Aflac

CONTINENTAL AMERICAN INSURANCE COMPANY

PO Box 427 • Columbia, South Carolina 29202 • 800.206.8826

GROUP LONG TERM DISABILITY INSURANCE

Long Term Disability insurance provides financial protection by paying a benefit in the event of a disability.

CERTIFICATE OF COVERAGE

Policy Number:	GLD0001033
Policy Effective Date:	January 1, 2023
Policyholder:	Activision Blizzard
Eligible Class(es):	All Classes
Policy Situs:	State of Texas

Continental American Insurance Company (referred to as CAIC) welcomes you as a Certificateholder. This is your Certificate of Coverage as long as you are eligible for coverage, and you become insured. Your benefits and rights under the policy will not be less than those stated in this Certificate of Coverage. **We certify that you are insured for the benefits described in this Certificate of Coverage, subject to the provisions of this Certificate of Coverage.**

READ YOUR CERTIFICATE CAREFULLY AND KEEP IT IN A SAFE PLACE. INSURANCE BENEFITS MAY BE SUBJECT TO CERTAIN REQUIREMENTS, REDUCTIONS, LIMITATIONS AND EXCLUSIONS.

The policy is issued in and governed by the laws of the State of Texas and in compliance with the Interstate Insurance Product Regulation Commission Standards, and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

Your coverage may be terminated or changed under the terms and provisions of the policy. You may inspect a copy of the policy by contacting the Policyholder. We will only make changes that are consistent with Interstate Insurance Product Regulation Commission ("the Commission") standards and any endorsements or amendments used to effect such changes are subject to prior approval by the Commission and will not affect the insurance provided until the effective date of the change unless retroactivity is required by the Interstate Insurance Product Regulation Commission.

If the terms and provisions of this Certificate of Coverage (issued to you) are different from the policy (issued to the Policyholder), the policy will govern. Your coverage may be terminated or changed under the terms and provisions of the policy.

This certificate replaces any previous certificate issued under a Policy that was issued by CAIC.

For purposes of effective dates and ending dates under this Certificate, all days begin at 12:01 a.m. and end at 12:00 a.m. midnight local time at the Policyholder's place of business.

CONFORMITY WITH INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION STANDARDS
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 and this certificate that on the provision's effective date is in conflict with Interstate Insurance Product Regulation Commission standards for group disability insurance is hereby amended to conform to the Interstate Insurance Product Regulation Commission standards for group disability insurance as of the provision's effective date.

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

The insurance department name and phone number of Policy Situs

appears on the listing following the Table of Contents

The policy covers disabilities due to Occupational and Non-Occupational Sickness or Injury

TABLE OF CONTENTS

STATE INSURANCE DEPARTMENT CONTACT INFORMATION

State	Insurance Department	Main Phone
Alabama	Alabama Department of Insurance	(334) 269-3550
Alaska	Alaska Division of Insurance	(907) 269-7900
Arizona	Arizona Department of Insurance	(602) 364-2499
Arkansas	Arkansas Insurance Department	(501) 371-2600
California	California Department of Insurance	(800) 927-4757
Connecticut	Connecticut Insurance Department	(860) 297-3800
Delaware	Delaware Department of Insurance	(302) 674-3700
District of Columbia	District of Columbia Department of Insurance Securities and Banking	(202) 727-8000
Florida	Florida Office of Insurance Regulation	(850) 413-3140
Georgia	Georgia Department of Insurance	(404) 656-2056
Hawaii	Hawaii Insurance Division	(808) 586-5790
Idaho	Idaho Department of Insurance	(208) 334-4250
Illinois	Illinois Department of Insurance	(217) 782-4515
Indiana	Indiana Department of Insurance	(317) 232-2385
Iowa	Iowa Insurance Division	(515) 654-6600
Kansas	Kansas Department of Insurance	(785) 296-3074
Kentucky	Kentucky Office of Insurance	(502) 564-3630
Louisiana	Louisiana Department of Insurance	(800) 259-5300
Maine	Maine Bureau of Insurance	(207) 324-8475
Maryland	Maryland Insurance Administration	(410) 468-2090
Massachusetts	Division of Insurance	(617) 521-7794
Michigan	Michigan Department of Insurance and Financial Services	(877) 999-6442
Minnesota	Minnesota Department of Commerce	(651) 539-1500
Mississippi	Mississippi Insurance Department	(800) 562-2957
Missouri	Missouri Department of Commerce and Insurance	(573) 751-3365
Montana	Montana Office of Commissioner of Securities and Insurance	(406) 444-2040
Nebraska	Nebraska Department of Insurance	(402) 471-2201
Nevada	Nevada Division of Insurance	(775) 687-0700

New Hampshire	New Hampshire Department of Insurance	(603) 271-2260
New Jersey	New Jersey Department of Banking and Insurance	(609) 292-7272
New York	New York Department of Financial Services	(800) 342-3736
New Mexico	Office of Superintendent of Insurance	(505) 827-4601
North Carolina	North Carolina Department of Insurance	(855) 408-1212
North Dakota	North Dakota Insurance Department	(701) 328-2440
Ohio	Ohio Department of Insurance	(614) 644-2658
Oklahoma	Oklahoma Department of Insurance	(405) 521-2828
Oregon	Oregon Insurance Division Consumer Advocacy Unit	(503) 947-7984
Pennsylvania	Pennsylvania Department of Insurance	(717) 787-2317
Puerto Rico	Puerto Rico Department of Insurance	(787) 304-8686
Rhode Island	Rhode Island Insurance Division	(401) 462-9520
South Carolina	South Carolina Department of Insurance	(803) 737-6180
South Dakota	South Dakota Department of Labor & Regulation	(605) 773-3101
Tennessee	Tennessee Department of Commerce & Insurance	(615) 741-2241
Texas	Texas Department of Insurance	(800) 252-3439
Utah	Utah Department of Insurance	(801) 538-3800
Vermont	Vermont Division of Insurance	(802) 828-3301
Virginia	Virginia Bureau of Insurance	(804) 371-9741
Washington	Washington State Office of Insurance	(360) 725-7000
West Virginia	Offices of the Insurance Commission	(304) 558-3354
Wisconsin	Office of Commissioner of Insurance	(608) 266-3585
Wyoming	Wyoming Department of Insurance	(307) 777-7401

SPECIAL NOTICES

CONTINENTAL AMERICAN INSURANCE COMPANY

You may contact us at:
Toll Free Number: 800.206.8826 TTY/RTT 711
Claim Information Toll Free Number: 800.206.8826 TTY/RTT 711

THE FOLLOWING NOTICES APPLY TO RESIDENTS OF THE FOLLOWING STATES

ARKANSAS

QUESTIONS OR PROBLEMS WITH YOUR POLICY?

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

Continental American Insurance Company
1932 Wynnton Road
Columbus, GA 31999
Telephone: (800) 433-3306

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

COLORADO

THIS IS A SUPPLEMENTAL HEALTH PLAN THAT IS NOT INTENDED TO PROVIDE THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE AFFORDABLE CARE ACT (ACA). UNLESS YOU HAVE ANOTHER PLAN (SUCH AS MAJOR MEDICAL COVERAGE) THAT PROVIDES MINIMUM ESSENTIAL COVERAGE IN ACCORDANCE WITH THE ACA, YOU MAY BE SUBJECT TO A FEDERAL TAX PENALTY. ALSO, THE BENEFITS PROVIDED BY THIS PLAN CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS PLAN CAREFULLY TO AVOID DUPLICATION OF COVERAGE.

GEORGIA

NOTICE

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

IDAHO

If you need the assistance of the governmental agency that regulates the business of insurance, you can contact the Idaho Department of Insurance by contacting:

Idaho Department of Insurance
Consumer Affairs
700 W State Street, 3rd Floor
P.O. Box 83720

Boise, ID 83720-0043

1-800-721-3272 or 208-334-4250 or www.DOI.Idaho.gov

INDIANA

NOTICE TO EMPLOYEES

Questions regarding your Policy or coverage should be directed to:

Continental American Insurance Company
1932 Wynnton Road, Columbus GA 31999
1-800-433-3036

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

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

Consumer Hotline: 1-800-622-4461
In the Indianapolis Ara: 1-317-232-2395

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

VIRGINIA

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions, you may contact the insurance company issuing this insurance at the following address and telephone number: P.O. Box 84079, Columbus, GA 31993-9101; 800.433.3036.

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at: the national toll free number 1-877-310-6560, and the local number 804-371-9691.
Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

WISCONSIN

YOUR RIGHT TO FILE A COMPLAINT

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

Continental American Insurance Company
1932 Wynnton Road, Columbus GA 31999
1-800-433-3036

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

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873

or you can call Toll Free 1-800-236-8517, or direct 608-266-0103 in Madison and request a complaint form.

THIS NOTICE IS FOR TEXAS RESIDENTS ONLY

IMPORTANT NOTICE

To obtain information or make a complaint:

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax (512) 490-1007

Web: http://eee.tdi.txas.gov

Email: consumerprotection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim you should contact Aflac first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part of or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Pueda escribir al Departmento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
Fax (512) 490-1007

Web: http://eee.tdi.txas.gov

Email: consumerprotection@tdi.texas.gov

DISPUTAS SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con Aflac primero. Si no se resuelve la disputa, puede entonces communicarse con el departmento (TDI)

UNA ESTE AVISO A SU POLIZA:

Este aviso es solo para proposito de informacion y no se convierte en parte o condicion de documento adjunto.

LONG TERM DISABILITY SCHEDULE OF BENEFITS

The Long Term Disability policy provides financial protection for you by paying a portion of your income while you are disabled. The amount you receive is based on the amount you earned before your disability began, subject to all policy provisions.

POLICYHOLDER: Activision Blizzard

POLICY NUMBER: GLD0001033

POLICY EFFECTIVE DATE: January 1, 2023

POLICY ANNIVERSARY DATE: January 1, 2024, and each following January 1st.

ELIGIBLE CLASS:
All persons in the following class(es) are eligible for Employee coverage:

Class 1 (Core and Buy-Up): All active, full-time employees of Activision Blizzard (and any of its subsidiaries and other affiliates) on the US payroll system regularly working a minimum of 30 hours per week, excluding all other employees classified as Executive.

Class 2: **(Core)** All active, full-time employees of Activision Blizzard (and any of its subsidiaries and other affiliates) on the US payroll system regularly working a minimum of 30 hours per week, classified as Executive.

Minimum Hours Requirements: 30 hours per week

Waiting Period: None

Who Pays for the Coverage:

Class 1:

Core Plan: Your employer pays the cost of your insurance.

Buy-Up Plan: You are required to pay the entire cost of your buy-up coverage (pre-tax).

Class 2:

Core Plan: Your employer pays the cost of your insurance.

Elimination Period: 180 days

The Elimination Period begins on the first day of your disability. Benefits for a Payable Claim begin the day after the Elimination Period is completed.

Interruption of Elimination Period: 30 day(s).

Monthly Benefits:

Class 1:

Monthly Benefit: 50% of covered monthly earnings to the maximum benefit of $5,000 per month, less Deductible Sources Of Income.

Buy-Up Benefit: 66 2/3% of Covered Monthly Earnings to the maximum benefit of $10,000 per month, less Deductible Sources Of Income.

Class 2:

Monthly Benefit: 66 2/3% of Covered Monthly Earnings to a maximum benefit of $21,000 per month, less Deductible Sources of Income.

Minimum Monthly Benefit: Greater of $100 or 10% of your Gross Disability Benefit.

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Pre-Existing Condition Limitation: 3/12, refer to the Certificate for a full description.

Monthly Earnings:

Class 1:

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

It does not include income received from commissions, bonuses, overtime pay, any other extra compensation, or income received from sources other than your employer.

Class 2:

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

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

Total Benefit Cap:

If you are eligible to receive payments under the policy in addition to your Monthly Benefit, 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. If you are participating in a Vocational Rehabilitation Program, 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.

Maximum Period of Payments:

Social Security Normal Retirement Age duration (SSNRA)

For a disability which begins before you reach age 62, the Maximum Period of Payment will be until the Social Security Normal Retirement Age (SSNRA) as shown in the following table:

Your Age When Disability Begins	**Maximum Period of Payment**
Less than age 62	To Social Security Normal Retirement Age (SSNRA)
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months
Year of Birth	**Social Security Normal Retirement Age**
1937 or before	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

Other Benefits:

Survivor Benefit: 3 times your Gross Disability Benefit.

Family Member Expense Benefit:

- $250 per Family Member per month, not to exceed a maximum of $1,000 per month for all Family Members.

Vocational Rehabilitation Services Program: assistance in returning to work to the extent of your ability.

Vocational Rehabilitation Monthly Benefit:

- an additional benefit of 5% of your Gross Monthly Benefit to a maximum of $1,000 per month;
- maximum period of payments of 3 months.

Workplace Modification benefit:

The greater of:

- $2,000; or
- the equivalent of two (2) months of your monthly benefit. This benefit is available to you on a one time only basis.

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.

DEFINITIONS

As used in this certificate, the terms listed below will have the meanings set forth below.

Unless defined differently within a particular provision, the terms “you” and “your” mean the insured Employee. The terms “we”, “our”, and “us”, mean Continental American Insurance Company. Other defined terms will appear in the certificate with their initial letters capitalized. The plural use of a term defined in the singular will share the same meaning.

Accident or Accidental means a sudden, unexpected event that was not reasonably foreseeable.

Active Employment, Actively Working 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:

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

We will consider you to be in Active Employment on weekends, holidays, vacations, and paid time off program that your Employer has approved and during a temporary business closure not to exceed 1 day if you were in Active Employment on the last scheduled work day immediately prior to such time off. A temporary business closure includes a closure due to inclement weather, power outage or public health agency orders.

If your employment status is being continued under a severance of termination agreement, you will not be considered in Active Employment.

Temporary workers are excluded from coverage. Seasonal workers are excluded from coverage.

Appropriate Care means that you:

- visit a Physician as frequently as medically required according to standard medical practice to effectively treat and manage your disabling condition(s); and
- receive care or treatment appropriate for the disabling condition(s), conforming with standard medical practice, by a Physician whose specialty or experience is appropriate for the disabling condition(s) according to standard medical practice; and
- have the obligation to minimize your disabling condition including having corrective treatment or minor surgery.

Buy-up Plan means any insurance for which the Policyholder requires a Certificateholder to pay any part of the Premium. The maximum amount that a Certificateholder may be required to contribute to the cost of his or her insurance may not exceed the Premium charged for such insurance.

Certificateholder means an Employee who is eligible for benefits provided by the Policy, who has received a Certificate, and for whom premium has been paid. Unless otherwise specified, the Certificateholder is entitled to exercise the rights and benefits granted under the Certificates attached to the Policy.

Contribution means any amount the Policyholder may require you to pay toward the total Premium that we charge for the insurance provided by the Policy

Child and Children means:

- your biological Child; or
- your adopted Child or a Child from the date of placement in your home pending adoption; or
- your stepchild including a Child of a domestic partnership or civil union; or
- a Child living in Your home for whom You are the legal guardian.

If a minor Child is entitled to benefits, we may at our option make a benefit payment to the person caring for and supporting the Child until a legal guardian is appointed.

Complication of Pregnancy means a condition, when pregnancy is not terminated, whose diagnosis is distinct from pregnancy but adversely affected or caused by pregnancy. Complication of Pregnancy includes, but is not limited to, non-

elective cesarean section, termination of ectopic pregnancy, spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible; acute nephritis or nephrosis; cardiac decompensation; missed abortion; and similar medical and surgical conditions of comparable severity. It does not include false labor; occasional spotting; morning sickness: Physician prescribed rest; hyperemesis gravidarum; pre-eclampsia; or any other condition associated with the management of a difficult pregnancy, not consisting of a nosologically distinct complication of pregnancy.

Confined or Confinement means a Hospital, Health Facility, or Institution stay of at least 8 hours per day.

Contributory Insurance means any insurance for which the Policyholder requires a Certificateholder to pay any part of the Premium. The maximum amount that a Certificateholder may be required to contribute to the cost of his or her insurance may not exceed the Premium charged for such insurance.

Core Plan means insurance for which the Policyholder does not require you to pay any part of the premium. This Certificate of Coverage specifies who pays the cost of the coverage.

Deductible Sources of Income means income from other sources as listed in the certificate which you receive or are eligible to receive while you are disabled. This income will be subtracted from your Gross Monthly Benefit.

Disability Earnings means the income which you receive from working while you are disabled. Disability Earnings do not include earnings from secondary employment if such employment began prior to your date of disability; however, it does include any increase in earnings from the secondary employment occurring after your date of disability.

Eligibility Date means the date you become eligible for insurance.

Eligible Survivor means your surviving relatives in the following order:

- your Spouse;
- if no Spouse or if your Spouse does not survive you, in equal shares to your Children;
- if no Child survives you, in equal shares to your surviving parents; or
- your siblings, in equal shares.

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

Employee means a person defined as such to the Policyholder. Employee excludes in any case, temporary Employees and Employees who work for the Employer less than the number of hours per week indicated in the Schedule of Benefits.

Employer means the entity that has been approved by us for coverage under the policy issued by the Policyholder.

Gainful Occupation means an occupation in the national economy for which you may reasonably become qualified based on your education, training or experience, including self-employment, that exceeds 60% of your Indexed Monthly Earnings.

Gainful occupation is used to determine your eligibility for benefits following the Regular Occupation period.

Good Cause means documented physical or mental impairments, which leave you unable to take part in or complete the agreed upon Vocational Rehabilitation Program or transitional work arrangement we developed. It can also mean that you are participating in:

- medical treatment(s) which prevent(s) or interfere(s) with your taking part in or completing the Vocational Rehabilitation Program under the policy; or
- another vocational rehabilitation program which is reasonably expected to return you to Active Employment.

We will review and consider your attending Physician's assessment; however, we reserve the right to make a Good Cause determination based on the medical opinion of our consulting Physician. If benefits are discontinued under this provision, you will have the right to appeal review of that decision.

Gross Monthly Benefit means your benefit before any reduction for Deductible Sources of Income and any adjustment for Disability Earnings.

Hospital, Health Facility, or Institution means an accredited facility licensed according to state and local laws to provide care and treatment for the condition causing your disability. The facility must be supervised by one or more Physicians with 24 hour registered graduate nursing staff. The facility may specialize in treating alcoholism, drug addiction, chemical dependency, or Mental Disorder. A facility specializing in treating alcoholism, drug addiction, chemical dependency or Mental

Disorder does not include a rest home, convalescent home, and home for the aged or a facility primarily for custodial, educational, or rehabilitative care.

Indexed Monthly Earnings means your Monthly Earnings adjusted on each anniversary of benefit payment by the lesser of 10% or 50% of the annual percentage change 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 is published by the U.S. Department of Labor. We may substitute a comparable measurement if the Department of Labor changes or stops publishing the CPI-U subject to approval by the Commission. Before a substitute index is used, we shall notify you of the substitution. 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 bodily injury resulting from an Accident, independent of disease, and not related to any other cause.

Insured Person means an Employee who is eligible for coverage and is the subject of insurance under the certificates attached to the policy for which premium is paid.

Leave of Absence means you are absent from Active Employment for a period that has been agreed to by your Employer. Your normal vacation time or any period of disability is not considered a Leave of Absence.

Material and Substantial Duties means duties that:

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

Maximum Monthly 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.

Mental Disorder 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 use 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. If the APA no longer publishes a DSM or the APA ceases to exist, we may substitute a comparable DSM subject to the approval by the Commission.

Modified Work Arrangement means changing or eliminating specific job duties within the Employee's Regular Occupation to meet the temporary work restrictions. After benefits have been paid for 12 months, a Modified Work Arrangement may be applied to any Gainful Occupation for which you are reasonably fitted by education and training.

Monthly Benefit means your benefit after any Deductible Sources of Income and any Disability Earnings have been subtracted from your Gross Monthly Benefit.

Monthly Earnings means your gross monthly income from your Employer as stated in the Schedule of Benefits.

Non-Contributory Insurance means insurance for which the Policyholder does not require you to pay any part of the premium. The Schedule of Benefits specifies who pays the cost of the coverage.

Part-time Basis means the ability to work and earn 40% or more of your Indexed Monthly Earnings. Ability is based on capacity and not market availability.

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

Physician means:

- a person performing tasks that are within the limits of his or her medical license; and
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph. D. or Psy. D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction; or

- any other person whose services according to applicable law, must be treated as Physician services for purposes of the policy. Each such person must be licensed in the jurisdiction where the service is performed and must act within the scope of that license. Such person must be certified and/or registered if required by jurisdiction.

We will not recognize you or your family members, including but not limited to, Spouse, domestic partner, 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 Physician for a claim that you send to us.

Policyholder means the entity to whom the policy is issued.

Prior Policy means the Policyholder's group long term disability insurance plan for which you were insured on the day prior to the Effective Date of our policy.

Proof means Written evidence satisfactory to us that a person has satisfied the conditions and requirements for eligibility for any benefit described in this certificate. When a claim is made for any benefit described in this certificate, Proof must establish:

- the nature and extent of the loss or condition;
- our obligation to pay the claim; and
- the claimant's right to receive payment.

Reasonable Accommodation means modifications or adjustments to a job, an employment practice or the work environment that makes it possible for a person with a disability to perform the Material and Substantial Duties of their occupation without causing undue hardship to any employer. It must meet federal standards of Reasonable Accommodation as defined by the Americans with Disabilities Act of 1991 and any later amendments.

Recurrent Disability means a disability which is due to the same cause(s) as your prior disability for which we made a Monthly Benefit.

Regular Care means:

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

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

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 for the benefit of all Employees covered under the policy. Salary Continuation or Accumulated Sick Leave does not include compensation paid to you by your Employer for work you actually perform after your disability begins. Such compensation is considered Disability Earnings and would be taken into account in calculating your Monthly Benefit.

Sickness means illness, disease, or Complications of Pregnancy.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper, electronic media, or other durable media and which is consistent with applicable law.

Spouse means your lawful Spouse and any other person required to be covered as your Spouse under the civil union, domestic partnership, marriage or other family or domestic relations laws, including the case law, of the state where the policy is delivered or issued for delivery.

If the policy and certificate are delivered or issued for delivery in different states, the certificate, if required, will comply with the applicable marriage laws, including marriage case law, of the state where the certificate is delivered or issued for delivery and,

if required, with the applicable domestic partnership and civil union laws of such state, with respect to coverage available for marital relationships, domestic partnerships, or civil unions.

Temporary Layoff means you are absent from Active Employment for a period of time where the Employee and the Employer maintain an intent that the Employee will return to work that has been agreed to in Writing by your Employer and premium has been paid. This includes absences that may be referred to as furloughs.

Your normal vacation time or any period of disability is not considered a Temporary Layoff.

Third Party means any person or entity whose act or omission, in full or in part, caused you to suffer a disability for which benefits are paid or payable under this plan. Third Party also includes your homeowner's, automobile, or other insurance company if they make payments to you because of the acts or omissions of another person or entity.

Vocational Rehabilitation Program means a Written plan that a vocational rehabilitation professional, designated by us, prepares in accordance with the Vocational Rehabilitation Services Program provision of the policy.

We, us, and our (with or without initial capital letters) means Continental American Insurance Company.

Written or In-Writing means a record which is on or transmitted by paper, electronic media, or other durable media and which is consistent with applicable law.

You, your (with or without initial capital letters) means the Certificateholder:

- who is a member of an Eligible Class;
- who is eligible for benefits;
- for whom premium has been paid while covered under the policy; and
- who has received a certificate.

ELIGIBILITY

Eligibility Class(es):

You may only become eligible for the insurance available if you are a member of an Eligible Class shown in the Schedule of Benefits. **Refer to the Schedule of Benefits or contact your Employer to determine if you are in an Eligible Class.**

When Are You Eligible for Coverage?

If you are in Active Employment, the date you are eligible for coverage is the later of:

- the Policy Effective Date;
- your date of hire; or
- the date you enter an Eligible Class.

Enrollment

Core Plan (Non-Contributory): If you are not required to contribute towards the cost of coverage, your enrollment will be handled by your Employer.

Buy-Up Plan (Contributory): You must contribute toward the cost. You may enroll by completing the enrollment process as instructed by the Policyholder. You need to enroll within 31 days of your eligibility date, otherwise you may be considered a late applicant.

Effective Date of Your Insurance

Subject to the requirements of the section below entitled Deferred Effective Date, your insurance will become effective as determined in this section if you are in Active Employment on the date coverage would take effect. If you are not in Active Employment on the date coverage is to take effect, your effective date of coverage will be determined in the section below entitled "Deferred Effective Date".

Coverage for eligible persons insured under the Prior Plan will be effective on the Policy's Effective Date.

For persons, who were not insured under the Prior Plan, and all new or newly eligible persons, coverage under the policy will become effective on the latest of the following dates:

Rule for Non-Contributory Insurance (Core Plan)

Non-Contributory Insurance will take effect in accordance with the rules stated below you must be in Active Employment on the date which such insurance is to take effect.

Non-Contributory Insurance will become effective the later of:

- the Policy Effective Date; or
- the date you become eligible for insurance.

Rules for Contributory Insurance (Buy-up Plan)

Contributory Insurance will take effect in accordance with the rules stated below. You must be in ActiveEmployment on the date such insurance is to take effect.

Insurance will become effective the later of:

- the date You become eligible for insurance if apply within 31 days of your Eligibility Date;
- the date for which the first premium for Your coverage is paid; or
- the Policy Effective Date;

Late Applicant Enrollment Requirements

If You do not enroll for coverage within Your eligibility period but wish to do so later, Your Employer] will provide You with information on when and how]You can enroll as a late applicant.

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Deferred Effective Date

Unless otherwise stated in the section entitled Continuity of Coverage, if you are not in Active Employment on the day before:

- the Policy Effective Date;
- the scheduled effective date of your insurance; or
- an increase in your insurance.

Your insurance, or an increase, will not become effective until the day after you return to Active Employment.

CHANGING YOUR COVERAGE

When Will Changes to Your Coverage Take Effect?

Once Your coverage begins, any increased or additional coverage will take effect the first of the month following the date of the change if you are in Active Employment or if You are on a covered Layoff or Leave of Absence. 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.

Effective Date for Benefit Changes Due to A Change in Covered Monthly Earnings

A change in your Monthly Benefit due to a change in your Monthly Earnings will be effective on the first of the next month following the date of the change, if you are in Active Employment. If you are not in Active Employment due to an Injury or Sickness, any increased or additional coverage will begin on the date you return to Active Employment.

Effective Date for Benefit Changes Due to a Change in your Eligible Class

A change in your Weekly Benefit due to a change in your Eligible Class on the first of the month. 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.

Effective Date for Benefit Changes by Policy Amendment

A change in your Monthly Benefit due to a change in the policy by an amendment elected by the Policyholder, will be effective on the date of the change, if you are in Active Employment. If you are not in Active Employment on the date a benefit payable change would otherwise be effective, any increased or additional coverage will begin on the date you return to Active Employment.

A change in your benefit payable because of a change made by us will normally be effective on the policy anniversary date, or otherwise determined by state or federal law, or by us. However, if you are not in Active Employment on the date a benefit payable change would otherwise be effective, the benefit payable change will not be in force until you return to Active Employment.

Effective Date of a Benefit Decrease

Any decrease in coverage will take effect immediately upon the effective date of the change.

Effect of a Change in Coverage on a Payable Claim

Neither an increase nor a decrease in coverage will affect a Payable Claim that occurs prior to the increase or decrease.

CONTINUITY OF COVERAGE

Transferred Coverage from A Prior Plan to This Plan

This provision provides continuity of coverage when you are in Active Employment when the Policyholder transfers prior group insurance to this plan, or by an employer which has merged with or otherwise combined with the Policyholder. If your coverage under the policy replaces any prior coverage that you had, the following rules apply.

What If You Are Not in Active Employment When Your Employer Replaces Insurance Coverage with Our Policy?

If you are not in Active Employment due to Injury or Sickness on the date your Employer changes insurance carriers to our policy, and you were covered under the Prior Policy at the time your Employer's coverage under our policy became effective, we will provide continuity of coverage under our policy. In order for this provision to apply, the Prior Policy's coverage must be similar to our policy.

If you are not in Active Employment due to Injury or Sickness on the effective date of our policy, and you would otherwise be eligible to become insured under our policy, we will provide Limited Coverage under our policy. Coverage under this provision will begin on our Policy Effective Date and will continue until the earliest of:

- the date you return to Active Employment; or
- the end of any period of continuance or extension provided under the Prior Policy.

If you are not in Active Employment due to Leave of Absence or Temporary Layoff on the date your Employer changes insurance carriers to our policy, and you were covered under the Prior Policy at the time your Employer's coverage under our policy became effective, we will provide continuity of coverage under our policy. In order for this provision to apply, the Prior Policy's coverage must be similar to our policy.

If you are not in Active Employment due to Leave of Absence or Temporary Layoff on the effective date of our policy, and you would otherwise be eligible to become insured under our policy, we will provide Limited Coverage under our policy. Coverage under this provision will begin on our Policy Effective Date and will continue until the earliest of:

- the date you return to Active Employment; or
- the end of any period of continuance or extension provided under the Prior Policy; or
- the date coverage would otherwise end, according to the provisions of our policy.

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

For the purposes of this provision the following definition applies:

> **Limited Coverage means benefits payable will be paid as if the Prior Policy had remained in effect and you continued to be insured under that policy. 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 of the date that policy terminated, the Effective Date of Your Insurance provision will apply.

How Does the Pre-Existing Condition Work If You Were Covered Under Your Employer's Prior Plan?

You may be eligible for a Monthly Benefit if your disability results from a Pre-Existing Condition if you were:

- in Active Employment and insured under the plan on its effective date; and
- insured by the Prior Policy at the time of change.

In order to receive a Monthly Benefit, you must satisfy a Pre-Existing Condition provision under:

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

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

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

If you only satisfy item 2, we will administer your claim according to our plan provisions. However, your Monthly Benefit will be the lesser of:

- the Monthly Benefit that would have been payable under the terms of the Prior Policy if it had remained in force; or
- the Monthly Benefit under our plan.

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

- the end of the Maximum Monthly Benefit under this plan; or
- the date benefits would have ended under the Prior Policy if it had remained in force.

When Continuity of Coverage Ends

You will remain covered under this Continuity of Coverage provision until the first to occur:

- the date you return to Active Employment at which time insurance in effect under the policy will not be subject to Prior Plan provisions or benefit limitations;

- the last day of a period of 12 consecutive months which begins on the Policy Effective Date, at which time coverage under the policy will also end;
- the date insurance would otherwise end for you in accordance with the terms and conditions of this certificate, at which time coverage under the policy will also end;
- the date on which insurance would have ended under the Prior Plan, had the Prior Plan not terminated at which time coverage under the policy will also end; or
- if the Prior Plan provided for extension of insurance without premium payment during a period of disability, on the earliest of:
    (a) the date you are approved for such benefit under the terms of the Prior Plan; and
    (b) the last day of the 12-month period following our Policy's Effective Date;
    (c) and coverage under our policy will also end.

Duplication of Coverage

If you qualify for benefits under the Prior Plan such that a duplication of coverage situation exists after coverage begins under the policy, you must exercise your rights under the Prior Plan and duplicate benefits will not be payable under the policy.

Coverage under the policy will not take effect if your coverage under the Prior Plan is continued under any disability provision or you have enrolled in a conversion plan option with the Prior Plan.

Premium Payments

Premium payments are required for all Insured Persons during the period Continuity of Coverage under this provision is in effect. We will not waive premium during the period coverage is continued.

CONTINUATION OF COVERAGE BY THE POLICYHOLDER

The Policyholder has elected to continue your insurance for any of the reasons specified below.

Premium for the continuation period must be paid on the same basis as Premium was paid on the day before your Sickness or Injury began.

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

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

If You Are Not in Active Employment Due to A Sickness or Injury Or Other Authorized Leave

If you are not in active employment due to illness or injury or other authorized leave as agreed to by your employer and us, your coverage may continue up to a maximum of three (3) months from the start of your absence or until stopped by your employer.

If You Are Not in Active Employment Due to Leave of Absence

If you are on an employer approved leave of absence, and if premium is paid, you will be covered up to a maximum of three (3) months from the start of your absence or until stopped by your employer.

If You Are Not in Active Employment Due Up to A Temporary Layoff

If you are on 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.

Continuation of Coverage While on A Family and Medical Leave of Absence

We will continue your coverage in accordance with the Policyholder's policy on family and medical leaves of absence if premium payments continue and the Policyholder approved your leave in Writing.

If you were granted a Leave of Absence according to the "Family and Medical Leave Act of 1993", your coverage will continue under this provision for the balance of your leave.

Coverage will be continued until the end of the later 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 national, state, or local law, or any similar law, plan, or act.

If the Policyholder's policy does not provide for continuation of your coverage during a family and medical Leave of Absence, your coverage will be reinstated when you return to Active Employment.

If you return to work immediately following your leave, we will not:

- apply a new Pre-Existing Conditions exclusion.

Continuation of Coverage While on Leave During Military Service

We may continue your insurance, if applicable, in accordance with the Policyholder's policies regarding leave of absence for Military service under the Uniformed Services Employment and Reemployment Act (USERRA) and applicable state law. Premiums must be paid for continued coverage for you. Coverage may be continued until the end of the period required by USERRA. If your coverage is not continued during a Leave of Absence for active military service, and you return to Active Employment, your coverage shall be reinstated in accordance with USERRA and applicable state law.

Concurrent Leaves

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.

End Of a Continuation Period

Continuation insurance will end on the earliest of the following:

- the date your continuation leave ends;
- the date the Policyholder ceases to pay your premiums, or otherwise terminates your insurance;
- the maximum continuation period has been reached; or
- the date the policy or this plan terminates.

At the end of any of a continuation period if you resume Active Employment in an Eligible Class you will continue to be covered under the policy.

If you do not resume Active Employment in an Eligible Class at this time, your employment will be considered to end, and all insurance will end in accordance with the provision When Does Your Coverage End.

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 Does Your Coverage End provision.

DATE COVERAGE ENDS

When Does Your Coverage End?

Your coverage under this plan ends on the earliest of:

- the date the policy or the plan is terminated;
- the date you voluntarily stop your coverage;
- the date you are no longer in an Eligible Class;
- the date you are no longer eligible for coverage;
- the date on which you voluntarily or involuntarily lose your professional license;
- the date your employment stops for any reason, including job elimination, or being placed on severance. This will be the date you stop Active Employment;
- the date your Eligible Class is no longer covered;
- the last day you are in Active Employment except as provided under the covered layoff or leave of absence provision;
- the date on which you retire; or
- the date on which you begin active duty in the armed forces of any country.

Reinstatement of Coverage

If You return to Active Employment within 6 months of the date Your coverage terminated and You request coverage from Your Employer within 31 days of Your return, the Pre-Existing Condition limitation requirement will apply only to the extent they would have applied if Your coverage had not ended.

LONG TERM DISABILITY BENEFIT INFORMATION

How Do We Define a Long Term Disability?

You are considered to be disabled if, solely and directly because of a Sickness or Injury, all of the following applies:

- you must be covered by this plan at the time you become disabled;
- you must be under the Appropriate Care of a Physician for your Sickness or Injury; and
- you must meet the definition of disability below.

During the elimination period and the first 24 months benefits are payable,

- you are disabled when we determine that:
- you are unable to perform the material and substantial duties of your Regular Occupation due solely to your sickness or injury; and
- you are under the regular care of a Physician; and
- you have a 20% or more loss in your Indexed Monthly Earnings due to that sickness or injury. After 24 months benefits have been payable, you are disabled when we determine that due to the same sickness or injury:
- you are unable to perform the duties of any Gainful Occupation for which you are reasonably fitted by education, training or experience; and
- you are under the regular care of a physician; and
- • you have a 40% or more loss in your Indexed Monthly Earnings due to the same Sickness or Injury.The loss of a professional or occupational license or certification does not in itself constitute disability.

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

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

Elimination Period

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

You must be continuously disabled through your Elimination Period. The days that you are not disabled will not count toward your Elimination Period. We will treat your disability as continuous if your disability stops during the Elimination Period or the number of days stated in the Interruption of The Elimination Period provision. No benefit is payable for or during the Elimination Period.

Your Elimination Period is described in the Schedule of Benefits.

Can You Satisfy Your Elimination Period If You Are Working?

Yes. If you are working while you are disabled, the days you are disabled will count toward your Elimination Period.

Interruption Of Elimination Period

Interruption Period if, during the Elimination Period, you return to Active Employment for less than 30 days, then the disability will be treated as continuous. Days that you are in Active Employment during this interruption period will not count towards the Elimination Period.

When Will You Begin To Receive Benefits?

The benefit payable is the Monthly Benefit shown in the Schedule of Benefits. The Monthly Benefit is based on your Monthly Earnings.

You will begin to receive benefits when your claim is approved, providing the Elimination Period. Has been satisfied, you are under the Regular Care of a Physician, and you are disabled as defined in this certificate. We will send you a Monthly Benefit for any period for which we are liable, but not beyond the Maximum Period of Payment shown in the Schedule of Benefits. No benefit is payable during the Elimination Period.

After the Elimination Period., if you are disabled for less than one (1) month, we will send you 1/30th of your Monthly Payment for each day of your disability.

If you are receiving, or are eligible to receive, benefits for a disability under a prior disability plan that was sponsored by your Employer or you were terminated before the Effective Date of this plan, then no benefits will be payable for the disability under the policy.

What Is the Maximum Period of Payment?

You will receive a benefit for each month you remain disabled up to the Maximum Period of Payment. The Maximum Period of Payment is described in the Schedule of Benefits.

Recurrent Disability

If you have a Recurrent Disability, we will treat your disability as part of your prior claim, and you will not have to complete another benefit Elimination Period if:

a) you are continuously insured under the plan for the period between the end of your prior claim and your Recurrent Disability; and
b) your Recurrent Disability occurs within six months from the end of your prior claim; and
c) the policy remains in force.

Your Recurring Disability will be subject to the same terms of the plan as your prior claim and will be treated as a continuation of that disability.

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

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

How Is Your Benefit Determined?

How Is Your Benefit Determined When Not Working?

We will follow this process to calculate your benefit amount:

1. Multiply your Monthly Earnings by the Monthly Benefit percentage shown in the Schedule of Benefits.
2. The maximum Monthly Benefit is listed in your Schedule of Benefits.
3. Compare the answer from item 1 with the Maximum Monthly Benefit. The lesser of these two amounts is your Gross Monthly Benefit.
4. Subtract any Deductible Sources of Income from your Gross Monthly Benefit.

The amount figured in item 4 is your Monthly Benefit. The Monthly Benefit will be recalculated when your income changes or you receive any new Deductible Sources of Income.

How Is Your Benefit Determined If You Were Disabled and Working?

You may continue to work or return to work while you are Disabled and still be eligible to collect your Monthly Benefit. Your Monthly Benefit may be reduced by your Disability Earnings from the Policyholder, or another employer for which you become employed after your disability began. 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.

Work Incentive Benefit

1. If you are disabled and return to work, we will not reduce your Monthly Benefit or Disability Earnings if:

    a) your monthly Disability Earnings, if any, or less than 20% of your Index Monthly Earnings; and

    b) you have satisfied the Elimination Period.

2. If you are disabled and your monthly Disability Earnings are 20% or more of your Indexed Monthly Earnings, we will calculate your Monthly Benefit as follows:

    a) during the first 12 months of benefits, while working, your Monthly Benefit will not be reduced by your Disability Earnings as long as Disability Earnings plus the Gross Monthly Benefit does not exceed 100% of Indexed Monthly Earnings.

        1) Add your monthly Disability Earnings to your Gross Monthly Benefit.

        2) Compare the answer in item 1) to your Indexed Monthly Earnings.

        If the answer from item 1) is less than or equal to 100% of your Indexed Monthly Earnings, we will not further reduce your Monthly Benefit.

If the answer from item 1) is more than 100% of your Indexed Monthly Earnings, we will subtract the amount over 100% from your Monthly Benefit.

b) After benefits have been payable for 12 months, while working, the amount of your Monthly Benefit will change, and we will consider a portion of your Disability Earnings to be Deductible Source of Income. 50% of your Disability Earnings will be added to your other Deductible Sources of Income, if any. The sun will be deducted from your Gross Monthly Benefit.

This amount will be your Monthly Benefit.

We may require you to send proof of your Disability Earnings on a quarterly basis. We will recalculate your benefit and adjust your Monthly Benefit based on your monthly Disability Earnings.

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

When Will Your Monthly Benefits End If Working While Disabled?

During the Regular Occupation Period, if your monthly Disability Earnings exceed 80% of your Indexed Monthly Earnings, we will stop your benefits and your claim will end.

Beyond the Regular Occupation, if your monthly Disability Earnings exceed 60% of your Indexed Monthly Earnings, we will stop your benefits and your claim will end.

We will review your status from time to time. We will require satisfactory proof of earnings and continued disability.

How Can We Protect You If Your Disability Earnings Fluctuate?

If your Disability Earnings routinely fluctuate widely from month to month, we may average your Disability Earnings over the most recent 3 months to determine if your claim should continue.

If we average your Disability Earnings, we will terminate your claim if:

- during the Regular Occupation Period, the average of your Disability Earnings from the last 3 months exceeds 80% of Indexed Monthly Earnings; or
- beyond the Regular Occupation Period, the average of your Disability Earnings from the last 3 months exceeds 60% of Indexed Monthly Earnings.

We will not pay you for any month during which Disability Earnings exceed the above amounts. The Minimum Monthly Benefit will not be paid when Disability Earnings exceed the above amounts.

What Are Deductible Sources of Income and How Do They Affect My Benefits?

Deductible Sources of Income are other income benefits you, your Spouse or child may be entitled to receive because of your disability or retirement. These benefits are taken into consideration when your Monthly Benefit is calculated and may reduce your Monthly Benefit.

We will only subtract Deductible Sources of Income which are payable as a result of your disability, with the exception of retirement payments, amounts earned or received from any form of employment and amounts received from any unemployment compensation law.

We will subtract from your Gross Monthly Benefit the following Deductible Sources of Income:

1. The amount that you receive or are entitled to receive under:
    - a workers' compensation law;
    - any state or federal occupational disease or injury law;
    - any other plan, act, or law, with similar intent.
2. The amount that you are entitled to receive as disability benefits under any:
    - state compulsory benefit act or law;
    - income payments under no fault motor vehicle plan;
    - other group insurance plan to the extent that such policy or plan covers the same pre-disability income;
    - governmental retirement system as a result of your job with your Employer.
3. The gross amount that you, your Spouse, and children receive or are entitled to receive as disability benefits because of your disability under:
    - the United States Social Security Act;
    - the Canada Pension Plan;
    - the Quebec Pension Plan;
    - the Railroad Retirement Act;
    - any similar plan, act, or law, of any country, state, or province.

    Amounts paid to your former Spouse or to your children living with such Spouse will not be included.
4. The gross amount that you receive as retirement payments or the amount your Spouse and Children receive as retirement payments because you are receiving retirement payments under:
    - the United States Social Security Act;
    - the Canada Pension Plan;
    - the Quebec Pension Plan;
    - the Railroad Retirement Act;
    - any similar plan, act, or law, of any country, state, or province.

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

    Benefits paid to your former Spouse or your children living with such Spouse will not be included.
5. The amount that you:
    - receive as disability benefits under your Employer's Retirement Plan;
    - voluntarily elect to receive as retirement benefits under your Employers Retirement Plan;
    - receive as retirement benefits when you reach the later of age 62 or normal retirement age, as defined in your Employer's Retirement Plan.

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

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

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

Amounts received do not include amounts rolled over or transferred to any eligible Retirement Plan. We will use the definition of eligible Retirement Plan as defined in section 402 of the Internal Revenue Code including any future amendments that affect the definition.

6. Third Party payments, damages, settlements, or judgments received or lost income for your disability (after subtracting attorney's fees). If the amount received from the Third Party does not specify the lost income amount, we will estimate the amount using a percentage of the settlement amount based on your covered Monthly Earnings, prorated to cover the period for which the settlement or judgment was made. If we elect to reduce a disability benefit on account of other benefits, or incomes for amounts received minus legal fees, for lost income due to a disability because of an act of omission of the Third Party, we will not elect subrogation for that same claim.
7. The amount you receive under Title 46, United States Code Section 688 (The Jones Act) and the Doctrine of Unseaworthiness.
8. The amount of loss of time benefits that you receive or are entitled to receive under any Salary Continuation and Accumulated Sick Leave.
9. Disability benefits received under state disability benefit plans and state family leave benefit plans, where permitted by state law.
10. The amount you receive or are entitled to receive under any unemployment income act or law due to the end of employment with your employer or payable by insured and uninsured plans or as a result of your membership or association in any group, union or other organization.

    With the exception of retirement payments, or amounts that you receive from a partnership, proprietorship or any similar draws, we will only subtract Deductible Sources of Income which are payable as a result of your disability.

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

What Are Not Deductible Sources Of Income?

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

- 401(k) plans;
- profit sharing plans;
- thrift plans;
- tax sheltered annuities;
- stock ownership plans;
- non-qualified plans of deferred compensation;
- pension plans for partners;
- military pension and disability income plans;
- credit disability insurance;
- franchise disability income plans;

individual retirement accounts (IRA);

- individual disability income plans;
- 457 deferred compensation plans;
- 403(b) tax sheltered annuity plans;
- a salary continuation or accumulated sick leave plan;
- retirement benefits from a former employer.

What If Subtracting Deductible Sources Of Income Results In A Zero Benefit (Minimum Monthly Benefit)? *(Class 2 only)*

If your Monthly Benefit is reduced to zero due to subtracting Deductible Sources of Income, you will receive a minimum Monthly Benefit. Your minimum Monthly Benefit is listed on the *Schedule of Benefits*.

We may apply your minimum Monthly Benefit toward any outstanding overpayment.

The minimum Monthly Benefit will not be paid in any month when Disability Earnings exceed 80% of your Indexed Monthly Earnings. This includes when we average your Disability Earnings as described above.

What Happens When You Receive a Cost of Living Increase from Deductible Sources of Income?

Once we have subtracted any deductible source of income from your Gross Monthly Benefit, we will not further reduce your Monthly Benefit due to a cost of living increase from that source.

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

When we determine that you may qualify for benefits in the Deductible Sources of Income section, we will estimate your entitlement to these benefits. We can reduce your Monthly Benefit by the estimated amounts if such benefits:

- have not been awarded or received; and
- have not been denied.

Your Monthly Benefit may NOT be reduced by the estimated amount if you:

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

If your benefit has been reduced by an estimated amount, your benefit will be adjusted when we receive Proof;

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

We will not estimate your entitlement to the following:

- payments you receive as disability payments under your Employer's Retirement Plan;
- payments you voluntarily elect to receive as retirement payments under your Employer's Retirement Payments Plan;
- payments you are eligible to receive as retirement payments when you reach the later of age 62 or normal retirement age, as defined in your Employer's Retirement Plan;
- the amount you receive as disability payments under any "no fault" motor vehicle plan; or
- the amount you receive from a Third Party (after subtracting attorney's fees) by judgment, settlement or otherwise as disability payments.

What Happens If You Receive a Lump Sum Payment?

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

When Will Disability Benefits Stop or Will Not Be Paid?

When Will Disability Payments Stop?

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

- the end of the Maximum Period of Payment;
- the date you are no longer disabled under the terms of the plan;
- during the first 24 months of payable benefits, when you are functionally able to work in your Regular Occupation on a Part-Time Basis, increase your hours, or increase the number or type of duties you perform in your Regular Occupation, but you choose not to;
- after 24 months of payable benefits, when you are able to work in any Gainful Occupation on a full time or Part-Time Basis, but you choose not to;
- if you are working and your monthly disability exceed 80% of your indexed monthly earnings;
- the date you fail to submit Proof of continuing disability;
- the date your earnings exceed 80%;
- incarceration or in a penal or correctional institution;
- your date of death; or

- the date any Employer offers you another or modified job position, which Physicians agree you are functionally able to perform at a pay rate that exceeds 80% of your Indexed Monthly Earnings.

When Will Disability Benefits Not Paid?

Disability Benefits will not be paid for any period of disability during which you:

- are not following a plan of Appropriate Care for your disability, or complications of your disability.;
- are not receiving Appropriate Care;
- failed to cooperate with us in the administration of the claim. Such cooperation includes, but is not limited to providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due;
- failed to complete your responsibilities under the Vocational Rehabilitation Program without Good Cause; or
- refuse to participate in Vocational Rehabilitation Program without Good Cause.

If you become covered under another group disability income policy or plan to the extent that such policy or plan covers the same pre disability income, you will not be eligible for benefits under this disability plan.

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:

- a Pre-Existing Condition;
- commission or attempt to commit a felony;
- intentionally self-inflicted harm;
- attempted suicide;
- injury or sickness while you are serving on full-time active duty in any armed forces.
- active participation in a riot, act of insurrection, rebellion or civil commotion, or act of terrorism;
- active service in the military, navy, armed forces, National Guard, or reserve forces of any country or international authority;
  - however, service in reserve forces does not constitute service in the armed forces, unless in connection with such reserve service an individual is on active military duty as determined by the applicable military authority other than weekend or summer training;
  - for purposes of this provision reserve forces are defined as reserve forces of any branch of the military of the United States or of any other country or international authority, including but not limited to the National Guard of the United States or the National Guard of any other country; or
- commission of a crime for which you have been convicted, this includes but is not limited to local, state, country, provincial or federal law, or the disability results from commission of, or attempting to commit a criminal act;
- the revocation, restriction or non-renewal of your license, permit or certification necessary to perform the duties of your occupation unless due solely to injury or illness otherwise covered by the Group Insurance Policy;
- engaging in any illegal occupation, work, employment, or activity.

What Is a Pre-Existing Condition?

You have a Pre-Existing Condition if both 1 and 2 are true:

1. you received medical treatment, consultation, care, or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage or the date and increase in benefits through amendment or your enrollment in another plan option, would otherwise be available; and
2. the disability began to the first 12 months after your effective date of coverage.

What Disabilities Have a Limited Pay Period Under Your Plan?

We will pay disability benefits on a limited basis for a disability caused by, or contributed to by, any one or more of the following conditions:

- Disabilities due in whole or in part to Mental Disorder have a maximum pay period of 24 months during your lifetime.
- Disabilities due in whole or in part to Substance Abuse (alcohol abuse, drug abuse or dependency) have a limited pay period of 24 months during your lifetime.

Benefit Extension for Mental Disorders

We will continue your benefits beyond the 24-month period if you are Confined to a Hospital, Health Facility, or Institution at the end of the 24-month period, we will continue your benefits during your Confinement.

We will continue your benefits 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 your benefits during your Confinement.

   If you are still disabled when you are discharged, we will continue your benefits for a recovery period of up to 180 days.

   If you become re-Confined at any time during the recovery period and remain Confined for at least 14 days in a row, we will continue your benefits during that additional Confinement and for one additional recovery period up to 180 more days.

In addition to item 1, if, after the 24 month period for which you have received benefits, you continue to be disabled and subsequently become Confined to a Hospital, Health Facility, or Institution for at least 14 days in a row, we will continue benefits during the length of the re-Confinement.

We will not pay Monthly Benefits beyond the Maximum Period of Payment.

We will not apply any period of confinement to your lifetime cumulative maximum.

Exceptions

We will not apply the Mental Disorder limitation to dementia if it is a result of:

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

OTHER BENEFITS

Survivor Benefit (Benefits If You Die)

When we receive proof that you have died, we will pay your Eligible Survivor a lump sum benefit equal to the amount shown in the Schedule of Benefits if, on the date of your death:

- your disability had continued for 6 or more consecutive months; and
- you were receiving or were eligible to receive payments under the policy.

If you have no Eligible Survivors, payment will be made to your estate.

However, we will first apply the Survivor Benefit to recover any overpayment that may exist on your claim. The Deductible Sources of Income provision will not be considered in calculating this benefit.

Vocational Rehabilitation Program

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. In order to be eligible for vocational rehabilitation services and a Vocational Rehabilitation Monthly Benefit, you must be medically able to participate in a return to work plan.

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. Nonparticipation in a Rehabilitation plan shall not affect our determination of whether you are disabled.

If we determine that vocational rehabilitation services are appropriate, we will provide you with a Written Vocational Rehabilitation Program developed specifically for you.

The Vocational Rehabilitation Program may include at our sole discretion, but is not limited to, the following services:

- coordination with your Employer to assist you to return to work;
- evaluation of adaptive equipment or Reasonable Accommodations to allow you to work;
- evaluation of possible workplace modifications which might allow you to return to work in your Regular Occupation or another job or occupation;
- vocational evaluation to determine how your disability may impact your employment options;
- job placement services, including resume preparation services and training in job seeking skills;
- alternative treatment plans such as recommendations for support groups, physical therapy, occupational therapy; or
- other treatment designed to enhance your ability to work.

When The Vocational Rehabilitation Program Ends

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

- the date we determine that you are no longer eligible to participate in a Vocational Rehabilitation Program;
- the date you are no longer participating in a Vocational Rehabilitation Program; or
- any other date on which Monthly Benefits would stop in accordance with the policy.

If you are participating in a Vocational Rehabilitation Services Program and fail to complete your responsibilities under the Vocational Rehabilitation Program without Good Cause, then we may discontinue our payment to you under the policy. If benefits are discontinued under this provision, you will have the right to an appeal review of that decision. Failure to complete your responsibilities under the Vocational Rehabilitation Program will not affect our determination of whether you are disabled.

Vocational Rehabilitation Monthly Benefit

If you are receiving Monthly Benefits under the policy, and you are participating in a Vocational Rehabilitation Program, you may be eligible for an additional Vocational Rehabilitation Monthly Benefit. We will pay an additional monthly benefit equal to the amount shown in the Schedule of Benefits for the number of months shown on the Schedule of Benefits.

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:

- the date we determine that you are no longer eligible to participate in a Vocational Rehabilitation Program;
- the date you are no longer participating in a Vocational Rehabilitation Program;
- the date the maximum benefit is paid; or
- any other date on which Monthly Benefits would stop in accordance with the policy.

Family Member Care Expense Benefit

If You are receiving Monthly Benefits under the policy, and You are participating in a Vocational Rehabilitation Program, You will be eligible for an additional Family Member Care Expense Benefit if You are incurring expenses to provide care for a Family Member who requires Personal Care Assistance.

We will pay the Family Member Care Expense Benefit shown in the *Schedule of Benefits*. .

Family Member Care Expense Benefit will end on the earliest of the following dates:

- The date You are no longer incurring Family Member care expenses;
- The date You are no longer participating in a Vocational Rehabilitation Program;
- After 24 months of Family Member Care Expense Benefits have been paid for each Family Member; or
- Any other date on which Monthly Benefits would stop in accordance with the policy.

To receive this benefit, You must provide satisfactory proof that You are incurring Family Member Care Expenses. Family Member Care Expenses must be documented by a caregiver receipt which includes his or her taxpayer identification information.

For the purpose of this benefit, the following additional definitions will apply:
Family Member means***:***

- means an individual who can be claimed as a dependent by You for federal income tax purposes;
- Your child under the age of 5 who requires child care or other supervised care by a care giver; or
- An impaired dependent adult in Your household who is mentally or physically handicapped who requires a care giver and dependent upon You for support and maintenance.

Family Member Care Expenses means the expense incurred for care, supervision, and support of a Family Member, provided by an adult other than a person who is Your Immediate Family Member including expenses incurred for a licensed day care program or childcare provided by an adult other than a person who is Your Immediate Family Member.
Personal Care Assistance means care or supervision of Your Child or Family Member; provided by a licensed child or adult-care center or a licensed caregiver who is not Your Immediate Family Member.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income.

Workplace Modification Benefit

If you are disabled and are receiving a payment from us, an additional Workplace Modification Benefit may be payable to your Employer for your benefit. We will assist the Employer, you and your Physician in identifying an appropriate workplace modification. We will pay the Workplace Modification Benefit shown in the *Schedule of Benefits*.

To qualify for this reimbursement, you must:

- be disabled according to the terms of the policy; and
- have the reasonable expectation of returning to Active Employment and remaining an Active Employment with the assistance of the proposed workplace modification.

Your Employer must give us a Written proposal of the proposed workplace modification. This proposal must include:

- input and approval from the Employer, you and your Physician;

- the purpose of the proposed workplace modification;
- the expected completion date of the workplace modification; and
- the cost of the workplace stop modification.

The Written proposal must be Signed by us, the Employer and you. We will reimburse the cost of the workplace modification when we:

- approved the proposal In Writing;
- receive proof from your Employer that the workplace modification is complete; and
- received proof of the cost incurred by your Employer for the workplace modification.

This benefit is available on a one time basis.

GENERAL PROVISIONS

Entire Contract

This insurance is provided under a contract of group disability insurance with the Policyholder. The entire contract with the Policyholder consists of:

- all policy provisions and any amendments and endorsements to the policy;
- this Certificate of Coverage and any amendments and endorsements to this Certificate of Coverage;
- the Policyholder's Signed application.

Fraud Notice

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Certificate Of Coverage

This Certificate of Coverage 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 will make a payment; and
- the limitations, exclusions and requirements that apply within the policy.

No benefits are payable under this certificate in the absence of payment of current premiums subject to the Grace Period and the Premium Section of the policy. Unless specifically provided for in any applicable termination or continuation of coverage provision described in this certificate or under the terms of the policy, this plan does not pay benefits for a disability incurred before coverage starts under this plan. This plan will not pay any benefits for any losses, claims or expenses that start after coverage ends.

Benefits may be modified during the term of this plan as specifically provided under the terms of the policy or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits apply) to any losses incurred that start on or after the effective date of the plan modification. There are no vested rights to receive any benefits described in the policy or in this certificate beyond the date of termination or renewal including if the loss, accident, or disability starts on or after the effective date of the plan modification, but prior to your receipt of amended plan documents. If the policy ends, it will not affect a claim otherwise payable under the certificate.

Incontestability

We consider any statement made by you a representation and not a warranty. No statement made by you will be used to reduce or deny any claim or to terminate your coverage unless:

- the statement is in Writing on an evidence of insurability form that is Signed by you; and
- a copy of that statement is given to you, your eligible survivor, or legally authorized representative.

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. For any applied or increased in coverage or reinstatement of coverage, a new two-year contestability period is applicable to the amount of the applied for increases, or reinstated coverage. Fraudulent statements will be used to contest the insurance for which the fraudulent statement was made when permitted by applicable law in the state where this certificate is delivered or issued for delivery.

No statement made by you will be used to contest the insurance under the policy unless the statement is material to the risk accepted by us.

Clerical Error

Clerical error or omission by us or the Policyholder will not:

- prevent you from receiving coverage, if you are entitled to coverage under the terms of the policy; or
- cause coverage to begin or continue for you when the coverage would not otherwise be effective; or
- continue benefit payments under the policy that otherwise should validly terminate.

If we or the Policyholder make a clerical error in keeping data that is required to compute premiums and administer the terms of the policy, we will:

- use the facts to decide whether you have coverage under the policy and in what amounts; and
- 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.

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.

Agency

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

Non-Dividend Paying Policy

The policy is not entitled to share in surplus distribution.

Termination Or Amendment of The Policy

If a disability for which Monthly Benefits are payable begins while your coverage under the policy is inforce, benefits will be payable after termination of your coverage to the same extent as if the coverage had not terminated.

CLAIM INFORMATION

Notice of Claim

We encourage you to notify us of your claim as soon as possible. This will help us make a claim decision in a timely manner. Written notice of a claim should be given to us within 30 days after the date your disability begins. 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.

Claim Forms

The claim form is available from your Employer, or you can request a claim form from us.

Within 15 days after we receive your notice of a claim, we will send claim forms. The claim form is also available from your Employer. If we do not send you the claim forms within 15 days after receiving notice of your claim, you shall be deemed to have complied with the requirements of proof of claim when you submit Written proof that covers the occurrence, character, and extent of the loss for which a claim is made.

Filing A Claim

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

Our customer service department will assist you to file your claim. Call the number in this certificate.

Proof of Your Claim

You must send us Written Proof of your disability claim no later than 90 days after your Elimination Period ends. Your proof of claim, provided at your expense, must show:

- that you are under the Appropriate Care of a Physician;
- the date your disability began as determined by your Physician;
- the cause of your disability;
- the appropriate documentation of your Monthly Earnings and Disability Earnings;
- the extent of your disability, including restrictions and limitations preventing you from performing your Regular Occupation;
- the name and address of any Hospital, Health Facility, or Institution where you received treatment, including all attending Physicians; and
- documentation of prior disability coverage, if applicable.

For all other claims you must send us Written Proof no later than 90 days after the date of the last 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. 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.

You will be required to give us Written authorization to obtain additional medical information and to provide non-medical information such as vocational, occupational, financial, and governmental as part of your Proof of claim. We will deny your claim, if the appropriate information is not submitted within 45 days of the request.

Continuing Proof of Claim

We may require you to provide continuing proof of your claim as often as it is reasonable to do so during the pendency of your claim. You will have 60 days from the date of our request to provide us with continuing proof of your claim. Failure to provide continuing proof of your claim shall not result in a reduction of your benefits, however your benefit payment may be delayed until the requested continuation Proof is provided. You must provide continuing Proof of claim no later than 1 year after the time Proof is otherwise required, except in the absence of legal capacity. This Proof shall be in Writing and satisfactory to us.

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

To Whom Payments Are Made

We will pay your benefits to you unless this certificate specifies otherwise. If any amount for which we are liable remains unpaid when you die, we will pay that amount to your Eligible Survivor or, if none, to your estate. If, however, it is necessary

for the establishment of a guardianship or conservatorship, or appointment of a trustee, executor or administrator, we may withhold further benefits until sufficient evidence is provided to us that any such establishment or appointment has been finalized. We will pay benefits within 30 days of receiving sufficient evidence of the establishment or appointment. If we pay benefits on or after the 31st day of receiving sufficient evidence, the delayed payment will be subject to a simple 10% interest rate per year, beginning with the 31st day and ending on the day benefits are paid.

Time Payment of Claims

Once your claim has been approved, we will send you a payment at the end of each month for any period for which we are liable. The first Monthly Benefit will be paid within 30 days of an approved claim. Any balance remaining unpaid by us upon termination. of such period for which we are liable will be paid within 30 days upon receipt of Proof of your claim. A delayed payment of your claim will be subject to a simple interest at a rate of 10% per year beginning on the 31st day after receipt of satisfactory Proof of your claim and ending on the day the claim is paid. Indemnities payable under the Policy for any loss other than loss for which the Policy provides periodic payments will be paid as they accrue immediately upon receipt of do written Proof of such loss.

Authority

The Policyholder has delegated to the insurance company or its designee certain rights. These include the right to make determinations regarding the eligibility for participation or benefits and to interpret the terms of the policy and certificate. This delegation is made for the purpose of claims and enrollment administration only. The insurance company is not the Plan Administrator, as defined by ERISA.

Physical Examination

We may require you to be examined by one or more Physicians, 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 during the pendency of a claim. 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.

Refund of Unearned Premium

Any unearned premium will be refunded to the Policyholder or the Insured Person as applicable.

Claims of Creditors

Disability benefit payments are exempt from legal or equitable process for your debts, where permitted.

Right to Reimbursement

We have the right to recover any overpayment due to:

- fraud;
- any administrative error we make in processing a claim; or
- your receipt of Deductible Sources of Income.

You must reimburse us in full. If we find that we should have paid a benefit amount different from the amount actually paid, we will adjust the benefit accordingly. If we underpaid your benefit, then we will adjust the benefit to make up the underpayment. If we overpaid your benefit, you shall reimburse us. Any future benefits that are determined to be due, including any applicable minimum benefit, will be applied to the over payment until we are reimbursed in full. If future benefits are not due, we will determine the method by which the repayment is to be made.

You shall not act or fail to act in any manner that will prejudice our right to reimbursement without our prior Written agreement. If you prejudice our right to reimbursement, fail to cooperate with us or fail to comply with this provision, we may withhold any and all benefits in addition to pursuing all remedies available to us under applicable law.

If we pursue legal action against you to obtain reimbursement, you will be required to pay our costs and attorney’s fees as permitted by applicable law. We reserve the right to recover any prior or current overpayment not only from the amounts you receive as Deductible Sources of Income (to the extent permitted by applicable law) but also from any benefits from any past, current, or new disability claim payable under the policy as well as from any other funds you may have.

You must notify us if you make a claim against any Third Party. Neither you nor anyone acting on your behalf may settle your claim against the Third Party without our prior Written consent. If you recover amounts from a Third Party by award, judgment, settlement or otherwise, you must reimburse us for lost income due to a disability because of an act or omission of the Third Party. You must reimburse us regardless of whether you have been made whole by the recovery, subject to limitations under applicable law where the policy is delivered or issued for delivery. If the amount received from the Third

Party does not specify the lost income amount, we shall estimate the amount using a percentage of the settlement amount based on your Monthly Earnings, prorated to cover the period for which the settlement or judgment was made. We shall have first right to reimbursement. The amount you reimburse us will be reduced by our pro rata share of your attorney's fees and costs. If another entity is also entitled to reimbursement but does not reduce its reimbursement by its pro rata share of such fees and costs, then our pro rata share will be calculated as if that entity did make such reductions.

Right To Subrogation

If we have paid or will pay benefits in connection with a disability which you suffered because of an act or omission of a Third Party, we reserve any and all rights of recovery available to us under applicable law in the state where the policy is delivered or issued for delivery that you have against the Third Party to the extent necessary to protect our interests. We have the right to bring legal action against the Third Party on your behalf to recover the payments made by us if you do not initiate legal action for the recovery of such payments from the Third Party in a reasonable period of time. You must agree to furnish all information and documents that are necessary to secure our rights. We will pay for any expenses connected with our pursuit of subrogation or recovery. You shall not act or fail to act in any manner that will prejudice our right to subrogation without our prior Written agreement. If you prejudice our right to subrogation, fail to cooperate with us or fail to comply with this provision, we may pursue all remedies available to us under applicable law.

If we bring a legal action against the Third Party on your behalf, we will not reduce your Disability Benefits by any other amounts you receive from the Third Party.

How We Handle Insurance Fraud

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

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

You or the Policyholder may be guilty of a criminal offense and subject to penalties under state law.

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 before the applicable statute of limitations has expired but not after 3 years from the date of Proof of claim is required unless otherwise provided under federal law.

Claim Review Procedures For ERISA Plans

Claim Procedures for ERISA Plans are included in the document "Applicability of ERISA" attached to this Certificate.

APPLICABILITY OF ERISA

If this Policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply.

Information about Your ERISA Plan

The benefits are provided in a fully insured plan issued by Continental American Insurance Company, a wholly-owned subsidiary of Aflac incorporated, and are described in the Certificate of Coverage.

You have certain rights and protections under ERISA.

1. **The right to receive information about Your plan and its benefits**.
    a. You have the right to review and the right to receive, free of charge, at the Plan Administrator's office (or in a place designated by the Plan Administrator all documents governing the plan, including but not limited to, insurance contracts or a copy of the latest annual report (Form 5500). The Form 5500 is filed by the Plan with the U.S. Department of Labor (DOL) and is available in the Public Disclosure Room of the Employee Benefits Security Administration.
    b. You have the right to receive an annual summary of the Plan's financial report.

2. **The right to prudent action by the Plan fiduciaries.**
    ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries. No one, including Your employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

3. **How to enforce Your rights.**
    a. If Your claim for a benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
    b. Under ERISA, there are steps You can take to enforce Your rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the requested materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.
    c. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or Federal court. You are required to complete administrative appeals prior to filing in court. Your right to file suit in state or Federal court may be affected if You do not complete the required appeals.
    d. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

4. **Need help?**
    a. If You have any questions about the Plan, please contact the Plan Administrator.
    b. If You have any questions about Your rights under ERISA, or if You need help getting documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration (EBSA) or the Division of Technical Assistance and Inquiries, EBSA, U.S. Dept. of Labor, 200 Constitution Ave. N.W., Washington, DC 20210.
    c. Certain publications about Your ERISA rights and responsibilities can be found by calling the EBSA publications hotline or visiting dol.gov/ebsa.

Claim Procedures

How to File a Claim

If You wish to file a claim for benefits, You should follow the claim procedures described in Your insurance certificate. To complete Your claim filing, we must receive the claim information requested from You (or Your authorized representative), the attending Physician, and Your employer. If You or Your authorized representative has any questions about what to do, please contact Us directly.

Claims Procedures

We will give You notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if We determine that such an extension is necessary due to matters beyond the control of the Plan and We notify You of the circumstances requiring the extension of time and the date by which We expect to render a decision. If such an extension is necessary due to Your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and You will be afforded at least 45 days within which to provide the specified information. If You deliver the requested information within the time specified, any 30-day extension period will begin after You have provided that information. If You fail to deliver the requested information within the time specified, the decision will be made with the information we have in the file.

Adverse Benefit Determination

An adverse benefit determination means a denial, a reduction, a termination or rescission of coverage, or a failure to provide or make payment for a benefit. If Your claim is denied, this is considered an adverse benefit determination. If there is an adverse benefit determination, We will send a notice. Notice may be provided in written or electronic form. Electronic notices will be provided only when You give Your consent to receive the notice. The adverse benefit determination will include the following:

- The specific reason(s) for the determination. This may include an explanation of:
    - **What You sent:** The views of health care professionals treating You and the vocational professional who evaluated You. These will be reports that You provided;
    - **Experts from the Plan:** The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
    - **Social Security:** A disability determination made by the Social Security Administration that You provided;
- Reference to specific Plan provision(s) on which the determination is based;
- When necessary, a description of additional material or information needed to complete the claim and why such information is necessary;
- A statement that You are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the claim for benefits;
- Identification of any internal rule, guideline, protocol or standard relied on for the claim determination;
- The Plan procedures and time limits for appealing; and
- Your right to obtain information about the appeal procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from us on appeal, including the limitation that any such lawsuit is brought no later than 3 years from the time proof of claim was required.

Right to appeal if there is an Adverse Benefit Determination

You or someone You name to act for You (authorized representative) may file an appeal. If someone files an appeal on Your behalf, You must let Us know that You have appointed this person as Your authorized representative. Your appeal must be In Writing and sent to Us. When You send Your appeal, You may include written comments, documents, records or other information related to Your claim. You have the right to one appeal.

Time Frame. You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. The appeal will be reviewed, and a determination notice will be sent within 45 days of receiving the appeal. Sometimes, it will take longer to review the appeal because additional information is needed to make a decision. If this happens, within 45-days, We will let You know that an extension is necessary and the reason for the extension. The review period may be extended twice, 90 days in total. If an extension is given to give You more time to submit information necessary to decide the appeal, the letter we send will tell You what is needed. You will be given 45-days to provide the information. The extension of time to review the information will begin after

the requested information is received. If You fail to send the requested information, the appeal will be decided based on the information we have at the end of the 45 days.

Information used to make an appeal decision. You will have the opportunity to submit written comments, documents, or other information in support of Your appeal. If We receive additional evidence or rationales that were not included when the benefit was first denied, We will notify You and give You a reasonable opportunity to respond to the information before the plan's decision is due.

Appeal Review. The appeal will be reviewed by someone who did not make the initial decision. This reviewer will look at all the information submitted and may consult with a qualified medical professional. The appeal reviewer will not give consideration to the initial decision. The appeal reviewer will review the evidence and the rationale that was included when the benefit was first denied. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or someone who works for them. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of Your claim, We will provide You with the names of each such expert, regardless of whether the advice was relied upon. In selecting a health care professional to review the appeal, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) are not made based upon the likelihood that the individual will support the denial of benefits. If We receive additional evidence or rationales that were not included when the benefit was first denied, We will notify You and give You a reasonable opportunity to respond to the information before the plan's decision is due.

Appeal Decision. We will send a Notice of the appeal decision. Notice may be provided in written or electronic form. Electronic notices will be provided only when You give Your consent to receive the notice. The appeal determination will include the following:

- The specific reason(s) for the determination. This may include an explanation of:
    - **What You sent:** The views of health care professionals treating You and the vocational professional who evaluated You. These will be reports that You provided;
    - **What We received or obtained:** An description of any new information received or obtained during the claim review or appeal review;
    - **Experts from the Plan:** The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
    - **Social Security:** A disability determination made by the Social Security Administration that You provided;
- Reference to specific Plan provision(s) on which the determination is based;
- When necessary, a description of additional material or information needed to complete the claim and why such information is necessary;
- A statement that You are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the claim for benefits; and
- Your right to obtain information about the appeal procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from us on appeal, including the limitation that any such lawsuit is brought no later than 3 years from the time proof of claim was required.

Requirement to File an Internal Appeal Before Filing a Lawsuit

If Your claim is denied, in whole or in part, after You have completed the appeal procedure, You may file a civil action in federal court under ERISA.

Procedures For Claim Review and Appeals Of Adverse Benefit Determinations.

Claims Procedures

How to File a Claim

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, we must receive the claim information requested from you (or your authorized representative), the attending Physician, and your Employer. If you or your authorized representative has any questions about what to do, please contact us directly.

We will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if we determine that such an extension is necessary due to matters beyond the control of the Plan and we notify

you of the circumstances requiring the extension of time and the date by which we expect to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30-day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, the decision will be made with the information we have in the file.

Adverse Benefit Determination

An adverse benefit determination means a denial, a reduction, a termination or rescission of coverage, or a failure to provide or make payment for a benefit. If your claim is denied, this is considered an adverse benefit determination. If there is an adverse benefit determination, we will send a notice. Notice may be provided in Written or electronic form. Electronic notices will be provided only when you give your consent to receive the notice.

Right To Appeal If There Is An Adverse Benefit Determination

You or someone you name to act for you (authorized representative) may file an appeal. If someone files an appeal on your behalf, you must let us know that you have appointed this person as your authorized representative. Your appeal must be In Writing and sent to us. When you send your appeal, you may include written comments, documents, records, or other information related to your claim. You may appeal the entire decision or part of the decision. Your appeal must be sent within 180 days of receiving the notice of the denial.

You are entitled to receive, upon request, free of charge any copies of documents, records, or other information relevant to the claim determination.

The appeal will be reviewed, and a determination notice will be sent within 45 days of receiving the appeal. Sometimes, it will take longer to review the appeal because additional information is needed to make a decision. If this happens, within 45-days, we will let you know that an extension is necessary and the reason for the extension.

The appeal will be reviewed by someone who did not make the initial decision. This reviewer will look at all the information submitted and may consult with a qualified medical professional. The appeal reviewer will not give consideration to the initial decision. The appeal reviewer will review the evidence and the rationale that was included when the benefit was first denied.

Need help?

If you have any questions about the Plan, please contact the Plan Administrator or us at:

Continental American Insurance Company
P.O. Box 427 • Columbia, South Carolina 29202 • 800.206.8826