Insurability to reinstate the coverage you had in effect before your leave began.

#### **WHAT HAPPENS TO YOUR COVERAGE IF YOU ARE ON A MILITARY SERVICES LEAVE OF ABSENCE?**

We will allow your coverage to continue, for up to 4 weeks in a 12 month period, if you enter the military service of the United States. While you are on a Military Services Leave of Absence, the premium must be paid according to the terms specified in the Policy to keep the insurance in force. Changes such as revisions to coverage because of age, class, or salary changes will apply during the leave except that increases in amount of insurance, whether automatic or subject to election, are not effective for you until you have returned to work from Military Services Leave of Absence for one full day.

All other terms and conditions of the Policy will remain in force during this continuation period. Your continued coverage will cease on the earliest of the following dates:

- The date the Policy terminates; or
- The date ending the last period for which any required premium was paid; or
- 4 weeks from the date your continued coverage began.

The Plan, however, does not cover any loss which occurs while on active duty in the military service if such loss is caused by or arises out of such military service, including but not limited to war or act of war (whether declared or undeclared). Benefits are also subject to any other exclusions listed in the WHEN WILL WE NOT COVER A DISABILITY? provisions in Section 4.

If you return to Active Employment at the end of the Military Services Leave of Absence, your coverage will continue under the Policy. If you do not return to Active Employment at the end of the Military Services Leave of Absence, your coverage will end in accordance with WHEN DOES YOUR COVERAGE UNDER THIS PLAN END? provision.

## **SECTION 4: SHORT TERM DISABILITY BENEFIT SPECIFICS**

### **WHAT DOES DISABILITY MEAN?**

**Disability or Disabled** means our determination that your Sickness or Injury:

- Prevents you from performing with reasonable continuity one or more of the Material and Substantial Duties of your Own Job; and
- As a result, the income you are able to earn is less than or equal to 80% of your Pre-disability Earnings.

#### Related Rules:

We will not consider you Disabled from work in an occupation because of a reduction in your earnings if such reduction results from a change in economic conditions or other factors not directly related to your Sickness or Injury. Examples of factors that we will not consider in determining whether you are Disabled include, but are not limited to, recession, job obsolescence, job restructuring or elimination, pay cuts, and job sharing.

We will not consider you Disabled from work in an occupation solely because of:

- Your Employer's work schedule that is inconsistent with the normal work schedule of your Regular Occupation;
- Issues in your relationship with your Employer or other employees of the Employer; or

- The physical relationship of your Employer's workplace that is inconsistent with the normal physical environment of your Regular Occupation.

We will not consider you Disabled from work in an occupation solely because of the loss, suspension, restriction, surrender, or failure to maintain a required state or federal license to engage in the occupation.

We will not consider you Disabled from work in an occupation solely because of your inability to work more than 40 hours per week in the occupation, even if you were regularly required to work more than 40 hours per week prior to becoming Disabled.

Your Disability must begin while you are covered under the Plan. Your loss of earnings must be as a result of or due to the same Sickness or Injury for which you are Disabled.

**DOES YOUR DISABILITY NEED TO CONTINUE FOR A PERIOD OF TIME BEFORE OUR PAYMENTS TO YOU BEGIN?**

Your Disability must continue through the Elimination Period before STD Benefits become payable.

**WHAT HAPPENS IF YOU RETURN TO WORK DURING THE ELIMINATION PERIOD?**

We will consider your Disability continuous if you have one or more periods of Temporary Recovery during the Elimination Period for a maximum of 14 days and become Disabled again due to the same Sickness or Injury.

**DO YOU NEED TO BE UNDER THE CARE OF A DOCTOR?**

We require you to be under the Regular Care of a Doctor for the Sickness or Injury causing your Disability in order to be eligible to receive payments from us.

**MAY WE REQUIRE THAT INDIVIDUALS OTHER THAN THE DOCTOR PROVIDING YOUR REGULAR CARE EXAMINE OR INTERVIEW YOU?**

We may require you to be examined by Doctor(s), other medical practitioner(s) or vocational expert(s) of our choice. Such examinations may include vocational testing and evaluations, or any other type of testing and evaluations we determine necessary to administer the terms and conditions of the Plan. We will pay for this examination. We can require an examination as often as it is reasonable to do so. In addition, we may require an interview with you by one of our authorized representatives.

**WHEN WILL WE NOT COVER A DISABILITY?**

We will not cover a Disability if it is due to:

- War, declared or not, or any act of war;
- Intentionally self-inflicted injuries or illness, while sane or insane;
- Your active participation in a riot;
- Your attempt to commit or your commission of a felony under federal or state law, or your being engaged in an illegal occupation or activity;
- An Injury arising out of, or in the course of, any work for wage or profit;
- A Sickness for which you are entitled to benefits under any Workers' Compensation law, unless you are a partner or sole proprietor not covered by this law;
- Active duty in the armed forces, military reserves or National Guard of any country or international authority, or in a civilian unit serving with such forces;
- Cosmetic or reconstructive surgery, except for complications arising from any such surgery, reconstructive surgery arising from congenital disease or anomaly resulting in a functional defect, or surgery necessary to correct a deformity caused by Sickness or Injury or arising from trauma, infection or other diseases of the involved part;
- An accident resulting from or caused by your operation of a motor vehicle while legally intoxicated according to the laws of the jurisdiction where the accident occurred; or
- An accident resulting from or caused by your voluntarily being under the influence of narcotics or any controlled substance, subject to the applicable laws in the state where the policy is issued for delivery, unless taken as prescribed by your Doctor.

No benefits are payable for any period of Disability during which you are legally incarcerated in a penal or correctional facility for a period of 30 or more consecutive days or for which you are not under the Regular Care of a Doctor.

If your professional or occupational license or your certification is suspended, revoked or surrendered, loss of your license or certification, by itself, does not mean you are Disabled.

#### **HOW DO I CALCULATE MY STD BENEFIT?**

Your STD Benefit will be equal to your NetGross Weekly Benefit, as determined below:

- Step 1: Multiply your Pre-disability Earnings by the Benefit Percentage, with the result not to exceed the Maximum Weekly Benefit. This is your Gross Weekly Benefit.
- Step 2: Subtract from your Gross Weekly Benefit your Other Income Amounts. This is the Net Weekly Benefit, but will not be less than the Minimum Weekly Benefit.

**TOTAL DISABILITY BENEFIT:** If you are working while Disabled and earning less than 20% of your Pre-disability Earnings, then the Other Income Amounts that we use to reduce your benefit will not include any of your Work Earnings.

**WORK INCENTIVE BENEFIT:** If you are working while Disabled and earning 20% or more of your Pre-disability Earnings, then the Other Income Amounts that we use to reduce your benefit will include Work Earnings only if your Gross Weekly Benefit and your Work Earnings exceed 100% of your Pre-disability Earnings.

#### **WHAT IF YOUR WORK EARNINGS FLUCTUATE?**

If your Work Earnings fluctuate, we may average amounts over a four (4) consecutive week period of time.

#### **WHAT IF YOU ARE DISABLED FOR ONLY PART OF A WEEK?**

Your weekly benefit from us is pro-rated. This means that if you are Disabled for only part of a week, you will receive a payment equal to 1/7th of a full weekly benefit for each day of the week you are Disabled.

#### **WHAT ARE OTHER INCOME AMOUNTS?**

These are weekly amounts, other than payments you are receiving from us, that include:

- Any benefits and awards, other than medical or death benefits, you receive or are eligible to receive under:
  - Workers' Compensation law;
  - Occupational disease or injury law; or
  - Any other similar federal or state act or law.
- Any disability income benefits you receive or are eligible to receive under:
  - Any governmental compulsory benefit act or law;
  - Any other group insurance plan with the Employer or with an association to the extent that such plan covers the same pre-disability income;
  - Any other group insurance plan with another employer, which you become insured under while you are Disabled under this Plan; or
  - Any governmental retirement system as a result of your job with the Employer.
- Any benefits under the United States Social Security Act, The Canada Pension Plan, The Quebec Pension Plan and includes any similar plan or act. Benefits include:
  - Disability benefits you, your Spouse, or your Children receive or are eligible to receive as a result of your Disability; or
  - Retirement benefits you, your Spouse or your Children receive because of your receipt of retirement benefits.

If your Disability begins after your 70th birthday, and you were receiving Social Security retirement benefits before your Disability began, then we will not reduce our payments to you by these retirement benefits.

- Any payments you receive from the Employer as part of a termination or severance agreement.

- Any benefits you receive from the Employer's sick leave or formal salary continuation plan.
- Any benefits you receive from the Employer's Personal Time Off (PTO) plan which, when added to the amount of your Gross Weekly Benefit, exceeds 100% of your Pre-disability Earnings.
- Any Work Earnings.
- Any benefits from the Employer's Retirement Plan you:
  - Receive as disability benefits;
  - Voluntarily choose to receive as retirement benefits; or
  - Receive as retirement benefits once you reach the greater of age 62 or normal retirement age (as defined in the Employer's Retirement Plan).
- Any benefits for loss of time or lost wages you receive from an automobile liability insurance policy or the mandatory portion of a no-fault motor vehicle insurance plan.
- Any amounts you receive under any unemployment compensation law.
- Any amounts related to lost income you receive from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise for a Disability caused or contributed to by an act or omission of the third party.

If the amount received from a third party does not specify the amount due to lost income, we will estimate the amount using a percentage of the amount received based on your Pre-disability Earnings, prorated to cover the period for which the judgment or settlement was made.

If you receive any of the Other Income Amounts in a lump sum payment, we will pro-rate the lump sum on a weekly 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 weekly basis according to its nature and purpose, but not beyond the end of your Maximum Payment Duration.

Other Income Amounts must be payable as a result of the same period of Disability as the one for which you are receiving a payment from us, except for retirement benefits and Work Earnings.

#### **WHAT IF SUBTRACTING OTHER INCOME AMOUNTS RESULTS IN A ZERO PAYMENT TO YOU?**

We will pay you a Minimum Weekly Benefit under this Plan, subject to any overpayments.

#### **DO WE HAVE THE RIGHT TO ESTIMATE OTHER INCOME AMOUNTS?**

We have the right to estimate the amount of disability benefits you may be eligible to receive under the first three bulleted items in the WHAT ARE OTHER INCOME AMOUNTS? provision. We can reduce our payments to you by this estimated amount if:

- You have not been awarded such benefits but have not been denied such benefits; or
- You have been denied such benefits and the denial is being appealed; or
- You are reapplying for such benefits.

We will not reduce our payments to you by these estimated amounts if:

- You apply (or reapply) for benefits and appeal your denial through all of the administrative levels we believe are necessary; and
- You sign our payment option form stating you will reimburse us any overpayment of benefits caused by an award.

If we reduce our payments to you by an estimated amount:

- Then we will adjust our payments to you when you give us proof of the amount awarded; or
- We will give you a lump sum refund of the estimated amount if you were denied benefits and have completed all appeals (or reapplications) we believe are necessary.

#### **ARE YOU REQUIRED TO APPLY FOR OTHER INCOME AMOUNTS?**

We will require you to apply for any Other Income Amounts that you may be eligible for as a result of the same period of Disability as the one you are claiming benefits for under this Plan. We may also require that you appeal a denial of your claim for these Other Income Amounts.

#### **ARE YOU REQUIRED TO APPLY FOR SOCIAL SECURITY DISABILITY BENEFITS?**

We will require you to apply for Disability benefits that may be available to you under the Social Security Act. If we disagree with the Social Security Administration's denial of your application, you will be required to follow the process set up by that agency to reconsider denials, and to continue in that process to the highest level of appeals. If denied again, you will be required to request a hearing. We will provide you with assistance in preparing for this hearing.

#### **WHAT ARE NOT OTHER INCOME AMOUNTS?**

We will not subtract from our payments to you any amounts you receive from the following:

- 401(k) plans;
- Profit sharing plans;
- Thrift plans;
- Tax sheltered annuities;
- Stock ownership plans;
- Credit disability insurance;
- Non-qualified plans of deferred compensation;
- Pension plans for partners;
- Military pension and military disability income plans;
- Disability benefits from the Veteran's Administration;
- A Retirement Plan from another employer;
- Individual retirement accounts (IRA);
- Informal salary continuation plan;
- Benefits from individual disability plans.

#### **WHAT HAPPENS IF YOU RECEIVE A COST OF LIVING INCREASE TO ANY OF THE OTHER INCOME AMOUNTS?**

Other than for increases in Work Earnings, once we have subtracted an Other Income Amount from your Gross STD Benefit, we will not reduce our payments to you due to a cost of living increase in that Other Income Amount.

#### **WHEN WILL OUR PAYMENTS TO YOU STOP?**

We will stop STD Benefit payments on the earliest of the following dates:

- The date you are no longer Disabled according to this Plan;
- The date you reach the end of the Maximum Payment Duration;
- The date your Work Earnings exceed 80% of your Pre-disability Earnings. If your Work Earnings fluctuate, we may average amounts over a four (4) consecutive week period of time instead of stopping our payments on the date your Work Earnings reach the earnings limit;
- The date you die;
- The date you fail to provide proof of continuing Disability;
- The date you cease to be under the Regular Care of a Doctor, or refuse to undergo, at our expense, an examination or testing by a Doctor or vocational, rehabilitation, or health assessment testing when we require such examination or testing;
- The date you refuse to receive medical treatment, including taking prescribed medicines, that your Doctor has recommended and that is generally acknowledged by Doctors to cure or improve the Sickness or Injury for which you are claiming benefits under the Plan so as to reduce its disabling effect;
- The date you refuse to make a good faith effort to adhere to necessary Wellness Programs, provided at our expense, that your Doctor has recommended and that are generally acknowledged by Doctors to cure or improve the Sickness or Injury for which you are claiming benefits under the Plan. We will work with your treating Doctor to determine the necessary Wellness Programs, if any, in accordance with generally accepted medical standards.

Nonparticipation in a Wellness Program does not affect our determination of your Disability; however, failure to participate in a Wellness Program without Good Cause may result in the

termination of your benefit payments. We will give you 30 days prior written notice of our intent to apply this provision to terminate your benefits. During those 30 days you will have an opportunity to begin or resume reasonable efforts to adhere to the medically necessary Wellness Programs. We will not terminate your benefits if there is no reasonable basis for believing that you will be able to return to productive employment in your Regular Occupation or another Gainful Occupation on a full-time or part-time basis if you adhere to the recommended Wellness Programs.

- The date you refuse to try or attempt to work with the assistance of:
  - Modifications made to your work environment, functional job elements or work schedule; or
  - Adaptive equipment or devices;That a qualified Doctor has indicated will accommodate the limiting factors of the Sickness or Injury for which you are claiming benefits under the Plan and will enable you to perform the Material and Substantial Duties of an occupation from which you must be considered Disabled in order to receive STD Benefits under the Plan;
- If you reside outside the United States or Canada. We will consider you residing outside of these countries if you have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of STD Benefits under the Plan.

#### **WHAT HAPPENS IF YOU HAVE A TEMPORARY RECOVERY BUT YOU BECOME DISABLED AGAIN DUE TO THE SAME SICKNESS OR INJURY AS A PRIOR DISABILITY?**

If you return to work and are no longer Disabled, and the same Sickness or Injury causes your Disability to occur again within 14 days of the date the prior Disability ended, we will resume our payments to you if you were continuously insured under the Plan for the period of your Temporary Recovery. You will not need to complete a new Elimination Period for this Disability.

Your current period of Disability will be subject to the same terms of the Plan that applied to your prior period of Disability.

If you become entitled to payments under any other group Short Term disability plan (including a plan with the Employer that became effective after your Disability began), you will not be eligible for payments under this Plan.

We will treat a Disability due to other causes as a new Disability, subject to all of the provisions of this Plan.

#### **WHAT IF THE EMPLOYER CHANGES INSURANCE PLANS AND YOU ARE NOT IN ACTIVE EMPLOYMENT DUE TO SICKNESS OR INJURY ON THE EFFECTIVE DATE OF THIS PLAN?**

##### **Continuity of Coverage**

We will cover you under this Plan if you were insured by the Prior Group STD Plan and the cost of your coverage under the Prior Group STD Plan was paid. However, the payments to you for a period of Disability that begins while you are insured under this Plan but before you satisfy the Active Employment requirement will be limited to the weekly amount the Prior Group STD Plan would have paid you had that plan stayed in effect. Our payments will be reduced by any amount the Prior Group STD Plan is responsible for paying.

**Prior Group STD Plan** means the group short term disability plan in effect with the Employer just before the effective date of this STD Plan.

## **SECTION 5: CLAIM INFORMATION**

#### **WHEN DO YOU NOTIFY US OF A CLAIM?**

You need to notify us in writing of your claim within 30 days after the date your Disability begins. If you are not able to notify us within this time, then you need to notify us as soon as reasonably possible. Notice includes a notice you give, or which is given on your behalf, to us at our home office or to an authorized agent of ours.

**WHEN DO YOU NEED TO GIVE US PROOF OF YOUR CLAIM?**

Early proof of claim will allow us to make a timely claim decision. You need to send to our home office written proof (or telephonic or electronic proof, if we have agreed to accept such forms)] of your claim within the first 90 days after the Elimination Period ends. If you are unable to give us proof of your claim within this time, then you must give us proof of your claim within the next 12 months. If you do not have the legal capacity to make responsible decisions concerning yourself, then you may give us proof of your claim after this period.

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

**HOW DO YOU FILE A CLAIM?**

Within 15 days after we receive your notice of claim, we will send you a claim form, or you may get one from the Employer. If we do not give you a claim form within 15 days after giving notice of loss, then you should send written proof (or telephonic or electronic proof, if we have agreed to accept such forms)] of your claim to us, including the occurrence, character and extent of the loss for which the claim is made, without waiting for the form.

You and the Employer must fill out your claim form. Once you and the Employer have completed the claim form, give the claim form to the Doctor providing you Regular Care for the Sickness or Injury causing your Disability. The Doctor must fill out the physician section of the form. Please send the completed form to us or, if we have agreed to accept proof of your claim in a telephonic or electronic format, you may start the process by contacting us at 800-894-4532 within the time frames stated above].

**WHAT AUTHORITY DO WE HAVE IN DETERMINING YOUR ELIGIBILITY FOR BENEFITS?**

We have the authority to determine your eligibility for benefits and to interpret the terms of the Plan for the purpose of making benefit determinations.

**WHAT INFORMATION DO YOU NEED TO INCLUDE IN YOUR PROOF OF CLAIM?**

Your proof of claim must include:

- That you are under the Regular Care of a Doctor;
- The date your Disability began;
- The cause of your Disability as determined by objective medical tests and examinations acceptable to the medical community;
- The extent of your Disability, including restrictions and limitations;
- The name and address of all pharmacies, Hospital(s) or Institution(s) where you received Treatment, including all Doctors who prescribed medications or provided Regular Care;
- Documentation of your Pre-disability Earnings as well as earnings, income or benefits of any kind that you may be receiving while also receiving disability benefits under the Plan;
- Documentation that you have applied for all Other Income Amounts that you may be eligible for as a result of the same period of Disability for which you are claiming disability benefits under the Plan; and
- Tax returns, including all associated schedules and worksheets, and accountant's statements.

We may request that you send proof of continuing Disability and that you are under the Regular Care of a Doctor. We must receive this proof within 60 days of the date we ask for it. In some cases, we will require you to give us authorization to obtain additional medical and non-medical information as part of your proof of claim. We may temporarily suspend our payments to you if you do not cooperate or do not submit the appropriate information.

**WHEN WILL YOU BEGIN TO RECEIVE YOUR BENEFIT PAYMENTS?**

Once we approve your claim, you will begin to receive payments after you complete the Elimination Period. We will send you a payment not less frequently than monthly for any period for which we are liable.

If the claim is paid more than 30 days after the date we have approved your claim, the payment will be subject to simple interest at the rate of 10% per year beginning on the 31<sup>st</sup> day after we have approved the claim and ending on the day the claim is paid. We will send you a benefit payment for any period for which we are liable under the Plan. If the Policy or Plan is canceled, the cancellation will not affect a payable claim.

**WHO DO WE MAKE BENEFIT PAYMENTS TO?**

Unless otherwise specified in the Policy or Certificate, we will make all benefit payments to you, if living. Benefit payments that become due or if any amount for which we are liable remains unpaid after your death will be made to your estate. If there are legal impediments to payment of benefits that depend on the actions of parties other than us, we may hold further benefits due until such impediments are resolved and sufficient evidence of the same is provided. Legal impediments to payment may include, but are not limited to, the establishment of guardianships and conservatorships, or the appointment and qualification of trustees, executors and administrators, as applicable.

#### **WHAT HAPPENS IF WE OVERPAY YOUR CLAIM?**

We have the right to recover overpayments that occur due to:

- Fraud;
- An error we make in processing your claim; or
- Your receipt of Other Income Amounts for periods during which you received unreduced disability benefits under the Plan.

If we determine that we should have paid you a different benefit amount from the amount actually paid on your claim, we will adjust the benefit accordingly. If we determine that we overpaid your claim, then we require that you repay us in full. We will determine the method by which you will repay us. We reserve the right to apply our future payments that are determined to be due to you, including any applicable minimum benefits, toward any outstanding overpayment balances, until we are reimbursed in full. We have the right to recover overpayments from your eligible survivors or estate. We reserve the right to deduct from your claim payment any unpaid premium due for your coverage. We will not recover more money from you than the benefit amounts we paid to you. If the overpayment is due to your receipt of amounts from a third party by judgment, settlement or otherwise for a Disability caused or contributed to by an act or omission of the third party, you are obligated to repay us for the overpayment in full regardless of whether you have been fully compensated for your injuries.

#### **WHAT IS THE PROCESS FOR NOTIFYING YOU OF OUR CLAIM DECISIONS?**

We will send you written notice of our claim decision within 45 days after we receive due proof of your loss. If there are special circumstances that require more time, we will send you a written notice within this timeframe that an additional 30 days is needed. If more time is still needed to make a claim determination, we will send you written notice during this initial 30 day extension stating the special circumstances that require an additional 30 days.

If we request additional information, you will have 45 days to respond to our request, and we will send written notice of our claim decision within 30 days after we receive your response.

If the claim is wholly or partly denied, our notice will include:

- Reasons for such denial;
- Reference to specific Plan provisions, rules or guidelines on which the denial was based;
- A description of the additional information needed to support your claim;
- Information concerning your right to request that we review our decision; and
- A description of our review procedures, and time limits, and notice to you of your right to bring a civil action.

#### **DO YOU HAVE THE RIGHT TO REQUEST A REVIEW OF A DENIED CLAIM?**

You may request us to review our denial of all or part of your claim. This request must be in writing and must be received by us no more than 180 days after you receive notice of our claim decision. As part of this review, you may:

- Send us written comments;
- Review any non-privileged information relating to your claim, upon request and free of charge; and
- Provide us with other information or proof in support of your claim.

We will review your claim promptly after receiving your request. We will advise you of the results of our review within 45 days after we receive your request, or within 90 days if there are special circumstances that



require more time. Our decision will be in writing and will include reference to specific Plan provisions, rules or guidelines on which the decision was based, and notice of your right to bring a civil action.

## **SECTION 6: ADDITIONS TO YOUR PLAN**

All the defined terms, conditions, limitations and exclusions applicable to payment of disability benefits under the Plan also apply to the provisions appearing in Section 6, unless otherwise noted within the provisions.

### **STD REHABILITATION BENEFIT**

#### **HOW CAN OUR REHABILITATION BENEFIT ASSIST YOU?**

If you are Disabled and receiving an STD Benefit from us, you may be eligible for our STD Rehabilitation Program services and incentives. The services offered by the Rehabilitation Program are available to assist you to return to work. They may include vocational testing, resume writing assistance, evaluation of job modifications or accommodations, job placement, or other services we find reasonably needed to assist you in returning to Active Employment either full-time or part-time.

A Rehabilitation Program proposal may be made by us, your Doctor or yourself. We will determine the extent to which Rehabilitation Program services may be provided. We will prepare a written program with input from you, your Doctor, your current Employer and/or your prospective Employer. Once we approve a program, you will be provided services according to the written program. We will pay for Rehabilitation Program services with the service provider(s), unless you and we agree to other arrangements.

The written Rehabilitation Program will describe:

- The goals of the program;
- What our responsibilities are;
- What your responsibilities are;
- What responsibilities are of any third party(ies) associated with this program;
- The expected dates of the services;
- The expected costs of the services; and
- The expected duration of the program.

We reserve the right to make the final decision concerning your eligibility to take part in a Rehabilitation Program and the type or amount of services you will be provided.

Nonparticipation in a Rehabilitation Program does not affect our determination of whether you are Disabled.

While we strongly encourage you to take advantage of the services provided by a Rehabilitation Program, participation in this program is strictly voluntary on your part. If you decline to actively participate in a rehabilitative program that we have approved, then you will not be eligible for any additional benefits that require participation in a Rehabilitation Program.

#### **WILL I BE ELIGIBLE FOR ADDITIONAL BENEFITS IF I AM WORKING AS PART OF AN APPROVED STD REHABILITATION PROGRAM?**

Yes. We will pay an additional STD Rehabilitation Program Benefit equal to 5% of your Gross Weekly Benefit, not to exceed a maximum of \$100 per week, if you meet all of the following:

- You are Disabled;
- You are receiving an STD Benefit from us; and
- You are working as part of an approved Rehabilitation Program.

STD Rehabilitation Program Benefits are payable while you are participating in the approved Rehabilitation Program. STD Rehabilitation Program Benefits are payable in addition to your benefit for Disability and are not subject to any STD Plan provisions which would otherwise increase or reduce your weekly STD Benefit.

## **SECTION 7: DEFINITIONS**

The following terms are used throughout the Certificate. Defined terms are capitalized throughout the Certificate. Other terms are defined in the PLAN HIGHLIGHTS section.

**Active Employment** means you are:

- Working for your Employer at their work site for earnings the Employer pays on a regular basis; and
  - Performing the Material and Substantial Duties of your Regular Occupation.
- Active Employment includes normal non-work days such as vacation, weekends and holidays if you were working for your Employer at their work site for earnings the Employer pays on a regular basis on the last normal work day prior to a period of normal non-work days.

Your work site must be:

- The Employer's usual place of business;
- An alternative location if directed by the Employer; or
- A location to which your occupation requires you to travel.

**Child or Children** includes any of your children of a civil union, domestic partnership, marriage or other family or domestic relationship where required by law of the state where the Policy is issued.

**Covered Pre-disability Earnings** means the maximum amount of your Pre-disability Earnings for which you are insured under this Plan. This does not include amounts of your Pre-disability Earnings in excess of the amount calculated by dividing the Maximum Benefit by the Benefit Percentage.

**Doctor** means a person regularly performing tasks that are within the limits of the person's medical license, and:

- Who is licensed to practice medicine and prescribe and administer drugs or to perform surgery;
- With a Doctoral degree in Psychology (Ph.D. or Psy.D.) and whose primary practice is treating patients; or
- Who is a legally qualified medical practitioner according to the laws and regulations of the jurisdiction in which Regular Care is being given.

We will not recognize you, your Spouse, Children, parents, or siblings, or anyone who shares a significant business interest with you, as a Doctor for a claim you submit.

**Elimination Period** means a period of continuous days of Disability before benefits become payable. The Elimination Period begins on the first day of your Disability. Your Elimination Period appears in the PLAN HIGHLIGHTS.

**Employee** means a person who is a citizen or legal resident of the United States or Canada or Mexico in Active Employment with the Employer unless we advise you otherwise. This Plan excludes temporary and seasonal workers from coverage.

**Employer** means an individual, company, or corporation where you are in Active Employment, and includes any division, subsidiary, or affiliated company named in the Policy.

**Evidence of Insurability** means a statement of your medical history, which is provided at our expense and which we will use to assess if you will be approved for coverage.

**Family or Medical Leave of Absence** means a leave of absence for:

- The birth, adoption or foster care of a Child;
- The care of your Child, Spouse or parent who has a serious health condition; or
- Your own serious health condition;

As those terms are defined by the federal Family and Medical Leave Act of 1993 and any amendments, or by applicable state law.

**Gainful Occupation** means any occupation that your past training, education, or experience would allow you to perform or for which you can be trained.

**Good Cause** means we have made the determination that you are unable to perform such employment or responsibilities of the Rehabilitation or Wellness Program based on the medical opinions of a physician or qualified rehabilitation specialist approved by us. While we will consider the opinion of your Doctor in this decision, we reserve the right to make the final determination. In the case of conflicting opinions, an adverse determination would be subject to the provisions set out in the DO YOU HAVE THE RIGHT TO REQUEST A REVIEW OF A DENIED CLAIM? part of Section 5.

**Gross Weekly Benefit** means your weekly benefit amount before we subtract your weekly Other Income Amounts, including your weekly Work Earnings, subject to the Plan's Maximum Weekly Benefit .

**Hospital or Institution** means an accredited facility licensed to provide care and treatment for the condition causing you to be Disabled. The facility must be supervised by one or more physicians and operated under state and local laws. The facility must have 24-hour nursing services by registered graduate nurses and cannot be a rest home, convalescent home, home for the aged, or a facility primarily for custodial, educational, or rehabilitative care.

**Injury** means a bodily injury that occurs while you are insured and is the direct result of an accident and not related to any other cause. It does not include risk of Injury.

**Layoff or Leave of Absence** means the Employer has agreed in writing and in advance to a temporary absence from Active Employment for a specified period of time. Your normal vacation time or any period of Disability is not considered a temporary Layoff or Leave of Absence.

**Material and Substantial Duties** means duties that:

- Are normally required for the performance of the occupation; and
- Cannot be reasonably omitted or changed.

**Maximum Payment Duration** means the longest period of time for which STD Benefits are payable for any one continuous period of Disability, whether from one or more causes. Your STD Maximum Payment Duration is shown in the STD Coverage Highlights section of this Certificate. The STD Maximum Payment Duration begins at the end of the STD Elimination Period.

**Net Weekly Benefit** means the weekly payment amount after we subtract your weekly Other Income Amounts, including your weekly Work Earnings.

**Occupational Sickness or Occupational Injury** means a Sickness or Injury caused by or aggravated by any employment for pay or profit. This Plan does not cover an Occupational Sickness or Occupational Injury.

**Own Job** means the specific job you were regularly performing for the Employer immediately prior to the date you became Disabled, as evidenced by Employer documents including, but not limited to, a job description, performance reports, and/or management reports, and which was the source of your income from the Employer.

**Plan** means STD coverage under the Policy.

**Plan Year** means January 1st to December 31st.

**Regular Care** means:

- You personally visit a Doctor as often as is medically required to effectively manage and treat your disabling condition(s), according to generally accepted medical standards, but not if you remain Disabled after reaching your maximum point of recovery or if we determine it would be of no value to you; and
- You are receiving appropriate treatment and care, according to generally accepted medical standards. Treatment and care for the Sickness or Injury causing your Disability must be given by a Doctor whose specialty or experience is appropriate.

**Regular Occupation** means the occupation, as it is performed nationally, that you are routinely performing when your Disability begins. Your Regular Occupation does not mean the job you are performing for a specific Employer or at a specific location.

**Retirement Plan** means a defined contribution plan or defined benefit plan, as defined in §402 of the Internal Revenue Code of 1986 and including future amendments to §402 affecting the definition. These are plans that provide retirement benefits to Employees and are not funded entirely by Employee contributions.

Disability benefits received from a Retirement Plan are benefits that are paid due to disability and which do not reduce the retirement benefit that would have been paid if the disability had not occurred.

Retirement benefits under a Retirement Plan are benefits that are paid based on the Employer's contribution to the Retirement Plan. Disability benefits that reduce the retirement benefit under the Retirement Plan will also be considered a retirement benefit.

Regardless of how the retirement funds from the Retirement Plan are distributed, for the purposes of figuring our payment to you, we consider Employee and Employer contributions to be distributed at the same time throughout your lifetime.

This Plan does not reduce payments you receive from us for your contributions to the Employer's Retirement Plan, or for amounts you rollover or transfer to an eligible Retirement Plan.

**Sickness** means an illness, disease, or complications of pregnancy. It also includes an Injury which occurs before you are insured. It does not include risk of Sickness.

**Spouse** means a person to whom you are legally married. It also includes any other person required to be covered as your Spouse under the civil union, domestic partnership, marriage or other family relations laws, including case law, in the state where the Policy is issued.

**STD Benefit** means your weekly benefit payment, as calculated in the provision titled HOW DO I CALCULATE MY STD BENEFIT? in Section 4, SHORT TERM DISABILITY BENEFIT SPECIFICS.

**Temporary Recovery** means any time when we do not consider you to be Disabled. The days you are not Disabled will not count toward the Elimination Period.

**Treatment** means:

- Consulting with a Doctor;
- Receiving care or services from a Doctor or from other medical professionals a Doctor recommends you see;
- Taking prescribed medicines;
- Being prescribed medicines; or
- Receiving diagnostic measures.

**Waiting Period** is the number of days you must be in Active Employment in an Eligible Class before you may become covered under the Plan. Your Waiting Period appears in the PLAN HIGHLIGHTS.

**Work Earnings** means weekly income you earn or receive while Disabled from any form of employment. Work Earnings include earnings from your Rehabilitation Program, unless otherwise noted. We may require you to send us proof of your income. We will adjust our payments to you based on this information. As a part of the proof, we can require you to send us appropriate tax and financial records we believe we need to substantiate your income.