ZURICH AMERICAN LIFE INSURANCE COMPANY
Policy Endorsement # 1

Endorsement Effective Date: July 1, 2017

This Policy Endorsement ("Endorsement") is attached to and made a part of Policy No. CLPEX01033 issued by the Zurich American Life Insurance Company ("Company") to the POLICYHOLDER,

Activision Blizzard

The Policy, the Short Term Disability (STD) Certificate are hereby amended to incorporate the Endorsement as part of the insurance plan. The Endorsement takes effect at 12:01 a.m. Eastern Standard Time on the Endorsement Effective Date. All other provisions of the Policy remain in full force and effect.

The following provision regarding Salary Continuance and Sick Leave is hereby removed from the Short Term Disability Certificate:

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

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

The new rates for STD due to the change are:

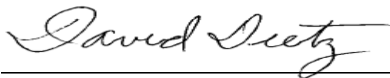
Core coverage: $0.049/$10 of weekly benefit
Buy-Up coverage: $0.074/$10 of weekly benefit

The Policyholder agrees upon receipt of this Endorsement to deliver a copy of this Endorsement to Eligible Classes of Employees.

This Endorsement terminates when the Policy Terminates in accordance with the termination provisions stated in the Policy.

Nothing herein contained shall be held to vary, waive, alter, or extend any of the terms, conditions, or provisions of the Policy, other than as herein stated.

This Endorsement is signed by Zurich American Life Insurance Company to take effect as of July 1, 2017, the Endorsement Effective Date.



President

Secretary

Policyholder Contact, Print Name, Title

Policyholder Signature

Zurich American Life Insurance Company

Short Term Disability Plan

Benefits Schedule

This *Plan* provides financial protection for *you* by paying a portion of *your income* if *you* become disabled due to a *sickness* 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* Short 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 govern.

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 1st.
Eligible Classes: All persons in the following class(es)are eligible for *employee* coverage: **Class 1 (Core and Buy-Up):** All active, *full-time employees* of Activision 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 *employees* classified as Executive.
Minimum Hours Requirement For Active Employment: **Full-Time Employees:** *Employees* must be working at least 30 regularly scheduled hours per week.
Service Waiting Period: **Full-Time Employees:** For *employees* in an *eligible class* on or before the *Policyholder's Policy* effective date: First day of the month coincident with or next following the date of hire. For *employees* in an *eligible class* after the *Policyholder's Policy* effective date: First day of the month coincident with or next following the date of hire.
Who Pays For The Coverage: **Basic Plan:** *Your employer* pays the cost of *your* coverage. **Buy-Up Plan:** *You* pay the cost of *your* coverage.
Elimination Period: For a *Sickness or Injury*: 7 days Benefits begin the day after the *elimination period* is completed.

WEEKLY BENEFIT	
Core Benefit: 60% of *your weekly earnings* up to $2,037, less *deductible sources of income*. **Buy-Up Benefit:** 80% of *your weekly earnings* up to $3,076, less *deductible sources of income*.	
Maximum Weekly Benefit: Core Benefit: Buy-Up Benefit:	 $2,037 $3,076
Minimum Weekly Benefit:	$25 ***You* are not eligible for the minimum *weekly benefit* during periods of overpayment until the overpayment has been recovered by *us*, or offset by *your weekly benefit*.**
Pre-Existing Condition Limitation:	3/12 applies, for *Late Applicant* Buy-Up Benefit only.
Maximum Weekly Benefit Period:	25 weeks
Rehabilitation Program:	Included, refer to the Certificate for program details.
***Your* benefit may be reduced by *deductible sources of income* and *disability earnings*.** **Some disabilities may not be covered.**	

Limited and Excluded Conditions and Disabilities:

Your weekly benefit amount may not be more than 60% (Core Benefit) or 80% (Buy-Up Benefit) of your *covered weekly earnings*. At any time that "*Deductible Sources of Income*" are payable to *you* while receiving *your weekly benefit*, *your weekly benefit* amount may be reduced by the total amount exceeding 100% of *your covered weekly earnings*. For additional information regarding "Deductible Sources of Income", refer to *your* Certificate.

Your plan does not cover disabilities related to all *injuries*, *sickness* or disease. Refer to *your* Certificate for a complete list of exclusions and 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 *you* were 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

Short Term Disability Plan

Policyholder: Activision Blizzard
Policy Number: CLPEX01033

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

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

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

Your coverage may be cancelled or changed 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, IL   60196

Our toll free number is: 877-278-7556
Our website address is: www.zurichna.com

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Special Notices

Zurich American Life Insurance Company

Toll Free Number:	877-278-7556
Social Security Advocacy Program:	877-278-7556
Claim Information Toll Free Number:	877-278-7556

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

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

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 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 Short Term Disability Plan

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

What Is The Certificate?

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

- the coverage to which *you* may be entitled;
- claim processing and administrative proceduree s;
- 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* Short 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 employe*r determines the criteria that are used to define the *eligible class(es)* for insurance coverage under this *Plan*. *Your employer* determines if *you* are in an *eligible class*. Such criteria are based solely upon the conditions related to *your* employment. *We* will rely upon the representation of the *employer* as to *your* eligibility for coverage under this *Plan* and as to any fact concerning such eligibility.

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

When Are You Eligible for Coverage?

If *you* are working for *your employer* in an *eligible class*, the date *you* are eligible for coverage is the 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
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 *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 a new benefits will not begin until the date *you* return to *active employment*.

Enrollment

How Do You Enroll For Coverage?

You will be provided with *Plan* design and enrollment information when *you* first become eligible to enroll. If *you* 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*. However, *you* are required to enroll for optional coverage.

If *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*.

When Do You Enroll?

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

- *you* complete the requirements for a *late applicant* described below; and
- *we* approve *you* as a *late applicant*; or
- until the next *enrollment period*.

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

Late Applicant Enrollment Requirements

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

***IMPORTANT NOTE:* As a *late applicant, you* may be denied coverage if *your evidence of insurability* is not satisfactory. *Your* effective date of coverage may be delayed or *your* benefits may be reduced.**

You must complete an enrollment form and submit *evidence of insurability* to *us*. *We* will review the information and solely determine *your eligibility date*. *We* will notify *you* and *your employer* of *our* decision.

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

After Coverage Begins

When May You Elect to Change Your Coverage (Class 1)?

You will need to contact *your employer* to determine when *you* may increase *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 by Election
Once *your* coverage begins, any increased or additional coverage will take effect the first of the month following the date of the change if *you* are in *active employment* or if *you* are on a covered *layoff or leave of absence.* If *you* are not in *active employment* due to *injury* or *sickness,* any increased or additional coverage will begin on the date *you* return to *active employment*.

Effective Date for Benefit Changes Due to a Change in Covered Weekly Earnings
A change in *your weekly benefit* due to a change in *your covered weekly earnings* will be effective on the first of the month next 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 weekly benefit* due to a change in *your eligible class* will be effective on the first of the month next 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*.

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

Effective Date For Benefit Changes By Policy Amendment
A change in *your covered weekly 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*.

An increase in *your* Short Term Disability coverage will be subject to a *pre-existing condition* limitation or exclusion as described in this Certificate.

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.

When Coverage Ends

When Does Your Coverage End?

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

- the date the *Policy* or a *Plan* is cancelled;
- the date *you* voluntarily stop *your* coverage;
- the date *you* are no longer in an *eligible class;*
- the date *you* are no longer eligible for coverage;
- the date *your eligible class* is no longer covered;
- the last day of the period for which *you* made any required contributions;

- the last day *you* are in *active employment* except as provided under the covered *layoff* or *leave of absence* provision;
- the date *your* employment stops for any reason, including job elimination, or being placed on severance. This will be either the date *you* stop *active employment*, or the day before the first premium due date that occurs after *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 *sickness* or *injury*, sabbatical 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, until stopped by *your employer*.

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, *your* coverage may continue up to a maximum of three (3) months from the start of *your* absence, until stopped by *your employer*.

Reinstatement Of Coverage

If *your* Short 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. *We* will notify *you* of *your* reinstatement 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.

If *you* were previously insured under this *Policy* and *your* insurance terminated for a reason other than cancellation of *your* payroll deduction, and *you* later become employed in one of the classes of eligible *employees* within 3 months after *your* insurance terminated under this *Policy*, any *service waiting period* will be waived for *you*.

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 Policy* is in force, *we* may use any written 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, and unless the statement is contained in written instrument signed by *you*, the validity of *your Policy* may not be contested by *us*.

Subrogation And Right Of Reimbursement

As used herein, the term "*Third Party*," means any party that is, or may be, or is claimed to be responsible for *illness* or *injuries* to *you* that caused *your* disability. Such *illness* or injuries are

referred to as "*Third Party Injuries.*" "*Third Party*" includes any party responsible for payment of benefits for loss of time or wages as a result of *third party injuries*.

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

Any lien or trust will be established by a court. *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?

The coverage under a *Plan* does not replace or affect the requirements for coverage by workers' compensation or state disability insurance.

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

Insurance fraud occurs when *you* or *your Policyholder* knowingly and with intent to defraud or deceive *us*, provide *us* with false information or file a claim for benefits that contains any false,

incomplete or misleading information, or conceals for the purpose of misleading, information concerning any material fact.

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

Does The Policyholder Act As Our Agent?

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

SHORT TERM DISABILITY INCOME BENEFITS

The Short Term Disability *Plan* provides *you* with a source of income if *you* should become disabled because of a *sickness* or *injury* related condition while covered under this *Plan*. Short Term Disability coverage will pay a *weekly benefit* if *you* are disabled and unable to work because of:

- a *sickness* that is non-*occupational sickness;* or
- an *injury* that is a non-*occupational injury*.

An *occupational sickness or injury* is any *sickness* or *injury* that:

- arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a *full-time* basis; or
- results in any form of *sickness* or *injury*.

However, if proof is provided to *us* that a claim has been made under any type of workers' compensation *law* and that no benefit, award, settlement or redemption has been or will be made under such *law* for that *sickness* or *injury*, then that *sickness* or *injury* will not be considered an *occupational sickness* or an *occupational injury*.

How Do We Define A Short Term Disability?

You are considered to be disabled if, solely and directly because of a non-occupational *sickness* or *injury,* if all of the following applies:

- *you* must be covered by this *Plan* at the time *you* become disabled;
- *you* must be under the *regular care* of a *physician* for *your sickness* or *injury*; and
- *you* must meet the definition of disability below.

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 40% or more loss in *your covered weekly earnings* due to that *sickness* or *injury*.

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

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

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.* No benefit is payable for or during the *elimination period. You* must be under the care of a *physician* during the *elimination period.*

Your elimination period is described in the Benefits Schedule.

Can You Satisfy Your Elimination Period If You Are Working?

No, *you* may not satisfy this *Plan's elimination period* while working.

When Will You Begin To Receive Benefits?

The *benefit payable* is the *weekly benefit* shown in the Benefits Schedule. The *weekly benefit* is based on *your covered weekly earnings.*

You will begin to receive *benefits* when *we* approve *your* claim, providing the *elimination period* has been satisfied and *you* are disabled as defined in the *Plan. We* will send *you* a *weekly benefit* for any period for which *we* are liable but not beyond the *maximum weekly benefit period* shown in the Benefits Schedule. No benefit is payable during the *elimination period.*

What Are Your Covered Weekly Earnings?

"Covered Weekly Earnings" means *your* gross weekly *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.

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 weekly earnings* by the *weekly benefits* percentage shown in the Benefits Schedule.
2) The *maximum weekly benefit* is listed in *your* Benefits Schedule.
3) Compare the answer from item 1) with the maximum *weekly 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 weekly benefit.* The *weekly benefit* will be recalculated when *you* receive any new *deductible sources of income.*

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

Maximum weekly 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 25 weeks of payable benefits:

1. If *you* are disabled and return to work, *we* will not reduce *your weekly benefit* for *disability earnings* if:

   - *your weekly disability earnings,* if any, are less than 40% of *your weekly covered earnings* due to the same *sickness* or *injury*; and
   - *you* have satisfied the *elimination period*.

2. If *you* are disabled and *your we*ekly *disability earnings* are 40% or more of *your weekly covered earnings*, due to the same *sickness* or *injury*, *we* will calculate *your weekly benefit* as follows:

   - *your weekly benefit* will not be reduced by *your disability earnings* as long as *disability earnings* plus the *gross disability benefit* does not exceed 100% of *weekly covered earnings.*

     1) Add *your we*ekly *disability earnings* to *your gross disability benefit*.
     2) Compare the answer in item 1) to *your weekly covered earnings*.

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

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

When You Are Disabled For Less Than One Week

After the *elimination period*, if *you* are disabled for less than 1 week, *we* will send *you* 1/7th of *your weekly benefit* for each day of disability.

When Will Your Weekly Benefits End If Working While Disabled?

During the 25 weeks of disability *benefits*, if *your weekly disability earnings* exceed 60% of *your covered weekly 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.

We will review *your* status periodically. *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 Weekly 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* weekly 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 week to week, *we* may average *your disability earnings* over the most recent 3 weeks to determine if *your* claim should continue.

If *we* average *your disability earnings*, *we* will not terminate *your* claim unless the average of *your disability earnings* from the last three (3) weeks exceeds 60% of *covered weekly earnings*. *We* will not pay *you* a benefit for any week during which *disability earnings* exceed 60% of covered *weekly earnings*.

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

- during the 25 weeks of disability benefits, the average of *your disability earnings* from the last three (3) weeks exceeds 60% of *covered weekly earnings.*

We will not pay *you* for any month during which *disability earnings* exceed the above amounts. The *minimum weekly 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 weekly benefit* is calculated and may reduce *your weekly 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 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*.

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

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

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

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

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

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

We offer a Social Security Advocacy Program. Refer to the Additional Benefits and Program Section of this Certificate for more information.

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

4. 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*; or
   - 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.

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

6. 100% of the amount *you* receive under the maritime doctrine of maintenance, wages and cure. This includes only the "wages" part of such benefits.

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

8. 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.

With the exception of retirement payments, *we* will only subtract *deductible sources of income* which are payable as a result of the same disability.

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

What Are Not Deductible Sources Of Income?

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

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

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

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

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

The *minimum weekly benefit* will not be paid in any week when *disability earnings* exceed 60% of *your* covered *weekly earnings*. This includes when *we* average *your disability earnings* as described above.

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

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

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

When *we* determine that *you* may qualify for benefits in the *deductible sources of income* section, *we* will estimate *your* entitlement to these benefits. *We* can reduce *your weekly 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 weekly benefit may **NOT** be reduced by the estimated amount if *you*:

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

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

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

What Happens If You Receive A Lump Sum Payment?

If *you* receive a lump sum payment from any *deductible source of income*, the lump sum will be pro-rated on a weekly basis over the time period for which the sum was given. If no time period is stated, *we* will use a reasonable one. If any part of the lump sum payment dates back to a prior date it may be allocated on a retroactive basis. *We* will prorate the lump sum payment over *your* remaining benefit period.

What Is The Maximum Weekly Benefit Period?

You will receive a benefit for each week *you* remain disabled up to the *maximum benefit period. Your maximum benefit period* is described in the Benefits Schedule.

When Will Benefits Stop?

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

- the end of the *maximum weekly benefit period*;
- the date *you* are no longer *disabled* under the terms of the *Plan*;
- when *you* are able to work in *your regular occupation* on a *part-time basis*, or increase *your* hours, or increase the number or type of duties *you* perform in *your* own job but *you* choose not to;

- if *you* are working and *your weekly disability earnings* exceed 60% of *your covered weekly earnings*;
- the date *you* fail to submit proof of continuing disability;
- if *you* are incarcerated;
- the date *you* die; or
- the date *your employer* offers *you* another or modified job position, which *physicians* agree *you* are able to perform, at a pay rate that exceeds 60% of *your* covered *weekly 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, this includes effective treatment for alcholism or drug abuse, if alcoholism or drug abuse is the cause (or part of the cause of *your* disability);
- are not receiving *appropriate care*;
- refuse to be examined by an independent *physician* or a licensed certified health care practitioner as requested by *us* when provided at *our* expense;
- refuse to participate in *our Rehabilitation Program*, or refuse modification to *your* worksite or a job process designed to suit indentifed medical limitations, or adaptive equipment or devices that would allow *you* to perform *your* own job, a transitional work arrangement or other modified work arrangement which may be for *your regular occupation* or *any reasonable occupation*;
- *you* fail to cooperate with *us* in the administration of the claim. Such cooperation includes, but is not limited to provding any information or documents needed to determine whether benefits are payable or the actual *benefit amount* due; or
- the date *you* refuse to interview with *our* representative about *your* disability.

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:

- *illness* or *injury* for which workers' compensation benefits are paid, or may be paid if duly claimed;
- intentionally self-inflicted injuries or attempted suicide;
- active participation in a riot or an act of insurection, rebellion or civil commotion;
- participation in an illegal activity or illegal act or to which a contributing cause was *your* being engaged in an illegal occupation;
- commission of a crime for which *you* have been convicted, this includes but is not limited to local, state, country, provincial or federal *law*, or the disability results from commison of, or attempting to commit a criminal act;
- *injury* or *sickness* while *you* are serving on full-time active duty in any armed forces
- occupational *illness* or occupational *injury*;
- *injury* sustained as a result of doing any work for pay or profit for another employer;
- cosmetic, experimental or investigational surgery or surgical procedure that is not medically necessary, except if the disability is caused by *your* donation of an organ in a non-experimental organ transplant procedure;
- 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*; or
- a *pre-existing condition (*for buy-up benefit*).*

Your Plan does not cover a disability while *you* are outside the United States or the territories and possessions of the United States, or Canada. This applies whether or not *you* were outside such area when *your* disability began.

What Is A Pre-Existing Condition (Buy-Up Benefit Only)?

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

1. *you* received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the three (3) months (*look back period)* 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; 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 Your Are Not In Active Employment When Your Employer Changes Insurance Carriers To Us? (Continuity of Coverage for Class 1)

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

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

If *you* return to active work and *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 14 days from the end of *your* prior claim and *your* return to active work.

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 14 continuous days 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 Short 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*, after *you* are no longer covered under this *Plan*, *you* will no longer be covered under this *Plan*.

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

Programs

REHABILITATION PROGRAM

A Program To Help You Return To Work

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

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

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

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

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*.

Employee Assistance Program

We provide *you* access to an Employee Assistance Program designed to assist *you* with questions and information about *your* disability and the problems of daily living.

You can call and request assistance for virtually any personal or professional issue, from helping find a day care or transportation for an elderly parent, to researching possible colleges for a child, to helping to deal with the stress of the workplace. This program is available for everyday issues as well as crisis support.

CLAIM INFORMATION

Zurich American Life Insurance Company

Short Term Disability

Reporting Of Claims

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

When Do You Notify Us Of A Claim?

We encourage *you* to notify *us* of *your* disability claim as soon as possible, so that a claim decision will be made in a timely manner. Written or telephonic notice of a claim should be sent within 30 days after the date *your* disability begins. Failure to give notice within the time prescribed does not invalidate or reduce any claim if it is shown that it was not reasonably possible to give the notice within that time, and notice was given as soon as was reasonably possible. However, *you* must send *us* written proof of *your* claim no later than 90 days after *your* elimination period. If it is not possible to give proof within 90 days, it must be given no later than one (1) year 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* weekly covered income;
3. appropriate documentation that *you* are not working at any job during the *elimination period* for *your* Short Term Disability claim;
4. the date *your* disability began;
5. the cause of *your* disability;
6. the extent of *your* disability, including restrictions and limitations preventing *you* from performing *your regular occupation* or any *gainful occupation*; and

7. the name and address of any inpatient or outpatient facility, *hospital*, *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.

Claim Notification

We will notify a claimant in writing of the acceptance or rejection of a claim no later than the 15th business day after the date *we* receive all items, statements, and forms required by *us* to secure final proof of loss.

If *we* are unable to accept or reject the claim, *we* will notify the claimant of the reasons that *we* need additional time within 15 business days of *our* receipt of the claim information. *We* will accept or reject the claim within 45 days after the date of this notice.

If *we* reject the claim, the notice *we* will state the reasons for the rejection.

Who Will We Make Benefit Payment To?

If *your* claim is approved, benefits will be paid to *you* weekly. Benefits are paid at the end of each benefit period for which *we* are liable while *you* remain disabled up to the *maximum benefit period*.

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.

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 Benefits Schedule and any additional summary *Plan* description information provided by the *Plan Administrator*. Benefit determinations are controlled exclusively by the *Policy*, *your* Certificate of Coverage, and the information in this document.

How To File A Claim

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

Claims Procedures

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

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

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

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

Appeal Procedures

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

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

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

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

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

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

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

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

Other Rights

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

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*.

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 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 Weekly Earnings means *your* gross *we*ekly *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*.

Credible Coverage means *you* had prior coverage under a group *disability benefit plan* or a *disability benefit plan*.

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

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

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

Disability Earnings are the earnings *you* receive while *you* are disabled and working. *Salary continuation* paid to supplement *your disability earnings* will not be considered payment for work performed.

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

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

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* in the United States with the *employer* and the *employees*, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the *employe*r 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 *employe*r less than the number of hours per week indicated in the Benefits Schedule. 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*, and *we* have approved such request.

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*.

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*.

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

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

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

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.

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 Period of Payment means the longest period of time *we* will make payments to *you.*

Optional Plan means the option to purchase additional insurance beyond the Core *Plan*. 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* covered weekly 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 group insurance *Policy* obtained by the *Policyholder* under which *your employer* participates and receives group Short Term Disability insurance to cover eligible *employees*.

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

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

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

Reasonable Occupation means any gainful activity for which *you* are, or may reasonably become fitted by education, training, or experience; and which results in, or can be expected to result in an *income* of more than:

- 60% of *your* covered *weekly earnings*;
- or if less, the amount of the *maximum weekly benefit*.

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

Recurrent Disability means a disability, which is:

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

Regular Care means:

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

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

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

Retirement Plan means a defined contribution plan or defined benefit plan. These are plans, which provide retirement benefits to *employees* and are not funded entirely by *employee*

contributions. *Retirement plan* includes but is not limited to any plan that is part of any federal, state, county, municipal or association retirement system.

Salary Continuation or **Accumulated Sick Leave** means continued payments to *you* by *your employer* of all or part of *your weekly earnings*, after *you* become disabled as defined by the *Policy*. This continued payment must be part of an established *Plan* maintained by *your employer* for the benefit of all *employees* covered under the *Policy*. *Salary continuation* or *accumulated sick leave* does not included compensation paid to *you* by *your employer* for work *you* actually perform after *your* disability begins. Such compensation is considered *disability earnings*, and would be taken into account in calculating *your weekly 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; Illness means an *illness* or disease. The *sickness* must begin while *you* are covered under this *Plan*. Pregnancy and childbirth and complications of pregnancy are considered a *sickness* under this *Policy*.

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

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

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

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