



The Lincoln National Life Insurance Company
 A Stock Company Home Office Location: Fort Wayne, Indiana
 Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066
 800-423-2765 Online: www.LincolnFinancial.com

In Consideration of the Application for this Policy made by

Elon University

(herein called the Policyholder)

and the payment of all premiums when due, The Lincoln National Life Insurance Company agrees to make the payments provided in this Policy to the person or persons entitled to them.

Policy No. 000010007392 The original Policy Effective Date was June 1, 1994; Reissued Policy Effective Date is October 1, 1999 but only with respect to claims commencing on or after such date.

Monthly Premium: .37% of Total Covered Payroll per Month

Policy Anniversaries will be annual beginning on: January 1, 2026

The first premium is due on this Policy's Effective Date, and subsequent premiums are due on July 1, 1994, and on the same day of each month thereafter.

This Policy is delivered in the state of North Carolina and subject to the laws of that jurisdiction.

The Lincoln National Life Insurance Company has executed this Policy at its Group Insurance Service Office in Omaha, Nebraska this 27th day of June, 2024.

SECRETARY

PRESIDENT

PRE-EXISTING CONDITION EXCLUSION: ANY DISABILITY DUE TO A PRE-EXISTING CONDITION TREATED WITHIN 3 MONTHS PRIOR TO THE EFFECTIVE DATE OF INSURANCE WILL BE COVERED ONLY IF IT BEGINS AFTER THE INSURED EMPLOYEE HAS GONE 6 MONTHS IN A ROW WITHOUT TREATMENT FOR THAT CONDITION, OR HAS BEEN INSURED UNDER THIS POLICY FOR AT LEAST 12 MONTHS.

THIS POLICY IS A LEGAL CONTRACT BETWEEN THE POLICYHOLDER AND THE COMPANY. THIS POLICY IS RENEWABLE AT THE COMPANY'S OPTION. PLEASE READ THIS POLICY CAREFULLY. IMPORTANT CANCELLATION INFORMATION - PLEASE READ THE PROVISION ENTITLED "POLICY TERMINATION," FOUND ON PAGE "GL3001-LTD-10 04 NC".

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the Company, or by calling 1-800-MEDICARE (1-800-633-4227), or online at www.medicare.gov/Publications.

GROUP LONG-TERM DISABILITY INSURANCE POLICY

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

TABLE OF CONTENTS

Schedule of Benefits.....	3
Definitions.....	5
General Provisions.....	10
Claims Procedures.....	12
Eligibility.....	15
Effective Dates.....	15
Individual Termination.....	17
Policy Termination.....	18
Premiums and Premium Rates.....	19
Total Disability Monthly Benefits.....	21
Progressive Income Benefit.....	22
Partial Disability Monthly Benefit.....	24
Other Income Benefits.....	26
Recurrent Disability.....	27
Pre-Existing Condition Exclusion.....	28
Mental Illness Limitation.....	29
Prior Insurance Credit Upon Transfer of Insurance Carriers.....	30
Family Income Benefit.....	31
Recovery Benefit For Commissioned Employees.....	32
Notice.....	33

Elon University
000010007392
SCHEDULE OF BENEFITS

ELIGIBLE CLASS

Class 1 All Full-Time Employees

Elon University
000010007392
SCHEDULE OF BENEFITS
For
Class 1 - All Full-Time Employees

MINIMUM HOURS: 30 hours per week

WAITING PERIOD: (For date insurance begins, refer to “Effective Date” section)
None

CONTRIBUTIONS: Insured employees are required to contribute to the cost of the Long-Term Disability coverage.

LONG-TERM DISABILITY BENEFITS

BENEFIT PERCENTAGE: 70%

MAXIMUM MONTHLY BENEFIT: \$8,000

MINIMUM MONTHLY BENEFIT: \$50

Long-Term Disability Benefits for PRE-EXISTING CONDITIONS will be subject to the Pre-Existing Condition Exclusion on the Exclusion page.

The Maximum Monthly Benefit will not exceed the Benefit Percentage times Basic Monthly Earnings.

ELIMINATION PERIOD: 180 calendar days of Disability caused by the same or a related Sickness or Injury, which must be accumulated within a 360 calendar day period.

MAXIMUM BENEFIT PERIOD: (For Sickness, Injury or Pre-Existing Conditions): The Insured Employee’s Social Security Normal Retirement Age, or the Maximum Benefit Period shown below (whichever is later).

<u>Age at Disability</u>	<u>Maximum Benefit Period</u>
Less than Age 60	To Age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and Over	12 months

OWN OCCUPATION PERIOD means a period beginning at the end of the Elimination Period and ending:

1. 60 months later for an Insured Employee who is an officer, administrator, executive, manager or other professional and whose Annual Salary is \$30,000 or greater;
2. 60 months later for an attorney, physician, engineer, architect or CPA (regardless of Annual Salary); or
3. 36 months later for all other Insured Employees.

DEFINITIONS

As used in this Policy, the following words and phrases shall have the meanings indicated:

ACTIVE WORK or **ACTIVELY-AT-WORK** means an Employee's full-time performance of all customary duties of such Employee's occupation at:

1. the Employer's usual place of business; or
2. any other business location to which the Employer requires the Employee to travel.

BASIC MONTHLY EARNINGS or **PREDISABILITY INCOME** means the Insured Employee's average monthly base salary or hourly pay from the Employer before taxes on the Determination Date. The "**Determination Date**" is the last day worked just prior to the date the Disability begins.

It also includes:

1. paid commissions averaged over the 12 months just prior to the Determination Date; or over the actual period of employment with the Employer just prior to that date, if shorter.

It does **not** include bonuses, overtime pay, or any other extra compensation. It does **not** include income from a source other than the Employer. It will not exceed the amount shown in the Employer's financial records, the amount for which premium has been paid, or the Maximum Covered Monthly Earnings permitted by this Policy; whichever is less. (Maximum Covered Monthly Earnings equals the Maximum Monthly Benefit divided by the Benefit Percentage shown in the Schedule of Benefits.) Exception: For purposes of determining the Partial Disability Monthly Benefit, Basic Monthly Earnings will not exceed the amount shown in the Employer's financial records.

COMPANY means The Lincoln National Life Insurance Company, an Indiana corporation, whose Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

DAY OR DATE means the period of time which begins at 12:01 a.m. and ends at 12:00 midnight, standard time, at the Policyholder's place of business. When used with regard to effective dates, it means 12:01 a.m. When used with regard to termination dates, it means 12:00 midnight.

DISABLED or **DISABILITY** means Totally Disabled and/or Partially Disabled.

DISABILITY BENEFIT when used with the term Retirement Plan, means a benefit which:

1. is payable under a Retirement Plan due to disability as defined in that plan; and
2. does not reduce the benefits which would have been paid as Retirement Benefits at the normal retirement age under the plan if the disability had not occurred.

If the payment of the benefit does cause such a reduction, the benefit will be deemed a Retirement Benefit as defined in this Policy.

DEFINITIONS
(Continued)

ELIMINATION PERIOD means the number of days of Disability during which no benefit is payable. The Elimination Period shown in the Schedule of Benefits:

1. begins on the first day of Disability; and
2. is satisfied when the required number of days is accumulated within a period which does not exceed two times the Elimination Period.

Only days of Disability due to the same or a related Sickness or Injury will count towards the Elimination Period.

During a period of Disability, the Insured Employee may return to full-time work for an accumulated number of days not to exceed the Elimination Period. Such return to work may be at the Insured Employee's own or any other occupation. Exceptions are as follows:

1. If an Insured Employee becomes Disabled after a return to full-time work, at his or her own occupation, for a continuous period of six months or more; then:
 - (a) a new period of Total Disability will begin; and
 - (b) a new Elimination Period will be required; in accord with the Recurrent Disability provision.
2. If an Insured Employee becomes eligible for any other group long term disability insurance during the Elimination Period; then only continuous days of Disability will count towards that Elimination Period.

Days on which the Insured Employee returns to work on a full-time basis will not count towards the Elimination Period.

EMPLOYEE means a person:

1. whose employment with the Employer is:
 - (a) on a regular full-time basis;
 - (b) the person's principle occupation; and
 - (c) for regular wage or salary;
2. who is regularly scheduled to work at such occupation at least the minimum number of hours shown in the Schedule of Benefits;
3. who is a member of an Eligible Class which is eligible for coverage under this Policy; and
4. who is a permanent resident of the United States.

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

Residual Disability

DEFINITIONS
(Continued)

FAMILY OR MEDICAL LEAVE means a leave of absence which is approved in writing by the Employer; and which is subject to:

1. the federal Family and Medical Leave Act of 1993, and any amendments to it; or
2. any similar state law requiring the Employer to grant family or medical leaves.

It does not include a period of Disability which applies toward the Elimination Period; or for which Policy benefits are paid.

HOSPITAL or INSTITUTION means a facility licensed to provide care and treatment for the condition causing the Insured Employee's Disability.

INSURED EMPLOYEE means an Employee for whom Policy coverage is in effect.

INJURY means bodily injury which is caused by and results directly from an accident, independently of all other causes. For purposes of determining benefits under this Policy, a Disability will be considered due to an Injury only if:

1. the Disability begins within 90 days after the Injury; or
2. the Injury occurred while the Employee was insured under this Policy.

The term "Injury" shall not include any:

1. condition to which a physical or mental sickness, the natural progression of a sickness, or the treatment of a sickness is a substantial contributing factor; (based upon the preponderance of medical evidence);
2. condition caused solely by emotional stress or mental trauma;
3. repetitive trauma condition which results from repetitious, physically traumatic activities that occur over time;
4. pregnancy; except for complications which result from a covered Injury;
5. condition caused by infection; except for a pyogenic bacterial infection of a covered Injury; or
6. condition caused by medical or surgical treatment; except when the treatment is needed solely because of a covered Injury.

MONTHLY BENEFIT means the amount payable monthly by the Company to the Insured Employee who is Totally or Partially Disabled.

OWN OCCUPATION PERIOD means a period as shown in the Schedule of Benefits.

PARTIAL DISABILITY or PARTIALLY DISABLED shall be as defined in the Partial Disability Monthly Benefit provision.

**DEFINITIONS
(Continued)**

PHYSICIAN means a medical practitioner who:

1. is a legally qualified Physician or surgeon (or is a professional person deemed by state law to be the same as a legally qualified physician); and
2. is acting within the lawful scope of his or her license.

Physician does not include a person who:

1. is the Insured Employee receiving treatment; or
2. is a relative of the Insured Employee receiving treatment.

POLICY means this Group Long Term Disability Insurance Policy issued by the Company to the Policyholder.

POLICYHOLDER means the person, individual, firm, trust or other organization as shown on the Face Page of this Policy.

PREDISABILITY INCOME - See Basic Monthly Earnings definition.

RETIREMENT BENEFIT when used with the term Retirement Plan, means a benefit which:

1. is payable under a Retirement Plan either in a lump sum or in the form of periodic payments;
2. does not represent contributions made by an Employee (payments which represent Employee contributions are deemed to be received over the Employee's expected remaining life regardless of when such payments are actually received); and
3. is payable upon:
 - (a) early or normal retirement; or
 - (b) disability if the payment does reduce the benefit which would have been paid at the normal retirement age under the plan if disability had not occurred.

RETIREMENT PLAN means a defined benefit or defined contribution plan which provides Retirement Benefits to Employees and which is not funded wholly by Employee contributions. The term shall not include any 401(k), profit-sharing or thrift plan; informal salary continuance plan; individual retirement account (IRA); tax sheltered annuity (TSA); stock ownership plan; or a non-qualified plan of deferred compensation. An Employer's Retirement Plan is deemed to include any Retirement Plan:

1. which is part of any federal, state, county, municipal or association retirement system; and
2. for which the Employee is eligible as a result of employment with the Employer.

SICKNESS means illness, pregnancy or disease.

TOTAL COVERED PAYROLL is the total amount of Basic Monthly Earnings for all Employees insured under this Policy.

DEFINITIONS
(Continued)

TOTAL DISABILITY or TOTALLY DISABLED means that an Insured Employee, due to an Injury or Sickness is unable:

1. during the Elimination Period and the Own Occupation Period, to perform each of the main duties of the Insured Employee's regular occupation; and
2. after the Own Occupation Period, to perform each of the main duties of any gainful occupation for which the Insured Employee's training, education or experience will reasonably allow.

For Insured Employees employed as pilots, co-pilots or crew of aircraft, Total Disability or Totally Disabled means that the Insured Employee due to an Injury or Sickness is unable to perform the main duties of any gainful occupation for which the Insured Employee's training, education or experience will reasonably allow. The loss of a pilot's license for any reason does not, by itself, constitute Total Disability.

WAITING PERIOD means the period of time that begins with an Employee's most recent date of employment with the Employer and ends on the day prior to the day such Employee is eligible for coverage under this Policy.

GENERAL PROVISIONS

ENTIRE CONTRACT. The entire contract between the parties shall consist of:

1. this Policy and any amendments to it;
2. the Policyholder's application (a copy of which is attached);
3. any Participating Employers' applications or Participation Agreements; and
4. any individual applications of the Insured Employees.

In the absence of fraud, all statements made by the Policyholder and by Insured Employees are representations and not warranties. No statement made by an Insured Employee will be used to contest the coverage provided by this Policy, unless:

1. it is contained in a written statement signed by that Insured Employee; and
2. a copy of the statement has been furnished to that Insured Employee.

AUTHORITY TO MAKE OR AMEND CONTRACT. Only a Company Officer located in the Company's Group Insurance Service Office has the authority to:

1. determine the insurability of a group or any individual within a group;
2. make a contract in the Company's name;
3. amend or waive any provision of this Policy; or
4. extend the time for payment of any premium.

No change in this Policy will be valid, unless it is made in writing and signed by such a Company Officer.

INCONTESTABILITY. Except for the non-payment of premiums or fraud, the Company may not contest the validity of this Policy after it has been in force for two years from its date of issue; and as to any Insured Employee, after his or her coverage has been in force for two years during his or her lifetime. This clause does not preclude, at any time, the assertion of defenses based upon:

1. this Policy's eligibility requirements, exclusions and limitations; and
2. other Policy provisions unrelated to the validity of coverage.

RESCISSION. The Company has the right to rescind any insurance for which Evidence of Insurability was required, if:

1. an Insured Employee incurs a claim during the first two years of coverage; and
2. the Company discovers that the Insured Employee made a Material Misrepresentation on his or her application.

A "**Material Misrepresentation**" is an incomplete or untrue statement that caused the Company to issue coverage that it would have disapproved, had it known the truth. "**To rescind**" means to cancel insurance back to its effective date. In that event, the Company will refund all premium paid for the rescinded insurance, less any benefits paid for the Insured Employee's claims. The Company reserves the right to recover any claims paid in excess of such premiums.

NON-PARTICIPATION. This is a non-participating Policy. It will not share in the divisible surplus of the Company.

INFORMATION TO BE FURNISHED. The Employer is required to furnish the Company any information needed to administer this Policy, including:

1. information about Employees:
 - a. who become eligible for insurance;
 - b. whose amounts of coverage change; or
 - c. whose eligibility or coverage ends;
2. occupational information and other facts that may be needed to manage a claim; and
3. any other information that the Company may reasonably require.

The Company may inspect any of the Employer's records that relate to this Policy, at any reasonable time.

GENERAL PROVISIONS
(Continued)

Clerical error by the Employer:

1. will not void or terminate insurance that otherwise would be in effect;
2. will not result in insurance coverage that otherwise would not be in effect; and
3. will not continue insurance that otherwise would be terminated.

Once an error is discovered, a fair adjustment in premium will be made. If a premium adjustment involves the return of unearned premium, the amount of the return will be limited to the 12-month period that precedes the date the Company receives proof that such an adjustment should be made.

MISSTATEMENTS OF FACTS. If relevant facts about any person were misstated:

1. a fair adjustment of the premium will be made; and
2. the true facts will decide if and in what amount insurance is valid under this Policy.

If an Insured Employee's age has been misstated, any benefits shall be in the amount the paid premium would have purchased at the correct age.

ACTS OF THE POLICYHOLDER. In administering this Policy, the Policyholder must:

1. treat Employees the same in like situations; and
2. allow the Company, without inquiry, to rely on its acts.

POLICYHOLDER'S AGENCY. For all purposes of this Policy, the Policyholder acts on its own behalf or as the Employee's agent. Under no circumstances will the Policyholder be deemed the Company's agent.

CERTIFICATES. The Employer will be furnished with individual Certificates for delivery to each Insured Employee. These Certificates summarize the benefits provided by this Policy. If there is a conflict between this Policy and the Certificate, this Policy will control.

CONFORMITY WITH STATE STATUTES. If, on its effective date, any provision of this Policy conflicts with any applicable law, the provision will be deemed to conform to the minimum requirements of the law.

CURRENCY. In administering this Policy:

1. all Predisability Income will be expressed in U.S. dollars; and
2. all premium and benefit amounts must be paid in U.S. dollars.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE. This Policy does not replace or provide benefits required by:

1. Workers' Compensation laws; or
2. any state disability insurance plan laws.

ASSIGNMENT. The rights and benefits under this Policy may not be assigned.

CLAIMS PROCEDURES

NOTICE OF CLAIM. Written notice of claim must be given during the Elimination Period or as soon as reasonably possible after that*. The notice must be sent to the Company's Group Insurance Service Office. It should include:

1. the Insured Employee's name and address; and
2. the number of this Policy.

CLAIM FORMS. When notice of claim is received, the Company will send claim forms to the Insured Employee. If the Company does not send the forms within 15 days, the Insured Employee may send the Company written proof of Disability in a letter. It should state the date the Disability began, its cause and degree. The Company will periodically send the Insured Employee additional claim forms.

PROOF OF CLAIM. The Company must be given written proof of claim within 180 days after the end of the Elimination Period; or as soon as reasonably possible after that*.

Proof of claim must be provided at the Insured Employee's own expense. It must show the date the Disability began, its cause and degree. Documentation must include:

1. completed statements by the Insured Employee and the Employer;
2. a completed statement by the attending Physician, which must describe any restrictions on the Insured Employee's performance of the duties of his or her Regular Occupation;
3. proof of any other income received;
4. proof of any benefits available from other income sources, which may affect Policy benefits;
5. a signed authorization for the Company to obtain more information; and
6. any other items the Company may reasonably require in support of the claim.

Proof of continued Disability, Regular Care of a Physician, and any Other Income Benefits affecting the claim must be given to the Company. This should be supplied within 45 days after the Company requests it. If it is not, benefits may be suspended. Such proof must be given to the Company within 180 days after the end of the period for which the Company is liable; or as soon as reasonably possible after that*.

* **Exception.** Failure to give notice or furnish proof of claim within the required time period will not invalidate or reduce the claim; if it is shown that it was done:

1. as soon as reasonably possible; and
2. in no event more than one year after it was required.

These time limits will not apply while the claimant lacks legal capacity.

EXAMINATION. The Company may have the Insured Employee examined:

1. by a Physician, specialist or vocational rehabilitation expert of the Company's choice;
2. as often as reasonably required while a claim or appeal is pending.

Any such exam will be at the Company's expense.

The Company may determine that (in its opinion) the Insured Employee has:

1. failed to cooperate with an examiner;
2. failed to take an exam scheduled by the Company; or
3. postponed such an exam more than twice.

In that event, benefits may be denied or suspended, until the required exam is completed.

TIME OF PAYMENT OF CLAIMS. Benefits payable under this Policy will be paid immediately after the Company receives complete proof of claim and confirms liability. After that:

1. Any benefits will be paid monthly, during any period for which the Company is liable. If benefits are due for less than a month, they will be paid on a pro rata basis. The daily rate will equal 1/30 of the Monthly Benefit.
2. Any balance, which remains unpaid at the end of the period of liability, will be paid immediately after the Company receives complete proof of claim and confirms liability.

CLAIMS PROCEDURES
(Continued)

TO WHOM PAYABLE. All benefits are payable to the Insured Employee, while living. After his or her death, benefits will be payable as follows.

1. Any Survivor Benefit will be payable in accord with that section.
2. Any other benefits will be payable to the Insured Employee's estate.

If a benefit becomes payable to:

1. the Insured Employee's estate; or
2. a minor or any other person who is not legally competent to give a valid receipt;

then up to \$3,000 may be paid to any relative of the Insured Employee that the Company finds entitled to payment. If payment is made in good faith to such a relative, the Company will not have to pay that benefit again.

NOTICE OF CLAIM DECISION. The Company will send the Insured Employee a written notice of its claim decision. If the Company denies any part of the claim, the written notice will explain:

1. the reason for the denial, under the terms of this Policy and any internal guidelines;
2. how the Insured Employee may request a review of the Company's decision; and
3. whether more information is needed to support the claim.

This notice will be sent within 15 days after the Company resolves the claim. It will be sent within 45 days after the Company receives the first proof of claim, if reasonably possible.

Delay Notice. The Company may need more than 15 days to process the claim, due to matters beyond its control. If so, an extension will be permitted. In that event, the Company will send the Insured Employee a written delay notice:

1. by the 15th day after receiving the first proof of claim; and
2. every 30 days after that, until the claim is resolved.

The notice will explain:

1. what additional information is needed to determine liability; and
2. when a decision can be expected.

If the Insured Employee does not receive a written decision by the 105th day after the Company receives the first proof of claim, there is a right to an immediate review, as if the claim was denied.

Exception: The Company may need more information from the Insured Employee to process a claim. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for claim processing.

REVIEW PROCEDURE. Within 180 days after receiving a denial notice, the Insured Employee may request a claim review by sending the Company:

1. a written request; and
2. any written comments or other items to support the claim.

The Insured Employee may review certain non-privileged information relating to the request for review.

The Company will review the claim and send the Insured Employee a written notice of its decision. The notice will state the reasons for the Company's decision, under the terms of this Policy and any internal guidelines. If the Company upholds the denial of all or part of the claim, the notice will also describe:

1. any further appeal procedures available under this Policy;
2. the right to access relevant claim information; and
3. the right to request a state insurance department review, or to bring legal action.

This notice will be sent within 45 days after the Company receives the request for review, or within 90 days if a special case requires more time.

CLAIMS PROCEDURES (Continued)

Delay Notice. If the Company needs more than 45 days to process an appeal, in a special case:

1. an extension of up to 45 more days will be permitted; and
2. the Company will send the Insured Employee a written delay notice, by the 30th day after receiving the request for review.

The notice will explain:

1. the special circumstances which require the delay;
2. whether more information is needed to review the claim; and
3. when a decision can be expected.

Exception: The Company may need more information from the Insured Employee to process an appeal. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974). Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under this Policy, the plan participant or beneficiary must first seek two administrative reviews of the adverse claim decision, in accord with this section. After the required reviews:

1. an ERISA plan participant or beneficiary may bring legal action under Section 502(a) of ERISA; and
2. the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

RIGHT OF RECOVERY. If benefits have been overpaid on any short-term disability or long-term disability claim, full reimbursement to the Company is required within 60 days. If reimbursement is not made, the Company has the right to:

1. reduce future benefits and suspend payment of the Minimum Monthly Benefit under this Policy, until full reimbursement is made;
2. reduce benefits payable to the Insured Employee or his or her beneficiary under any group insurance policy issued by the Company, until full reimbursement is made; or
3. recover such overpayments from the Insured Employee or his or her estate.

Such reimbursement is required whether the overpayment is due to:

1. the Company's error in processing a claim;
2. the Insured Employee's receipt of Other Income Benefits;
3. fraud, misrepresentation or omission of relevant facts; or
4. any other reason.

LEGAL ACTIONS. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than three years after the date written proof of claim is required.

COMPANY'S DISCRETIONARY AUTHORITY. Except for the functions that this Policy clearly reserves to the Policyholder or Employer, the Company has the authority to manage this Policy, interpret its provisions, administer claims and resolve questions arising under it. The Company's authority includes (but is not limited to) the right to:

1. establish administrative procedures, determine eligibility and resolve claims questions;
2. determine what information the Company reasonably requires to make such decisions; and
3. resolve all matters when an internal claim review is requested.

Any decision the Company makes in the exercise of its authority shall be conclusive and binding; subject to the Insured Employee's rights to request a state insurance department review or to bring legal action.

This provision does not apply to residents of California.

ELIGIBILITY

ELIGIBLE CLASSES. The classes of Employees eligible for insurance are shown in the Schedule of Benefits. The Company has the right to review and terminate any or all classes eligible under this Policy, if any class ceases to be covered by this Policy.

ELIGIBILITY DATE. An Employee becomes eligible for coverage provided by this Policy on the later of:

1. this Policy's date of issue; or
2. the date the Waiting Period is completed.

Prior Service Credit Towards Waiting Period. The Waiting Period is shown in the Schedule of Benefits. Prior service in an Eligible Class will apply toward the Waiting Period, when:

1. a former Employee is rehired within one year after his or her employment ends; or
2. an Employee returns from an approved Family or Medical Leave within:
 - a. the 12-week leave period required by federal law; or
 - b. any longer period required by a similar state law; or
3. an Employee returns from a Military Leave within the period required by federal USERRA law.

EFFECTIVE DATES

EFFECTIVE DATE. An Employee's initial amount of coverage becomes effective at 12:01 a.m. on the latest of:

1. the first day of the Insurance Month following the date the Employee becomes eligible for the coverage;
2. the date the Employee resumes Active Work, if not Actively at Work on the day he or she becomes eligible;
3. the date the Employee makes written application for coverage and signs:
 - a. a payroll deduction order, if the Employees pay any part of the Policy premium; or
 - b. an order to pay premiums from the Employee's Flexible Benefits Plan account, if premiums are paid through such an account; or
4. the date the Company approves the Employee's Evidence of Insurability, if required.

Any increased or additional coverage becomes effective at 12:01 a.m. on the latest of:

1. the first day of the Insurance Month coinciding with or next following the date on which the Insured Employee becomes eligible for the increase, if Actively at Work on that day;
2. the date the Insured Employee resumes Active Work, if not Actively at Work on the day the increase would otherwise take effect; or
3. the date any required Evidence of Insurability is approved by the Company.

Any decrease will take effect on the day of the change, whether or not the Insured Employee is Actively at Work.

EVIDENCE OF INSURABILITY. Evidence of Insurability satisfactory to the Company must be submitted (at the Employee's expense) when:

1. an Employee makes written application for coverage (or an increased amount of coverage) more than 45 days after becoming eligible for the coverage;
2. an Employee makes written application to enroll for coverage after he or she has requested:
 - a. to cancel insurance;
 - b. to stop payroll deductions for the insurance; or
 - c. to stop premium payments from the Flexible Benefits Plan account;
3. coverage is elected after the Employee has caused insurance to lapse, by failing to pay the required premium when due; or
4. optional, supplemental or voluntary coverage is elected in excess of any Guaranteed Issue Amounts shown in the Schedule of Benefits.

EFFECTIVE DATES
(Continued)

EFFECTIVE DATE FOR CHANGE IN ELIGIBLE CLASS. An Insured Employee may become a member of a different Eligible Class. Coverage under the different Eligible Class will be effective:

1. on the first day of the Insurance Month coinciding with or next following the date of the change;
2. except as stated in the Effective Date provision for increases or decreases.

REINSTATEMENT RIGHTS. If an Insured Employee's coverage terminates due to one of the following breaks in service, he or she will be entitled to reinstate the coverage upon resuming Active Work with the Employer within the required timeframe. "**Reinstatement**" or "**to reinstate**" means to re-enroll for Policy coverage, without satisfying a new Waiting Period or providing Evidence of Insurability. Reinstatement is available upon:

1. return from an approved Family or Medical Leave within:
 - a. the 12-week period required by federal law; or
 - b. any longer period required by a similar state law; or
2. return from a Military Leave within the period required by federal USERRA law.

To reinstate coverage, the Employee must apply for coverage or be re-enrolled within 31 days after resuming Active Work in an Eligible Class. The reinstated amount of insurance may not exceed the amount that terminated. Reinstatement will take effect on the date the Insured Employee returns to Active Work.

If the above conditions are met, then:

1. the months of leave will count towards any unmet Pre-Existing Condition Exclusion period; and
2. a new Pre-Existing Condition Exclusion will not apply to the reinstated amount of insurance.

A new Pre-Existing Condition Exclusion will apply to any increased amount of insurance.

INDIVIDUAL TERMINATION

INDIVIDUAL TERMINATION OF COVERAGE. An Insured Employee's coverage will terminate at 12:00 midnight on the earliest of:

1. the date this Policy or the Employer's participation terminates; (but without prejudice to any claim incurred prior to termination);
2. the date the Insured Employee's Class is no longer eligible for insurance;
3. the date such Insured Employee ceases to be a member of an Eligible Class;
4. the last day of the Insurance Month in which the Insured Employee requests termination;
5. the last day of the last Insurance Month for which premium payment is made on the Insured Employee's behalf;
6. the end of the period for which the last required premium has been paid;
7. with respect to a particular insurance benefit, the date the portion of this Policy providing that benefit terminates;
8. the date on which the Insured Employee's employment with the Employer terminates; unless coverage is continued as provided below; or
9. the date the Insured Employee enters the armed services of any state or country on active duty, except for duty of 30 days or less for training in the Reserves or National Guard. (If the Insured Employee sends proof of military service, the Company will refund any unearned premium.)

CONTINUATION RIGHTS. Ceasing Active Work results in termination of the Insured Employee's eligibility for insurance, but coverage may be continued as follows.

1. **Disability.** If an Insured Employee is absent due to Total Disability, or is engaged in Partial Disability Employment, coverage may be continued during:
 - a. the Elimination Period; provided the Company receives the required premium from the Employer; and
 - b. the period for which benefits are payable, without payment of premium.Premium payments will be waived from the satisfaction of the Elimination Period until the end of the period for which benefits are payable. If coverage is to be continued following a period for which premiums were waived, premium payments must be resumed, as they become due.
2. **Family or Medical Leave.** If an Insured Employee goes on an approved Family or Medical Leave, and is **not** entitled to the more favorable continuation available during Disability, coverage may be continued, until the earliest of:
 - a. the end of the leave period approved by the Employer;
 - b. the end of the 12-week leave period required by federal law, or any more favorable period required by a similar state law;
 - c. the date the Insured Employee notifies the Employer that he or she will not return; or
 - d. the date the Insured Employee begins employment with another employer.The required premium payments must be received from the Employer, throughout the period of continued coverage.
3. **Military Leave.** If an Insured Employee goes on a Military Leave, coverage may be continued for the same period allowed for an approved Family or Medical Leave. The required premium payments must be received from the Employer, throughout the period of continued coverage.
4. **Lay-off or Other Leave.** When an Insured Employee ceases work due to a temporary lay-off, or due to an approved leave of absence (other than an approved Family or Medical Leave or a Military Leave); coverage may be continued until the end of the calendar month following the month in which the lay-off or leave begins. The required premium payments must be received from the Employer, throughout the period of continued coverage.

INDIVIDUAL TERMINATION (Continued)

Conditions. In administering the above continuation(s), the Employer must not act so as to discriminate unfairly among Employees in similar situations. Insurance may **not** be continued when an Insured Employee ceases Active Work due to a labor dispute, strike, work slowdown or lockout.

INDIVIDUAL TERMINATION DURING DISABILITY. Termination of an Insured Employee's coverage during a Disability will have no effect on benefits payable for that period of Disability.

POLICY TERMINATION

POLICY TERMINATION BY THE COMPANY. To terminate this Policy, the Company must give the Group Policyholder at least 45 days advance written notice of its intent to do so, except when termination is due to nonpayment of premium. The Company may terminate this Policy on the due date of any premium if:

1. the number of Insured Employees totals less than 10;
2. part of the premium is paid by the Insured Employee and less than 75% of those eligible for coverage are insured;
3. all of the premium is paid by the Policyholder and less than 100% of those eligible for coverage are insured;
4. the Policyholder, without good cause, fails to:
 - a. promptly furnish any information which the Company may reasonably require;
 - b. perform its duties pertaining to this Policy in good faith;
5. the Employer ceases to be covered under the state Workers' Compensation program or any other program of like intent.
6. the Company terminates all other policies where permitted by their terms, which provide long-term disability benefits in the same state in which this Policy was issued; or
7. state law otherwise requires this Policy to be terminated.

POLICY TERMINATION BY THE POLICYHOLDER. The Policyholder may terminate this Policy at any time by giving the Company advance written notice. This Policy will then terminate on:

1. the date the Company receives the notice; or
2. some later date on which the Policyholder and the Company have agreed.

However, termination will not become effective during any period for which premium has been paid to the Company. The Policyholder remains liable for the payment of premiums to the date of termination.

AUTOMATIC POLICY TERMINATION. If any premium is not paid before the end of the Grace Period; then this Policy will terminate at the end of the Grace Period, without any action on the Company's part. The Policyholder remains liable for the payment of premiums to the date of termination.

POLICY TERMINATION DURING DISABILITY. Termination of this Policy or an Employer's participation during a Disability shall have no effect on benefits payable to the Insured Employee for that period of Disability.

PREMIUMS AND PREMIUM RATES

PAYMENT OF PREMIUM. No coverage provided by this Policy will be in effect until the first premium for such coverage is paid. For coverage to remain in effect, the Employer must pay each subsequent premium on or before its due date at the Company's Group Insurance Service Office. The premium must be paid in U.S. dollars.

PREMIUM RATES. The initial premium rates for this Policy are shown on the Face Page of this Policy. Premium rates are subject to change.

PREMIUM RATE CHANGE. The Company may change any premium rate on any of the following dates:

1. the date this Policy's terms are changed;
2. the date the Company's liability is changed due to a change in federal, state or local law;
3. the date the Company's liability is changed because the Policyholder (or any covered division, subsidiary or affiliated company):
 - a. relocates, dissolves or merges, or is added to or removed from this Policy; or
 - b. ceases to be covered by the state Workers' Compensation program or any other program of like intent; or
 - c. ceases to provide or reduces Sick Leave or Salary Continuance Plan benefits;
4. the date any coverage for one or more classes ceases to be provided under this Policy;
5. the date the number of Insured Employees changes by 25% or more from the enrollment on the date this Policy took effect, or the most recent Rate Guarantee Date expired, if later;
6. on any premium due date on or after this Policy's first anniversary, or any later rate guarantee date agreed upon by the Company; provided the change is based upon at least 12 month's experience; and an increase is not made more often than once in any six month period.

Unless the Company and the Policyholder agree otherwise, the Company will give at least 45 days' advance written notice of any increase in premium rates.

MONTHLY PREMIUM AMOUNT. The amount of monthly premium due on each due date will be the Total Covered Payroll multiplied by the premium rate. Changes will not be pro-rated daily. Instead, premium will be adjusted as follows.

1. When an Insured Employee's insurance (or increased amount of insurance) takes effect, premium will be charged from the monthly due date coinciding with or next following that change.
2. When all or part of an Insured Employee's insurance terminates, the applicable premium will cease on the monthly due date coinciding with or next following that termination.
3. When premiums are paid other than monthly, increases or decreases will result in an adjustment from the premium due date coinciding with or next following that change.

The above manner of charging premium is for accounting purposes only. It will not extend insurance coverage beyond a date it would have otherwise terminated.

PREMIUMS AND PREMIUM RATES (Continued)

Each premium payment will include any adjustments in past premiums, which are needed due to changes that have not yet been taken into account. If a premium adjustment involves a return of unearned premium, the amount of the return will be limited to the prior 12-month period.

GRACE PERIOD. A Grace Period of 31 days from the due date will be allowed for the payment of each premium after the first. This Policy will remain in effect during the Grace Period. The Policyholder will be liable to the Company for the payment of all premiums due for the period this Policy remains in effect, however.

WAIVER OF PREMIUM. Premium will be administered as follows during any period for which benefits are payable.

1. Premium payments are waived for an Insured Employee who is Disabled:
 - a. from the first premium due date following the satisfaction of the Elimination Period;
 - b. until the end of any period for which benefits are payable.
2. If coverage is to be continued following a period during which premiums were waived, premium payments must be resumed as they become due.

TOTAL DISABILITY MONTHLY BENEFIT

The Company will pay a Total Disability Monthly Benefit to an Insured Employee after the completion of the Elimination Period if such Insured Employee:

1. is Totally Disabled;
2. requires the regular attendance of a Physician; * and
3. submits proof of continued Total Disability, at the Insured Employee's expense, to the Company upon request.

The Total Disability Monthly Benefit will cease on the earliest of:

1. the date the Insured Employee ceases to be Totally Disabled;
2. the date the Insured Employee dies; or
3. the date the Maximum Benefit Period ends.

The amount of the Total Disability Monthly Benefit equals:

1. the Insured Employee's Basic Monthly Earnings multiplied by the Benefit Percentage (limited to the Maximum Monthly Benefit); minus
2. Other Income Benefits.

The amount of the Total Disability Monthly Benefit will not be less than the Minimum Monthly Benefit. The Benefit Percentage, Maximum Monthly Benefit, Minimum Monthly Benefit and Maximum Benefit Period are shown in the Schedule of Benefits.

***NOTE:** If there is no doubt that an Insured Employee is permanently Disabled and such Insured Employee's Physician feels that the Insured Employee has reached the maximum point of recovery, and that future or continued treatment would serve no useful purpose; then, the requirement for regular attendance of a Physician will be waived.

PROGRESSIVE INCOME BENEFIT

EFFECTIVE DATE. An Insured Employee will become insured for the Progressive Income Benefit on:

1. the effective date of his or her coverage for Long Term Disability Benefits under this Policy; or
2. the effective date of this provision, if it is added later by amending this Policy.

Exception: The effective date will be delayed for an Insured Employee who is unable to perform one or more Activities of Daily Living or suffers from a Cognitive Impairment on that date. In that event, the Insured Employee will become insured for this benefit on the first day he or she:

1. is able to safely and completely perform all of the Activities of Daily Living without another person's active, hands-on help; or
2. no longer suffers from a Cognitive Impairment.

BENEFIT. After completion of the Elimination Period shown in the Schedule of Insurance, the Company will pay an additional monthly benefit to an Insured Employee; if he or she:

1. is receiving Total Disability or Partial Disability Monthly Benefits under this Policy; and
2. submits proof of suffering the Loss of Activities of Daily Living or a Cognitive Impairment (as defined below).

Proof must be submitted at the Insured Employee's own expense.

AMOUNT. The amount of the Progressive Income Benefit:

1. will equal 10% of the Insured Employee's Basic Monthly Earnings; but
2. will not exceed the Maximum Monthly Benefit for Long Term Disability Benefits, or \$5,000 per month (whichever is less).

The Maximum Monthly Benefit for Long Term Disability Benefits is shown in the Schedule of Insurance. The Progressive Income Benefit will not be reduced by any Other Income Benefits, or by earnings from any form of employment.

DURATION. This Progressive Income Benefit will cease on the earliest of:

1. the date the Insured Employee no longer suffers from the Loss of Activities of Daily Living or Cognitive Impairment (as defined below);
2. the date the Insured Employee is no longer entitled to Total Disability or Partial Disability Monthly Benefits under this Policy;
3. the date the Maximum Benefit Period ends; or
4. the date the Insured Employee dies.

If this Policy includes a Family Income Benefit, the amount paid to the Eligible Surviving Spouse or Children will not increase due to the Insured Employee's receipt of this Progressive Income Benefit.

DEFINITIONS

"Loss of Activities of Daily Living" means that, due to an Injury or Sickness, the Insured Employee has lost the ability to safely and completely perform **two or more** of the following six Activities of Daily Living without another person's active, hands-on help with all or most of the activity.

The six Activities of Daily Living are:

1. **Bathing** - washing self in a tub, in a shower or by sponge bath; with or without equipment.
2. **Dressing** - putting on, taking off, fastening or unfastening garments, any medically necessary braces, or any artificial limbs normally worn.
3. **Toileting** - getting to, from, on and off toilet and performing related personal hygiene.
4. **Transferring** - moving in and out of bed, chair or any wheelchair; with or without equipment such as canes, walkers, crutches, grab bars, other support devices, or mechanical or motorized devices.
5. **Continence** - voluntarily maintaining control of bladder and bowel function; or performing related personal hygiene, including care of any catheter or colostomy bag, if not continent.
6. **Eating** - once food is prepared and made available, getting nourishment into one's body by any means. This includes eating from a table, tray or container (such as a bowl or cup); or using special equipment (such as a feeding tube or intravenous tube).

PROGRESSIVE INCOME BENEFIT
(Continued)

"Cognitive Impairment" means that due to an Injury or Sickness, the Insured Employee:

1. has suffered a permanent deterioration or loss of cognitive or intellectual capacity; and
2. requires another person's active, hands-on help or verbal cues to prevent harm to self or others, due to that impairment.

The impairment must be diagnosed by a Physician, based upon clinical evidence and reliable standardized tests of short or long-term memory; orientation as to person, place and time; and deductive or abstract reasoning. It may result from moderate to severe head trauma, stroke, Alzheimer's disease or other form of irreversible dementia.

"Mental Sickness," as used in this provision, means any emotional, behavioral, psychological, personality, adjustment, mood or stress-related abnormality, disorder, disturbance, dysfunction or syndrome; regardless of its cause. It includes, but is not limited to:

1. schizophrenia or schizoaffective disorder;
2. bipolar affective disorder, manic depression, or other psychosis; and
3. obsessive-compulsive, depressive, panic or anxiety disorders.

These conditions are usually treated by a psychiatrist, a clinical psychologist or other qualified mental health care provider. Treatment usually involves psychotherapy, psychotropic drugs or similar methods of treatment.

Mental Sickness does **not** include irreversible dementia resulting from stroke; trauma; viral infection; Alzheimer's disease; or other conditions which are not usually treated by a mental health care provider using psychotherapy, psychotropic drugs, or similar methods of treatment.

"Pre-Existing Condition," as used in this provision, means a Sickness or Injury for which the Insured Employee received treatment within 3 months prior to his or her effective date for this benefit. Treatment includes a Physician's consultation, care and services; diagnostic measures; and the prescription, refill or taking of prescribed drugs or medicines.

EXCLUSIONS AND LIMITATIONS

Prior Disability. This benefit will not be payable during a period of Disability which begins before the Insured Employee's effective date of coverage under this benefit.

Pre-Existing Conditions. This benefit will not be payable for a Loss of Activities of Daily Living or Cognitive Impairment:

1. which is caused or contributed to by, or results from a Pre-Existing Condition (as defined above); and
2. which begins in the first 12 months after the Insured Employee's effective date under this benefit; unless the Insured Employee received no medical or surgical treatment of the Pre-Existing Condition for 6 consecutive months after his or her effective date under this benefit.

Mental Sickness and Substance Abuse. This benefit will not be payable during a period of Disability which is caused or contributed to by or results from a Mental Sickness, alcoholism, or voluntary use of a Controlled Substance; unless prescribed by a Physician. Controlled Substances are those defined as such in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, and any amendments to it.

Other Provisions. This benefit will be subject to all of the Definitions, Exclusions, Proof of Claim, Waiver of Premium and other provisions of this Policy.

PARTIAL DISABILITY MONTHLY BENEFIT

The Company will pay a Partial Disability Monthly Benefit to an Insured Employee, after completion of the Elimination Period; if he or she:

1. is Disabled;
2. is engaged in Partial Disability Employment;
3. is earning at least 20% of Predisability Income when Partial Disability Employment begins;
4. submits proof of Partial Disability, at his or her own expense, to the Company upon request; and
5. requires regular attendance of a Physician; except this part 5 will be waived when:
 - (a) there is no doubt that the Disability is permanent; and
 - (b) the attending Physician certifies in writing that:
 - (i) the Insured Employee has reached the maximum point of recovery; and
 - (ii) continued treatment would serve no useful purpose.

The Insured Employee does not have to be Totally Disabled prior to receiving Partial Disability Monthly Benefits. The Elimination Period may be satisfied by consecutive days of Total Disability, Partial Disability or any combination thereof.

The Partial Disability Monthly Benefit will cease on the earliest of:

1. the date the Insured Employee ceases to be Partially Disabled or dies;
2. the date the Maximum Benefit Period ends;
3. the date the Insured Employee earns more than 99% of Predisability Income, until Partial Disability Monthly Benefits have been paid for 24 months for the same period of Disability; or
4. the date the Insured Employee earns more than 85% of Predisability Income, after Partial Disability Monthly Benefits have been paid for 24 months for the same period of Disability.

The Company has the option to average earnings over three consecutive months, in the event that the Insured Employee earns less than 85% of Predisability Income in the succeeding months.

DEFINITIONS

PARTIAL DISABILITY or **PARTIALLY DISABLED** means that, as a result of a Sickness or Injury, the Insured Employee is:

1. able to perform one or more, but not all, of the main duties of such Insured Employee's own or any other occupation on a full-time or part-time basis; or
2. able to perform all of the main duties of such Insured Employee's own or any other occupation, but only on a part-time basis.

PARTIAL DISABILITY EMPLOYMENT means the Insured Employee continues or resumes working at his or her own or any other occupation; but because of a Partial Disability:

1. the Insured Employee's hours are reduced; or
2. one or more main duties of the job are eliminated or reassigned.

After the Insured Employee has received Partial Disability Monthly Benefits for 24 months for the same period of Disability, his or her current earnings may not exceed 85% of Predisability Income. This reduction in earnings must be due to the injury or sickness causing the Partial Disability.

**PARTIAL DISABILITY MONTHLY BENEFIT
(Continued)**

BENEFIT AMOUNT. The Partial Disability Monthly Benefit will replace the Insured Employee's Lost Income; provided it does not exceed the Total Disability Monthly Benefit, which would otherwise be payable during Total Disability without the Partial Disability Employment.

Thus, the amount of the Partial Disability Monthly Benefit will equal the lesser of A or B below.

- A. **LOST INCOME:** The Insured Employee's Predisability Income, minus all Other Income Benefits (including earnings from Partial Disability Employment).

- B. **TOTAL DISABILITY MONTHLY BENEFIT** otherwise payable:
 - 1. The Insured Employee's Predisability Income multiplied by the Benefit Percentage (limited to the Maximum Monthly Benefit); minus
 - 2. Other Income Benefits, except for earnings from Partial Disability Employment.

The Partial Disability Monthly Benefit will never be less than the Minimum Monthly Benefit. The Benefit Percentage, Maximum Monthly Benefit, Minimum Monthly Benefit, and Maximum Benefit Period are shown in the Schedule of Benefits.

Progressive Calculation

OTHER INCOME BENEFITS

OTHER INCOME BENEFITS mean those benefits shown below:

1. Any temporary or permanent benefits or awards for which the Insured Employee is eligible under:
 - (a) Workers' or Workmen's Compensation Law;
 - (b) occupational disease law; or
 - (c) any other act or law of like intent.
2. Any disability income benefits for which the Insured Employee is eligible under any compulsory benefit act or law.
3. Any disability income benefits for which the Insured Employee is eligible under:
 - (a) any other group plan, sick leave or formal salary continuance plan of the Employer; or
 - (b) any governmental retirement system as a result of the Insured Employee's job with the Employer.
4. Any Disability Benefits or Retirement Benefits the Insured Employee receives under a Retirement Plan.
5. Benefits under the Social Security Act, or any similar plan or act as follows:
 - (a) disability or unreduced retirement benefits for which:
 - i. the Insured Employee is eligible; and
 - ii. the Insured Employee's spouse, child or children are eligible because of the Insured Employee's Disability; or
 - iii. the Insured Employee's spouse, child or children are eligible because of the Insured Employee's eligibility for unreduced retirement benefits; or
 - (b) reduced retirement benefits received by:
 - i. the Insured Employee; and
 - ii. the Insured Employee's spouse, child or children because of the Insured Employee's receipt of the reduced retirement benefits.
6. Earnings the Insured Employee earns or receives from any form of employment.

These Other Income Benefits, except Retirement Benefits, are benefits resulting from the same Disability for which a Monthly Benefit is payable under this Policy.

COST-OF-LIVING FREEZE. After the first deduction for each of the Other Income Benefits, the Monthly Benefit will not be further reduced due to any cost-of-living increases payable under these Other Income Benefits.

LUMP SUM PAYMENTS. Other Income Benefits which are paid in a lump sum will be prorated on a monthly basis over the time period for which the sum is given. If no time period is stated, the sum will be prorated on a monthly basis over the time the Company expects the Insured Employee to live.

RECURRENT DISABILITY

A Recurrent Disability will be treated as a new period of Disability and a new Elimination Period must be completed before further Monthly Benefits are payable if the Insured Employee returns to such Insured Employee's regular occupation on a full-time basis for six months or more.

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

A Recurrent Disability will be treated as part of the prior Disability if an Insured Employee returns to such Insured Employee's regular occupation on a full-time basis for less than six months.

To qualify for a Monthly Benefit, the Insured Employee must earn less than 80% of Predisability Income.

Monthly Benefit payments will be subject to the terms of this Policy for the prior Disability.

If an Insured Employee becomes eligible for coverage under any other group long term disability policy, this Recurrent Disability Provision will cease to apply to that Insured Employee.

EXCLUSIONS

GENERAL EXCLUSIONS. This Policy will not cover any Total or Partial Disability due to:

1. war, declared or undeclared, or any act of war;
2. intentionally self-inflicted injuries;
3. active participation in a riot; or
4. the Insured Employee's committing of or the attempting to commit a felony or any type of assault or battery.

PRE-EXISTING CONDITION EXCLUSION. This Policy will not cover any Total or Partial Disability:

1. which is caused or contributed to by, or results from a Pre-Existing Condition; and
2. which begins in the first 12 months after the Insured Employee's Effective Date, unless such Insured Employee received no Treatment of the condition for 6 consecutive months after the Insured Employee's Effective Date.

"Pre-Existing Condition" means a Sickness or Injury for which the Insured Employee received Treatment within 3 months prior to the Insured Employee's Effective Date.

"Treatment" means consultation, care or services provided by a Physician including diagnostic measures and taking prescribed drugs and medicines.

3/6/12 Pre-Existing Condition Exclusion

MENTAL ILLNESS LIMITATION

Benefits for Total or Partial Disability due to Mental Illness will not exceed 24 months of Monthly Benefit payments unless the Insured Employee:

1. is in a Hospital or Institution at the end of the 24 month period. The Monthly Benefit will be paid during confinement. If the Insured Employee remains Totally or Partially Disabled when discharged, the Monthly Benefit will be paid for a recovery period of up to 90 days.

If the Insured Employee is again confined during the 90 day recovery period for at least 14 days in a row, benefits will be paid for the reconfinement and another recovery period of up to 90 more days.

2. continues to be Totally or Partially Disabled and becomes confined in a Hospital or Institution after the 24 month period and for at least 14 consecutive days. The Monthly Benefit will be payable during the confinement.

In any case, the Monthly Benefit will not be payable beyond the Maximum Benefit Period.

"Mental Illness" means mental, nervous or emotional diseases and disorders of any type.

PRIOR INSURANCE CREDIT UPON TRANSFER OF INSURANCE CARRIERS

To prevent loss of coverage for an Employee because of a transfer of insurance carriers, this Policy will provide Prior Insurance Credit for employees insured under the prior carrier's policy on its termination date as follows.

FAILURE TO BE ACTIVELY-AT-WORK DUE TO INJURY OR SICKNESS. Subject to premium payments, this Policy will provide coverage to an Employee:

1. who was insured by the prior carrier's policy at the time of transfer; and
2. who was not Actively-At-Work due to Injury or Sickness on this Policy's Effective Date.

The coverage will be that provided by the prior carrier's policy, had it remained in force. The Company will pay:

1. the benefit that the prior carrier would have paid; minus
2. any amount for which the prior carrier is liable.

DISABILITY DUE TO A PRE-EXISTING CONDITION. Benefits may be payable for a Total Disability due to a Pre-Existing Condition for an Employee who:

1. was insured by the prior carrier's policy at the time of transfer; and
2. was Actively-At-Work and insured under this Policy on this Policy's Effective Date.

The benefits will be determined as follows:

1. The Company will apply this Policy's Pre-Existing Condition Exclusion. If the Insured Employee qualifies for benefits, such Insured Employee will be paid according to this Policy's benefit schedule.
2. If the Insured Employee cannot satisfy this Policy's Pre-Existing Condition Exclusion, but can satisfy the prior carrier's pre-existing condition exclusion giving consideration towards continuous time insured under both policies; then he or she will be paid in accord with the benefit schedule and all other terms, conditions and limitations of:
 - (a) this Policy without applying the Pre-Existing Condition Exclusion; or
 - (b) the prior carrier's policy;whichever is less.
3. If the Insured Employee cannot satisfy the Pre-Existing Condition Exclusion of this Policy or that of the prior carrier, no benefit will be paid.

Prior Insurance Credit

FAMILY INCOME BENEFIT

The Company will pay a lump sum benefit to the Eligible Survivor when proof is received that an Insured Employee died:

1. after Disability had continued for 180 or more consecutive days; and
2. while receiving a Monthly Benefit.

The benefit will be equal to three times the Insured Employee's Last Monthly Benefit.

"Last Monthly Benefit" means the gross Monthly Benefit payable to the Insured Employee immediately prior to death. Any reductions for Other Income Benefits, or for earnings the Insured Employee received for Partial Disability Employment, will not apply.

"Eligible Survivor" means the Insured Employee's:

1. surviving spouse; or, if none
2. surviving children who are under age 25 on the Insured Employee's date of death.

If payment becomes due to the Insured Employee's children; then payment will be made to:

1. the surviving children, in equal shares; or
2. a person named by the Company to receive payments on the children's behalf.

This payment will be valid and effective against all claims by others representing, or claiming to represent, the children.

If there are no Eligible Survivors, payment will be made to the Insured Employee's estate.

**RECOVERY BENEFIT
FOR COMMISSIONED EMPLOYEES**

BENEFIT. The Company will pay a Recovery Benefit to an Insured Employee who returns to Full-Time employment in his or her Own Occupation with the Employer and:

1. earned commissions as part of Predisability Income;
2. has received Total or Partial Disability Benefits for at least 1 month;
3. upon return continues to earn commissions; and
4. earns less than 100% of Predisability Income.

AMOUNT. The amount of the Recovery Benefit equals the Insured Employee's Predisability Income minus all Other Income Benefits, limited to the Maximum Monthly Benefit.

TERMINATION OF RECOVERY BENEFIT. An Insured Employee's Recovery Benefit will terminate on the earliest of:

1. the date the Insured Employee's earnings upon return to Full-Time employment equal or exceed 100% of Predisability Income; or
2. six months after the Insured Employee returns to Full-Time employment in his or her Own Occupation with the Employer.

**NOTICE CONCERNING COVERAGE
LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA
LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT**

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies and Health Maintenance Organizations (HMOs) licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer or HMO becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted *in the box* below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The North Carolina Life and Health Insurance Guaranty Association
Post Office Box #10218
Raleigh, North Carolina 27605-0218

North Carolina Department of Insurance
Consumer Services Division
1201 Mail Service Center
Raleigh, North Carolina 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. *On the back of this page* is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

Coverage

Generally, individuals will be protected by the life and health insurance guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer or HMO. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

Exclusions From Coverage

However, persons holding such policies are not protected by this association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange;
- They acquired rights to receive payments through a structured settlement factoring transaction.

The association also does not provide coverage for:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed the average rate specified in the law;
- Dividends;
- Experience or other credits given in connection with the administration of a policy for a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered; or
- A policy or contract commonly known as Medicare Part C, Medicare Part D, Medicaid or any regulations issued pursuant thereto.

Limits On Amount Of Coverage

The act also limits the amount the association is obligated to pay out as follows:

- (1) The guaranty association cannot pay more than what the insurance company would owe under the policy or contract.
- (2) Except as provided in (3), (4) and (5) below, the guaranty association will pay a maximum of \$300,000 per individual, per insolvency, no matter how many policies or types of policies issued by the insolvent company.
- (3) The guaranty association will pay a maximum of \$500,000 with respect to a health benefit plan.
- (4) The guaranty association will pay a maximum of \$1,000,000 with respect to the payee of a structured settlement annuity.
- (5) The guaranty association will pay a maximum of \$5,000,000 to any one unallocated annuity contract holder.