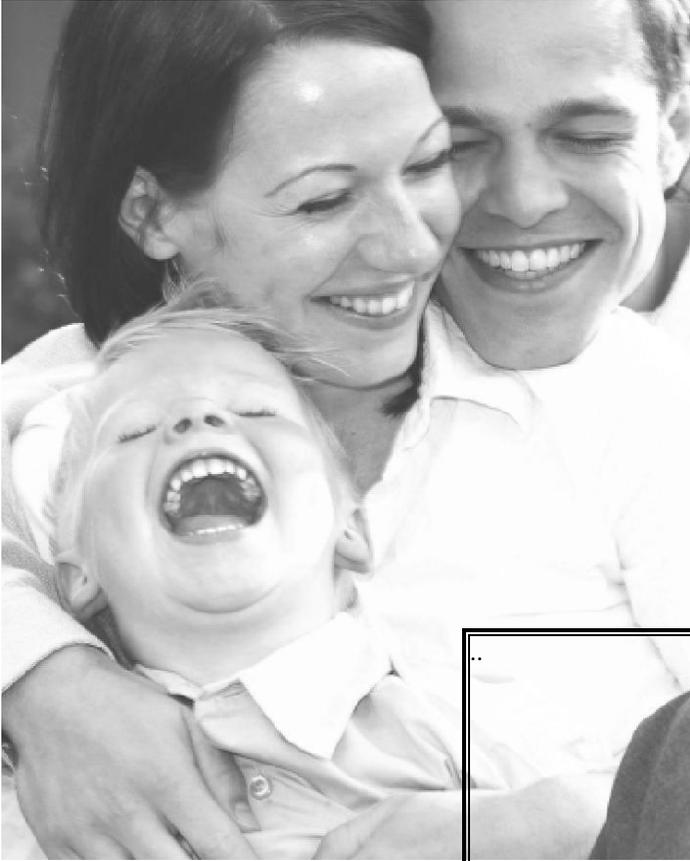


# Summary Plan Description



## Short Term Disability Benefits Program

## A guide to your benefits

**Plan Sponsor:** Virginia Association of Counties Group Self Insurance Risk Pool  
("VACORP")

**Participating Employer:** Your Employer participating in VACORP

**Class:** 01

**Class Description:** All Eligible Employees participating in the VRS Hybrid Retirement Plan

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# Short Term Disability Benefit Program

## Introduction

The following summary describes the benefit features of Your Employer's Short Term Disability (STD) income program (called "Program" in this summary).

The Plan Sponsor self-insures this Program. In this summary, Your employer is a participant of the Plan Sponsor and is referred to as "Employer" or "Participating Employer."

Anthem Life Insurance Company is the claims administrator for the Program, and does not underwrite or insure the Program. In this summary, the claims administrator is called "We" or "Us."

"You" and "Your" means an Eligible Employee covered under this Program.

We will administer claims in accordance with the agreement between the Plan Sponsor and Us.

## Schedule of Benefits for Short Term Disability Benefit Program

**Class 1:** All Eligible Employees participating in the VRS Hybrid Retirement Plan

**For a Work-Related Disability, meaning a Disability that is due to Your Injury or Illness that occurs because of Your job:**

**For Eligible Employees who have been enrolled for less than 60 months** in the Virginia hybrid retirement program during employment with the Employer when Disability begins, the benefit is 60% of Weekly Earnings in effect just prior to Disability, reduced by Deductible Sources of Income, and payable for up to 125 workdays of Disability.

**For Eligible Employees who have who have been enrolled for at least 60 months but less than 120 months** in the Virginia hybrid retirement program during employment with the Employer when Disability begins, the benefit before being reduced by Deductible Sources of Income, and payable during a maximum of 125 workdays of Disability, is:

- For up to the first 85 such workdays: 100% of Weekly Earnings in effect just prior to Disability;
- For up to the next 25 such workdays: 80% of Weekly Earnings in effect just prior to Disability; and
- For up to the next 15 such workdays of Disability: 60% of Weekly Earnings in effect just prior to Disability.

**For Eligible Employees who have who have been enrolled for at least 120 months** in the Virginia hybrid retirement program during employment with the Employer when Disability begins, the benefit before being reduced by Deductible Sources of Income, and payable during a maximum of 125 workdays of Disability, is:

- For up to the first 85 such workdays: 100% of Weekly Earnings in effect just prior to Disability;
- For up to the next 40 such workdays: 80% of Weekly Earnings in effect just prior to Disability.

**For a Non-work Related Disability:**

**For Eligible Employees who have been enrolled for less than 12 months** in the Virginia hybrid retirement program during employment with the Employer when Disability begins, there is no benefit for such Disability.

**For Eligible Employees who have who have been enrolled for at least 12 months but less than 60 months** in the Virginia hybrid retirement during employment with the Employer when Disability begins, the benefit is 60% of Weekly Earnings in effect just prior to Disability, reduced by Deductible Sources of Income and thereafter payable for up to 125 workdays of Disability.

**For Eligible Employees who have who have been enrolled for at least 60 months but less than 120 months** in the Virginia hybrid retirement program during employment with the Employer when Disability begins, the benefit before being reduced by Deductible Sources of Income and thereafter payable during a maximum of 125 workdays of Disability, is:

- For up to the first 25 such workdays: 100% of Weekly Earnings in effect just prior to Disability;
- For up to the next 25 such workdays: 80% of Weekly Earnings in effect just prior to Disability; and
- For up to the next 75 such workdays of Disability: 60% of Weekly Earnings in effect just prior to Disability.

**For Eligible Employees who have who have been enrolled for at least 120 months but less than 180 months** in the Virginia hybrid retirement program during employment with the Employer when disability begins, the benefit before being reduced by Deductible Sources of Income and thereafter payable during a maximum of 125 workdays of Disability, is:

- For up to the first 25 such workdays: 100% of Weekly Earnings in effect just prior to Disability;
- For up to the next 50 such workdays: 80% of Weekly Earnings in effect just prior to Disability; and
- For up to the next 50 such workdays of Disability: 60% of Weekly Earnings in effect just prior to Disability.

**For Eligible Employees who have who have been enrolled for at least 180 months** in the Virginia hybrid retirement program during employment with the Employer when Disability begins, the benefit before being reduced by Deductible Sources of Income and thereafter payable during a maximum of 125 workdays of Disability, is:

- For up to the first 25 such workdays: 100% of Weekly Earnings in effect just prior to Disability;

- For up to the next 75 such workdays: 80% of Weekly Earnings in effect just prior to Disability; and
- For up to the next 25 such workdays of Disability: 60% of Weekly Earnings in effect just prior to Disability.

**Minimum Weekly Benefit**      None.

**Elimination Period:**                      Begins on the first day that You meet the definition of Disability and ends after:

- 7 days of injury; and/or
- 7 days of illness

If You return to work for 3 or less days during the Elimination Period, those days will interrupt the Elimination Period. However, the Disability will be treated as continuous if it is from the same or a related condition. Only those days during which You are Disabled will be used to satisfy the Elimination Period. You must complete the full 7-day Elimination Period within a total period of not more than 10 consecutive days.

**Maximum Benefit Period:**                      125 workdays based on a Monday-Friday workweek, including paid holidays

**Disabilities caused by pregnancy-related conditions, as well as complications of pregnancy, are eligible for benefits.**

## Definitions

**Accident or Accidental** means accidental bodily Injury which is sustained independently of disease, illness, or bodily infirmity.

**Actively at Work means** reporting to the Employer's regular place of employment and carrying out the regular duties of Your occupation for the number of hours required by the Employer but in no case less than 10 hours a week. You will be considered Actively at Work on each day of a regular paid vacation or on a regular non-workday provided that You were capable of performing normal duties of Your Own Occupation during those days and You were Actively at Work on the last workday prior to such paid vacation or non-workday.

**Disability Work Earnings** mean for Short Term Disability benefits, weekly wages or salary which You receive while You are Disabled and working.

**Eligible Employee** means You meet all of the following:

- You are an employee of the Employer who is participating in the Virginia hybrid retirement program described in Section 51.1-169 of the Code of Virginia; and
- You are a regular full-time or part-time employee of the Employer, working for pay on a scheduled normal week of at least 10 hours required per week; and
- You perform that work at the Employer's usual place of business, except for duties of a kind that must be done elsewhere; *and*
- You are in a covered Class named under the Plan; *and*
- You are a legal citizen or legal resident of the United States. In the case of a legal resident, You will become ineligible for coverage if You leave the United States for one hundred eighty (180) or more consecutive days.

Temporary, seasonal, or contract employees are not included as Eligible Employees under the Program.

**Elimination Period** means the period of continuous Disability which must be satisfied before You are eligible to receive benefits under the Program. The Elimination Period is shown in the Schedule of Benefits of this Program and begins on the first day that You meet the Definition of Disability.

If You return to work for 3 or less days during the Elimination Period, those days will interrupt the Elimination Period. However, the Disability will be treated as continuous if it is from the same or a related condition. Only those days during which You are Disabled will be used to satisfy the Elimination Period. You must complete the full 7-day Elimination Period within a total period of not more than 10 consecutive days.

**Employer and Participating Employer** means Your Employer which is participating in VACORP (the Plan Sponsor).

**Full-Time Basis** means the ability to work and earn more than 80% of your Weekly Earnings. Ability is based on capacity and not market availability.

**Hospital or Medical Facility** means a facility accredited by JCAHO (Joint Commission on Accreditation of Health Care Organizations) duly licensed by the state to provide medical evaluation and treatment of patients under the direction of an active staff of licensed physicians.

**Hospitalization** means being an in-patient 24 hours a day.

**Illness** means a sickness or disease and will include pregnancy. Disability resulting from the sickness or disease must begin while You are covered under the Program

**Injury** means bodily injury resulting directly from an Accident and independent of all other causes, and which produces at the time of the Accident, objective symptoms. The Injury must occur and Disability must begin while You are covered under the Program. An Injury that occurs before You are covered under the Program will be treated as an Illness for any subsequent claims.

Any Disability which begins more than 7 days after an Injury will be considered an Illness for the purpose of determining Short Term Disability benefits.

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

- are normally required for the performance of Your Own Occupation or any occupation;  
*and*
- cannot be reasonably omitted or modified except that We will consider You able to perform the Material and Substantial duties if You are working or have the capability to work your normal scheduled work hours.

**Own Occupation** means the occupation that You regularly performed and for which You were covered under the Program immediately prior to the date Your Disability began. The occupation will be considered as it is generally performed in the national economy, and is not limited to the specific position You held with the Employer.

**Part-Time Basis** means the ability to work and earn between 20% and 80% of Your Weekly Earnings.

**Physician** means:

- a person licensed to practice medicine in the jurisdiction where such services are performed; *or*
- any other person whose services must be treated as a Physician's for the purposes of the Program according to applicable law. Each such person must be licensed in the jurisdiction where he or she performs the service and must act within the scope of that license. He or she must also be certified and/or registered if required by such jurisdiction.

Physician does not include:

- You
- Your Spouse
- Anyone employed by the Employer, or any business partner of You or the Employer.
- Any member of Your immediate family, including Your and/or Your Spouse's:
  - Parents
  - Children (natural, step, or adopted)
  - Siblings

- Grandparents
- Grandchildren
- In-Laws

**Recurrent Disability** means a Disability which is related or due to the same cause(s) as a prior Disability for which a benefit was payable.

**Regular Care** means:

- You are under the continuing care of and personally visit a Physician as frequently as is medically required according to standard medical practice, to effectively diagnose, manage and treat Your disabling condition(s); *and*
- You are receiving appropriate treatment and care of Your disabling condition(s) which conforms with standard medical practice by a Physician whose specialty and clinical experience is appropriate for Your disabling condition(s) according to standard medical practice.

**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.

**We, Us, and Our** means the claims administrator.

**Weekly Earnings** is defined in one of the two following paragraphs that fits Your situation:

*If You are paid on an annual contract basis*, Your Weekly Earnings is Your weekly rate of creditable compensation based on one-fifty-second (1/52nd) of your annual contract salary received from the Employer, including any

1. Contributions you make through a salary reduction agreement with your Employer to:
  - a. An Internal Revenue Code (IRC) Section 401(k), 403(b), 408(k), 408(p), or 457 deferred compensation arrangement; or
  - b. An executive nonqualified deferred compensation arrangement.
2. Shift differential pay.
3. Amounts contributed to your fringe benefits according to a salary reduction agreement under an IRC Section 125 plan.

*If You are paid hourly wages*, Your Weekly Earnings is Your weekly rate of creditable compensation based on your hourly pay rate multiplied by the number of hours you are regularly scheduled to work per week by Your Employer, but not more than 40 hours. If you do not have regular work hours, your weekly rate of earnings is based on the average number of hours you worked per week for the Employer during the preceding 12 calendar months (or during your period of employment if less than 12 months), but not more than 40 hours. Weekly Earnings also includes:

1. Contributions you make through a salary reduction agreement with your Employer to:
  - a. An Internal Revenue Code (IRC) Section 401(k), 403(b), 408(k), 408(p), or 457 deferred compensation arrangement; or
2. Shift differential pay.
3. Amounts contributed to your fringe benefits according to a wage reduction agreement under an IRC Section 125 plan.

In either case above, Weekly Earnings will be determined according to Your Employer's records.

**Weekly Benefit Payment** means the amount of income replacement payable to You while You are Disabled, subject to the terms of the Program, and after any amounts shown in the Deductible Sources of Income section and any Disability Work Earnings have been subtracted.

## When Short Term Disability Benefits End

Weekly Benefit Payments end on the first to occur of the following dates:

1. You are no longer Disabled under the terms of the Program; *or*
2. You are no longer receiving, accepting or following Regular Care from a Physician; *or*
3. The Maximum Benefit Period from the Schedule of Benefits ends; *or*
4. Preceding the date of Your death; *or*
5. We ask You for Proof that You are still Disabled, if We do not receive Proof of Disability within 31 days of Our request; *or*
6. We ask You for details about Your Deductible Sources of Income, including Your tax returns, if You do not give Us details within 31 days of Our request; *or*
7. We ask You to be examined by:
  - a Physician; *or*
  - health care professionalIf You do not reasonably cooperate with the examiner or if You unreasonably decline to be examined; *or*
8. Your Disability Work Earnings exceed the amount allowable under the Program; *or*
9. You cease to reside in the United States. If You are outside the United States for a total period of 6 months or more during any 12 consecutive months of Weekly Benefit Payments, You will be considered to have ceased to reside in the United States; *or*
10. You are confined to a penal or correctional institution; *or*
11. With respect to a mental illness, that You are not under the continuing Regular Care of a Physician specializing in psychiatric care; *or*
12. With respect to Alcoholism and Drug Addiction, that You are not being actively supervised by and receiving continuing treatment from a rehabilitation center or a designated institution approved for such treatment by an appropriate body in the governing jurisdiction, or, if none, by Us; *or*
13. You or Your Physician fail to submit any medical or psychiatric information requested by Us; *or*
14. You would be able to work in Your Own Occupation on a part-time basis earning 20% or more of Your Weekly Earnings, but choose not to do so; *or*
15. You would be able to increase Your current earnings to more than 80% of Your Weekly Earnings by increasing the number of hours worked or the number of duties performed in Your Own Occupation, but choose not to do so.

If it is determined that You have applied for benefits under fraudulent circumstances, benefit payments will cease and the appropriate fraud defense action will be taken.

## **Termination of Coverage**

Your coverage under the Program ends on the earliest of the following dates:

- the date the Plan Sponsor's self-insured Program ends;
- The date Your Employer no longer participates in the Plan Sponsor, VACORP;
- the date You no longer meet the definition of an Eligible Employee (for example, You retire or otherwise end employment or are no longer regularly working the minimum number of hours per week);
- the date you cease to be a member of a covered Class;
- the date You cease to be Actively at Work. However, the employer may continue Your coverage unless it ends due to any of the above reasons during an absence from work due to a Leave of Absence that is in compliance with the Family Medical Leave Act of 1993 ("FMLA") or applicable state, family and medical leave law.

## Short Term Disability Income Coverage

Short term disability benefits are payable to You if You lose income due to a Disability. In order to receive short term disability benefits:

- You must be under the regular care of a Physician;
- the Physician must provide proof satisfactory to Us that You are Disabled; *and*
- the Disability must begin while:
  - You are employed by the Participating Employer ; *and*
  - You are covered under the Program.

### Definition of Disability and Disabled for Short Term Disability

**Disabled and Disability** mean during the Elimination Period and thereafter because of Your Injury or Illness, *all* of the following are true:

- You are unable to do the Material and Substantial Duties of Your Own Occupation; or Your Disability Work Earnings, if any, are less than or equal to 80% of Your Weekly Earnings.

Your Disability must start while You are covered under the Program. You must be receiving Regular Care from a Physician for Your Injury or Illness for any period that You are Disabled.

Your loss of earnings must be a direct result of Your Injury or Illness. You will not be considered Disabled from an occupation solely due to:

- Loss, suspension, restriction or failure to maintain a professional license, occupational license, permit or certification; *or*
- Loss of earnings due to economic factors such as, but not limited to, recession, job elimination, job restructuring, temporary lay offs, pay cuts and job-sharing; *or*
- The Employer's work schedule that is inconsistent with the normal work schedule of Your Own Occupation; *or*
- Your relationship with the Employer or other employees of the Employer; *or*
- Failure or inability of the Employer to maintain the workplace in a manner consistent with the normal physical environment of Your Own Occupation; *or*
- Your inability to work more than 40 hours per week in the occupation, even if You were regularly required to work more than 40 hours per week prior to Your Injury or Illness.

### Short Term Disability Benefits

Short Term Disability benefits will be payable for a period of Disability in accordance with the terms of the Program, if:

- The Disability starts while You are covered under the Program; *and*
- The Disability continues during and past the Elimination Period; *and*

- We receive Proof of Your Disability.

The Short Term Disability Benefit is shown in the Schedule of Benefits. The Short Term Disability Benefit may be reduced in accordance with the provisions of the *Deductible Sources of Income* section. The Short Term Disability Benefit will not:

- exceed Your amount of coverage; *or*
- be paid for longer than the Maximum Benefit Period.

You will begin to receive payments when We approve Your claim, provided the Elimination Period has been met. We will send You a payment each week for Short Term Disability benefits for any period payable under the Program.

### **Calculating Your Short Term Disability Benefit**

*Select one calculation method*

We will calculate Your Weekly Benefit Payment as follows:

#### **Part A**

If You are Disabled and not working:

1. Multiply Your Weekly Earnings by the Benefit Percentage shown in the Schedule of Benefits.
2. Take the amount from Step 1 above and subtract any amounts shown in the Deductible Sources of Income section. The amount calculated in **Step 2** is Your Weekly Benefit Payment.

#### **Part B (Work Incentive)**

If You are Disabled and working, and Your Disability Work Earnings are less than or equal to 80% of Your Weekly Earnings:

1. Add Your Disability Work Earnings to Your gross Weekly Benefit (i.e. Your Weekly Benefit Payment before any Deductible Sources of Income are subtracted);
2. Compare the amount determined from item 1 immediately above with your Weekly Earnings just before Your Disability
3. If the amount determined from item 1 is greater than Your Weekly Earnings, the difference will be a Deductible Source of Income.

If You are working and Your Disability Work Earnings are more than 80% of Your Weekly Earnings, no Short Term Disability benefit will be payable.

We may require You to send Proof of Your weekly Disability Work Earnings. We will adjust Your Weekly Benefit Payment based on Your Disability Work Earnings.

As Part of Your Proof of Disability Work Earnings, We may require that You send Us any appropriate financial records which We believe necessary as Proof of Your income.

### **If Your Disability Work Earnings Fluctuate**

If Your Disability Work Earnings routinely fluctuate widely from week to week, We may average Your Disability Work Earnings over the most recent three weeks to determine if Your claim should continue.

If We average Your Disability Work Earnings, We will not terminate Your claim unless the average of Your Disability Work Earnings for a three week period exceeds 80% of Your Earnings.

We will not pay You for any week during which Your Disability Work Earnings exceed the amount allowable under the Program.

### **Recurrent Disability Provision for Short Term Disability**

If You have a Recurrent Disability, and after Your prior Disability ended, You return to work for Your Employer for 45 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 Benefit 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 and conditions of the Program as Your prior claim.

Your Disability will be treated as a new claim if Your current Disability:

- is unrelated to Your prior Disability; *or*
- after Your prior Disability ended, You returned to work for the Employer for more than 45 consecutive days.

The new claim will be subject to all of the provisions of the Program and You will be required to satisfy a new Elimination Period.

### **Period of Disability extended by a new condition**

If a period of Disability is extended by a new condition while You are receiving Weekly Benefit Payments, then the extension of the period of Disability will be treated as a part of the same continuous period of Disability, subject to the same Maximum Benefit Period. All other requirements, limitations and exclusions of the Program will apply to the new condition as well as to the original cause of Disability.

## Deductible Sources of Income

Deductible Sources of Income, except for Retirement Benefits, must be payable as a result of the same disability for which We pay a benefit. We will require You to apply for any of the Deductible Sources of Income for which You may be eligible, except for Retirement Benefits that would only be provided on a reduced basis. You may be required to sign a reimbursement agreement stating that if You receive any payments for Deductible Sources of Income, You will reimburse the Plan Sponsor for any overpayment of benefits. You must immediately disclose to Us the amount of any retroactive payment You may receive from any of the Deductible Sources of Income.

### The following are Deductible Sources of Income:

1. The amount that You receive, or are eligible to receive, under:
  - a workers' compensation law; *or*
  - an occupational disease law; *or*
  - unemployment compensation law
  - any other Act or Law with similar intent.
  
2. The amount that You receive, or are eligible to receive, as disability income payments under any:
  - state compulsory benefit Act or Law; *or*
  - governmental retirement system as a result of Your employment with the Employer; *or*
  - Veteran's Administration or any other foreign or domestic governmental agency; *or*
  - automobile liability insurance policy; *or*
  - individual disability income plans which are wholly or partially paid for by the Employer; *or*
  - any plan or arrangement of disability coverage, whether insured or not, resulting from Your employment by or association with the Participating Employer or any other employer, or resulting from Your membership in or association with any group, association, union or other organization.
  
- 3a. The amount that You, Your spouse, and children receive, or are eligible to receive, as disability payments because of Your Disability under:
  - The United States Social Security Act; *or*
  - the Canada Pension Plan; *or*
  - the Quebec Pension Plan; *or*
  - any similar plan or act.
  
- 3b. The amount that You receive, or are eligible to 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; *or*
  - the Canada Pension Plan; *or*
  - the Quebec Pension Plan; *or*
  - any similar plan or act.

4. Any disability benefits You receive or are eligible to receive under the Plan Sponsor's retirement plan, including a public employee retirement system, a state teacher retirement system, and a plan arranged and maintained by a union or employee association for the benefit of its members. You and the Plan Sponsor's contributions will be considered as distributed simultaneously throughout Your lifetime, regardless how funds are distributed from the retirement plan.

If any of these plans has two or more payment options, the option which comes closest to providing You a weekly income for life with no survivor benefit will be a Deductible Source of Income, even if you choose a different option.

5. The amount that You:
  - receive as disability payments under the Employer's Retirement Plan; *or*
  - voluntarily elect to receive as retirement payments under the Employer's Retirement Plan; *or*
  - are eligible to receive as retirement payments when You reach the later of age 62 or normal retirement age, as defined in the 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 the Plan Sponsor's contribution to the Retirement Plan. Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement payment.

Regardless of how the retirement funds from the Retirement Plan are distributed, We will consider the Plan Sponsor and Your contributions to be distributed simultaneously throughout Your lifetime.

6. The amount You receive as a result of any action brought under Title 46, United States Code Section 688 (The Jones Act).
7. The amount You receive from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.
8. The amount You receive under the mandatory portion of any "no fault" motor vehicle plan.
9. Commissions, severance allowance, sick pay or any similar employer sponsored paid time off plan where You receive income from the employer, vacation pay or any salary continuation plan. Any earnings from any work or employment may be used to reduce Your Weekly Benefit Payment unless otherwise specified by the terms of the Program.
10. Any amounts from partnership, proprietorship draws, or similar draws.

## **Lump Sum Payments**

If You receive a lump sum payment of a Deductible Source of Income, We will deduct the lump sum from Your Weekly Benefit Payment by prorating the lump sum on a weekly basis over the time period for which the lump sum was given. If no time period is stated, the lump sum will be pro-rated based on the lesser of the Maximum Benefit Period or Your expected lifetime as determined by Us.

## **Non-Deductible Sources of Income**

We will not subtract from Your Weekly Benefit Payment any 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 or mortgage disability insurance;
7. non-qualified plans of deferred compensation;
8. pension plans for partners;
9. military pension and disability income plans;
10. individual disability plans paid by the Employee;
11. a retirement plan from another employer;
12. individual retirement accounts (IRA);
13. Accelerated death benefits paid from a life insurance policy
14. Keogh (HR-10) plan.
15. Reimbursement for hospital, medical or surgical expense

If the gross Weekly Benefit Payment and Your Disability Work Earnings exceed 100% of Your Weekly Earnings, We will subtract the amount in excess of 100% from Your Weekly Benefit Payment.

### **If You May Qualify for Deductible Income Benefits**

When We determine that You may qualify for benefits under items 1, 2 and 3a & b in the Deductible Sources of Income section, We will estimate Your entitlement to these benefits. We can reduce Your payment by the estimated amounts if such benefits:

- have not been awarded or denied; *or*
- have been denied and the denial is being appealed.

### **Social Security Benefits**

You must apply for benefits under the Federal Social Security Act if there is a reasonable basis for application. To apply for Social Security benefits means to pursue such benefits until You receive approval from the Social Security Administration, or a notice of denial of benefits from an administrative law judge.

We may require You to:

- Send Us Proof that You have applied for Social Security Benefits; *and*
- Sign a reimbursement agreement in which You agree to repay the Plan Sponsor for any overpayments We may make to You under the Program; *and*
- Sign a release that authorizes the Social Security Administration to provide information directly to Us regarding Your Social Security benefits eligibility.

When You receive approval or final denial for Your claim for Social Security benefits as described above, You must notify Us immediately. We will adjust the amount of Your Weekly Benefit Payment. You must promptly repay Us for any overpayment.

### **Recovery of Overpayment**

We have the right to recover any amount that We determine to be an overpayment. This includes any prior or current overpayment from any past, current or new payable claim under the Program. An overpayment occurs if We determine that:

- The total amount paid by Us on Your claim is more than the total amount then due to You under the Program; *or*
- Payment made by Us should have been made under another plan.

If such overpayment occurs, You have an obligation to reimburse the Plan Sponsor in full within 60 days of Our Written notice to You.

If the Plan Sponsor does not receive reimbursement in full within 60 days, We may, at Our sole discretion, use any available legal means to collect the overpayment, including but not limited to one or both of the following:

- Taking legal action;
- Stopping or reducing any future payments under the Program, which might otherwise be payable to You or any other Claimant or payee.

You must immediately disclose to Us the amount of any retroactive payment You may receive from any of the Deductible Sources of Income. We have the right to obtain any information We may require relating to Your eligibility, application or receipt of Deductible Sources of Income. You must provide Us with Your Signed authorization to obtain such information upon Our request.

### **Adjustment for Underpayment**

If We determine that You have been paid less than You are entitled to under the Program, We will pay You the difference in one lump sum.

### **Proration**

Any Short Term Disability Benefit payable for less than a week will be prorated based on a 7 day week.

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## **Additional Benefit for Vocational Rehabilitation Program**

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If You are Disabled and receiving Weekly Disability Payments under the Policy, You may be eligible for Vocational Rehabilitation services.

**Vocational Rehabilitation Program** means a program of services that have been approved by Us for the purpose of helping You to return to work. The Vocational Rehabilitation Program may include, at Our sole discretion, but is not limited to, the following services:

1. coordination with Your Plan Sponsor to assist You to return to work;
2. evaluation of adaptive equipment or job accommodations to allow You to work;
3. evaluation of possible workplace modifications which might allow You to return to work in Your Own Occupation or another job or occupation;
4. vocational evaluation to determine how Your disability may impact Your employment options;
5. job placement services, including resume preparation services and training in job-seeking skills;
6. alternative treatment plans such as recommendations for support groups, physical therapy, occupational therapy, or other treatment designed to enhance Your ability to work.

We will determine the extent to which these services may be provided. We will pay the service provider(s) for these services unless We agree in writing to other arrangements.

Our decision to offer a Vocational Rehabilitation Program will be based on:

1. Your education, training and experience;
2. Your transferable skills;
3. Your physical and mental abilities;
4. Your motivation to return to active employment;
5. the labor force demand for workers in the proposed occupation in Your geographic area;  
*and*
6. the expected liability for Your long term Disability claim.

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## Vocational Rehabilitation Program (continued)

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To qualify for these services, You must:

1. have a Disability which prevents You from performing some or all of the Material and Substantial Duties of Your Own Occupation;
2. lack of skills, training, or experience You would need to perform another Gainful Occupation;
3. possess the physical and mental abilities You need to complete a rehabilitation program;  
*and*
4. be reasonably expected to return to active employment with the assistance of these services.

A Vocational Rehabilitation Program proposal may be made either by Us, Your Physician or You. We will prepare a written program with input from You, Your Physician, Your current employer and/or Your prospective employer. Once We approve a program, You will be provided services according to the written program.

The written program will describe:

1. the goals of the Vocational Rehabilitation Program;
2. Our responsibilities;
3. Your responsibilities;
4. the responsibilities of any third party(ies) associated with this program;
5. the expected dates of the services;
6. the expected costs of the services;
7. the expected duration of the program.

We reserve the right to make the final decision concerning Your eligibility to take part in this program, and the amount of services You will be provided.

If You agree to participate in the program and fail to complete Your responsibilities under the program without Reasonable Care, Your Weekly Benefit Payment may be reduced or discontinued.

**Reasonable Cause** means documented physical or mental impairments which leave You unable to take part in or complete the agreed upon program. It may also mean that You are involved in:

- medical treatment which prevents or interferes with Your taking part in or completing the program; *or*
- some other vocational rehabilitation program which conflicts with Your taking part in or completing the program developed by Us, and that program is reasonably expected to return You to active employment.

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## **Additional Benefit for Work Retention Assistance**

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If You:

1. have a medical condition or functional impairment that You report to Us and that We determine in Our sole discretion has the potential to result in a Disability; but
2. have not yet become Disabled,

We may provide vocational rehabilitation services and assistance We determine necessary and appropriate to minimize the effects of such condition or impairment and to assist You in retaining the ability to perform the Material and Substantial Duties of Your Own Occupation or of another appropriate gainful occupation offered by the Plan Sponsor.

The vocational rehabilitation services may include, at Our sole discretion, payment of certain expenses for education, training, accommodation, or assistive technology in connection with the Vocational Rehabilitation Program We have approved for You.

Examples of conditions or impairments for which We may be able to provide services under this Additional Benefit for Work Retention Assistance include, but are not limited to:

1. Diabetes with complications or other endocrine disorders;
2. Vision or hearing loss;
3. Arthritis and other degenerative or progressive musculoskeletal conditions;
4. Multiple Sclerosis and other progressive neurological disorders; and
5. Cancer and complications of cancer treatment.

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## Additional Benefit for Catastrophic Conditions

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To receive payments under this Additional Benefit, You must be receiving Weekly Benefit Payments. You are eligible to receive this Additional Benefit, when We receive satisfactory Proof that due to the Disability for which You are receiving Weekly Benefit Payments under the Policy, You:

- lose the ability to safely and completely perform at least 2 Activities of Daily Living without another person's assistance or verbal cueing; or
- have a deterioration or loss in intellectual capacity and need another person's assistance or verbal cueing for Your protection or for the protection of others.

For the purposes of this Additional Benefit, **Activities of Daily Living** mean:

1. **Bathing:** the ability to wash Yourself either in the bathtub or shower or by sponge bath with or without equipment or adaptive devices including the task of getting into or out of the bathtub or shower.
2. **Dressing:** the ability to put on and take off all garments and medically necessary braces or artificial limbs usually worn;
3. **Toileting:** the ability to get to and from and on and off the toilet, and performing associated personal hygiene.
4. **Transferring:** the ability to move in and out of a chair or bed with or without equipment such as canes, quad canes, walkers, crutches or grab bars or other support devices including mechanical or motorized devices.
5. **Continence:** the ability to either:
  - voluntarily control bowel and bladder function; or
  - if incontinent, be able to perform associated personal hygiene (including caring for a catheter or colostomy bag).
6. **Eating:** the ability to get nourishment into the body.

An Activities of Daily Living loss that existed prior to coverage under this program will not be considered as a loss under this Additional Benefit.

The Additional Benefit for Catastrophic Conditions is 20% of pre-disability Weekly Earnings, but when combined with Weekly Benefit Payments, is not to exceed 80% of Weekly Earnings.

The Additional Benefit for Catastrophic Conditions is not subject to Deductible Sources of Income. This benefit plus Your Weekly Benefit Payment will not exceed the Maximum Weekly Benefit shown in the Schedule of Benefits.

The Additional Benefit for Activities of Daily Living will end on the earliest of the following dates:

1. You cease to be paid a Weekly Benefit Payment;

2. You recover the Activities of Daily Living that were lost as a result of Your Disability;
3. You die.
4. any other requirement or condition of the Policy is not met, including but not limited to those listed in the When Disability Benefits End section.

No survivor benefits are payable under the Additional Benefit for Catastrophic Conditions.

## Exclusions

***DISCLAIMER: Non-insured benefit specifications may differ from state insured benefit plans.***

**The following exclusions apply to any and all benefits under the Program, including any Additional Benefits or Additional Provisions unless otherwise specifically referenced.**

The Program does not cover any disabilities or loss caused by, resulting from, or related to any of the following:

1. War or an act of war, declared or undeclared, whether civil or international;
2. Service in the armed forces, military reserves or National Guard of any country or international authority, or in a civilian unit serving with such forces;
3. Self-inflicted Injury or Illness or your attempt to commit suicide while sane or insane;
4. Active participation in a riot or civil commotion;
5. Participating in, committing or attempting to commit a felony, or any type of assault or battery, or engaging in an unlawful act or illegal occupation. This exclusion applies even if You plead to a lesser charge or no contest;
6. Operating any Motorized Vehicle if;
  - a. under the influence of any intoxicant or drug whether or not prescribed by a physician; *or*
  - b. Your blood alcohol concentration is in excess of the legal limit in the state in which the Accident or Injury occurred.
7. Any accident, Injury or Illness caused by, resulting from, or related to Your being under the influence of any illicit drug, narcotic, controlled substance or chemical, unless you are participating in good faith in a treatment plan, program or course of medical treatment;
8. Loss of professional license, occupational license or certification;
9. Any Illness or Injury caused by or during employment for wage or profit, if You are eligible for coverage under Workers' Compensation insurance as allowed by the Employer's state of domicile.

In addition, the Program will not pay a benefit for any period for which any of the following applies:

1. You are no longer receiving, accepting or following Regular Care from a Physician, except for a period wherein the Physician certifies that treatment is not warranted;
2. With respect to a mental disorder, any period during which You are not under the continuing Regular Care of a Psychiatrist specializing in psychiatric care. With respect to Alcoholism and Drug Addiction, any period during which You are not being actively supervised by and receiving continuing treatment from a rehabilitation center or a designated institution approved for such treatment by an appropriate body in the governing jurisdiction, or, if none, by Us.
3. You have applied for benefits under fraudulent circumstances and these circumstances resulted in a conviction of fraud.
4. You unreasonably fail to submit to an Independent Medical Exam requested by Us.

5. You are confined to a penal or correctional institution.
6. Disability results from cosmetic or reconstructive surgery, except for complications arising from such surgery, or surgery necessary to correct a deformity caused by Illness or accidental Injury.
7. You or Your Physician fail to provide within 31 days any medical or any psychiatric records which We reasonably request.
8. Any period that any other requirement or condition of the Program is not met, including but not limited to those listed in the *When Disability Benefits End* section.

## **General Provisions**

### **Currency**

All payments made to or by Us will be made in United States dollars.

### **Class Membership**

You may only be insured under one Class at any time.

### **Agency**

The Agent for claims adjudication appointed by the Plan Sponsor is not liable for any acts or omissions.

### **Changes to Program**

The Program may be amended at any time by the Plan Sponsor without the consent of or notice to any other individual. Any amendment will be in Writing and communicated to you.

It is understood that, if the Program is amended during Your continuous period of Disability, the amendment will have no effect on the amount of insurance during that same continuous period of Disability.

### **Enforcement of Program Terms**

If at any time We do not enforce a provision of the Program, We will still retain Our right to enforce that provision at Our option.

## **Claims**

### **Notice of Claim**

Notice of a claim must be given to Us within 30 days after a covered loss starts, or as soon as reasonably possible. Reference to a “loss” merely means that an event occurred or an expense was incurred for which a benefit is payable under the Program. The notice must identify You. You must notify Us immediately if You return to work in any capacity.

### **Claim Forms**

When We receive the notice of claim, We will send You forms for filing Proof of Disability. If these forms are not given to the Claimant within 15 days, the Claimant can meet the Proof of Disability requirements by giving Us a Written statement of the nature and extent of the loss within the time limit stated in the Proof of Disability section.

### **Proof of Disability**

Due Written Proof of Disability must be given to Us within 90 days after such loss. Failure to furnish the Proof within that time shall not invalidate or reduce the claim if the Proof is given as soon as reasonably possible. But, unless delayed by Your legal incapacity, the required Proof must be furnished within 12 months of the specified time. If the Program terminates, the Claimant must give Written notice and Proof of Disability for a Disability that began before the Program ended within 90 days after the Program terminated.

Proof of Disability will include information from Your Physician about Your condition. You must authorize the release of Your medical information. You must give Us any other information and items that We require to support Your claim. We reserve the right to determine if Your Proof of Disability is satisfactory in accordance with the Program and any applicable Act or Law.

### **Filing Claim Forms**

The Proof of Loss claim forms contain instructions as to how they should be completed and where they should be sent. Be sure to fully complete Your portion of the forms. Unanswered questions may delay the processing of Your claim.

### **Proof of Continuing Disability**

From time to time You must give Proof satisfactory to Us at Your expense that You are still Disabled. We will ask You for this Proof at reasonable intervals. Such Proof must be provided to Us within 30 days, or as soon as reasonably possible thereafter. We will stop benefit payments if You do not give Proof satisfactory to Us that You are still Disabled. We may require You to provide Us with the name and address for any Hospital, health facility or institution where You received treatment, including all attending physicians, and to give us Your Written authorization to obtain additional medical information, including but not limited to complete copies of medical records. We may investigate Your claim at any time.

## **Proof of Financial Loss**

We have the right to require Written Proof of Financial Loss. This includes, but is not limited to:

1. statements of income received from other sources while You are claiming benefits under the Program;
2. evidence that due application has been made for all other available benefits;
3. tax returns and worksheets, tax statements, and accountants' statements; and
4. any other Proof that We may reasonably require.

We may perform financial audits at Our expense as often as We may reasonably require. Payment of benefits may be contingent upon Proof of Financial Loss being satisfactory to Us.

## **Payment of Claims**

Upon receiving the required Proof of Disability or Loss, We will pay any Disability benefits due during any period of covered Disability. Any balance remaining unpaid at the end of the period for which We are liable will be paid at that time.

Unless otherwise specifically provided by the terms of the Program, all benefit payments will be made to:

- You, if living; *or*
- Your estate, if due to You after Your death.

If benefits are payable to Your estate, to a minor, or to a person who is incompetent, We may pay up to \$1,000 to any of Your relatives or any other person who We deem entitled to it as a result of having incurred expenses for Your maintenance, medical attendance, or burial. We will be discharged to the extent of any payments made in good faith under this provision.

## **Notice of Claim Decisions**

We will send You Written notice of Our claim decision within 45 days after We receive due Proof of Your loss. If there are special circumstances that require more time, We will send You a Written notice within this timeframe that an additional 30 days is needed. If more time is still needed to make a claim determination, We will send You Written notice during this initial 30 day extension stating the special circumstances that require an additional 30 days. If We request additional information, You will have 45 days to respond to Our request, and We will send You a Written notice of Our claim decision within 30 days after We receive Your response.

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

1. Reasons for such denial;
2. Reference to specific Program provisions, rules or guidelines on which the denial was based;
3. A description of the additional information needed to support Your claim;
4. Information concerning Your right to request that We review Our decision; *and*
5. A description of Our review procedures, and time limits, and notice to You of Your right to bring a civil action.

## **Reconsideration of a Denied Claim**

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

- Send Us written comments;
- Review any non-privileged information relating to Your claim; *and*
- Provide Us with other information or Proof in support of Your claim.

We will review Your claim promptly after receiving Your request. We will advise You of the results of Our review within 45 days after We receive Your request, or within 90 days if there are special circumstances that require more time. If We request additional information, You will have 45 days to respond to Our request, and We will send written notice of Our claim decision within 30 days after We receive Your response. Our decision will be in Writing and will include reference to specific Program provisions, rules or guidelines on which the decision was based, and notice to You of Your right to bring a civil action.

## **Examinations**

We may require that You undergo an Independent Medical Exam at reasonable intervals, at Our expense. No benefits will be paid beyond any date that:

- due Proof that You remain Disabled is not provided when requested by Us; *or*
- You do not allow a Physician to examine You when required by Us.

If You die, We may require an autopsy, unless it is prohibited by law. Such exam or autopsy as required by this section will be at Our expense.

We may require You to be examined at Our expense by one or more Physicians, health care professionals, or vocational evaluators of Our choice. We may require examinations at any time and as often as reasonably necessary. The examinations may include such testing as We determine necessary to administer the terms and conditions of the Program, including but not limited to medical testing and vocational testing. We will deny or stop benefit payments if You decline to be examined or if You do not cooperate with the examiner. Additionally, We reserve the right to have You interviewed by Our authorized representative.

## **Discretionary Authority for Benefit Determination**

We will make the final decision on claims for benefits under the Program. When making a benefit determination, We will have discretionary authority to interpret the terms and provisions of the Program. This discretionary authority should not be construed to limit the legal action that may be taken by an insured or beneficiary in accordance any applicable state or federal law.

## **Release of Information**

You agree that We may request, and anyone may give to Us, any information, (including copies of records) about an Illness, Injury or condition for which benefits are claimed, and that We may give similar information if requested to anyone providing similar benefits to You.