New York Life Insurance Company
(A Mutual Company Founded in 1845)
51 Madison Avenue, New York, NY 10010
1-800-225-5695
http://www.newyorklife.com

GROUP SHORT TERM DISABILITY INCOME INSURANCE
CERTIFICATE OF COVERAGE

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

POLICYHOLDER: **GERRITY'S SUPERMARKET**

POLICY NUMBER: **54430476**

POLICY EFFECTIVE DATE: **NOVEMBER 1, 2018**

GOVERNING JURISDICTION: **PENNSYLVANIA**

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

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

Your coverage may be canceled or changed under the terms and provisions of the policy. Contact the **Policyholder** if **you** wish to inspect a copy of the policy. **We** will only make changes that are consistent with Interstate Insurance Product Regulation Commission ("the Commission") standards and any endorsements or amendments used to effect such changes are subject to prior approval by the Commission.

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

The policy is delivered in and is governed by the **laws** of the governing jurisdiction. To the extent applicable, it is also governed by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

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

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

Amy Miller — Secretary

John Kim — President

The insurance department name and phone number of the Governing Jurisdiction appear on the listing following the Table of Contents.

This policy does not cover disabilities due to an occupational sickness or injury. The policy does not replace or affect the requirements for coverage by any Workers' Compensation or state disability insurance.

CERTIFICATE OF COVERAGE

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STATE INSURANCE DEPARTMENT CONTACT INFORMATION

State	Insurance Department	Main Phone
Alabama	Alabama Department of Insurance	(334) 269-3550
Alaska	Alaska Division of Insurance	(907) 269-7900
Arizona	Arizona Department of Insurance	(602) 364-2499
Arkansas	Arkansas Insurance Department	(501) 371-2600
Colorado	Colorado Division of Insurance	(303) 894-7499
Georgia	Georgia Department of Insurance	(404) 656-2056
Hawaii	Hawaii Insurance Division	(808) 586-2790
Idaho	Idaho Department of Insurance	(208) 334-4250
Illinois	Illinois Department of Insurance	(217) 782-4515
Indiana	Indiana Department of Insurance	(317) 232-2385
Iowa	Division of Insurance	(515) 281-5705
Kansas	Kansas Department of Insurance	(785) 296-3071
Kentucky	Kentucky Office of Insurance	(502) 564-3630
Louisiana	Department of Insurance	(800) 259-5300
Maine	Maine Bureau of Insurance	(207) 624-8475
Maryland	Maryland Insurance Administration	(410) 468-2090
Massachusetts	Division of Insurance	(617) 521-7794
Michigan	Michigan Department of Insurance and Financial Services	(877) 999-6442
Minnesota	Minnesota Department of Commerce	(651) 539-1500
Mississippi	Mississippi Insurance Department	(800) 562-2957
Missouri	Missouri Department of Insurance, Financial Institutions and Professional Registration	(573) 751-3365

STATE INSURANCE DEPARTMENT CONTACT INFORMATION

State	Insurance Department	Main Phone
Nebraska	Nebraska Department of Insurance	(402) 471-2201
Nevada	Nevada Division of Insurance	(775) 687-0700
New Hampshire	New Hampshire Department of Insurance	(603) 271-2261
New Jersey	New Jersey Department of Banking and Insurance	(609) 292-7272
New Mexico	Office of Superintendent of Insurance	(505) 827-4601
North Carolina	North Carolina Department of Insurance	(855) 408-1212
Ohio	Ohio Department of Insurance	(614) 644-2658
Oklahoma	Oklahoma Department of Insurance	(405) 521-2828
Oregon	Oregon Insurance Division Consumer Advocacy Unit	(503) 947-7984
Pennsylvania	Pennsylvania Department of Insurance	(717) 787-2317
Puerto Rico	Puerto Rico Department of Insurance	(787) 304-8686
Rhode Island	Rhode Island Insurance Division	(401) 462-9520
South Carolina	South Carolina Department of Insurance	(803) 737-6180
Tennessee	Tennessee Department of Commerce & Insurance	(615) 741-2241
Texas	Texas Department of Insurance	(800) 252-3439
Utah	Utah Department of Insurance	(801) 538-3800
Vermont	Vermont Division of Insurance	(802) 828-3301
Virginia	Virginia Bureau of Insurance	(804) 371-9741
Washington	Washington State Office of Insurance	(360) 725-7000
West Virginia	Offices of the Insurance Commission	(304) 558-3354
Wisconsin	Office of the Commissioner of Insurance	(608) 266-3585

BENEFITS AT A GLANCE

SHORT TERM DISABILITY

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

This is a **noncontributory insurance** plan.

NAME OF EMPLOYER: GERRITY'S SUPERMARKET

POLICY NUMBER: 54430476

ELIGIBLE CLASS(ES):

All **Employees** in **active employment** in the United States with the **Employer**.

You must be an **Employee** of the **Employer** and in an Eligible Class.

Temporary workers are excluded from coverage.

Seasonal workers are excluded from coverage.

Persons who are not legal residents or citizens of the United States are not eligible for coverage.

ELIGIBILITY DATE

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

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

WHEN COVERAGE BEGINS

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

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

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

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

MINIMUM HOURS REQUIREMENT:

36 hours per week

WAITING PERIOD:

For persons in an Eligible Class on or before the policy effective date:
End of the month in which **you** complete a continuous period of 90 Day(s) of **active employment**.

For persons entering an Eligible Class after the policy effective date:
End of the month in which **you** complete a continuous period of 90 Day(s) of **active employment**.

REHIRE:

If **your** employment ends and **you** are rehired within 12 month(s) **your** previous work while in an Eligible Class will apply toward the **waiting period**. All other policy provisions apply.

WHO PAYS FOR THE COVERAGE:

Your Employer pays the cost of **your** coverage.

WAIVER OF PREMIUM

Premium payments are not required for **your** coverage beginning the first of the month following 30 consecutive days of disability, and thereafter while **you** are receiving Short Term Disability payments.

ELIMINATION PERIOD

7 consecutive days for disability due to **injury**.
7 consecutive days for disability due to **sickness**.

The elimination period begins on the first day of **your** disability.

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

WEEKLY BENEFIT

60% of **weekly earnings** to a **maximum benefit** of $1,700.00 per week.

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

MAXIMUM BENEFIT AMOUNT WITHOUT EVIDENCE OF INSURABILITY

$1,700.00 per week.

WEEKLY EARNINGS

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

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

MAXIMUM PERIOD OF PAYMENT: 12 weeks

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

DEFINITIONS

ACCIDENT OR ACCIDENTAL means a sudden, unexpected event that was not reasonably foreseeable.

ACTIVE EMPLOYMENT means **you** are working for **your Employer** for earnings that are paid regularly and that **you** are performing the **material and substantial duties** of **your regular occupation**. **You** must be working at least the minimum number of hours as described under the MINIMUM HOURS REQUIREMENT in the BENEFITS AT A GLANCE.

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

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

We will consider **you** to be in **active employment** on weekends, holidays, and planned vacations that **your Employer** has approved in advance and during a temporary business closure not to exceed 15 day(s) if **you** were in **active employment** on the last scheduled work day immediately prior to such time off. A temporary business closure includes a closure due to inclement weather, power outage or public health agency orders.

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

APPROPRIATE CARE means that **you**:

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

CERTIFICATEHOLDER means the person who is eligible for benefits provided by the **Policyholder's** policy and who has received a Certificate of Coverage.

CONTRIBUTION means the amount the **Policyholder** may require an **insured person** to pay towards the total **premium** that **we** charge for the insurance provided under the policy.

CONTRIBUTORY INSURANCE means insurance for which the **Policyholder** requires the **insured person** to pay all or a portion of the premium. The Certificate of Coverage specifies who pays the cost of the coverage.

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

DISABILITY EARNINGS means the income which **you** receive from working while **you** are disabled, plus the earnings **you** could receive if **you** were working to **your maximum capacity**.

Disability earnings do not include earnings from secondary employment if such employment began prior to **your** date of disability; however, it does include any increase in earnings from the secondary employment occurring after **your** date of disability.

DOCTOR means:

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

We will not recognize **you** or **your** family members, including but not limited to, **spouse**, domestic partner, child(ren), parents, including in-laws, or siblings, including in-laws, a business or professional partner, or any person who has a financial affiliation or business interest with **you** as **a doctor** for a claim that **you** send to **us**.

ELIGIBLE SURVIVOR means **your spouse**, if living; otherwise, **your** child(ren).

EMPLOYEE means a person who is in **active employment** with the **Employer** in the United States.

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

For contributory insurance:

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

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

EVIDENCE OF INSURABILITY means a statement of **your** medical history that **we** will use to determine if **you** are approved for coverage. **Evidence of insurability** will be provided at our expense.

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

GRACE PERIOD means the 31 day period following the Premium Due Date during which **premium** payment for the policy may be made by the **Policyholder**.

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

HOSPITAL, HEALTH FACILITY OR INSTITUTION means an accredited facility licensed according to state and local laws to provide care and treatment for the condition causing **your** disability. The facility must be supervised by one or more **doctors** with 24 hour registered graduate nursing staff. The facility may specialize in treating alcoholism, drug addiction, chemical dependency or **mental illness.** A facility specializing in treating alcoholism, drug addiction, chemical dependency or **mental illness** does not include a rest home, convalescent home, and home for the aged or a facility primarily for custodial or educational care.

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

INSURED PERSON means a person who is eligible for the coverage under this policy, becomes covered according to the terms of the policy, and whose coverage remains in effect according to the terms of the policy.

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

LEAVE OF ABSENCE means **you** are absent from **active employment** for a period of time that has been agreed to in advance in **writing** by **your Employer**.

Your normal vacation time or any period of disability is not considered a leave of absence.

MATERIAL AND SUBSTANTIAL DUTIES means the important duties, tasks, functions and operations that:

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

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

MAXIMUM CAPACITY means, based on **your** restrictions and limitations, the greatest extent of work **you** are able to do in **your regular occupation**.

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, or disorders related to stress or to substance abuse or dependency. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of a disability. If the APA no longer publishes a DSM or the APA ceases to exist, **we** may substitute a comparable DSM subject to the approval by the Commission.

NONCONTRIBUTORY INSURANCE means insurance for which the **Policyholder** does not require the **insured person** to pay any part of the premium.

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

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

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

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

POLICY MONTH means the month that begins on the effective date of the policy. Subsequent policy months will begin on the same day of each subsequent calendar month.

PREMIUM means the amount the **Policyholder** will pay to **us** for the insurance provided under the policy.

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

1. received medical treatment, advice, consultation, or diagnostic testing; or
2. taken or were prescribed drugs or medicine.

PRIOR POLICY means the **Policyholder's** group short term disability income insurance plan for which **you** were insured on the day prior to the effective date of **our** policy.

RECURRENT DISABILITY means a disability which is:

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

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

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

SALARY CONTINUATION or **ACCUMULATED SICK LEAVE** means continued payments to **you** by **your Employer** of all or part of **your 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**, and includes salary continuation or accumulated sick leave or any similar **Employer** sponsored paid time off plan.

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

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

SPOUSE means **your** lawful spouse or any other person required to be covered as **your** spouse under the civil union, domestic partnership, marriage or other family or domestic relations **law** of the Governing Jurisdiction.

If **you** reside in a State different from the Governing Jurisdiction of the policy, the Certificate of Coverage shall, if required, comply with the applicable civil union, domestic partnership, marriage or other family or domestic relations law of the State in which **you** reside.

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

WAITING PERIOD means the continuous period of time (shown in the BENEFITS AT A GLANCE) that **you** must be in **active employment** in an Eligible Class before **you** are eligible for coverage under the policy.

WEEKLY EARNINGS means **your** gross weekly income from **your Employer** as stated in the BENEFITS AT A GLANCE.

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

WE, **US**, and **OUR** means New York Life Insurance Company.

WRITTEN or **WRITING** means a record which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable **law**.

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

GENERAL PROVISIONS

ENTIRE CONTRACT

The insurance for **insured persons** is provided under a contract of group disability income insurance with the **Policyholder**, and the entire contract with the **Policyholder** consists of:

1. all policy provisions and any amendments and endorsements to the policy;
2. the Certificate of Coverage and any amendments and endorsements to the Certificate of Coverage;
3. the **Policyholder's signed** application; and
4. for **contributory insurance**, the **insured persons' signed enrollment forms**.

CERTIFICATE OF COVERAGE

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

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

CHANGES TO YOUR COVERAGE

Once **your** coverage begins, any increased or additional coverage will take effect immediately if **you** are in **active employment** or if **you** are on a covered **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**.

Any decrease in coverage will take effect immediately but will not affect a **payable claim** that occurs prior to the decrease.

IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER REPLACES INSURANCE COVERAGE WITH OUR POLICY (Continuity of Coverage)

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

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

1. the end of the month following the date **you** return to **active employment**; or
2. the end of any period of continuance or extension provided under the **prior policy**.

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

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

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

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

For the purposes of this provision the following definition applies:

LIMITED COVERAGE means benefits payable will be paid as if the **prior policy** had remained in effect and **you** continued to be insured under that policy. **We** will reduce **your** payment by an amount for which the prior carrier is liable.

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

IF YOU HAVE A DISABILITY DUE TO A PRE-EXISTING CONDITION AFTER YOUR EMPLOYER REPLACES INSURANCE COVERAGE WITH OUR POLICY (Continuity of Coverage)

In order for this provision to apply, the **prior policy's** coverage must be similar to **our** policy.

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

1. **you** were covered under the **prior policy** at the time **your Employer** changed insurance carriers to **our** policy; and
2. **you** have been continuously covered under **our** policy from the effective date of **our** policy through the date **your** disability began.

In order to receive a payment, **you** must satisfy the PRE-EXISTING CONDITION LIMITATION provision under:

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

If **you** satisfy the PRE-EXISTING CONDITION LIMITATION provision of **our** policy, **we** will determine **your** payments according to **our** policy's provisions.

If **you** do not satisfy the PRE-EXISTING CONDITION LIMITATION provision of this policy, but y**ou** do satisfy the **prior policy's** pre-existing condition provision:

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

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

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

All other provisions of **our** policy will apply.

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

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

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

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

If **you** are on a **leave of absence** other than an FMLA or State FML **leave of absence**, and if all **premium** is paid when due, **you** may be covered through the end of the month that immediately follows 1 month(s) after the date **you** stopped **active employment**.

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

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

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

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

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

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

WAIVER OF PREMIUM

Your disability insurance **premium** will be waived if **you** qualify as described below.

You must be disabled through **your** elimination period. **Your** elimination period is as stated in the BENEFITS AT A GLANCE and is the period of continuous disability **you** must satisfy.

The **Policyholder** may continue **premium** payments until **we** notify the **Policyholder** of the date **your** disability insurance premium waiver begins. For insurance to continue under the group policy, full **premium** when due is required.

Your Waiver of Premium will begin when **we** approve **your** claim, if the elimination period has ended, and **you** meet the following conditions:

1. **you** remain disabled during the elimination period;
2. **you** meet the notice and proof of claim requirements for disability, as described in the CLAIM INFORMATION section of the policy, while **your** disability insurance is in effect;
3. **your** claim is approved by **us**; and
4. all required **premiums** have been paid until **we** have approved the Waiver of Premium.

We will send **you written** notice advising whether **you** are approved for the Waiver of Premium and, if approved, the amount of **premium** being waived. If **we** approve **your** claim, **we** will not require further **premium** payments for **you** while **you** remain **disabled** according to the terms and provisions of the policy. **Your** disability insurance amount will not increase while **your** disability insurance **premiums** are being waived. **Your** disability insurance amount will reduce or cease at any time it would reduce or cease if **you** had not been **disabled. Premiums** waived under this provision will not be deducted from any benefits paid under the policy.

If **you** die and **you** are entitled to any refund of premiums that **you** have paid, when **we** receive proof that **you** have died, **we** will refund any **premiums** to:
1. If **you** are insured for Group Term Life Insurance with **us**, **we** will pay the beneficiary **you** designated.
2. If **you** are not insured for Group Term Life Insurance with **us**, **we** will pay the **eligible survivors**. If **you** have no **eligible survivors**, payment will be made to your estate.

WHEN YOUR WAIVER OF PREMIUM ENDS

Your Waiver of Premium will automatically end on the earliest of the following:

1. the date **you** are no longer disabled;
2. the date **you** fail to submit proof of continuing disability;
3. the end of the **maximum period of payment** shown in the BENEFITS AT A GLANCE;
4. the date **premium** has been waived for 52 weeks and **you** are considered to reside outside the United States or Canada. **You** will be considered to reside outside these countries when **you** have been outside the United States or Canada for a total period of 6 months or more during any 52 consecutive weeks for which **premium** has been waived; or
5. the date **you** die.

There is no limit to the number of times **you** are eligible for the Waiver of Premium.

WHEN YOUR COVERAGE ENDS

Your coverage under the policy ends on the earliest of:

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

LEGAL ACTION

You can start legal action regarding **your** claim 60 days after proof of claim has been given to **us**, and before the applicable statute of limitations has expired but not after 3 years from the date of proof of claim is required unless otherwise provided under federal **law**.

INCONTESTABILITY

We consider any statements made by an **insured person** a representation and not a warranty. No statement made by an **insured person** will be used to reduce or deny any claim or to cancel an **insured person's** coverage unless:

1. the statement is in **writing** on an **enrollment form** or **evidence of insurability form** that is **signed** by the **insured person**; and
2. a copy of that statement is given to the **insured person**, the **eligible survivor** or legally authorized representative.

No statement made by an **insured person** relating to his or her insurability will be used to contest the insurance for which the statement was made after the coverage has been in force for two years. For any applied for increases in coverage or reinstatement of coverage, a new two year contestability period is applicable to the amount of the applied for increase or reinstated coverage. Fraudulent statements will be used to contest the insurance for which the fraudulent statement was made when permitted by applicable **law** in the state where the Certificate is delivered or issued for delivery.

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

CLERICAL ERROR

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

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

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

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

MISSTATEMENT OF AGE

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

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE

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

AGENCY

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

EXTENSION OF BENEFITS

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

SHORT TERM DISABILITY
BENEFIT INFORMATION

DEFINITION OF DISABILITY

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

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

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

ELIMINATION PERIOD

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

The elimination period begins on the first day of **your** disability.

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

WHEN YOU RECEIVE PAYMENTS

You will begin to receive payments when **we** approve **your** claim, providing the elimination period has been met, **you** are under the **appropriate care** of a **doctor**, and **you** are disabled. **We** will send **you** a **weekly payment** at the end of each week for any period for which **we** are liable.

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

TO WHOM PAYMENTS ARE MADE

We will pay **your** benefits to **you** unless this certificate specifies otherwise. If any amount for which **we** are liable remains unpaid when **you** die, **we** will pay that amount according to the TIME PAYMENT OF CLAIMS provision in this certificate. If, however, it is necessary for the establishment of a guardianship or conservatorship, or appointment of a trustee, executor or administrator, **we** may withhold further benefits until sufficient evidence is provided to **us** that any such establishment or appointment has been finalized. **We** will pay benefits within 30 days of receiving sufficient evidence of the establishment or appointment. If **we** pay benefits on or after the 31st day of receiving sufficient evidence, the delayed payment will be subject to a simple 10% interest rate per year, beginning with the 31st day and ending on the day benefits are paid.

AMOUNT OF PAYMENT

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

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

1. Multiply **your weekly earnings** by 60%.
2. The **maximum benefit** is $1,700 per week.
3. Compare the answer from Item 1 with the **maximum benefit**. The lesser of these two amounts is **your gross weekly payment**.
4. Subtract from **your gross weekly payment** any **deductible sources of income**.

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

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

You will receive payments based on the percentage of income **you** are losing due to **your disability**. **We** will follow this process to determine **your weekly payment**:

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

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

C. IF YOU ARE DISABLED AND WORKING, AND YOUR DISABILITY EARNINGS ARE MORE THAN 80% OF YOUR WEEKLY EARNINGS

If **you** are working and **your disability earnings** are more than 80% of **your weekly earnings**, no benefit will be payable.

If **you** are able to perform all the **material and substantial duties** of **your regular occupation** and **your disability earnings** are more than 80% of **your weekly earnings**, no benefit will be payable.

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

As part of **your** proof of **disability earnings**, **we** can require that **you** send **us** appropriate financial records that **we** believe are necessary to substantiate **your** income.

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

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 three 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 weeks exceeds 80% of **your weekly earnings**.

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

DEDUCTIBLE SOURCES OF INCOME

With the exception of retirement payments, amounts earned or received from any form of employment and amounts received from any unemployment compensation law, **we** will only subtract **deductible sources of income** which are payable as a result of the same disability.

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

1. The amount that **you** receive, or are eligible to receive, as disability income payments under any:

   a. state compulsory benefit **act** or **law**;
   b. individual disability income **plans** which are paid for by the **Policyholder** and purchased on or after the effective date of this policy to the extent that cumulative benefits payable would exceed **your weekly earnings**;
   c. military disability benefit plan;
   d. governmental retirement system as a result of **your** job with **your Employer**; or
   e. other group insurance policy with the **Employer.**

2. The amount **you** receive as disability income payments under any automobile liability insurance policy or "no fault" motor vehicle plan, whichever is applicable.

3. The amount **you** receive as a result of any action brought under Title 46, United States Code Section 688 (The Jones Act, the Maritime Doctrine of Maintenance and Cure, or the Doctrine of Unseaworthiness)

4. The amount **you** receive from a **third party** (after subtracting attorney's fees) by judgment, settlement or otherwise.

5. The amount **you** receive under any **salary continuation** or **accumulated sick leave** plan.

6. The amount that **you**:

   a. receive as disability payments under **your Employer's retirement plan**; or
   b. voluntarily elect to receive as retirement payments under **your Employer's retirement plan**.

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

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

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

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

7. The amount that **you**, **your spouse**, or **your** child(ren) receive, or are eligible to receive, as disability payments because of **your** disability under:

   a. the United States Social Security **Act**;
   b. the Canada Pension **Plan**;
   c. the Quebec Pension **Plan**; or
   d. any similar **Plan** or **Act**.

8. The amount that **you** receive as retirement payments or the amount **your spouse** or **your** child(ren) receive as retirement payments because **you** are receiving retirement payments under:

   a. the United States Social Security **Act**;
   b. the Canada Pension **Plan**;
   c. the Quebec Pension **Plan**; or
   d. any similar **Plan** or **Act**.

   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.

9. The amount **you** earn or receive from any form of employment.

   If **you** have income from secondary employment, and such employment began prior to **your** date of disability, the amount of income **you** were receiving from that secondary employment before **your** disability began is not a **deductible source of income**. Any increase in income from that secondary employment occurring after **your** date of disability is a **deductible source of income**.

10. The amount **you** receive from any unemployment compensation **law**.

IF YOU QUALIFY FOR DEDUCTIBLE SOURCES OF INCOME

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

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

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

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

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

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

If **you** receive a lump sum payment from any **deductible source of income**, the lump sum will be pro-rated on a weekly basis over the time period for which the sum was given. If no time period is stated, the sum will be pro-rated on a weekly basis from the date of the award over **your** expected lifetime as determined by **us**.

We will not estimate **your** entitlement to the following:

1. Payments **you** receive as disability payments under your Employer's retirement plan;
2. Payments **you** voluntarily elect to receive as retirement payments under your Employer's retirement plan;
3. Payments **you** are eligible to receive as retirement payments when you reach the later of age 62 or normal retirement age, as defined in your Employer's retirement plan;
4. The amount **you** receive as disability income payments under any automobile liability insurance policy or "no fault" motor vehicle plan, whichever is applicable; or
5. The amount **you** receive from a **third party** (after subtracting attorney's fees) by judgment, settlement or otherwise as disability income payments.

NON-DEDUCTIBLE SOURCES OF INCOME

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

1. 401(k) plans;
2. profit sharing plans;
3. thrift plans;
4. tax-sheltered annuities;
5. stock ownership plans;
6. credit disability insurance;
7. non-qualified plans of deferred compensation;
8. pension plans for partners;
9. military pension plans;
10. franchise disability income plans;
11. individual disability plans paid for by the **insured person**;
12. a retirement plan from another employer;
13. individual retirement accounts (IRA).

MINIMUM PAYMENT

The minimum payment each week for a **payable claim** is:

1. $ 25

We may apply this amount to recover an outstanding overpayment.

DURATION OF PAYMENTS

We will send **you** a payment each week up to the **maximum period of payment**. **Your maximum period of payment** is stated in the BENEFITS AT A GLANCE and will be paid during a continuous period of disability.

WHEN PAYMENTS END

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

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

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

DISABILITIES NOT COVERED UNDER THE POLICY

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

1. commission or attempt to commit a felony;
2. intentionally self-inflicted harm;
3. attempted suicide, regardless of mental capacity;
4. operating a motor vehicle while under the influence of alcohol as evidenced by a blood alcohol level in excess of the state legal intoxication limit;
5. being under the influence of any narcotic, unless the narcotic is being taken on the advice of a **doctor**;
6. voluntary intake of poison, drugs or fumes, unless a direct result of an occupational accident;
7. participation in a war, declared or undeclared, or any act of war;
8. active duty in the military or the National Guard or similar government organizations;
9. active participation in a riot, insurrection or terrorist activity;
10. engaging in any illegal occupation, work, or employment;
11. commission of a crime for which **you** have been convicted;
12. elective or cosmetic surgery except when required for **your appropriate car**e as a result of **your injury** or **sickness**;
13. traveling in any aircraft other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline;
14. traveling in any aircraft or device operated by or under authority of military or any aircraft being used for experimental purposes or to travel beyond the earth’s atmosphere.
15. occupational sickness or injury.

RECURRENT DISABILITY

If **you** have a **recurrent disability**, and after **your** prior disability ended, **you** returned to work for **your Employer** for 14 days or less, **we** will treat **your** disability as part of **your** prior claim and **you** do not have to complete another elimination period.

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

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

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

1. is unrelated to **your** prior disability; or
2. after **your** prior disability ended, **you** returned to work for **your Employer** for more than 14 days.

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

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

CLAIM INFORMATION

NOTICE OF CLAIM

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

CLAIM FORMS

The claim form is available from the **Policyholder**, or **you** can request a claim form from **us.**

Within 15 days after **we** receive **your** notice of a claim, **we** will send claim forms. The claim form is also available from the **Policyholder**. The claim form must be completed and sent to us at **our** home office. If **we** do not send **you** the claim forms within 15 days after receiving notice of **your** claim, **you** shall be deemed to have complied with the requirements of proof of claim when **you** submit **written** proof that covers the occurrence, character and extent of the loss for which a claim is made.

FILING A CLAIM

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

PROOF OF YOUR CLAIM

You must send **us written** proof of **your** claim no later than 90 days after **your** elimination period. Failure to give such proof within this timeframe shall not invalidate or reduce any **payable claim** if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. **You** must provide proof of claim no later than 1 year after the time proof is otherwise required, except in the absence of legal capacity. **Your** proof of claim, provided at **your** expense, must show:

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

In some cases, **you** will be required to give **us written** authorization to obtain additional medical information and to provide non-medical information such as vocational, occupational, financial and governmental as part of **your** proof of claim. **We** will deny **your** claim, if the appropriate information is not submitted within 45 days of the request.

We may require **you** to provide continuing proof of **your** claim as often as it is reasonable to do so during the pendency of **your** claim. **You** will have 60 days from the date of **our** request to provide **us** with continuing proof of **your** claim. Failure to provide continuing proof of **your** claim shall not result in a reduction of your benefits, however **your** benefit payments may be delayed until the requested continuing proof is provided.

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

TIME PAYMENT OF CLAIMS

Once **your** claim has been approved, **we** will send **you** a payment at the end of each week for any period for which **we** are liable. Any balance remaining unpaid by us upon termination of such period will be paid within 30 days upon receipt of proof of **your**

claim. A delayed payment of **your** claim will be subject to a simple interest at a rate of 10% per year beginning on the 31st day after receipt of satisfactory proof of **your** claim and ending on the day the claim is paid.

AUTHORITY

The **Policyholder** has delegated to the insurance company or its designee certain rights. These include the right to make determinations regarding the eligibility for participation or benefits and to interpret the terms of the policy and certificate. This delegation is made for the purpose of administering the terms of the policy and certificate.

PHYSICAL EXAMINATION

We may require **you** to be examined by one or more **doctors**, other medical practitioners, or vocational experts of **our** choice. **We** will pay for this examination. **We** can require an examination as often as it is reasonable to do so during the pendency of a claim. **We** may also require **you** to be interviewed by **our** authorized representative. **Your** failure to comply with this request may result in denial or termination of benefits.

REVIEW OF DENIAL OF CLAIMS

If **your** claim is denied, **you** have the right to notify **us** in **writing** within 180 days of receiving notice of the denial that **you** would like **us** to review the denial.

Upon request, **you** have the right to review copies of all documents, records, and other information relevant to **your** claim free of charge. **You** may submit **written** comments, documents, records and other information relating to **your** claim that **you** would like **us** to consider in reviewing **your** denial.

We will review the denial of **your** claim and send **you** notice of **our** decision within 45 days of receiving **your** request. If **we** require an extension of the deadline to obtain more information, **we** will give **you** notice of **our** decision within 45 days after the end of the extension period. **Our** decision will state the reasons for **our** decision, refer to the relevant portions of **your** certificate and advise **you** of any further appeal rights.

RIGHT TO REIMBURSEMENT

We have the right to recover any overpayments due to:

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

You must reimburse **us** in full. **We** will determine the method by which the repayment is to be made. **You** shall not act or fail to act in any manner that will prejudice **our** right to reimbursement without **our** prior **written** agreement. If **you** prejudice **our** right to reimbursement, fail to cooperate with **us** or fail to comply with this provision, **we** may withhold any and all benefits in addition to pursuing all remedies available to **us** under applicable **law**.

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

You must notify **us** if **you** make a claim against any **third party.** Neither **you** nor anyone acting on **your** behalf may settle **your** claim against the **third party** without **our** prior **written** consent. If **you** recover amounts from a **third party** by award, judgment, settlement or otherwise, **you** must reimburse **us** for lost income due to a disability because of an act or omission of the **third party.** **You** must reimburse **us** regardless of whether **you** have been made whole by the recovery, subject to limitations under applicable **law** where the policy is delivered or issued for delivery. If the amount received from the **third party** does not specify the lost income amount, **we** shall estimate the amount using a percentage of the settlement amount based on **your monthly earnings**, prorated to cover the period for which the settlement or judgment was made. **We** shall have first right to reimbursement. The amount **you** reimburse **us** will be reduced by **our** pro rata share of **your** attorney's fees and costs. If another entity is also entitled to reimbursement but does not reduce its reimbursement by its pro rata share of such fees and costs, then **our** pro rata share will be calculated as if that entity did make such reductions.

RIGHT TO SUBROGATION

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

If **we** bring a legal action against the **third party** on **your** behalf, **we** will not reduce **your** disability benefits by any other amounts **you** receive from the **third party**.