

Zurich American Life Insurance Company

Long Term Disability Plan

Benefits Schedule

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

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

Policyholder:	Activision Blizzard
Policy Number:	CLPEX01033
Policy Effective Date:	January 1, 2017
Plan Year:	January 1, 2017 through December 31, 2017 and each following January 1 st .
Eligible Classes: All persons in the following class(es) are eligible for <i>employee</i> coverage: Class 1 (Core and Buy-Up): All active, <i>full-time employees</i> of Activision Publishing, Inc. (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 <i>employees</i> classified as Executive. Class 2: All active, <i>full-time employees</i> of Activision Publishing, Inc. (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 Requirement For Active Employment: Full-Time Employees: <i>Employees</i> must be working at least 30 regularly scheduled hours per week.	
Service Waiting Period: <ul style="list-style-type: none">• For <i>employees</i> in an <i>eligible class</i> on or before the <i>Policyholder's Policy</i> effective date: First day of the month coincident with or next following the date of hire.• For <i>employees</i> in an <i>eligible class</i> after the <i>Policyholder's Policy</i> effective date: First day of the month coincident with or next following the date of hire.	
Who Pays For The Coverage: Core Benefit: <i>Your employer</i> pays the cost of your coverage.	

Buy-Up Benefit (Class 1):

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

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

Elimination Period:

Benefits start after the first 180 days of an approved disability.

Benefits begin the day after the *elimination period* is completed.

Accumulation Period:

30 days

MONTHLY BENEFIT

Class 1:

Monthly Benefit Percentage: 40% of *covered monthly earnings* to the maximum benefit of \$5,000 per month, less *deductible sources of income*.

Buy-Up Benefit: 60% of *covered monthly earnings* to the maximum benefit of \$10,000 per month, less *deductible sources of income*.

Class 2:

Monthly Benefit Percentage: 60% of *covered monthly earnings* to a maximum benefit of \$10,000 per month less *deductible sources of income*.

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

The Minimum Monthly Benefit is:

Greater of \$100 or 10% of *your gross disability benefit*.

You are not eligible for the minimum *monthly benefit* during periods of overpayment until the overpayment has been recovered by *us*, or offset by *your monthly benefit*.

Survivor Benefit:

3 times the *gross disability benefit*.

Rehabilitation Program Benefit: 5% of *your gross disability benefit* to a maximum of \$1,000 per month.

Refer to the Certificate for program details.

In addition, we will provide a *monthly benefit* to you for 3 months following the date *your* disability ends if we determine you are no longer disabled while:

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

Child Care Expense Benefit: While you are participating in *our rehabilitation program*, you may receive payments to cover certain child care expenses limited to the following amounts:

Child Care Expense Benefit Amount: \$250 per month per child.

Child Care Expense Maximum Benefit Amount: \$1,000 per month for all children.

Limited Benefits for Mental Illness, Mental Disorders, Substance Abuse, Drug or Alcohol Addiction:

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

Pre-Existing Condition Limitation:

3/12 applies, refer to the Certificate for a full description.

Maximum Benefit Duration Table

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

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

Limited and Excluded Conditions and Disabilities:

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

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

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

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 was terminated before the effective date of this *Plan*, then no benefits will be payable for the disability under this *Policy*.

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

Zurich American Life Insurance Company

Certificate of Coverage

Long Term Disability Plan

Policyholder: Activision Blizzard

Policy Number: CLPEX01033

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

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

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

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

Your coverage may be cancelled or changed in whole or in part under the terms and provisions of the *Policy*. The *Policy* is delivered in and is governed by the *laws* of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

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

Zurich American Life Insurance Company is located at:

**1299 Zurich Way
Schaumburg, Illinois 60196**

Our toll free number is: 877-856-2268
Outside the United States: 719-268-2416
Our website address is: www.zurichna.com

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Special Notices

Zurich American Life Insurance Company

Toll Free Number:	877-856-2268
Social Security Advocacy Program:	877-856-2268
Claim Information Toll Free Number:	877-856-2268
Outside the United States:	719-268-2416

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

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

This *Policy* prohibits a distinction on the basis of marital status for lack of marital status between an *Insured* and the other parent in the determination of the *dependents* for the *beneficiaries* of the *Insured*, or both.

Fraud Notice

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits or an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and subjects the person to civil and criminal penalties.

GENERAL PROVISIONS

Zurich American Life Insurance Company

Your Long Term Disability Plan

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

What Is The Certificate?

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

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

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

Eligibility

Who Is Eligible For Coverage?

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

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

Determining Your Eligible Class

Your employer determines the criteria that are used to define the *eligible class(es)* for insurance coverage under this *Plan*. Such criteria are based solely upon the conditions related to *your* employment.

The criteria describing *eligible classes* of *employees* are listed on the Schedule of Benefits attached to this Certificate. 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 working for *your employer* in an *eligible class*, the date *you* are eligible for coverage is the later of:

- the *Plan* effective date; or
- the day after *you* complete *your service waiting period*.

New Hires

If *you* are in an *eligible class* on the date of hire, *your eligibility date* is the date *you* are hired. If *you* enter an *eligible class* after *your* date of hire, *your eligibility date* is the date *you* complete *your service waiting period*. If *you* have already satisfied the *service waiting period* with the *Policyholder* before *you* enter the *eligible class*, *your eligibility date* is the date *you* enter the *eligible class*.

What Is A Service Waiting Period?

Once *you* enter an *eligible class*, *you* will need to complete the *service waiting period* before *your* coverage under the *Plan* begins. The *service waiting period* is the continuous length of time that *you* must be in *active employment* and in an *eligible class* before *you* are eligible for coverage under this *Plan*. The *service waiting period* will be extended by the number of days *you* are not in *active employment*. The *service waiting period* is shown on the Benefits Schedule.

Except as noted in the "Reinstatement Provision", if *you* terminate this insurance and later wish to reapply, or if *you* are a former *employee* who is rehired, a new *service waiting period* must be satisfied.

Effective Date Of Coverage

When Does Your Coverage Begin?

Core Plan

When *your employer* pays 100% of the cost of *your* coverage under a *Plan*, *your* coverage will begin at 12:01 a.m. Central Standard Time on the first day of the following month on which *you* are eligible for coverage.

Buy-Up Plan (Class 1 Only)

When *you* and *your employer* share the cost of *your* coverage under a *Plan* or when *you* pay 100% of the cost of *your* coverage, *you* will be covered at 12:01 a.m. Central Standard Time on the latest of:

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

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

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

Enrollment

How Do You Enroll For Coverage?

You will be provided with the *Plan* design and enrollment information when *you* first become eligible. If *you* are not required to contribute towards the cost of coverage, *you* are not required to

request coverage or complete an enrollment form. *Your* enrollment will be handled by *your employer*.

If *you* must contribute towards the cost of coverage or *you* elect to purchase additional coverage at the time of enrollment *you* are required to enroll for coverage. To do so, *you* must complete and sign a group insurance enrollment form, satisfactory to *us*, and deliver it to *your employer*.

After Coverage Begins

When May You Elect To Change Your Coverage?

You will need to contact *your employer* to determine when *you* may increase or decrease *your* coverage. *Your employer* will provide *you* with information and forms *you* need to initiate the process. *Your employer* will notify *us* of the date of the change.

When Will Changes To Your Coverage Take Effect?

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 covered monthly earnings* will be effective the first of the next 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 Insurance Class

A change in *your monthly benefit* due to a change in *your eligible class* will be effective the first of the next 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 by Policy Amendment

A change in *your covered 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*, or if *you* are on a covered *layoff or leave of absence*. 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 the Company will normally be effective on the *Policy* anniversary date, or as 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*.

Neither an increase nor a decrease in coverage will affect a *payable claim* that occurs prior to the increase or decrease.

How Do You Pay For Your Coverage?

We will bill *your employer* for the premium and any amount *you* owe. *Your employer* will pay the premium on *your* behalf.

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

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

When Coverage Ends

When Does Your Coverage End?

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

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

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

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

If *you* are not in *active employment* due to *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*. *Your* coverage will not continue beyond the end of the next *Policy* month after the *Policy* month in which *your* absence started.

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.

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*.

Reinstatement Of Coverage

If *your* Long Term Disability coverage ends, *you* may apply to reinstate coverage subject to the rules described in the "When Does Your Coverage Begin" Section. If *we* approve *your* request, the reinstatement will be effective on the first day of the month coinciding with or following the approval date.

If *you* return to *active employment* within six (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 and the *service waiting period* requirement will apply only to the extent they would have applied if *your* coverage had not ended.

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

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

- the leave period required by the federal Family and Medical Leave of Absence Act of 1993 and any amendments; or
- the leave period required by applicable national, state or local *law*, or any similar *law, plan* or *act*; or
- 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 within six (6) months, we will not:

- apply a new *service waiting period*; or
- apply a new *pre-existing conditions* exclusion.

For the above exceptions to apply, *you* must request to reinstate contributory coverage within 31 days of *your* return to *active work*.

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

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

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

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

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

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

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

Incontestability

During the first two (2) years that *your* insurance is in force, we may use any statement *you* have made in contesting the validity of that coverage. This also applies to any increase in *your* coverage for the two (2) years that follow the effective date of that increase, if *evidence of insurability* was required in order for the increase to take effect.

Once coverage, including an increase in coverage has been continuously in effect for two (2) years, in the absence of fraud, the validity of *your* insurance may not be contested by *us*.

Subrogation And Right Of Reimbursement

This provision does not reduce or delay disability benefits. As used herein, the term "*Third Party*," means any party that is, or may be, or is claimed to be responsible for *illness* or *injuries* to *you* that caused *your* disability. Such *illness* or *injuries* are referred to as "*Third Party Injuries*". "*Third Party*" includes any party responsible for payment of benefits for loss of time or wages as a result of *third party Injuries*.

By accepting benefits under this *Plan*, *you* specifically acknowledge *our* right of subrogation. When this *Plan* pays benefits for disabilities incurred due to *third party injuries*, *we* shall be subrogated to *your* right of recovery against any party to the extent of all benefits provided by this *Plan*. *We* may proceed against any party with or without *your* consent.

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

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

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

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

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

Recovery Of Overpayments

If payments are made in amounts greater than the benefits that *you* are entitled to receive, *we* have the right to recover any overpayments. Refer to the claim information section for the process *we* use to recover overpayments.

How Will We Handle Insurance Fraud?

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

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

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

Does The Policyholder Act As Our Agent?

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

LONG TERM DISABILITY BENEFITS

How Do We Define A Long Term Disability?

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

- *you* are unable to perform the *material and substantial duties* of *your regular occupation* due solely to *your sickness or injury*; 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*.

You must be under the *regular care* of a *physician* in order to be considered disabled.

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

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

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

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

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

Your elimination period is 180 days.

Can You Satisfy Your Elimination Period If You Are Working?

Yes. If *you* are working while *you* are disabled, as defined under this *Plan*, only the days *you* are determined to be disabled will count toward *your elimination period*.

When Will You Begin To Receive Benefits?

You will begin to receive benefits when we approve your claim, providing the *elimination period* has been satisfied and you are disabled, but not beyond the *maximum monthly benefit* period shown in the Benefits Schedule. No benefits are payable during the *elimination period*.

We will send you a *monthly benefit* for any period for which we are liable.

What Are Your Covered 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.

As of the first of each year, the employee's salaries will be frozen and premium will be paid on that amount. Claims will be based on current salaries.

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.

As of the first of each year, the employee's salaries will be frozen and premium will be paid on that amount. Claims will be based on current salaries.

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

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

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

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

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

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

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

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

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

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

For the first 12 months of payable benefits:

1. If *you* are disabled and return to work, we will not reduce *your monthly benefit* for *disability earnings* if:
 - *your monthly disability earnings*, if any, are less than 20% of *your indexed monthly earnings* due to the same *sickness* or *injury*; and
 - *you* have satisfied the *elimination period*.
2. If *you* are disabled and *your monthly disability earnings* are 20% or more of *your indexed monthly earnings*, due to the same *sickness* or *injury*, we will calculate *your monthly benefit* as follows:
 - During the first 12 months of payable benefits, while working, *your monthly benefit* will not be reduced by *your disability earnings* as long as *disability earnings* plus the *gross disability benefit* does not exceed 100% of *indexed monthly earnings*.
 - 1) Add *your monthly disability earnings* to *your gross disability benefit*.
 - 2) Compare the answer in item 1) to *your indexed monthly earnings*.

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

If the answer from item 1) is more than 100% of *your indexed monthly earnings*, we will subtract the amount over 100% from *your monthly benefit*.

- After benefits have been payable for 12 months, while working, the amount of *your monthly benefit* will change and we will consider a portion of *your disability earnings* to be a *deductible source of income*. 50% of *your disability earnings* will be added to *your other deductible sources of income*, if any. The sum will be deducted from *your gross disability benefit*. This amount will be *your monthly benefit*.

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

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

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

When Will Your Monthly Benefits End If Working While Disabled?

During the first 24 months of *disability benefits*, if *your monthly disability earnings* exceed 80% of *your indexed monthly earnings*, we will stop *your* benefits and *your* claim will end.

Beyond 24 months of *disability benefits*, if *your monthly disability earnings* exceed 60% of *your indexed monthly earnings*, we will stop *your* benefits and *your* claim will end.

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

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

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

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

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

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

How Can We Protect You If Your Disability Earnings Fluctuate?

If *your disability earnings* routinely fluctuate widely from month to month, we may average *your disability earnings* over the most recent three (3) months to determine if *your* claim should continue.

If we average *your disability earnings*, we will terminate *your* claim if:

- during the first 24 months of disability benefits, the average of *your disability earnings* from the last three (3) months exceeds 80% of *indexed monthly earnings*;
- or
- beyond 24 months of disability benefits, the average of *your disability earnings* from the last three (3) months exceeds 60% of *indexed monthly earnings*.

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

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

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

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

1. The amount that *you* receive or are entitled to receive under:
 - a workers' compensation law;
 - an occupational disease law;
 - any other *plan, act or law* with similar intent.

2. The amount that *you* receive or are entitled to receive as disability *income* benefits under any:
 - state compulsory benefit act or law;
 - automobile liability insurance policy;
 - other group insurance plan;
 - 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.

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

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

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

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

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

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

6. 100% of the amount *you* receive under Title 46, United States Code Section 688 (The Jones Act).
7. *Third party* payments, damages, settlements or judgments received for *your* disability (after subtracting attorney's fees).
8. 100% of the amount *you* receive under the maritime doctrine of maintenance, wages and cure. This includes only the "wages" part of such benefits.
9. The amount of loss of time benefits that *you* receive or are entitled to receive under any *salary continuation* or *accumulated sick leave*.
10. 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 the same disability.

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

What Are Not Deductible Sources Of Income?

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

- 401(k) plans;
- profit sharing plans;
- thrift plans;
- tax sheltered annuities;
- stock ownership plans;
- non-qualified plans of deferred compensation;
- individual retirement accounts (IRA);
- individual disability income plans;
- 457 deferred compensation plans;
- 403(b) tax sheltered annuity plans;
- retirement benefits from a former employer.

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

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

We may apply *your* minimum *monthly benefit* toward any outstanding overpayment.

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

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

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

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

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

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

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

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

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

What Happens If You Receive A Lump Sum Payment?

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

What Is The Maximum Benefit Period?

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

When Will Benefits Stop?

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

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

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

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

What Disabilities Have A Limited Pay Period Under Your Plan?

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

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

Mental Illness

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

Drug or Alcohol Abuse

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

Benefit Extension

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* 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.

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

Exceptions

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

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

What Disabilities Are Not Covered Under Your Plan?

Your Plan does not cover any disabilities caused by, contributed to by, or resulting directly or indirectly from:

- a *pre-existing condition*;
- intentionally self-inflicted injuries or attempted suicide;
- active participation in a riot or an act of insurrection, rebellion or civil commotion;
- military service;
- 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;
- participation in an illegal activity or illegal act or to which a contributing cause was *your* being engaged in an illegal occupation;
- commission of a crime for which *you* have been convicted, this includes but is not limited to local, state, country, provincial or federal *law*, or the disability results from commission of, or attempting to commit a criminal act;

- active participation in terrorism; or
- *injury* or *sickness* while *you* are serving on full-time active duty in any armed forces.

What Is A Pre-Existing Condition?

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

1. (a) *you* received medical treatment, consultation, care or services including diagnostic measures, or were prescribed drugs or medicines in the three (3) months just prior to *your* effective date of coverage or the date an increase in benefits through amendment or *your* enrollment in another plan option, would otherwise be available; (b) or *you* had symptoms for which an ordinarily prudent person would have consulted a health care provider in the three (3) months just prior to *your* effective date of coverage or the date an increase in benefits would otherwise be available; and
2. the disability begins in the first 12 months after *your* effective date of coverage.

How Does A Pre-Existing Condition Affect An Increase In Your Benefits?

If there is an increase in *your* benefits due to an amendment of the *Plan*; or *your* enrollment in another plan option, a benefit limit will apply to the increased amount only if *your* disability is due to a *pre-existing condition*.

You will be limited to the benefits *you* had on the day before the increase if *your* disability begins during the 12 months period starting with the date the increase in benefits would have been effective.

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

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

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

Your coverage is subject to payment of premium.

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

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

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

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

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

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

If *you* do not satisfy item 1) or 2) above, we will not pay benefits under *our Plan*.
If *you* satisfy item 1), we will determine *your* benefits according to *our Plan* provisions.
If *you* only satisfy item 2), we will administer *your* claim according to *our Plan* provisions.

However, *your monthly benefit* will be the lesser of:

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

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

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

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

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

- *you* were continuously insured under the *Plan* for the period between the end of *your* prior claim and *your recurrent disability*; and
- *your recurrent disability* occurs within six (6) months from the end of *your* prior claim.

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

Any disability, which occurs after six (6) 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*.

What Happens If You Return To Work Full Time For An Employer Other Than The Employer And Your Disability Occurs Again?

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 *elimination period* if:

- *you* were continuously working *full-time* for the period between the end of *your* prior claim and *your recurrent disability*; and
- *your recurrent disability* occurs within six (6) months from the end of *your* prior claim.

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

If *you* become entitled to benefits under any other group Long Term Disability plan, *you* will not be eligible for benefits under this disability *Plan*

Additional Long Term Disability Benefits and Programs

Zurich American Life Insurance Company

Survivor Benefit

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

Death Benefit

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

- your disability had continued for six (6) months; and
- you were receiving or were entitled to receive payments under this *Plan*.

However, we will first apply the survivor benefit to any overpayment that may exist on your claim. If you have no *eligible survivors*, payment will be made to your estate.

Rehabilitation Program

A Program To Help You Return To Work

We have a vocational *rehabilitation program* available to assist you in returning to work. We will determine whether you are eligible for this program. In order to be eligible for rehabilitation services and benefits, you must be medically able to engage in a return to work program.

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

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

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

Additional Benefits While You Participate In Our Rehabilitation Program

We will pay an additional benefit of 5% of your *gross disability benefit* to a maximum benefit of \$1,000 per month. This benefit is not subject to *Policy* provisions which would otherwise increase or reduce the *benefit amount* such as *deductible sources of income*. However, the maximum benefit and maximum benefit period will apply.

In addition, we will continue benefits for *you* for three (3) months following the date *your* disability ends if we determine *you* are no longer disabled while:

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

This benefit payment may be paid in a lump sum.

When Will The Rehabilitation Program Benefits End?

Benefits for the *rehabilitation program* will end on the earliest of the following dates:

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

Dependent Care Expense Benefits While You Participate In A Rehabilitation Program

While *you* are participating in *our rehabilitation program*, we will pay a *dependent care expense* benefit when *you* are disabled and *you* are incurring expenses:

- to provide care for a child under the age of five (5); and/or
- for a family member who requires personal care assistance on a daily basis.

The payment of the *dependent care expense* benefit will begin immediately after *you* start *our rehabilitation program*. Our payment of the *dependent care expense* benefit will:

- be \$250 per month, per *dependent*; and
- not exceed \$1,000 per month for all *dependent care expenses* combined.

To receive this benefit, *you* must provide satisfactory proof that *you* are incurring expenses that entitle *you* to the *dependent care expense* benefit.

Dependent care expense benefits will end on the earlier of the following:

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

Worksite Modification Benefit

How Can We Help Your Employer Identify And Provide Worksite Modification?

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

- \$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.

Plan Conversion Option

What Insurance Is Available If You End Employment (Conversion)?

If *you* end employment with *your employer*, *your* coverage under this *Plan* will end. *You* may be eligible to purchase insurance under *our* Group Conversion Policy. To be eligible, *you* must have been insured under *your employer's* group *Plan* for at least 12 consecutive months. *We* will consider the amount of time *you* were insured under *our Plan* and the plan it replaced, if any.

You must apply for insurance under the conversion policy and pay the first quarterly premium within 60 days after the date *your* employment ends. *We* will determine the coverage *you* will have under the conversion policy. The conversion policy may not be the same coverage *we* offered *you* under *your employer's* group *Plan*.

You are not eligible to apply for coverage under *our* Group Conversion Policy if:

- *you* are or become insured under another group Long Term Disability plan within 31 days after *your* employment ends;
- *you* are disabled under the terms of the *Plan*;
- *you* recover from a disability and do not return to work for *your employer*;
- *you* are on a *leave of absence*; or
- *your* coverage under the *Plan* ends for any of the following reasons:
 - 1) the *Plan* is cancelled;
 - 2) the *Plan* is changed to exclude the group of *employees* to which *you* belong;
 - 3) *you* end *your* working career or retire and receive payment from any *employer's retirement plan*;
 - 4) *you* are age 70 or older; or
 - 5) *you* fail to pay the required premium under this *Plan*.

Claim Information

Long Term Disability

Reporting Of Claims

You are required to submit a claim to *us* in writing by mail or fax. Claim forms may be obtained from *your employer* or from *us*. Follow the procedure chosen by *your employer* to report a disability claim to *us*.

When Do You Notify Us Of A Claim?

We encourage *you* to notify *us* of *your* disability claim as soon as possible, so that a claim decision will be made in a timely manner. Written notice of a claim should be sent within 90 days after the date *your* disability begins. Failure to give notice within the time prescribed does not invalidate or reduce any claim if it is shown that it was not reasonably possible to give the notice within that time, and notice was given as soon as was reasonably possible. However, *you* must send *us* written proof of *your* claim no later than 180 days after *your elimination period*. If it is not possible to give proof within 180 days, it must be given no later than two (2) years after the time proof is otherwise required except in the absence of legal capacity.

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

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

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

How Do You File A Claim?

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

What Information Is Needed As Proof Of Your Claim?

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

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

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

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

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

Who Will We Make Benefit Payment To?

Benefits will be paid to *you*.

What Happens If We Overpay Your Claim?

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

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

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

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

Examples of *deductible sources of income* are:

- workers' compensation;
- federal Social Security benefits;
- disability payments made by, or on behalf of, a *third party* as a result of any person's action or inaction.

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

Unpaid Premium Due

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

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

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

What Are The Time Limits For Legal Proceedings?

You can start legal action regarding *your* claim 60 days after proof of claim has been given to *us* and up to three (3) years from the time proof of claim is required, unless otherwise provided under federal *law*.

Claim Procedures and Appeal Information

Zurich American Life Insurance Company

Applicability Of ERISA

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

How To File A Claim

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

Claims Procedures

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

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

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

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

Appeal Procedures

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

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

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

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

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

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

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements. Unless there are special circumstances, this administrative appeal process must be completed before *you* begin any legal action regarding *your* claim.

Other Rights

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

Delegation Of Authority

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

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

GLOSSARY

General definitions used throughout this Certificate include:

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

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

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

Your work site must be:

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

Normal vacation is considered *active employment*.

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

Temporary and seasonal workers are excluded from coverage.

Administrator means Zurich American Life Insurance Company.

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

Benefit Amount; Benefit Payable means the disability *income* payable to *you* according to the terms of the *Policy*.

Confined or Confinement means a *hospital* stay of at least eight (8) hours per day.

"Covered monthly earnings" for **Class 1** 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*.

As of the first of each year, the *employee's* salaries will be frozen and premium will be paid on that amount. Claims will be based on current salaries.

"Covered monthly earnings" for **Class 2** 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.

As of the first of each year, the *employee's* salaries will be frozen and premium will be paid on that amount. Claims will be based on current salaries.

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

Dependent means:

- *your* child(ren) under the age of 15; and
- *your* child(ren) age 15 or over or a family member who requires personal care assistance.

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

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

Eligible Class(es) means the classes of *employees* that *your employer* has selected as being eligible to receive coverage under a *Plan*. *Your employer* alone determines the criteria that is used to define the *eligible class(es)* for insurance coverage under this *Plan*.

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

Eligible Survivor means *your spouse*, if living, otherwise *your* children under age 26 equally.

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 who is in *active employment* working and residing inside the United States with the *employer* and the *employees*, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the *employer* and such affiliated corporations, proprietorships or partnerships is under common control. *Employee* shall exclude in any case, *part-time employees*, temporary *employees* and *employees* who work for the *employer* less than the number of hours per week indicated in the Schedule of Benefits. This term does not include *employees* who normally work less than 30 hours a week for the *employer*.

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

Full-Time as used with the Education Benefit means a full course load as defined by the accredited post-secondary school.

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

Gainful Occupation means an occupation for which *you* are or become reasonably fitted by training, education or experience.

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

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

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

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

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

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

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

Income means *income you* earn, while disabled and working, from *your employer* or any other *employer*. However, any *income* earned by working for another *employer* will be considered *income* only to the extent that it exceeds the amount of *income you* were earning from such *employer* immediately before *you* became disabled.

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

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

Intoxicated means that *your* blood alcohol level equals or exceeds the legal limit for operating a *motor vehicle* in the state where the *accident* occurred.

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

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

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

Material and Substantial Duties means duties that:

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

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

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

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

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

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

Normal Retirement Age means the Social Security *normal retirement age* as stated in the 1983 revision of the United States Social Security Act. It is determined by *your* date of birth.

Optional Plan means the option to purchase additional insurance beyond the core *Plan* under which *you* are currently covered. This insurance is elected and paid for by the *Insured*.

Partial Disability or Partially Disabled means as a result of the *illness* or *injury* following a period of total disability for which benefits were payable, we will pay a *partial disability benefit* if *you*:

- are *partially disabled* within 31 days of the date *your* total disability benefits cease; and
- give us upon request and at *your* own expense, proof of continued disability.

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

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

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

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

We will not recognize *you* or a person related to *you* as a *physician* for a claim that *you* send to *us*. This includes but not limited to *your spouse*, children, parents, siblings, brother-in-laws, sister-in-laws, or step children.

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

Policy means the *Policy* provided to the *employer*.

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

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

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

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

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

Recurrent Disability means a disability, which is:

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

Regular Care means:

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

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

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

Salary Continuation or Accumulated Sick Leave means continued payments to *you* by *your employer* of all or part of *your monthly earnings*, after *you* become disabled as defined by the *Policy*. This continued payment must be part of an established plan maintained by *your employer* for the benefit of all *employees* covered under the *Policy*. *Salary continuation* or *accumulated sick leave* does not 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*.

Service Waiting Period means the continuous period of time that *you* must be in *active employment* in an *eligible class* before *you* are eligible for coverage under a *Plan*. The *employer* and *we* must agree upon the period.

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

Spouse means the *Insured's* lawful *spouse*.

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

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