YOUR GROUP **MONTHLY DISABILITY INCOME** INSURANCE PLAN

For Employees of

The University of Chicago Optional Plan

B-19731 (11/22)

6CC000

All Local 73 and Local 743 Employees

GROUP LONG TERM DISABILITY INCOME INSURANCE
CERTIFICATE OF COVERAGE

RELIASTAR LIFE INSURANCE COMPANY
20 Washington Avenue South
Minneapolis, Minnesota 55401

POLICYHOLDER:	The University of Chicago
GROUP POLICY NUMBER:	72389-4LTD2011
POLICY EFFECTIVE DATE:	January 1, 2022
GOVERNING JURISDICTION:	Illinois

ReliaStar Life Insurance Company (ReliaStar Life) certifies that it has issued the group policy listed above to the **Policyholder.** The policy is available for **you** to review if **you** contact the **Policyholder** for more information. **This is your Certificate of Coverage as long as you are eligible for coverage and you become insured. Please read it carefully and keep it in a safe place.** This Certificate of Coverage replaces any other certificates ReliaStar Life may have given **you** under the policy.

The Certificate of Coverage summarizes and explains the parts of the policy which apply to **you.** The Certificate of Coverage is part of the group policy but by itself is not a policy. **Your** coverage may be changed under the terms and conditions of the policy.

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

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

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

Registrar

Arizona residents:
Notice: This certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read this certificate carefully.

California residents:

If you are age 65 or older on the effective date of any coverage under the group policy for which you are required to pay all or part of the premium, then you have 30 days from the date you receive your initial Certificate of Coverage to cancel your coverage and have your full premium contribution refunded, by returning the Certificate of Coverage to the Policyholder for cancellation without claim.

Florida residents:
THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED BY THE LAW OF A STATE OTHER THAN FLORIDA.

Maryland residents:

Notice: This certificate of insurance may not provide all benefits required for a policy issued and delivered in Maryland.

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BENEFITS AT A GLANCE

The Long Term Disability policy provides benefits to replace a portion of **your** income while **you** are disabled. The amount **you** receive is based on the amount **you** earned before **your** disability began, subject to all policy provisions.

EMPLOYER:	The University of Chicago
GROUP POLICY NUMBER:	72389-4LTD2011

ELIGIBLE CLASS(ES)
All Fulltime and Part-time United States **employees** Local 73 or Local 743 **employees** selecting the Optional plan, in **active employment** with the **Employer** in the United States.

You must be an **employee** of the **Employer** and in an eligible class.

Temporary and seasonal workers are excluded from coverage.

MINIMUM HOURS REQUIREMENT
20 hours per week

WAITING PERIOD
For persons in an eligible class on or before the policy effective date: None

For persons entering an eligible class after the policy effective date: None

WHO PAYS FOR THE COVERAGE
You and **your Employer** share the cost of **your** coverage.

WAIVER OF PREMIUM
We do not require premium payments for **your** coverage while **you** are receiving or are entitled to receive Long Term Disability payments under the policy.

ACCUMULATION OF ELIMINATION PERIOD
Elimination period: 90 consecutive days.
Accumulation period: 180 consecutive days.

The elimination period and the accumulation period begin on the first day of **your** disability.

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

MONTHLY BENEFIT
60% of **monthly earnings** to a **maximum benefit** of $20,000 per month.

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

MONTHLY EARNINGS
Monthly earnings mean **your monthly earnings** paid to **You** by the University of Chicago including Annual Base Salary, Administrative Supplement, Clinical Term Allowance, and Ministerial Housing Allowance for the calendar month prior to **your** date of loss. It includes **your** total income before taxes, and any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, any other extra compensation, or income received from sources other than **your Employer**.

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

BENEFITS AT A GLANCE

MAXIMUM PERIOD OF PAYMENT
For a disability which begins before **you** reach age 60, the **maximum period of payment** will be until the Social Security Normal Retirement Age (SSNRA) as shown in the following table:

Year of Birth	Social Security Normal Retirement Age (SSNRA)*
Before 1938	65 years
1938	65 years and 2 months
1939	65 years and 4 months
1940	65 years and 6 months
1941	65 years and 8 months
1942	65 years and 10 months
1943-1954	66 years
1955	66 years and 2 months
1956	66 years and 4 months
1957	66 years and 6 months
1958	66 years and 8 months
1959	66 years and 10 months
1960 and after	67 years

For a disability which starts on or after **you** reach age 60, the **maximum period of payment** will be determined according to the following table:

Your Age When Disability Begins	Maximum Period of Payment
Age 60	60 months or to SSNRA*, whichever is greater
Age 61	48 months or to SSNRA*, whichever is greater
Age 62	42 months or to SSNRA*, whichever is greater
Age 63	36 months or to SSNRA*, whichever is greater
Age 64	30 months or to SSNRA*, whichever is greater
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

*Age at which **you** are entitled to unreduced Social Security benefits based on the Social Security Amendments of 1983.

TOTAL BENEFIT CAP
If **you** are eligible to receive payments under the policy in addition to **your monthly payment,** the total benefit payable to **you** on a monthly basis (including all benefits provided under the policy) will not exceed 100% of **your monthly earnings.** However, if **you** are participating in a **vocational rehabilitation plan,** the total benefit payable to **you** on a monthly basis (including all benefits provided under the policy) will not exceed 110% of **your monthly earnings.**

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

DEFINITIONS

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

To be in **active employment, your** work site must be one of the following:
- **Your Employer's** usual place of business.
- An alternative work site at the direction of **your Employer,** including **your** home.
- A location to which **your** job requires **you** to travel.

Normal vacation is considered **active employment.**
Temporary and seasonal workers are excluded from coverage.

APPROPRIATE CARE means that all of the following are true:
- **You** visit a **doctor** as frequently as medically required according to standard medical practice to effectively treat and manage **your** disabling condition(s).
- **You** receive care or treatment appropriate for the disabling condition(s), conforming with standard medical practice, by a **doctor** whose specialty or experience is appropriate for the disabling condition(s) according to standard medical practice.
- **You** have the obligation to minimize **your** disabling condition including having corrective treatment or minor surgery.

CONTEST means that, if **we** determine **you** made a material misrepresentation in **your** application for coverage under the policy, **we** notify **you** in writing that such coverage was therefore never effective. This is subject to the INCONTESTABILITY provision. Any premium **you** paid will be refunded to **you.**

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

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

DOCTOR means a person performing tasks that are within the limits of his or her medical license, and also meets one of the following requirements:
- Is licensed to practice medicine and prescribe and administer drugs or to perform surgery.
- Has a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients.
- Is a legally qualified medical practitioner according to the **laws** and regulations of the jurisdiction where treatment occurred.

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

ELIGIBLE SURVIVOR means **your** spouse, if living; otherwise, **your** children under age 26. "Spouse" includes **your** domestic partner if **you** have completed and signed an affidavit of domestic partnership on a form acceptable to **your Employer.**

EMPLOYEE means a person who is a citizen or legal resident of the United States in **active employment** with the **Employer** in the United States.

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

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

DEFINITIONS

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

EVIDENCE OF INSURABILITY means a statement of **your** medical history that **we** will use to determine if **you** are approved for coverage.

EVIDENCE OF INSURABILITY FORM means the supplement to the **enrollment form** that **you** complete and submit to **us** that contains a statement of **your** medical history. Only the **evidence of insurability form** provided by **us** will be accepted. Completion of the **evidence of insurability form** is at **your** own expense.

FAMILY MEMBER means an individual who can be claimed as a dependent by **you** for federal income tax purposes.

GRACE PERIOD means the 60 day period following the premium due date during which premium payment for the policy may be made by the **Policyholder.**

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

HOSPITAL, HEALTH FACILITY or INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing **your** disability.

INDEXED MONTHLY EARNINGS means **your monthly earnings** adjusted on each anniversary of benefit payment by the lesser of 10% or the current annual percentage increase in the Consumer Price Index. **Your indexed monthly earnings** may increase or remain the same, but will never decrease.

The Consumer Price Index CPI-U is published by the U.S. Department of Labor. **We** reserve the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-U. Indexing is only used as a factor in the determination of the percentage of lost earnings while **you** are disabled and working, and in the determination of gainful occupation.

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

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

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

LEAVE OF ABSENCE means **you** are absent from **active employment** for a period of time that has been agreed to in advance in writing by **your Employer.** **Your** normal vacation time or any period of disability is not considered a **leave of absence.**

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

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

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

MAXIMUM PERIOD OF PAYMENT means the longest period of time **we** will make payments to **you** for any one period of disability.

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

DEFINITIONS

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

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

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

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

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

PRE-EXISTING CONDITION means any condition for which **you** have done any of the following at any time during the 6 months just prior to **your** effective date of coverage, whether or not that condition is diagnosed or misdiagnosed:
- Received medical treatment or consultation.
- Taken or were prescribed drugs or medicine.
- Received care or services, including diagnostic measures.

RECURRENT DISABILITY means a disability for which both of the following are true:
- It is caused by a worsening in **your** condition.
- It is due to the same cause(s) as **your** prior disability for which **we** made a **monthly payment.**

REGULAR OCCUPATION means the occupation **you** are routinely performing when **your** disability begins. **We** will look at **your** occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location. **We** may use the Dictionary of Occupational Titles published by the Department of Labor and any other appropriate resource in making **our** determination.

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

SALARY CONTINUATION or ACCUMULATED SICK LEAVE means continued payments to **you** by **your Employer** of all or part of **your monthly earnings,** after **you** become disabled as defined by the policy. This continued payment must be part of an established plan maintained by **your Employer,** and includes **salary continuation or accumulated sick leave** or any similar **Employer** sponsored paid time off plan.

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

VOCATIONAL REHABILITATION PLAN means a written plan that a vocational rehabilitation professional, designated by **us,** prepares in accordance with the VOCATIONAL REHABILITATION SERVICES provision of the certificate.

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

WE, US and **OUR** means ReliaStar Life Insurance Company.

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

GENERAL PROVISIONS

CERTIFICATE OF COVERAGE

This Certificate of Coverage is a written statement prepared by **us** and may include riders, endorsements and/or amendments. It tells **you:**

- The coverage to which **you** may be entitled.
- To whom **we** will make a payment.
- The limitations, exclusions and requirements that apply within the policy.

ELIGIBILITY DATE

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

- The policy effective date.
- The day after **you** complete **your** waiting period.

WHEN COVERAGE BEGINS

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

- The date **you** are eligible for coverage, if **you enroll** for insurance on or before that date.
- The date **you enroll** for insurance, if **you enroll** within 31 days after the date **you** become eligible for coverage.
- The date **we** approve **your evidence of insurability form,** if **evidence of insurability** is required.

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

CHANGES TO YOUR COVERAGE

Once **your** coverage begins, any increased or additional coverage will take effect immediately if **you** are in **active employment** or if **you** are on a covered **leave of absence.** If **you** are not in **active employment** due to **injury** or **sickness,** any increased or additional coverage will begin on the date **you** return to **active employment.**

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

WHEN EVIDENCE OF INSURABILITY IS REQUIRED

Evidence of insurability is required in any of these situations:

- **You** are a late enrollee, which means **you enroll** for coverage more than 31 days after the date **you** are eligible for coverage.
- **You** voluntarily canceled **your** coverage and are reapplying.
- **You** previously converted **your** coverage and are surrendering **your** conversion coverage to reapply as an eligible **insured person.**

An **evidence of insurability form** can be obtained from **your Employer.**

LEAVE OF ABSENCE AFTER YOUR COVERAGE BEGINS

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

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

- The leave period permitted by the federal Family and Medical Leave **Act** of 1993 and any amendments.

- The leave period permitted by applicable state **law.**

If **you** are on a **leave of absence** other than an FMLA or State FML **leave of absence,** and if premium is paid, **your** coverage will be continued through the end of the 24 months that immediately follows the month in which **your leave of absence** begins.

If **you** are on a **leave of absence** for active military service as described under the Uniformed Services Employment and Reemployment Rights **Act** of 1994 (USERRA) and applicable state **law, your** coverage may be continued until the end of the later of:
- The length of time the coverage may be continued under the Certificate of Coverage for an FMLA or State FML **leave of absence.**
- The length of time the coverage may be continued under the Certificate of Coverage for a **leave of absence** other than an FMLA or State FML **leave of absence.**

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

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

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

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

TEMPORARY LAYOFF

If **you** are not in **active employment** due to a **temporary layoff,** and if premium is paid, **you** will be covered through the end of the 2 months that immediately follows the month in which **your temporary layoff** begins.

FACULTY EMPLOYEES PHASED RETIREMENT

Your insurance may continue for up to 60 months during a Faculty Employees Phased Retirement (the Faculty Retirement Incentive Program) as long as you are earning 2/3 of your salary and continue to work at least 10 hours per week.

This continuation of coverage includes all riders that were in effect on the date before the Faculty Employees Phased Retirement began.

MILITARY LEAVE

If **you** are not in **active employment** due to a military leave, and if premium is paid, **you** will be covered through the end of the 24 months that immediately follows the month in which **your** military leave begins.

WHEN YOUR COVERAGE ENDS

Your coverage under the policy ends on the earliest of the following dates:
- The date the policy is canceled.
- The date **you** are no longer in an eligible class.
- The date **your** eligible class is no longer covered.
- The end of the period for which **you** paid premiums, if **you** stop making a required premium contribution.
- The end of the **Policyholder's grace period**, if the **Policyholder** does not remit premium to **us** by the end of such period.
- The last day **you** are in **active employment** except as provided under a covered **leave of absence.**

GENERAL PROVISIONS

We will provide coverage for a **payable claim** that occurs while **you** are covered under the policy. Termination of the policy during a disability will have no effect on a **payable claim.**

CONVERSION

(Not available to residents of CO, FL, IN, LA, MI, NY, OR, SD or WV)

If **your** coverage stops under the policy, **you** may have a conversion right. The conversion right allows **you** to obtain long term disability income insurance without **evidence of insurability.**

You may convert **your** coverage if it stops under the policy for any of the following reasons:

- **You** resign.
- **You** are terminated for cause.
- **You** are laid-off.
- **You** go on a **leave of absence.**

You do not have to supply **evidence of insurability** in order to convert **your** coverage. **You** must have been covered for at least 12 consecutive months prior to **your** coverage terminating under the policy. The 12 months can be a combination of insurance under the policy and a prior plan of group long term disability coverage, whether insured or self-funded, sponsored by **your Employer.**

You must apply for conversion and pay the first premium within 60 days after termination of **your** coverage under the policy. If approved, **your** long term disability conversion insurance coverage will become effective on the date after **your** coverage under the group policy ends. The benefits and amounts of insurance under the conversion coverage may differ from those under the group policy. **We** reserve the right to have **your** conversion coverage issued by another insurance company.

You may not convert **your** coverage if **your** coverage terminates for any of the following reasons:

- Termination of the policy.
- The policy is amended to exclude from coverage the class of **insured persons** to which **you** belong.
- **You** no longer belong to a class eligible for coverage under the policy.
- **You** retire.
- **You** fail to pay any contributions required for **your** coverage.
- **You** are disabled under the terms of the policy.

If **you** become covered for long term disability benefits under another group plan within 31 days after termination of **your** coverage under the group policy, **you** are not eligible to convert **your** coverage.

TIME LIMITS FOR LEGAL PROCEEDINGS

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

REPRESENTATIONS NOT WARRANTIES

We consider any statements the **Policyholder** and **you** make in an application representations and not warranties. No statements made by **you** will be used to reduce or deny any claim or to cancel **your** coverage unless both of the following are true:

- The statement is in writing and is signed by **you.**
- A copy of that statement is given to **you** or **your** beneficiary, or **your** personal representative.

INCONTESTABILITY

Except in the case of fraud, no statement made by **you** in the application relating to **your** insurability will be used to **contest** the insurance for which the statement was made after the coverage has been in force for two years during **your** lifetime.

Beyond the periods stated in the PRE-EXISTING CONDITION LIMITATION provision, no claim for disability with respect to which the claim is made shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of disability, had existed prior to the effective date of the coverage.

GENERAL PROVISIONS

CLERICAL ERROR

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

- Prevent **you** from receiving coverage, if **you** are entitled to coverage under the terms of the policy.
- Cause coverage to begin or continue for **you** when the coverage would not otherwise be effective.

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

- Use the facts to decide whether **you** have coverage under the policy and in what amounts.
- Make a fair adjustment of the premium.

MISSTATEMENT OF AGE

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

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE

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

AGENCY

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

LONG TERM DISABILITY BENEFIT INFORMATION

DEFINITION OF DISABILITY

You are considered disabled when **we** review **your** claim and determine that, due to **your sickness** or **injury,** both of the following are true:
• **You** are unable to perform all the **material and substantial duties** of **your regular occupation.**
• **You** have a 20% or more loss in **your indexed monthly earnings.**

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

You must be under the **appropriate care** of a **doctor** in order to be considered disabled.

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

ACCUMULATION OF ELIMINATION PERIOD

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

If **you** return to work while satisfying **your** elimination period, **you** may satisfy **your** elimination period within the accumulation period. The accumulation period is as stated in the BENEFITS AT A GLANCE.

The days that **you** are not disabled will not count toward **your** elimination period.

If **you** do not satisfy the elimination period within the accumulation period, a new period of disability will begin.

The elimination period and the accumulation period begin on the first day of **your** disability.

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

SATISFYING YOUR ELIMINATION PERIOD IF YOU ARE WORKING

If **you** are working while **you** are disabled, the days **you** are disabled will count toward **your** elimination period.

WHEN YOU RECEIVE PAYMENTS

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

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

AMOUNT OF PAYMENT

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

We will follow this process to figure **your** payment:
1. Multiply **your monthly earnings** by 60%.
2. The **maximum benefit** is $20,000 per month.
3. Compare the answers from Step 1 and Step 2. The lesser of these two amounts is **your gross monthly payment.**
4. Subtract from **your gross monthly payment** any **deductible sources of income.**

The amount figured in Step 4 is **your monthly payment.** If this amount is less than the MINIMUM PAYMENT amount under the policy, **your** payment will be subject to the MINIMUM PAYMENT provision.

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

During the first 24 months of payments, the sum of **your gross monthly payment** plus **disability earnings** may be less than or equal to, but not more than, 100% of **your indexed monthly earnings.** If the sum exceeds 100% of **your indexed monthly earnings, we** will reduce **your** payment under the policy by the excess amount.

To determine whether the sum of **your gross monthly payment** plus **disability earnings** is less than or equal to or exceeds 100% of **your indexed monthly earnings, we** will follow this process:

1. Multiply **your monthly earnings** by 60%.
2. The **maximum benefit** is $20,000 per month.
3. Compare the answers from Step 1 and Step 2. The lesser of these two amounts is **your gross monthly payment.**
4. Add **your disability earnings** to **your gross monthly payment.**

If the answer in Step 4 above is less than or equal to 100% of **your indexed monthly earnings, your monthly payment** will be **your gross monthly payment** minus any **deductible sources of income.** If this amount is less than the MINIMUM PAYMENT amount under the policy, **your** payment will be subject to the MINIMUM PAYMENT provision.

If the answer in Step 4 above is greater than 100% of **your indexed monthly earnings, we** will follow this process to figure **your monthly payment:**

a. Add **your disability earnings** to **your gross monthly payment.**
b. From the answer in Step a, subtract **your indexed monthly earnings.** If the result is zero or less, record **your** answer as zero.
c. From **your gross monthly payment,** subtract the answer in Step b and any **deductible sources of income.**

The amount figured in Step c is **your monthly payment.** If this amount is less than the MINIMUM PAYMENT amount under the policy, **your** payment will be subject to the MINIMUM PAYMENT provision.

After 24 months of **monthly payments, you** will receive payments based on the percentage of income **you** are losing due to **your** disability. **We** will follow this process to determine **your monthly payment:**

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

The answer in Step 4 is **your monthly payment.** If this amount is less than the MINIMUM PAYMENT amount under the policy, **your** payment will be subject to the MINIMUM PAYMENT provision.

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

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

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

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

LONG TERM DISABILITY BENEFIT INFORMATION

IF YOUR DISABILITY EARNINGS FLUCTUATE

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

If **we** average **your disability earnings, we** will not terminate **your** claim unless the average of **your disability earnings** from the last three months exceeds 80% of **your indexed monthly earnings.**

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

WE WILL NEVER PAY MORE THAN 100% OF MONTHLY EARNINGS

If **you** are eligible to receive benefits under the policy in addition to the **monthly payment,** the total benefit payable to **you** on a monthly basis (including all benefits provided under the policy) will not exceed 100% of **your monthly earnings.** However, if **you** are participating in a **vocational rehabilitation plan,** the total benefit payable to **you** on a monthly basis (including all benefits provided under the policy) will not exceed 110% of **your monthly earnings.**

DEDUCTIBLE SOURCES OF INCOME

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

- The amount that **you** receive, or are eligible to receive, as disability income payments under any:
  - State compulsory benefit **act** or **law.**
  - Automobile liability insurance policy or "no fault" motor vehicle plan, whichever is applicable.
  - Military disability benefit plan.
  - Governmental retirement system as a result of **your** job with **your Employer.**
  - Other group insurance policy.
- The amount **you** receive as a result of any action brought under Title 46, United States Code Section 688 (The Jones **Act**).
- The amount **you** receive from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.
- The amount **you** receive under any **salary continuation or accumulated sick leave** plan.
- The amount that **you:**
  - receive as disability payments under **your Employer's retirement plan;**
  - voluntarily elect to receive as retirement payments under **your 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 **your Employer's retirement plan.**

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

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

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

  Amounts received do not include amounts rolled over or transferred to any eligible **retirement plan. We** will use the definition of eligible **retirement plan** as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.
- The amount that **you, your** spouse and **your** children receive, or are eligible to receive, as disability payments because of **your** disability under:
  - The United States Social Security **Act.**
  - The Canada Pension **Plan.**
  - The Quebec Pension **Plan.**

- Any similar **Plan** or **Act.**

- The amount that **you** receive as retirement payments or the amount **your** spouse and **your** children receive as retirement payments because **you** are receiving retirement payments under:
  - The United States Social Security **Act.**
  - The Canada Pension **Plan.**
  - The Quebec Pension **Plan.**
  - Any similar **Plan** or **Act.**
- The amount **you** receive from any form of employment.
- The amount **you** receive from any unemployment compensation **law.**
- The amount that **you** receive, or are eligible to receive, under:
  - A workers' compensation **law.**
  - An occupational disease **law.**
  - Any other **act** or **law** with similar intent.

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

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

COST OF LIVING INCREASES FOR DEDUCTIBLE SOURCES OF INCOME

Other than for increases in any income **you** earn from any form of employment, once **we** have subtracted any **deductible sources of income** from **your gross monthly payment, we** will not further reduce **your** payment due to a cost of living increase from that source.

IF YOU QUALIFY FOR DEDUCTIBLE SOURCES OF INCOME

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

- Not been awarded or denied.
- Been denied and the denial is being appealed.

Your gross monthly payment will NOT be reduced by the estimated amount if both of the following are true:

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

If **your gross monthly payment** has been reduced by an estimated amount, **your gross monthly payment** will be adjusted when **we** receive either of the following:

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

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

NON-DEDUCTIBLE SOURCES OF INCOME

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

- 401(k) plans.

- Profit sharing plans.
- Thrift plans.
- Tax-sheltered annuities.
- Stock ownership plans.
- Credit disability insurance.
- Non-qualified plans of deferred compensation.
- Pension plans for partners.
- Military pension plans.
- Franchise disability income plans.
- Individual disability plans wholly paid for by the **insured person.**
- A retirement plan from another employer.
- Individual retirement accounts (IRA).

MINIMUM PAYMENT

The minimum payment each month for a **payable claim** is the greater of:

- $100.
- 10% of **your gross monthly payment.**

We may apply this amount to recover any outstanding overpayment.

DURATION OF PAYMENTS

We will send **you** a payment each month up to the **maximum period of payment. Your maximum period of payment** is stated in the BENEFITS AT A GLANCE, will be paid during a continuous period of disability, and will be based on **your** age at disability.

WHEN PAYMENTS END

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

- The end of the **maximum period of payment.**
- The date **you** are no longer disabled under the terms of the policy.
- The date **you** fail to submit proof of continuing disability.
- The date **you** die.
- When **you** are able to return to work in **your regular occupation** on a **part-time basis** but **you** do not.
- The date **your disability earnings** exceed 80% of **your indexed monthly earnings.**
- The date **you** refuse to participate in **your vocational rehabilitation plan.**
- After 12 months of payments if **you** are considered to reside outside the United States or Canada. **You** will be considered to reside outside these countries when **you** have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits.

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

DISABILITIES NOT COVERED UNDER THE POLICY

The policy does not cover any disabilities resulting from **your:**

- Loss of professional license, occupational license or certification.
- Commission of or attempt to commit a felony.
- Intentionally self-inflicted injuries.
- Attempted suicide, regardless of mental capacity.
- Being legally intoxicated as defined and determined by the laws of the state where the incident occurred, or being under the influence of any narcotic, unless the narcotic is taken under the direction of and as directed by a **doctor.**
- Participation in a war, declared or undeclared, or any act of war.
- Active military duty.
- Active participation in a riot.
- Engaging in any illegal or fraudulent occupation, work or employment.
- Commission of a crime for which **you** have been convicted.

- Elective surgery except when required for **your appropriate care** as a result of **your injury** or **sickness.**
- Traveling or flying on any aircraft operated by or under the authority of military or any aircraft being used for experimental purposes.

PRE-EXISTING CONDITION LIMITATION

Benefits will not be paid if **your** disability begins in the first 9 months following the effective date of **your** coverage and **your** disability is the result of a **pre-existing condition.**

CONTINUITY OF COVERAGE

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

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

- The date **you** return to **active employment.**
- The end of any period of continuance or extension provided under the prior policy.
- The date coverage would otherwise end, according to the provisions of **our** policy.

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

Any benefits payable under this provision will be paid as if the prior policy had remained in force. **We** will reduce **your** payment by any amount for which the prior carrier is liable.

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

CONTINUITY OF COVERAGE AND PRE-EXISTING CONDITIONS

We may pay benefits if **your** disability is caused by, contributed by or results from a **pre-existing condition** if both of the following are true:

- **You** were insured by the prior policy at the time **your Employer** changed insurance carriers to **our** policy.
- **You** have been continuously covered under **our** policy from the effective date of **our** policy through the date **your** disability began.

In order to receive a payment, **you** must satisfy the **pre-existing condition** provision under either **our** policy or under the prior policy, if benefits would have been paid had that policy remained in force.

If **you** satisfy the **pre-existing condition** provision of **our** policy, **we** will determine **your** payments according to **our** policy's provisions.

If **you** do not satisfy the **pre-existing condition** provision of **our** policy, but **you** do satisfy the prior policy's **pre-existing condition** provision, then both of the following apply:

- **Your monthly payment** will be the lesser of:
  - the **monthly payment** that would have been payable under the terms of the prior policy had it remained in force.
  - the **monthly payment** under **our** policy.
- Benefits will end on the earlier of:
  - the date benefits end under **our** policy, as described under the WHEN PAYMENTS END provision.
  - the date benefits would have ended under the prior policy if it had remained in force.

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

We will require proof that **you** were insured under the prior policy. All other provisions of **our** policy will apply.

RECURRENT DISABILITY

If **you** have a **recurrent disability,** and after **your** prior disability ended, **you** returned to work for **your Employer** for 6 months or less, **we** will treat **your** disability as part of **your** prior claim and **you** do not have to complete another elimination period. Only one **maximum period of payment** will apply when **your** disability is considered part of **your** prior claim.

Your monthly payment will be based on **your monthly earnings** as of the date of **your** initial claim. **Your** disability, as outlined above, will be subject to the same terms of the policy as **your** prior claim.

Your disability will be treated as a new claim if either of the following is true:

- **Your** current disability is unrelated to **your** prior disability.
- After **your** prior disability ended, **you** returned to work for **your Employer** for more than 6 consecutive months.

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

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

VOCATIONAL REHABILITATION SERVICES

We have vocational rehabilitation services available to assist **you** in returning to work to the extent of **your** ability. **We** will review **your** disability claim to determine whether **you** are eligible for these services. In order to be eligible for vocational rehabilitation services and benefits, **you** must be medically able to participate in a return to work plan.

Your claim file will be reviewed by a vocational rehabilitation professional to determine if rehabilitation services might help **you** return to gainful employment. As **your** file is reviewed, medical and vocational information will be analyzed to determine an appropriate return to work plan.

We will make the final determination of **your** eligibility for these services.

If **we** determine that vocational rehabilitation services are appropriate, **we** will provide **you** with a written **vocational rehabilitation plan** developed specifically for **you.**

The **vocational rehabilitation plan** may include, but is not limited to the following services:

- Coordination with **your Employer** to assist **you** to return to work.
- Evaluation of adaptive equipment or job accommodations to allow **you** to work.
- Evaluation of possible workplace modifications which might allow **you** to return to work in **your regular occupation** or another job or occupation.
- Vocational evaluation to determine how **your** disability may impact **your** employment options.
- Job placement services, including resume preparation services and training in job-seeking skills.
- Alternative treatment plans such as recommendations for support groups, physical therapy, occupational therapy or other treatment designed to enhance **your** ability to work.

Your failure to participate with **your** full cooperation in the **vocational rehabilitation plan,** without good cause, will result in the termination of **your** long term disability benefits. "Good cause" means a medical reason preventing implementation of the **vocational rehabilitation plan.** If **your** benefits terminate, **your** coverage under the policy will terminate.

VOCATIONAL REHABILITATION BENEFIT

If **you** are receiving **monthly payments** under the policy, and **you** are participating in a **vocational rehabilitation plan, you** may be eligible for an additional Vocational Rehabilitation Benefit. **We** will pay an additional benefit of 10% of **your gross monthly payment** to a maximum of $1,000 per month.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as **deductible sources of income.** However, the Total Benefit Cap will apply.

Vocational Rehabilitation Benefits will end on the earliest of the following dates:
- The date **we** determine that **you** are no longer eligible to participate in a **vocational rehabilitation plan.**
- The date **you** are no longer participating in a **vocational rehabilitation plan.**
- Any other date on which **monthly payments** would stop in accordance with the policy.

FAMILY MEMBER CARE EXPENSE BENEFIT

If **you** are receiving **monthly payments** under the policy, and **you** are participating in a **vocational rehabilitation plan, you** will be eligible for an additional **Family Member** Care Expense Benefit if **you** are incurring expenses to provide care for a **family member** who requires personal care assistance.

We will pay a **Family Member** Care Expense Benefit of $750 per **family member** not to exceed a maximum of $1,000 per month.

The **Family Member** Care Expense Benefit will end on the earliest of the following dates:
- The date **you** are no longer incurring **family member** care expenses.
- The date **you** are no longer participating in a **vocational rehabilitation plan.**
- After 24 months of **Family Member** Care Expense Benefits have been paid for each **family member.**
- Any other date on which **monthly payments** would stop in accordance with the policy.

To receive this benefit, **you** must provide satisfactory proof that **you** are incurring a **family member** care expense.

Family member care means care or supervision of **your family member** and care is given by a licensed child-care center or a licensed caregiver who is not related to **you** by blood or marriage.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as **deductible sources of income.** However, the Total Benefit Cap will apply.

WORKPLACE MODIFICATION BENEFIT

If **you** are disabled and are receiving a payment under the policy from **us,** a Workplace Modification Benefit may be payable to **your Employer.** Subject to the maximum amount below, **we** will reimburse **your Employer** for 100% of the reasonable costs **your Employer** incurs through modifications to the workplace to accommodate **your** return to work, and to assist **you** in remaining at work.

The amount **we** pay will not exceed the lesser of the following:
- Two times **your** last **monthly payment.**
- $2,000.

You must meet both of the following requirements:
- Be disabled according to the terms of the policy.
- Have the reasonable expectation of returning to **active employment** and remaining in **active employment** with the assistance of the proposed workplace modification.

Your Employer must give **us** a written proposal of the proposed workplace modification. This proposal must include all of the following:
- Input from the **Employer, you** and **your doctor.**
- The purpose of the proposed workplace modification.
- The expected completion date of the workplace modification.
- The cost of the workplace modification.

We will reimburse the costs of the workplace modification when all of the following are true:
- **We** approve the proposal in writing.
- **We** receive proof from **your Employer** that the workplace modification is complete.
- **We** receive proof of the costs incurred by **your Employer** for the workplace modification.

The Workplace Modification Benefit is available on a one-time basis for each **insured person** under the policy.

SURVIVOR BENEFIT

When **we** receive proof that **you** have died, **we** will pay **your eligible survivor** a lump sum benefit equal to three (3) times **your gross monthly payment** if, on the date of **your** death, both of the following are true:

- **Your** disability had continued for 180 or more consecutive days.
- **You** were receiving or were eligible to receive payments under the policy.

If **you** have no **eligible survivors,** payment will be made to **your** estate, unless there is none. In this case, no payment will be made.

However, **we** will first apply the Survivor Benefit to recover any overpayment that may exist on **your** claim.

CLAIM INFORMATION

NOTICE OF CLAIM

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

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

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

FILING A CLAIM

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

PROOF OF YOUR CLAIM

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

Your proof of claim, provided at **your** expense, must show all of the following:

- That **you** are under the **appropriate care** of a **doctor.**
- The date **your** disability began.
- The cause of **your** disability.
- The appropriate documentation of **your** earnings and **your** activities.
- The extent of **your** disability, including restrictions and limitations preventing **you** from performing **your regular occupation.**
- The name and address of any **hospital, health facility or institution** where **you** received treatment, including all attending **doctors.**
- Documentation of prior disability coverage, if applicable.

In some cases, **you** will be required to give **us** authorization to obtain additional medical information, and to provide non-medical information as part of **your** proof of claim, or proof of continuing disability. **We** will deny **your** claim, or stop sending **you** payments, if the appropriate information is not submitted within 45 days of the request.

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

MAKING PAYMENTS

Once **your** claim has been approved, **we** will send **you** a payment at the end of each month for any period for which **we** are liable. Any balance remaining unpaid at the termination of a period of disability will be paid immediately upon receipt of **your** proof of claim.

If **your** approved claim is not paid within 30 days of **our** receipt of **your** proof of claim, **we** will pay interest on the late payment at 9% per year accruing from the 30th day after receipt of **your** proof of claim until the date of payment.

CLAIM INFORMATION

OVERPAID CLAIMS

We have the right to recover any overpayments due to any of the following:

- Fraud.
- Any administrative error **we** make in processing a claim.
- **Your** receipt of **deductible sources of income.**

You must reimburse **us** in full. **We** will determine the method by which the repayment is to be made. **We** will not recover more money than the amount **we** paid **you.** However, **we** reserve the right to recover any prior or current overpayment from any past, current or new payable disability claim under the policy.

ReliaStar Life Insurance Company

20 Washington Avenue South, Minneapolis, MN 55401

NOTICE TO CALIFORNIA POLICYHOLDERS/CERTIFICATEHOLDERS
KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

If you have a question about your policy, if you need assistance with a problem, or if you have questions about a claim, you may write to us at the above address or call 1-800-955-7736.

You will need to provide your policy number with any communication.

If you do not reach a satisfactory resolution after having discussions with us, or our agent or representative, or both, you may contact the following unit within the Department of Insurance that deals with consumer affairs:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, California 90013

Outside Los Angeles: 1-800-927-HELP (1-800-927-4357)
Los Angeles: (213) 897-8921

Web Site: www.insurance.ca.gov/01-consumers/101-help

RELIASTAR LIFE INSURANCE COMPANY

ILLINOIS CIVIL UNION ENDORSEMENT

All references to "spouse" in the policy/certificate and any riders or endorsements include a partner to a civil union that is recognized by the State of Illinois. Any reference to "stepchild" includes a child of a partner to a civil union that is recognized by the State of Illinois. Any reference to "divorce" includes the dissolution of a civil union according to the requirements of the State of Illinois.

A civil union or same sex civil union or marriage entered into outside of Illinois, which is valid under the laws of the jurisdiction under which the relationship was legally entered into, will be treated as a civil union under Illinois Law.

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota 55440

MASSACHUSETTS CERTIFICATE ENDORSEMENT

for Group Disability Income Insurance

Your certificate has been changed as follows. Please keep this endorsement with your certificate. This endorsement is subject to all other terms of the Group Policy.

I. EMPLOYEE'S INSURANCE

The following statements are added to the "Termination of Insurance" provision:

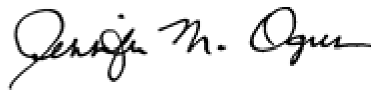
If your insurance ends because you leave the group covered by the Group Policy, your coverage will continue under the Group Policy for a period of 31 days unless during that period you are otherwise entitled to similar benefits. Premium payment is required.

If your insurance ends because your employment is terminated due to a plant closing or a partial closing (as defined in section 71A of Chapter 151A, Massachusetts Statutes), your coverage will continue under the Group Policy for a period of 90 days unless during that period you are otherwise entitled to similar benefits. Premium payment is required.

II. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Group Policy Effective Date.
- The effective date of your insurance.



Secretary
ReliaStar Life Insurance Company

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota 55440

NEW HAMPSHIRE CERTIFICATE ENDORSEMENT

for Group Long Term Disability Income Insurance

Your Certificate of Coverage has been changed as follows. Please keep this endorsement with **your** certificate. This endorsement is subject to all other terms of the policy/certificate.

I. CERTIFICATE COVER PAGE

The insurance company's toll-free telephone number is **[**800-955-7736**]**.

The following statement is added to **your** certificate:

> **If you are not satisfied with this certificate for any reason, you may return it within 30 days after receipt for a refund of any premium you paid.**

II. BENEFITS AT A GLANCE

If the Maximum Period of Payment provision in **your** certificate is more than 1 year but less than or equal to 2 years, then **your** ELIMINATION PERIOD for both **sickness** and **injury** is no more than 180 days.

If the Maximum Period of Payment provision in **your** certificate is more than 2 years, then **your** ELIMINATION PERIOD for both **sickness** and **injury** is no more than 365 days.

III. GENERAL PROVISIONS

The TIME LIMITS FOR LEGAL PROCEEDINGS provision for **you** is as follows:

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

The INCONTESTABILITY provision for **you** is as follows:

> No statement made by **you** in the application relating to **your** insurability will be used to **contest** the insurance for which the statement was made after the coverage has been in force for two years during **your** lifetime.
>
> Beyond the periods stated in the PRE-EXISTING CONDITION LIMITATION provision, no claim for disability with respect to which the claim is made shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of disability, had existed prior to the effective date of the coverage.

IV. LONG TERM DISABILITY BENEFIT INFORMATION

If the DEFINITION OF DISABILITY provision in **your** certificate states that after the **regular occupation period your** disability is based on **activities of daily living** or **cognitive impairment** or **terminal illness**, then this provision is changed to state the following:

> After the **regular occupation period**, **you** are considered disabled when **we** review **your** claim and determine that, due to **your sickness** or **injury**, **you** are unable to perform the duties of any **gainful occupation** for which **you** are reasonably qualified based on **your** training, education and experience.

If **your** certificate includes a SUPPLEMENTAL DISABILITY BENEFIT, this benefit is not available to **you**.

V. CLAIM INFORMATION

If **your** certificate includes the following statement under the PROOF OF YOUR CLAIM provision:

> **You** must provide proof of claim no later than 1 year after the time proof is otherwise required, except in the absence of legal capacity.

then this statement does not apply to **you**.

VI. EFFECTIVE DATE

This endorsement is effective for **you** on or after the later of the following dates:

- The Policy Effective Date.
- The effective date of **your** insurance.

Megan Huddleston
Secretary

Texas Residents: Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

ReliaStar Life Insurance Company

To get information or file a complaint with your insurance company:

Call: Customer Contact Center Manager at 1-800-955-7736

Toll-free: 1-888-238-4840 for Life Insurance and 1-877-236-7564 for Supplemental Benefits Insurance

Email: LifeClaims@voya.com

Mail: 20 Washington Avenue South, Minneapolis, MN 55401

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamacion o con su prima de seguro, llame primero a su compania de seguros. Si no puedo resolver el problema, es possible que el Departamento de Seguros de Texas (Texas Department of Insurance, pro su nombre en ingles) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, tamblen debe presenter una queja a traves del proceso de quejas o de apelaciones de su compania de seguros. Si no lo hace, podria perder su derecho para apelar.

ReliaStar Life Insurance Company

Para obtener informacion o para presenter una queja ante su compania de seguros:

Llame a: Customer Contact Center Manager at 1-800-955-7736

Telefono gratuito: 1-888-238-4840 for Life Insurance and 1-877-236-7564 for Supplemental Benefits Insurance

Correo electronico: LifeClaims@voya.com

Direccion postal: 20 Washington Avenue South, Minneapolis, MN 55401

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacion ada con los seguros o para presenter una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electronico: ConsumerProtection@tdi.texas.gov

Direccion postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota 55440

VERMONT CERTIFICATE ENDORSEMENT

for Group Long Term Disability Income Insurance

Your Certificate of Coverage has been changed as follows. Please keep this endorsement with **your** certificate. This endorsement is subject to all other terms of the policy/certificate.

I. DEFINITIONS

If **your** certificate includes a definition of **Eligible Survivor**, then the reference to "spouse" in this definition includes **your** civil union partner according to Vermont law.

II. EFFECTIVE DATE

This endorsement is effective for **you** on or after the later of the following dates:

- The Policy Effective Date.
- The effective date of **your** insurance.

Megan Huddleston
Secretary

Wisconsin Complaint Notice

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? – If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

ReliaStar Life Insurance Company
Customer Service
P.O. Box 20
Minneapolis, MN 55440-0020
1-800-955-7736

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can file a complaint electronically with the **OFFICE OF THE COMMISSIONER OF INSURANCE** at its website at http://oci.wi.gov/, or by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517
608-266-0103.

The Summary Plan Description on the following pages is provided to you at the request of the Policyholder. It is not a part of the insurance certificate.

SUMMARY PLAN DESCRIPTION

For a Plan of Insurance Underwritten by
ReliaStar Life Insurance Company
P.O. Box 20
Minneapolis, Minnesota 55440

Plan Name, Number and Name and Address of Policyholder:
The University of Chicago Employee Benefit Plan
72389-4LTD2011
The University of Chicago
6054 Drexel Avenue
Chicago, Illinois, 60637

Name, Address, and Telephone Number of the Plan Administrator:
The University of Chicago
6054 Drexel Avenue
Chicago, Illinois, 60637

Identification Numbers
IRS Employer Identification Number: 36-2177139
Plan Number: 508

Agent for Legal Process: Plan Administrator

Trustees: None

Collective Bargaining or Multiple-Employer Agreements under which Plan is Established: None

Type of Administration: Records maintained by Policyholder.

Premium Payments: Employer and Employee paid

Plan Year: January 1 to December 31

Claim Procedures: Please refer to CLAIM PROCEDURES section(s).

Statement of ERISA Rights: Please refer to STATEMENT OF ERISA RIGHTS section.

Eligibility and Circumstances Limiting Eligibility: As described in the Certificate of Insurance.

Type of Plan: As described in the Certificate of Insurance.

Benefits in Plan: As described in the Certificate of Insurance.

Amendment or Termination of Plan: The Policyholder makes no promise to continue these benefits in the future and rights to future benefits will never vest. The Policyholder reserves the right to amend, modify, revoke or terminate the plan, in whole or part, at any time.

ReliaStar Life's Group Policy may be amended or terminated as set forth in the Group Policy.

Benefits, Rights, and Obligations after Termination: As described in the Certificate of Insurance.

SUMMARY PLAN DESCRIPTION

CLAIM PROCEDURES FOR DISABILITY INCOME INSURANCE

1. Information regarding claim submission may be obtained from the Plan Administrator or Human Resource Department.
2. ReliaStar Life Insurance Company (ReliaStar Life) will process the claim and make payment or issue a denial notice.
3. Written notice of denial of a claim will be furnished to the claimant within 45 days after receipt of the claim. Up to two extensions of 30 days each will be allowed for processing the claim for matters beyond the Plan's control or if additional information is needed from the claimant. The claimant will be given notice of any such extension. The notice will state the standards on which the entitlement to the benefit is based, the unresolved issues that prevent a decision on the claim, the additional information needed to resolve those issues, if any, and the date a decision is expected.
4. The notice of denial will be written in an understandable manner and include the following:
   a. The specific reason(s) for the denial.
   b. Specific reference to the provision, internal rule, guideline or protocol which forms the basis of the denial.
   c. A description of additional information, if any, which would enable a claimant to receive the benefits sought and an explanation of why it is needed.
   d. An explanation of the claim review procedure, including the time limits applicable to such procedures and notice of the claimant's right to bring a civil action pursuant to Section 502(a) of ERISA following an adverse decision on appeal.
5. The claimant may request an appeal at any time during the 180-day period following receipt of the notice of denial of the claim.
6. ReliaStar Life will consider requests for an appeal of a denied claim upon written application of the claimant or his or her duly authorized representative. As part of the appeal, the claimant has the right, upon request and free of charge, to access or obtain copies of all documents, records and other information that is relevant to the claim for benefits. The claimant may, in the course of this appeal, submit to ReliaStar Life written comments, documents, records, and other information relating to the claim. ReliaStar Life will provide a full and fair review that takes into account all comments, documents, records and other information submitted by the claimant without regard to whether such information was submitted or considered in the initial benefit determination. Review of claim denials and final decisions on appeal are the responsibility of ReliaStar Life.
7. ReliaStar Life will provide the claimant with a written decision of the final determination of the claim. This decision will be written in an understandable way, state the specific reason(s) for the decision, and make specific reference to the provision(s) on which the decision is based. This decision will be issued as soon as practicable from the date of appeal, but not longer than 45 days unless an extension is needed. An extension of 45 days will be allowed for making the decision for matters beyond the Plan's control or if additional information is needed from the claimant. The claimant will be given notice if this extension is necessary, stating the reason for the extension, the date a decision is expected, and the additional information needed from the claimant, if any. If the decision on review is not received within these time limits, the claim may be considered denied. If the claimant receives an adverse benefit determination, the claimant will then have the right to bring a civil action pursuant to Section 502(a) of ERISA.
8. ReliaStar Life has final discretionary authority to determine all questions of eligibility and status, to interpret and construe the terms of this policy(ies) of insurance, and to make claim determinations.

SUMMARY PLAN DESCRIPTION

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Office of Participant Assistance, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.