

CHUBB®

ACE Property & Casualty Insurance Company

Home Office Address: 436 Walnut Street • Philadelphia, PA 19106
Policyholder Service Address: P. O. Box 6700, Scranton, PA 18505-0700
Telephone Number: 1-866-445-8874

Group Voluntary Disability Income Insurance Certificate

Group Voluntary Disability insurance provides a benefit in the event of a loss as a result of a covered Disability. The amount You receive is based on the amount You earned before Your Disability began, subject to all Policy provisions.

POLICYHOLDER: Hutto Independent School District
POLICY NUMBER: 100000124
POLICY EFFECTIVE DATE: 09/01/2023
GOVERNING JURISDICTION: TEXAS

ACE Property & Casualty Insurance Company ("the Company," "We," "Us," and "Our") welcomes You as a Certificateholder. This is Your Certificate as long as You are eligible for coverage and You become insured. Your benefits and rights under this Policy will not be less than those stated in this Certificate. We certify that You are insured for the benefits described in this Certificate, subject to the provisions of this Certificate. This Certificate replaces any other Certificate(s) We may have given You under this Policy.

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

THIS CERTIFICATE MAY BE SUBJECT TO A PREMIUM INCREASE OR NON-RENEWAL ON ANY POLICY ANNIVERSARY DATE.

If the terms and provisions of the Certificate (issued to You) are different from this Policy (issued to the Policyholder), this Policy will govern. Your coverage may be canceled or changed under the terms and provisions of this Policy. You may inspect a copy of this 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 under this Policy, all days begin at 12:01 a.m. Standard Time at the Policyholder's address. For purposes of ending dates under this Policy, all days end at 12:00 midnight Standard Time at the Policyholder's address.

This Certificate is signed at our home office by:



Brandon Peene, Secretary



Richard Williams, President

This Policy does not replace or affect the requirements for coverage by any Workers' Compensation or state disability insurance.

TABLE OF CONTENTS

Certificate Sections

Page Number

COVER PAGE	1
TABLE OF CONTENTS	2
BENEFITS SCHEDULE	3
DEFINITIONS	6
ELIGIBILITY AND EFFECTIVE DATE INFORMATION	10
DISABILITY BENEFITS	14
DEDUCTIBLE SOURCES OF INCOME	18
OTHER BENEFITS	20
EXCLUSIONS AND LIMITATIONS	24
GENERAL PROVISIONS	26
CLAIM INFORMATION	29

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO 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 or HMO. If you don't, you may lose your right to appeal.

ACE Property & Casualty Insurance Company

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

Call: 1-866-445-8874

Online: www.chubb.com

Email: ChubbUSCustomerServices@chubb.com

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con

Mail: P. O. Box 6703
Scranton, PA 18505-0703

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

Correo electrónico:

su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

ACE Property & Casualty Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: al 1-866-445-8874

En línea: www.chubb.com

ChubbUSCustomerServices@chubb.com

Dirección postal: P. O. Box 6703
Scranton, PA 18505-0703

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

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

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

Correo electrónico:

ConsumerProtection@tdi.texas.gov

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

BENEFITS SCHEDULE

DISABILITY BENEFITS

NAME OF EMPLOYER: HUTTO INDEPENDENT SCHOOL DISTRICT

POLICY NUMBER: 100000124

PLAN TYPE

This is a Contributory Insurance plan.

ELIGIBLE CLASS(ES)

Class 1: All Employees Actively at Work in the United States with the Employer

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

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: First of the month coincident with or next following the date You begin Actively at Work.

ELIMINATION PERIOD

Option A

0 days for Disability due to an Injury

7 days for Disability due to a Sickness

If because of Your Disability, You are hospital confined as an In-Patient, benefits begin on the first day of In-Patient confinement.

Option B

14 days for Disability due to an Injury

14 days for Disability due to a Sickness

If because of Your Disability, You are hospital confined as an In-Patient, benefits begin on the first day of In-Patient confinement.

Option C

30 days for Disability due to an Injury

30 days for Disability due to a Sickness

If because of Your Disability, You are hospital confined as an In-Patient, benefits begin on the first day of In-Patient confinement.

Option D

90 days for Disability due to an Injury

90 days for Disability due to a Sickness

Option E

180 days for Disability due to an Injury

180 days for Disability due to a Sickness

The Elimination Period begins on the first day of Your Disability.

Benefits for a Payable Claim begin the day after the Elimination Period is completed.

REHIRE

If Your employment ends and You are rehired within 12 months, Your previous work while in an Eligible Class will apply toward the Waiting Period. All other Policy provisions apply.

REGULAR OCCUPATION PERIOD

24 Months

TOTAL BENEFIT CAP

If You are eligible to receive payments under this Policy in addition to Your Monthly Payment, the total benefit payable to You on a monthly basis (including all benefits provided under this 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 this Policy) will not exceed 110% of Your Monthly Earnings.

WHO PAYS FOR THE COVERAGE

You pay the cost of Your coverage.

WAIVER OF PREMIUM

Premium payments are not required for Your coverage following 90 consecutive days of Disability payments, and thereafter while You are receiving Disability payments under the Policy and have satisfied and continue to satisfy the requirements of the WAIVER OF PREMIUM provision.

MONTHLY EARNINGS

For enrollment purposes only, **Monthly Earnings** means Your monthly income, as defined below, in effect on the date You are enrolling for coverage for the first time or at any subsequent annual enrollment period. During enrollment, Your monthly earnings are only used to determine the highest monthly benefit for which You are eligible.

Monthly Earnings means 1/12th of Your annual salary in effect just prior to Your date of disability. It is Your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It includes stipends paid by Your Employer or contracted in writing to be paid by Your Employer, for the contract year during which You became disabled. It will only include stipends paid for participating as a coach or a leader in any school extracurricular activity for which You are paid.

Monthly Earnings does not include income received from car, housing or moving allowances, commissions, bonuses, overtime pay, Employer contributions to a qualified deferred compensation plan, or any other extra compensation, or income received from sources other than Your Employer.

MONTHLY DISABILITY BENEFIT

Option A

45% of Monthly Earnings to a Maximum Benefit of \$10,000 per month.

Option B

55% of Monthly Earnings to a Maximum Benefit of \$10,000 per month.

Option C

65% of Monthly Earnings to a Maximum Benefit of \$10,000 per month.

Your benefit may be reduced by any Deductible Sources of Income and adjusted by any Disability Earnings. Some disabilities may not be covered or may have limited coverage under this Policy.

MAXIMUM PERIOD OF PAYMENT

SOCIAL SECURITY NORMAL RETIREMENT AGE (SSNRA)

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:

<u>Year of Birth</u>	<u>*Social Security Normal Retirement Age</u>
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

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

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:

<u>Your Age When Disability Begins</u>	<u>Maximum Period of Payment</u>
Less than age 60	To Social Security Normal Retirement Age (SSNRA)*
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

DEFINITIONS

Accident or Accidental means a sudden, unexpected event that was not reasonably foreseeable.

Accidental Injury means a bodily Injury that is the direct result of a sudden, unexpected event that was not reasonably foreseeable, independent of disease and not related to any other cause. The Injury must occur, and Disability resulting from the Injury must begin while You are covered under this Policy. Injury that occurs before You are covered under this Policy will be treated as a Sickness.

Actively at Work 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 SCHEDULE.

To be Actively at Work, Your work site must be:

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

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

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

Appropriate Care means that You:

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

Certificateholder means the person who is eligible for benefits provided by the Policyholder's Policy and who has received a Certificate.

Change in Status means a Change in Status as defined in the regulations under Internal Revenue Code Section 125 unless Your Employer's cafeteria policy document or human resources policy contains more restrictive provisions. In that event Your Employer may restrict the situations where You can change Your coverage.

Contribution means the amount the Policyholder may require an Insured Person to pay towards the total Premium that We charge for the insurance provided under this Policy.

Contributory Insurance means insurance for which the Policyholder requires the Insured Person to pay all or a portion of the Premium. The Certificate specifies who pays the cost of the coverage.

Deductible Sources of Income means income from other sources as listed in this 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 income which You receive from working while You are Disabled, plus the earnings You could receive if You were working to Your Maximum Capacity.

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

Eligible Survivor means Your Spouse, if living; otherwise, Your child(ren).

Employee means a person who is Actively at Work with the Employer in the United States.

Employer means the Policyholder and includes any division, subsidiary, or affiliated company named in this Policy.

Enroll means You have completed the process of applying for coverage under this Policy.

Enrollment Form means the application, approved by Us, You complete and submit to Us to apply for coverage under this Policy.

Family and Medical Leave means the Family and Medical Leave Act of 1993 and any amendments ("FMLA"), or any other applicable state (including the District of Columbia), or local paid family and medical leave ("State FML").

Gainful Occupation means an occupation for which You are reasonably qualified based on Your training, education and experience that is or can be expected to provide You with an income within 12 months of Your return to work, that exceeds:

1. 80% of Your Indexed Monthly Earnings, if You are working; or
2. 60% of Your Indexed Monthly Earnings, if You are not working.

Grace Period means the 60 day period following the Premium Due Date during which premium payment for this Policy may be made by the Policyholder.

Gross Monthly Payment means Your benefit before any reduction for Deductible Sources of Income and any adjustment for Disability Earnings.

Hospital Confined means You are confined as an In-Patient in a Hospital, Health Facility or Institution.

Hospital, Health Facility or Institution means an accredited facility licensed according to state and local laws to provide care and treatment for the condition causing Your Disability. The facility must be supervised by one or more Physicians with 24 hour registered graduate nursing staff. The facility may specialize in treating alcoholism, drug addiction, chemical dependency or Mental Illness. A facility specializing in treating alcoholism, drug addiction, chemical dependency or Mental Illness does not include a rest home, convalescent home, and home for the aged or a facility primarily for custodial or educational care.

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 may substitute a comparable measurement if the Department of Labor changes or stops publishing the CPI-U subject to approval by the Commission. Before a substitute index is used, We shall notify You of the substitution. 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, independent of disease and not related to any other cause. The Injury must occur, and Disability resulting from the Injury must begin while You are covered under this Policy. Injury that occurs before You are covered under this Policy will be treated as a Sickness.

In-Patient means an individual who is physically confined for an overnight stay, as a registered bed patient in a Hospital, Health Facility or Institution.

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

Leave of Absence means You are absent and not Actively at Work for a period of time that has been agreed to in advance in Writing by Your Employer. Your normal vacation time or any period of Disability is not considered a Leave of Absence.

Material and Substantial Duties means the important duties, tasks, functions and operations that are normally required for the performance of Your Regular Occupation during the Elimination period, and any occupation reasonably qualified based on Your training, education and experience;

Maximum Benefit means the total Monthly Benefit amount for which You are insured under this Policy subject to all Policy provisions.

Maximum Capacity means, based on Your restrictions and limitations:

1. during the Regular Occupation Period, the greatest extent of work You are able to do in Your Regular Occupation; and
2. beyond the Regular Occupation Period, the greatest extent of work You are able to do in any Gainful Occupation for which You are reasonably fitted by education, training or experience.

Maximum Period of Payment means the longest period of time We will make payments to You for any one period of Disability.

Mental Illness means a psychiatric or psychological condition classified in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), published by the American Psychiatric Association, most current as of the start of a Disability. Such disorders include, but are not limited to, psychotic, emotional or behavioral disorders, or disorders related to stress or to substance abuse or dependency. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of a Disability. If the APA no longer publishes a DSM or the APA ceases to exist, We may substitute a comparable DSM subject to the approval by the Commission.

Monthly Earnings means Your gross monthly income from Your Employer as stated in the BENEFITS SCHEDULE.

Monthly Payment means Your benefit after any Deductible Sources of Income and any 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 this Policy.

Physician means:

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

We will not recognize You or Your family members, including but not limited to, Spouse, domestic partner, child(ren), parents, including in-laws, or siblings, including in-laws, a business or professional partner, or any person who has a financial affiliation or business interest with You as a Physician for a claim that You send to Us.

Policyholder means the Employer to whom this Policy is issued and who sponsored the coverage for its Employees.

Policy Month means the month that begins on the effective date of this Policy. Subsequent Policy months will begin on the same day of each subsequent calendar month.

Premium means the amount the Policyholder will pay to Us for the insurance provided under this Policy.

Pre-existing Condition means a condition for which, within the 3 months just prior to Your effective date of coverage, You have received medical advice or treatment.

Prior Policy means the Policyholder's group Disability Income insurance plan for which You were insured on the day prior to the effective date of this Policy.

Recurrent Disability means a Disability which 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

Regular Occupation Period is the period of time shown in the BENEFITS SCHEDULE that begins after the Elimination Period.

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

Salary Continuation or Accumulated Sick Leave means continued payments to You by Your Employer of all or part of Your Monthly Earnings, after You become Disabled as defined by this Policy. This continued payment must be part of an established plan maintained by Your Employer, and includes Salary Continuation or Accumulated Sick Leave.

Self-Reported Symptoms means the manifestations of Your condition which You tell Your Physician, that are not verifiable using tests, procedures or clinical examinations standardly accepted in the practice of medicine. Examples of self-reported symptoms include, but are not limited to headaches, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness and loss of energy.

Sickness means illness, disease or complications from pregnancy. If disabilities caused by pregnancy are covered under this Policy, then benefits for a pregnancy will be paid on the same basis as for a Sickness.

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

Temporary Layoff means You are absent and not Actively at Work for a period of time that has been agreed to in advance in Writing by Your Employer.

Your normal vacation time or any period of Disability is not considered a Temporary Layoff.

Third Party means any person or entity whose act or omission, in full or in part, caused You to suffer a Disability for which benefits are paid or payable under this Policy. Third Party also includes Your homeowner's, automobile or other insurance company if they make payments to You because of the acts or omissions of another person or entity.

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 this Policy.

Waiting Period means the continuous period of time (shown in the BENEFITS SCHEDULE) that You must be Actively at Work in an Eligible Class before You are eligible for coverage under this Policy.

We, Us, Our and **Company** means ACE Property and Casualty Insurance Company.

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

You and **Your** means an Employee who is eligible for coverage under this Policy.

ELIGIBILITY AND EFFECTIVE DATE INFORMATION

ELIGIBILITY DATE

If You are working for Your Employer in an Eligible Class, the date You are eligible for coverage is the later of:

1. the Policy Effective Date; or
2. the day You complete Your Waiting Period.

WHEN COVERAGE BEGINS

You will be covered at 12:01 a.m. on the first of the month coincident with or next following the date You are eligible for coverage, if You apply for insurance on or before that date.

If You first become eligible for coverage after the Policy Effective Date, You will be covered at 12:01 a.m. on the first of the month coincident with or next following the later of:

1. the date You are eligible for coverage, if You Enroll for insurance on or before that date; or
2. the date You Enroll for insurance, if You Enroll within 60 days after your eligibility date.

In order for Your coverage to begin, You must be Actively at Work. If You are not Actively at Work on the day Your coverage would otherwise be effective, Your coverage will begin on the date You are next Actively at Work. Your coverage is subject to payment of full Premium when due.

LATE APPLICANT ENROLLMENT REQUIREMENTS - IF YOU ENROLL FOR COVERAGE MORE THAN 60 DAYS AFTER YOUR ELIGIBILITY DATE

You can Enroll for coverage during an annual Enrollment period or within 60 days of a Change in Status. The Pre-Existing Condition Limitation will apply.

We and Your Employer will determine when the annual Enrollment period begins and ends. Coverage Enrolled for during the annual Enrollment period will begin at 12:01 a.m. on the first day of the month coincident with or next following the first day of the next Policy year.

If You Enroll for coverage due to a Change in Status, coverage will begin on the latest of:

1. the first of the month coincident with or next following the date of the Change in Status, if You Enroll on or before that date; or
2. the first of the month coincident with or next following the date You Enroll, if You Enroll within 60 days after the date of the Change in Status.

Changes in coverage must be appropriate and consistent with the Change in Status.

CHANGING YOUR COVERAGE (FOR CONTRIBUTORY INSURANCE PLANS)

You can change Your coverage during an annual Enrollment period or within 60 days of a Change in Status. During an annual Enrollment period, You may choose to:

1. increase Your coverage up to the Maximum Benefit available under the Policy;
2. decrease Your coverage, provided it is not to an amount less than what is available on the Policy;
3. keep Your coverage at the same benefit percentage; or
4. cancel Your coverage.

If this Policy provides additional coverage options for You to select from, You can also change Your coverage by applying for a different option. Refer to the BENEFITS SCHEDULE section and the DISABILITY BENEFITS section for the additional coverage options, if any.

In addition, at any time during the Policy year, You may:

1. cancel Your coverage; or
2. decrease Your coverage, provided it is not to an amount less than what is available on the Policy.

The Pre-Existing Condition Limitation will apply.

WHEN CHANGES TO COVERAGE BECOME EFFECTIVE

A change in coverage that is made during an annual Enrollment period will begin at 12:01 a.m. on the first of the month coincident with or next following the first day of the next Policy year.

Your coverage will end or be decreased on the later of:

1. the date You provide Written notice to Your Employer; or
2. the end of the period for which You paid Premiums, if You stop making a required Premium Contribution.

We will provide coverage for a Payable Claim which occurs while You are covered under the Policy. Any decrease in coverage will not affect a Payable Claim that occurs prior to the decrease.

If You are not Actively at Work on the day any increased or additional coverage would otherwise begin, Your increased or additional coverage will begin on the first of the month coincident with or next following the day You are next Actively at Work.

A change in coverage due to a Change in Status will begin on the latest of:

1. the first of the month coincident with or next following the date of the Change in Status, if You Enroll on or before that date; or
2. the first of the month coincident with or next following the date You Enroll, if You Enroll within 60 days after the date of the Change in Status.

Changes in coverage must be appropriate and consistent with the Change in Status.

IF YOU HAVE A DISABILITY DUE TO A PRE-EXISTING CONDITION AFTER YOUR EMPLOYER REPLACES INSURANCE COVERAGE WITH THIS POLICY (CONTINUITY OF COVERAGE)

In order for this provision to apply, the Prior Policy's coverage must be similar to this Policy.

We may send a payment if Your Disability is caused by, contributed to by, or results from a Pre-existing Condition if:

1. You were covered under the Prior Policy at the time Your Employer changed insurance carriers to this Policy; and
2. You have been continuously covered under this Policy from the effective date of this Policy through the date Your Disability began.

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

1. this Policy; or
2. the Prior Policy, if benefits would have been paid had that policy remained in force.

If You satisfy the PRE-EXISTING CONDITION LIMITATION provision of this Policy, We will determine Your payments according to this Policy's provisions.

If You do not satisfy the PRE-EXISTING CONDITION LIMITATION provision of this Policy, but you do satisfy the Prior Policy's Pre- Existing Condition provision:

1. Your Monthly Payment will be the lesser of:
 - a. the Monthly Payment that would have been payable under the terms of the Prior Policy if it had remained in force; or
 - b. the Monthly Payment under this Policy; and
2. Benefits will end on the earlier of:
 - a. the date benefits end under this Policy, as described under the DURATION OF PAYMENTS provision; or
 - b. the date benefits would have ended under the Prior Policy if it had remained in force.

If You do not satisfy either this 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 this Policy will apply.

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

If You are on a Leave of Absence, and if all Premium is paid when due, Your coverage may be continued beyond the date You are no longer Actively at Work, limited to the time periods described below.

If You are on a Leave of Absence as described under the Family and Medical Leave Act of 1993 (“FMLA”) or applicable state family and medical leave law (“State FML”), and Your Employer’s Human Resource policy provides for continuation of Disability coverage during an FMLA or State FML Leave of Absence, Your coverage will be continued until the end of the later of:

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

If You are on a Leave of Absence other than an FMLA or State FML Leave of Absence, and if all Premium is paid when due, You may be covered through the end of the school year in which You are no longer Actively at Work. If You are a contracted Employee on a Leave of Absence other than an FMLA or State FML Leave of Absence, and if all Premium is paid when due, You may be covered through the end of the school contract year in which You are no longer Actively at Work.

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), Your coverage may be continued until the end of the later of:

1. the length of time the coverage may be continued under the Certificate for an FMLA or State FML Leave of Absence; or
2. the length of time the coverage may be continued under the Certificate 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 Actively at Work, We will consider such leaves to be concurrent for the purpose of determining how long Your coverage may continue under this Policy.

If Your coverage is not continued during an FMLA or State FML Leave of Absence, and You are Actively at Work 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 apply a new Pre-Existing Condition Limitation.

If Your coverage is not continued during a Leave of Absence for active military service, and You are Actively at Work, Your coverage shall be reinstated in accordance with USERRA.

Once You are Actively at Work with the Employer in an Eligible Class Your insurance will continue under this Policy. In no event will Your coverage under this Policy be continued beyond the date Your coverage would otherwise end according to the terms of the WHEN YOUR COVERAGE ENDS provision.

IF YOU ARE NOT ACTIVELY AT WORK DUE TO A TEMPORARY LAYOFF

If You are not Actively at Work due to a Temporary Layoff, and if all Premium is paid when due, You may be covered through the end of the school year in which You are no longer Actively at Work. If You are a contracted Employee not Actively at Work due to a Temporary Layoff, and if all Premium is paid when due, You may be covered through the end of the school contract year in which You are no longer Actively at Work. Once You are Actively at Work with the Employer in an Eligible Class Your insurance will continue under this Policy. In no event will Your coverage under this Policy be continued beyond the date Your coverage would otherwise end according to the terms of the WHEN YOUR COVERAGE ENDS provision.

IF YOU ARE NOT ACTIVELY AT WORK DUE TO A SABBATICAL LEAVE OF ABSENCE

If You are not Actively at Work due to a sabbatical Leave of Absence, and if all Premium is paid when due, You may be covered through the end of the school year in which You are no longer Actively at Work. If You are a contracted Employee not Actively at Work due to a sabbatical Leave of Absence, and if all Premium is paid when due, You may be covered through the end of the school contract year in which You are no longer Actively at Work. Once You are Actively at Work with the Employer in an Eligible Class Your insurance will continue under this Policy. In no event will Your coverage under this Policy be continued beyond the date Your coverage would otherwise end according to the terms of the WHEN YOUR COVERAGE ENDS provision.

WHEN YOUR COVERAGE ENDS

Your coverage under this Policy ends on the earliest of:

1. the date this Policy is cancelled;
2. the date You are no longer in an Eligible Class;
3. the date Your Eligible Class is no longer covered;
4. the end of the period for which You paid Premiums, if You stop making a required Premium Contribution;
5. the end of this Policyholder's Grace Period if the Policyholder does not remit Premium to Us by the end of such period; or
6. the later of:
 - a. the last day You are Actively at Work; or
 - b. if applicable, the last day of Your contract with Your Employer but not beyond the end of Your Employer's current school contract year.

Termination of this Policy during a Disability will not affect a Payable Claim under this Certificate.

DISABILITY BENEFITS

DEFINITION OF DISABILITY AND DISABLED

You are considered Disabled when We review Your claim and determine that, due to Your Sickness or Injury:

1. You are unable to perform all the Material and Substantial duties of Your Regular Occupation;
2. You have a 20% or more loss in Your Indexed Monthly Earnings; and
3. during the Elimination Period, You are unable to perform any of the Material and Substantial duties of Your Regular Occupation, and You are not Actively at Work.

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.

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

ELIMINATION PERIOD

You must be continuously Disabled through Your Elimination Period. Your Elimination Period is as stated in the BENEFITS SCHEDULE and is the period of continuous Disability You must satisfy before You are eligible to receive benefits under this Policy.

Option A

If Your Disability stops during the Elimination Period, We will not consider Your Disability to be continuous.

Option B

If Your Disability stops during the Elimination Period, We will not consider Your Disability to be continuous.

Option C

If Your Disability stops during the Elimination Period, We will not consider Your Disability to be continuous.

Option D

For an Elimination Period more than 90 days, We will consider Your Disability as continuous if Your Disability stops during the Elimination Period for 30 days or less. The days that You are not Disabled will not count toward Your Elimination Period. The Elimination Period begins on the first day of Your Disability.

Option E

For an Elimination Period more than 180 days, We will consider Your Disability as continuous if Your Disability stops during the Elimination Period for 30 days or less. The days that You are not Disabled will not count toward Your Elimination Period. The Elimination Period begins on the first day of Your Disability.

AMOUNT OF PAYMENT

Option A

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 45%.
2. The Maximum Benefit is \$10,000 per month.
3. Compare the answer from Item 1 with the Maximum Benefit. 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 Item 4 is Your Monthly Payment.

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

During the first 12 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 this Policy by the excess amount, unless participating in a Vocational Rehabilitation Plan.

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 45%.
2. The Maximum Benefit is \$10,000 per month.
3. Compare the answer from Item 1 with the Maximum Benefit. 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 Item 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, except any income from any form of employment.

If the answer in Item 4 above is greater than 100% of Your Indexed Monthly Earnings, We will follow this process to figure Your Monthly Payment:

1. Add Your Disability Earnings to Your Gross Monthly Payment .
2. From the answer in Item a, subtract Your Indexed Monthly Earnings. If the result is zero or less, record Your answer as zero.
3. From Your Gross Monthly Payment , subtract the answer in Item b and any Deductible Sources of Income.

The amount figured in Item 3. is Your Monthly Payment.

Option B

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 55%.
2. The Maximum Benefit is \$10,000 per month.
3. Compare the answer from Item 1 with the Maximum Benefit. 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 Item 4 is Your Monthly Payment.

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

During the first 12 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 this Policy by the excess amount, unless participating in a Vocational Rehabilitation Plan.

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 55%.
2. The Maximum Benefit is \$10,000 per month.
3. Compare the answer from Item 1 with the Maximum Benefit. 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 Item 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, except any income from any form of employment.

If the answer in Item 4 above is greater than 100% of Your Indexed Monthly Earnings, We will follow this process to figure Your Monthly Payment:

1. Add Your Disability Earnings to Your Gross Monthly Payment .
2. From the answer in Item a, subtract Your Indexed Monthly Earnings. If the result is zero or less, record Your answer as zero.
3. From Your Gross Monthly Payment , subtract the answer in Item b and any Deductible Sources of Income.

The amount figured in Item 3. is Your Monthly Payment.

Option C

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 65%.
2. The Maximum Benefit is \$10,000 per month.
3. Compare the answer from Item 1 with the Maximum Benefit. 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 Item 4 is Your Monthly Payment.

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

During the first 12 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 this Policy by the excess amount, unless participating in a Vocational Rehabilitation Plan.

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 65%.
2. The Maximum Benefit is \$10,000 per month.
3. Compare the answer from Item 1 with the Maximum Benefit. 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 Item 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, except any income from any form of employment.

If the answer in Item 4 above is greater than 100% of Your Indexed Monthly Earnings, We will follow this process to figure Your Monthly Payment:

1. Add Your Disability Earnings to Your Gross Monthly Payment .
2. From the answer in Item a, subtract Your Indexed Monthly Earnings. If the result is zero or less, record Your answer as zero.
3. From Your Gross Monthly Payment , subtract the answer in Item b and any Deductible Sources of Income.

The amount figured in Item 3. is Your Monthly Payment.

Options A, B and C

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 at least quarterly. 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.

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 Disability.

MINIMUM PAYMENT

The minimum payment each month for a Payable Claim is the greater of:

1. \$100; or
2. 10% of Your Gross Monthly Payment .

We may apply this amount to recover an outstanding overpayment.

WE WILL NEVER PAY MORE THAN 100% OF MONTHLY EARNINGS

If You are eligible to receive benefits under this Policy in addition to the Monthly Payment, the total benefit payable to You on a monthly basis (including all benefits provided under this 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 this Policy) will not exceed 110% of Your Monthly Earnings.

DEDUCTIBLE SOURCES OF INCOME

DEDUCTIBLE SOURCES OF INCOME

With the exception of retirement payments, amounts earned or received from any form of employment and amounts received from any unemployment compensation law, We will only subtract Deductible Sources of Income which are payable as a result of the same Disability.

The following are Deductible Sources of Income:

1. The amount You receive from Your Employer's sabbatical leave plan, or similar leave of absence plan, less the cost of paying a substitute teacher if You are required to do so;
2. The amount You receive from Your Employer's assault leave plan, or similar leave of absence plan, as a result of Your being physically assaulted while acting in Your official capacity;
3. The amount You receive from an extended sick leave plan as described in Louisiana Revised Statutes 17:1202, 17:500.2 or any other act or law with similar intent;

After 3 Monthly Benefit payments the following benefits that You or Your Dependents receive will be considered Deductible Sources of Income:

4. the amount that You receive, or are eligible to receive, as Disability income payments under any:
 - a. federal, state or local (including the District of Columbia) compulsory benefit act or law;
 - b. governmental retirement system as a result of Your job with Your Employer; or
 - c. other group insurance policy with the Employer;
5. the amount You receive as Disability income payments under any "no fault" motor vehicle plan;
6. the amount You receive as a result of any action brought under Title 46, United States Code Section 688 (the Jones Act);
7. the amount You receive for lost income from a Third Party (after subtracting attorney's fees) by award, judgment, settlement or otherwise;
8. the amount You receive under any Accumulated Sick Leave plan;
9. the amount that You:
 - a. receive as Disability payments under Your Employer's Retirement Plan;
 - b. voluntarily elect to receive as retirement payments under Your Employer's Retirement Plan; or
 - c. 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 Employee Contributions to be distributed simultaneously throughout Your lifetime.

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

9. the amount that You, Your Spouse, or Your child(ren) receive, or are eligible to receive, as Disability payments because of Your Disability under:
 - a. the United States Social Security Act;
 - b. the Canada Pension Plan;
 - c. the Quebec Pension Plan; or
 - d. any similar Plan or Act.

10. the amount that You receive as retirement payments or the amount Your Spouse or Your child(ren) receive as retirement payments because You are receiving retirement payments under:
 - a. the United States Social Security Act;
 - b. the Canada Pension Plan;
 - c. the Quebec Pension Plan; or
 - d. any similar Plan or Act.

We will not reduce Your payment by Your Social Security retirement income if Your Disability begins after age 65 and You were already receiving Social Security retirement payments.

11. the amount You receive as retirement payments, other than disability retirement payments, under any governmental retirement system; or
12. the amount that You receive, or are eligible to receive, under:
 - a. a workers' compensation law;
 - b. an occupational disease law; or
 - c. any other act or law with similar intent.

IF YOU RECEIVE A COST OF LIVING INCREASE FROM DEDUCTIBLE SOURCES OF INCOME

Other than for increases in any income You earn from any form of employment, once We have subtracted any Deductible Source of Income from Your Gross Monthly Payment, We will not further reduce Your payment due to a cost of living increase from that source.

WHEN YOU QUALIFY FOR DEDUCTIBLE SOURCES OF INCOME

After 3 Monthly Benefit payments, when We determine that You may qualify for benefits under items 4, 5 and 10 in the DEDUCTIBLE SOURCES OF INCOME provision, We will estimate Your entitlement to these benefits. We can reduce Your benefit under this Policy by the estimated amounts if such benefits have:

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

Your Gross Monthly Payment will NOT be reduced by the estimated amount if You:

1. apply for the Disability payments under items 4, 5 and 10 in the DEDUCTIBLE SOURCES OF INCOME provision and appeal Your denial to all administrative levels We determine are necessary; and
2. sign Our form. This form states that You promise to pay Us any overpayment caused by an award and We shall be entitled to impose a constructive trust on any such award.

If Your Gross Monthly Payment has been reduced by an estimated amount, Your Gross Monthly Payment will be adjusted when We receive proof:

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

If You receive a lump sum payment from any Deductible Source of Income, the lump sum will be pro-rated on a 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:

1. 401(k) plans;
2. Salary Continuation;
3. profit sharing plans;
4. thrift plans;
5. tax-sheltered annuities;
6. stock ownership plans;
7. credit disability insurance;
8. non-qualified plans of deferred compensation;
9. pension plans for partners;

10. military pension plans;
11. franchise disability income plans;
12. individual disability plans paid for by the Insured Person;
13. a Retirement Plan from another employer; and
14. individual retirement accounts (IRA).

OTHER BENEFITS

CHILD/FAMILY MEMBER CARE EXPENSE BENEFIT

If You are Disabled and receiving Monthly Payments, and You are participating in a Vocational Rehabilitation Plan, You will be eligible for an additional Child/Family Member Care Expense Benefit if You are incurring expenses to provide care for a child under age 15 or family member who requires Personal Care Assistance.

We will pay a Child/Family Member Care Expense Benefit of \$350 per child or family member not to exceed a maximum of \$1,000 per month.

The Child/Family Member Care Expense Benefit will end on the earliest of the following dates:

1. the date You are no longer incurring child or family member care expenses;
2. the date You are no longer participating in a Vocational Rehabilitation Plan; or
3. any other date on which Monthly Payments would stop in accordance with this Policy.

To receive this benefit, You must provide satisfactory proof of enrollment that You are incurring a child or family member care expense. Child/Family member care expenses must be documented by a caregiver receipt which includes his or her taxpayer identification information.

For the purpose of this benefit, the following additional definitions will apply:

Child means Your biological children, adopted children, stepchildren, unmarried grandchildren, and any other children required to be covered under the civil union, domestic partnership, marriage, or other family or domestic relations law of the Governing Jurisdiction. A child is considered adopted from the date You enter a suit seeking adoption of a child.

Family Member means an individual who can be claimed as a dependent by You for federal income tax purposes.

Personal Care Assistance means care or supervision of Your Child or Family Member; provided by a licensed child or adult-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.

EMPLOYEE SERVICES MEMBERSHIP BENEFIT

We will provide a membership to You and any of Your Eligible Dependents in a health care referral, consultation, and employee advocacy service through a vendor.

Your access to this membership is included with Your insurance and does not require enrollment or premium payment. You should contact the Policyholder for more information on the services available on their plan.

Membership in health care referral, consultation, and advocacy services includes, but is not limited to, an Insured's to access the following services:

1. Employee Assistance
2. Travel Assistance

Additional services may be available with this membership. For specific details, You may contact the health care referral, consultation, and advocacy service vendors directly.

You can obtain a description and contact information for noninsurance benefits and services by visiting <https://www.chubb.com/content/chubb-sites/chubb-com/na/cica-cwb/compsych.html>.

The services provided under this benefit are offered by third party vendors and are only intended to provide assistance, referral, consultation, and advocacy services. While We have arranged these benefits and services, the third party providers are liable to You for the provision of such benefit and services. No medical advice or treatment are being offered or provided by Us, nor are We endorsing the quality of any Physician or other health care provider selected through these services. You are not required to use these services to receive benefits under the Policy.

This membership benefit, will terminate at the earliest of the following:

1. the date the Policy terminates;
2. the date You are no longer in an Eligible Class;
3. forty-five (45) days after written notice of termination by Us has been sent to You at Your last known address;
or
4. the date You provide Written notification requesting termination.

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.

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 this Policy as Your prior claim. Your Disability will be treated as a new claim if Your current Disability:

1. Is unrelated to Your prior Disability; or
2. After Your prior Disability ended, You returned to work for Your Employer for more than 6 months.

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

If this Policy terminates and You become eligible for coverage under any other group Disability plan that replaces this Policy, You will not be eligible for coverage under this 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:

1. Your Disability had continued for 180 or more consecutive days; and
2. You were receiving or were eligible to receive payments under this Policy.

If You have no Eligible Survivors, payment will be made to Your estate.

However, We will first apply the Survivor Benefit to recover any over payment that may exist on Your claim.

The DEDUCTIBLE SOURCES OF INCOME provision will not be considered in calculating this benefit.

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 participation in a Vocational Rehabilitation Plan is voluntary, if You elect not to participate it will not affect Our determination of whether You are Disabled under this Policy. 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 at Our sole discretion, but is not limited to, the following services:

1. coordination with Your Employer to assist You to return to work;
2. evaluation of adaptive equipment and medical devices as prescribed by Your Physician, or job accommodations to allow You to work;
3. evaluation of possible workplace modifications which might allow You to return to work in Your Regular Occupation or another job or occupation;
4. vocational evaluation to determine how Your Disability may impact Your employment options;

5. job placement services, including resume preparation services and training in job-seeking skills; and
6. alternative treatment plans such as recommendations for support groups, physical therapy, occupational therapy, or other treatment designed to enhance Your ability to work.

We will not pay this benefit for hearing aids; dental aids, including false teeth; eye glasses; contact lenses; cosmetic prosthesis such as hair wigs; or joint replacement such as an artificial hip or knee.

VOCATIONAL REHABILITATION BENEFIT

If You are receiving Monthly Payments under this 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.

WHEN VOCATIONAL REHABILITATION BENEFITS END

Vocational Rehabilitation Benefits will end on the earliest of the following dates:

1. the date We determine that You are no longer eligible to participate in a Vocational Rehabilitation Plan;
2. the date You are no longer participating in a Vocational Rehabilitation Plan; or
3. any other date on which Monthly Payments would stop in accordance with this Policy.

WORKPLACE MODIFICATION BENEFIT

If You are Disabled and are receiving a payment from Us, an additional Workplace Modification Benefit may be payable to Your Employer for Your benefit. We will assist the Employer, You and Your Physician in identifying an appropriate workplace modification. We may reimburse Your Employer for up to 100% of there as on able 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 may pay will not exceed the lesser of:

1. two times Your last Monthly Payment; or
2. \$1,000.

To qualify for this reimbursement, You must:

1. be Disabled according to the terms of this Policy; and
2. have the reasonable expectation of returning to and remaining Actively at Work 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:

1. input and approval from the Employer, You and Your Physician;
2. the purpose of the proposed workplace modification;
3. the expected completion date of the workplace modification; and
4. the cost of the workplace modification.

The Written proposal must be signed by Us, the Employer and You. We will reimburse the costs of the workplace modification when We:

1. approve the proposal in Writing;
2. receive proof from Your Employer that the workplace modification is complete; and
3. receive proof of the costs incurred by Your Employer for the workplace modification.

This benefit is available on a one time basis.

WAIVER OF PREMIUM

Your Disability insurance premium will be waived if You qualify as described below.

You must be Disabled through Your Elimination Period. Your Elimination Period is as stated in the BENEFITS SCHEDULE and is the period of continuous Disability You must satisfy.

The Policyholder may continue premium payments until We notify the Policyholder of the date Your Disability insurance premium waiver begins. For insurance to continue under the group Policy, full Premium when due is required.

Your Waiver of Premium will begin when We approve Your claim, if the Elimination Period has ended, and You meet the following conditions:

1. You remain Disabled during the Elimination Period;
2. You meet the notice and proof of claim requirements for Disability, as described in the CLAIM INFORMATION section of this Certificate, while Your Disability insurance is in effect;
3. Your claim is approved by Us; and
4. all required Premiums have been paid until We have approved the Waiver of Premium.

We will send You Written notice advising whether You are approved for the Waiver of Premium and, if approved, the amount of Premium being waived. If We approve Your claim, We will not require further premium payments for You while You remain Disabled according to the terms and provisions of this Policy. Your Disability insurance amount will not increase while Your Disability insurance premiums are being waived. Premiums waived under this provision will not be deducted from any benefits paid under this Policy.

If You die and You are entitled to any refund of Premiums that You have paid, when We receive proof that You have died, We will refund any Premiums as follows:

1. if You are insured for Group Term Life Insurance with Us, We will pay the beneficiary You designated; or
2. if You are not insured for Group Term Life Insurance with Us, We will pay Your Eligible Survivors. If You have no Eligible Survivors, payment will be made to Your estate.

WHEN YOUR WAIVER OF PREMIUM ENDS

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

1. the date You are no longer Disabled;
2. the date You fail to submit proof of continuing Disability;
3. the end of the Maximum Period of Payment shown in the BENEFITS SCHEDULE;
4. the date Premium has been waived for 12 months and You are considered to reside outside the United States or, U.S. territories. You will be considered to reside outside these countries when You have been outside the United States or, U.S. territories for a total period of 6 months or more during any 12 consecutive months for which Premium has been waived; or
5. the date You die.

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

EXCLUSIONS AND LIMITATIONS

DISABILITIES NOT COVERED UNDER THIS POLICY

The Policy does not cover any Disability caused or contributed to by, or resulting from Your:

1. commission or attempt to commit a felony;
2. intentionally self-inflicted harm;
3. participation in a war, declared or undeclared, or any act of war; an act of war is military activity by one or more national governments and does not include terrorist acts, other random acts of violence not perpetrated by You, or civil war or community faction;
4. active participation in a riot, insurrection or terrorist activity; and
5. Occupational Sickness or Injury for the first 90 days.

We will not pay a benefit for any period of Disability during which You are legally incarcerated in a penal or correctional institution.

PRE-EXISTING CONDITION LIMITATION

Benefits will not be paid if Your Disability begins in the first 12 months following the effective date of Your coverage and Your Disability is caused by, contributed to by, or the result of a Pre-existing Condition.

In addition, this Policy will not cover an increase in Your coverage made during an annual Enrollment period if You have a Pre-existing Condition. An increase in coverage includes, if applicable to the Policy, applying for additional benefit units, selecting a greater Maximum Period of Payment and/or a shorter Elimination Period. Benefits due to an increase in coverage will not be paid if Your Disability begins in the first 12 months following the effective date of Your coverage and Your Disability is caused by, contributed to by, or the result of a Pre-existing Condition.

However, if during an annual Enrollment period, You increase Your Monthly Benefit to the maximum amount for which You are then eligible, and if Your Monthly Benefit in effect just prior to this annual Enrollment period was the maximum amount for which You were eligible on the date You last enrolled under Our plan, then the Pre-existing Condition will not apply to the increase in Your Monthly Benefit.

PRE-EXISTING CONDITION LIMITED BENEFIT

A limited benefit will be paid if Your Disability begins in the first 12 months following the effective date of Your coverage; and Your Disability is caused by, contributed to by, or the result of a Pre-existing Condition.

The monthly amount payable under this provision will be Your Monthly Payment as calculated in the AMOUNT OF PAYMENT section.

Benefits under this provision are payable for no more than 90 days during any one period of Disability. In no event will benefits be paid beyond the Maximum Period of Payment.

MENTAL ILLNESS, ALCOHOLISM OR DRUG ABUSE AND SELF-REPORTED SYMPTOMS

Subject to the applicable law in the state where this Policy is delivered or issued for delivery, the lifetime cumulative Maximum Period of Payment for all disabilities due to Mental Illness, Alcoholism or Drug Abuse, and Self-Reported Symptoms is 24 months. Only 24 months of benefits will be paid, even if the disabilities are not:

1. continuous; and/or
2. related.

We will continue to send You payments beyond the 24 month period if You meet one or both of these conditions:

1. If You are confined to a Hospital, Health Facility or Institution at the end of the 24 month period, We will continue to send You payment(s) during Your confinement.

If You are still Disabled when You are discharged, We will send You payment(s) for a recovery period of up to 90 days.

If You become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, We will send payment(s) during that additional confinement and for one additional recovery period up to 90 more days.

2. In addition to Item 1, if You continue to be Disabled after the 24 month period, and subsequently become confined to a Hospital, Health Facility or Institution for at least 14 days in a row, We will send payment(s) during the length of the reconfinement.

We will not make payments beyond the limited pay period as indicated above, or the Maximum Period of Payment, whichever occurs first.

We will not apply the Mental Illness Limitation to a Disability due to dementia if it is a result of:

1. stroke;
2. trauma;
3. viral infection; or
4. alzheimer's disease.

GENERAL PROVISIONS

AGENCY

For purposes of this Policy, the Policyholder acts on its own behalf or as Your agent. Under no circumstances will the Policyholder be deemed Our agent.

AUTHORITY

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

CERTIFICATE

This Certificate is a Written statement prepared by Us and may include attachments. It tells You:

1. the coverage to which You may be entitled;
2. to whom We will make a payment; and
3. the limitations, exclusions and requirements that apply within this Policy.

CHANGES TO YOUR COVERAGE

The terms and provisions of the Certificate, or any amendments or endorsements issued under it, may be changed at any time without the consent of the Insured Person or anyone else with a beneficial interest in this Certificate. We will issue amendments or endorsements to effect such changes, and only those forms signed by an officer of the Company will be valid. Any amendment or endorsement added to this Certificate after the date of issue that eliminates or reduces benefits or rights under this Certificate shall require signed acceptance by the Policyholder. We will provide a copy of the amendment or endorsement to the Policyholder for the Employees if the change affects this Certificate.

CLERICAL ERROR

Clerical error or omission by Us or the Policyholder will not:

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

If We or the Policyholder make a clerical error in keeping data that is required to compute Premiums and administer the terms of this Policy, We will:

1. use the facts to decide whether You have coverage under this Policy and in what amounts; and
2. make a fair adjustment of the Premium.

ENTIRE CONTRACT

The insurance for Insured Persons is provided under a contract of group Disability Income insurance with the Policyholder, and the Entire Contract with the Policyholder consists of:

1. all Policy provisions and any amendments and endorsements to this Policy;
2. the Certificate and any amendments and endorsements to the Certificate;
3. the Policyholder's signed application; and
4. for Contributory Insurance, the Insured Persons' signed Enrollment Forms.

EXTENSION OF BENEFITS

If a Disability for which Monthly Benefits are payable begins while Your coverage under this Policy is in force, benefits will be payable after discontinuation or termination of Your coverage to the same extent as if the coverage had not discontinued or terminated.

INCONTESTABILITY

Except for non-payment of premium, the validity of the Policy cannot be contested after such insurance has been in effect for a period of 2 years.

In the absence of fraud, a statement made by You relating to Your insurability may not be used in contesting the validity of the insurance:

1. after the insurance has been in force before the contest for two years during Your lifetime; and
2. unless the statement is contained in a written instrument signed by You.

This provision shall not preclude the assertion at any time of a defense to a claim based upon Your eligibility for insurance.

STATEMENTS

In the absence of fraud, all statements made by the Policyholder or You under the Policy will be deemed representations and not warranties. No statement made to affect this insurance will be used in any contest unless it is in writing and a copy of it is given to You, or Your beneficiary or personal representative.

LEGAL ACTION

You can start legal action regarding Your claim 60 days after proof of claim has been given to Us, and before the applicable statute of limitations has expired but not after 3 years from the date of proof of claim is required.

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.

PHYSICAL EXAMINATION

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

RIGHT TO REIMBURSEMENT

We have the right to recover any overpayments due to:

1. fraud;
2. any administrative error We make in processing a claim; or
3. Your receipt of Deductible Sources of Income.

You must reimburse Us in full. If We find that We should have paid a benefit amount different from the amount actually paid, We will adjust the benefit accordingly. If We underpaid Your benefit, then We will adjust the benefit to make up the underpayment. If We overpaid Your benefit, You shall reimburse Us. Any future benefits that are determined to be due, including any applicable minimum benefit, will be applied to the overpayment until We are reimbursed in full. If future benefits are not due, We will determine the method by which the repayment is to be made.

You shall not act or fail to act in any manner that will prejudice Our right to reimbursement without Our prior Written agreement. If You prejudice Our right to reimbursement, fail to cooperate with Us or fail to comply with this provision, We may withhold any and all benefits in addition to pursuing all remedies available to Us under applicable law.

RIGHT TO SUBROGATION

If Group Disability Income Benefits are paid or payable to You under this certificate as the result of any act or omission of a third party, We will be subrogated to all rights of recovery You may have in respect to any act or omission. You must execute and deliver to Us any instruments and papers as required and do whatever else is reasonably needed to secure Our rights. You must avoid doing anything to prejudice Our rights of subrogation.

If You notify Us before filing suit or settling Your claim against a third party, the amount We are subrogated will be reduced by a pro rata share of Your costs of recovery. If suit or action is filed, We may record a notice of Group Disability Income Benefit payments and Our notice will constitute a lien on any judgment recovered.

If You were not represented by an attorney in the recovery, the amount We may recover is equal to the lesser of:

1. one half of Your gross recovery from any third-party or
2. the total cost of benefits paid, provided or assumed by Us as a direct result of the tortious conduct of the third party.

We shall pay to an attorney representing You, a fee in an amount determined under an agreement entered into between the attorney and Us, plus a pro rata share of expenses incurred in connection with the recovery. In the absence of such agreement, the court shall award to the attorney, payable out of Our share of the total gross recovery, a reasonable fee for recovery of Our share, not to exceed one-third of Our recovery.

If You were represented by an attorney in the recovery, the amount We may recover is equal to the lesser of:

1. one-half of Your gross recovery less attorney's fees and procurement costs; or
2. the total cost of benefits paid, provided, or assumed by Us as a direct result of the tortious conduct of the third party, less attorney's fees and procurement costs.

The court shall award and apportion between Your and Our attorneys, a fee payable out of Our subrogation recovery. In apportioning the award, the court shall consider the benefit accruing to Us as a result of each attorney's service. The total attorney's fees may not exceed one-third of Our recovery.

If You or Your legal representatives fail to bring suit or action promptly against a third party, We may institute suit or action in Our name or in Your name. We are entitled to recover the amount of Group Disability Income Benefits paid or to be paid to You or on Your behalf, together with Our costs of recovery. In no event will We seek recovery against any first party insurance payments You receive, or are eligible to receive, and We will not seek attorney's fees We incur as a result of Our suit or action. The remainder of this recovery, if any, will be paid to You or as the court may direct.

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.

CLAIM INFORMATION

NOTICE OF CLAIM

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

CLAIM FORMS

The claim form is available from the Policyholder, or You can request a claim form from Us.

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

FILING A CLAIM

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

PROOF OF YOUR CLAIM

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

1. that You are under the Appropriate Care of a Physician;
2. the date Your Disability began;
3. the cause of Your Disability;
4. the appropriate documentation of Your earnings and Your activities;
5. the extent of Your Disability, including restrictions and limitations preventing You from performing Your Regular Occupation;
6. the name and address of any Hospital, Health Facility or Institution where You received treatment, including all attending Physicians; and
7. documentation of prior Disability coverage, if applicable.

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

CONTINUING PROOF OF CLAIM

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

You or Your Employer must notify Us immediately when You return to work in any capacity.

REVIEW OF DENIAL OF CLAIMS

If Your claim is denied, You have the right to notify Us in Writing within 180 days of receiving notice of the denial that You would like Us to review the denial.

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

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

TIME PAYMENT OF CLAIMS

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 by Us upon termination of such period will be paid as soon as possible after receipt of proof of Your claim. Any premium due from You and unpaid may be deducted from Your benefit payment.

TO WHOM PAYMENTS ARE MADE

We will pay Your benefits to You or Your assignee unless this Certificate specifies otherwise. If any amount for which We are liable remains unpaid when You die, We will pay that amount according to the TIME PAYMENT OF CLAIMS provision in this Certificate. If, however, it is necessary for the establishment of a guardianship or conservatorship, or appointment of a trustee, executor or administrator, We may withhold further benefits until sufficient evidence is provided to Us that any such establishment or appointment has been finalized. We will pay benefits within 30 days of receiving sufficient evidence of the establishment or appointment.

WHEN YOU RECEIVE PAYMENTS

You will begin to receive payments when We approve Your claim, providing the Elimination Period has been met, You are under the Appropriate Care of a Physician, and You are Disabled. We will send You a payment at the end 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.

IF YOUR DISABILITY EARNINGS FLUCTUATE

If Your Disability Earnings routinely fluctuate widely, We may average Your Disability Earnings over the most recent three months, as applicable 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 period during which Your Disability Earnings exceed the amount allowable under this Policy. In no event will benefits be paid beyond the Maximum Period of Payment.

DURATION OF PAYMENTS

We will send You a payment up to the Maximum Period of Payment as stated in the BENEFITS SCHEDULE and will be paid during a continuous period of Disability.

WHEN PAYMENTS END

We will stop sending You payments and Your claim will end on the earliest of the following:

1. the end of the Maximum Period of Payment;
2. the date You are no longer Disabled under the terms of this Policy;
3. the date You fail to submit proof of continuing Disability;
4. the date You die;
5. during the Regular Occupation Period when You are able to return to work in Your Regular Occupation on a Part-time Basis but You do not;
6. after the Regular Occupation Period, when You are able to work in any Gainful Occupation for which You are reasonably qualified on a Part-time Basis but You do not; or
7. the date Your Disability Earnings exceed 80% of Your Indexed Monthly Earnings.

**IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE AND
HEALTH INSURANCE GUARANTY ASSOCIATION**

(For insurers declared insolvent or impaired on or after September 1, 2011)

Texas law establishes a system to protect Texas policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association ("the Association") administers this protection system. Only the policyholders of insurance companies that are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

It is possible that the Association may not protect all or part of your policy because of statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas (**regardless of where the policyholder lived when the policy was issued**)
- Residents of other states, **ONLY** if the following conditions are met:
 - 1) The policyholder has a policy with a company domiciled in Texas;
 - 2) The policyholder's state of residence has a similar guaranty association; and
 - 3) The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of \$500,000 for basic hospital, medical-surgical, and major medical insurance, \$300,000 for disability or long term care insurance, or \$200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of \$100,000 under one or more policies on a single life; or
- Death benefits up to a total of \$300,000 under one or more policies on a single life; or
- Total benefits up to a total of \$5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of \$250,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of \$250,000 on any one life; or
- Present value of unallocated benefits up to a total of \$5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- \$300,000 on any one life with the exception of the \$500,000 health insurance limit, the \$5,000,000 multiple owner life insurance limit, and the \$5,000,000 unallocated group annuity limit.

These limits are applied for each insolvent insurance company.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.

Texas Life and Health Insurance
Guaranty Association
515 Congress Avenue, Suite 1875
Austin, Texas 78701
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.texas.gov

CHUBB GROUP U.S. PRIVACY NOTICE

FACTS WHAT DOES CHUBB GROUP DO WITH YOUR PERSONAL INFORMATION?

Why? Insurance companies choose how they share your personal information. Federal and state law gives consumers the right to limit some but not all sharing. Federal and state law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.

What? The types of personal information we collect and share depend on the product or service you have with us. This information can include:

- Social Security number and payment history
- insurance claim history and medical information
- account transactions and credit scores

When you are no longer our customer, we continue to share information about you as described in this notice.

How? All insurance companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons insurance companies can share their customers' personal information; the reasons the Chubb Group chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does Chubb share?	Can you limit this sharing?
For our everyday business purposes – such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes – to offer our products and services to you	Yes	No
For joint marketing with other financial companies	Yes	No
For our affiliates' everyday business purposes – information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes – information about your creditworthiness	No	We don't share
For our affiliates to market to you	No	We don't share
For nonaffiliates to market to you	No	We don't share

Questions? Call 1-800-258-2930 or go to <https://www2.Chubb.com/us-en/privacy.aspx>

Who we are

Who is providing this notice?

The Chubb Group. A list of these companies is located at the end of this document.

What we do

How does Chubb Group protect my personal information?

To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings.

We restrict access to personal information to our employees, affiliates' employees, or others who need to know that information to service the account or to conduct our normal business operations.

How does Chubb Group collect my personal information?

We collect your personal information, for example, when you

- apply for insurance or pay insurance premiums
- file an insurance claim or provide account information
- give us your contact information

We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.

Why can't I limit all sharing?

Federal law gives you the right to limit only

- sharing for affiliates' everyday business purposes – information about your creditworthiness
- affiliates from using your information to market to you
- sharing for nonaffiliates to market to you

State laws and individual companies may give you additional rights to limit sharing. See below for more on your rights under state law.

Definitions

Affiliates

Companies related by common ownership or control. They can be financial and nonfinancial companies.

- Our affiliates include those with a Chubb name and financial companies, such as Westchester Fire Insurance Company and Great Northern Insurance Company.

Nonaffiliates

Companies not related by common ownership or control. They can be financial and nonfinancial companies.

- Chubb does not share with nonaffiliates so they can market to you.

Joint Marketing

A formal agreement between nonaffiliated financial companies that together market financial products or services to you.

- Our joint marketing partners include categories of companies such as banks.

Other important information

For Insurance Customers in AZ, CA, CT, GA, IL, MA, ME, MN, MT, NV, NC, NJ, OH, OR, and VA only: Under state law, under certain circumstances, you have the right to see the personal information about you that we have on file. To see your information, write Chubb Group, Attention: Privacy Inquiries, 202 Hall's Mill Road, P.O. Box 1600, Whitehouse Station, NJ 08889-1600. Chubb may charge a reasonable fee to cover the costs of providing this information. If you think any of the information is not accurate, you may write us. We will let you know what actions we take. If you do not agree with our actions, you may send us a statement. If you want a full description of privacy rights that we will protect in accordance with the law in your home state, please contact us and we will provide it. We may disclose information to certain third parties, such as law enforcement officers, without your permission.

For Nevada residents only: We may contact our existing customers by telephone to offer additional insurance products that we believe may be of interest to you. Under state law, you have the right to opt out of these calls by adding your name to our internal do-not-call list. To opt out of these calls, or for more information about your opt out rights, please contact our customer service department. You can reach us by calling 1-800-258-2930, emailing us at privacyinquiries@Chubb.com, or writing to Chubb Group, Attention: Privacy Inquiries, 202 Hall's Mill Road, P.O. Box 1600, Whitehouse Station, NJ 08889-1600. You are being provided this notice under Nevada state law. In addition to contacting Chubb, Nevada residents can contact the Nevada Attorney General for more information about your opt out rights by calling 775-684-1100, emailing bcpinfo@ag.state.nv.us, or by writing to: Office of the Attorney General, Nevada Department of Justice, Bureau of Consumer Protection: 100 North Carson Street, Carson City, NV 89701.

For Vermont residents only: Under state law, we will not share information about your creditworthiness within our corporate family except with your authorization or consent, but we may share information about our transactions or experiences with you within our corporate family without your consent.

Chubb Group Companies Providing This Notice

This notice is being provided by the following Chubb Group companies to their customers located in the United States: ACE American Insurance Company, ACE Capital Title Reinsurance Company, ACE Fire Underwriters Insurance Company, ACE Insurance Company of the Midwest, ACE Life Insurance Company, ACE Property and Casualty Insurance Company, Agri General Insurance Company, Atlantic Employers Insurance Company, Bankers Standard Fire and Marine Company, Bankers Standard Insurance Company, Century Indemnity Company, Chubb Custom Insurance Company, Chubb Indemnity Insurance Company, Chubb Insurance Company of New Jersey, Chubb Lloyds Insurance Company of Texas, Chubb National Insurance Company, Executive Risk Indemnity Inc., Executive Risk Specialty Insurance Company, Federal Insurance Company, Great Northern Insurance Company, Illinois Union Insurance Company, Indemnity Insurance Company of North America, Insurance Company of North America, Pacific Employers Insurance Company, Pacific Indemnity Company, Penn Millers Insurance Company, Texas Pacific Indemnity Company, Vigilant Insurance Company, Westchester Fire Insurance Company and Westchester Surplus Lines Insurance Company.

Chubb Group

Notice of HIPAA Privacy Practices for Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is effective as of June 15, 2018.

The Chubb Group of Companies, as affiliated covered and hybrid entities, (the "Company") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information, and to inform you about:

- The Company's uses and disclosures of Protected Health Information ("PHI");
- Your privacy rights with respect to your PHI;
- The Company's duties with respect to your PHI;
- Your right to file a complaint with the Company and to the Secretary of the U.S. Department of Health and Human Services ("HHS"); and
- The person or office to contact for further information regarding the Company's privacy practices.

PHI includes all individually identifiable health information transmitted or maintained by the Company, regardless of form (e.g. oral, written, electronic).

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), regulates PHI use and disclosure by the Company. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.

I. Notice of PHI Uses and Disclosures

A. Required Uses and Disclosures

Upon your request, the Company is required to give you access to certain PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of Health and Human Services to investigate or determine the Company's compliance with the privacy regulations.

B. Uses and Disclosures to Carry Out Treatment, Payment, and Health Care Operations

The Company and its business associates will use PHI without your consent, authorization or opportunity to agree or object to carry out treatment, payment and health care operations. The Company also may also disclose PHI to a plan sponsor for purposes related to treatment, payment and health care operations and as otherwise permitted under HIPAA to the extent the plan documents restrict the use and disclosure of PHI as required by HIPAA.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. For example, the Company may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.

Payment includes, but is not limited to, actions to make coverage determinations and payment (including establishing employee contributions, claims management, obtaining payment under a contract of reinsurance, utilization review and pre-authorizations). For example, the Company may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Company.

Health care operations include, but are not limited to, underwriting, premium rating and other insurance activities relating to creating or reviewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Company may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing

functions. The Company will not use or disclose PHI that is genetic information for underwriting purposes.

The Company also may contact you to provide appointment reminders or information about treatment alternatives or health-related benefits and services that may be of interest to you.

C. Uses and Disclosures that Require Your Written Authorization

The Company will not use or disclose your PHI for the following purposes without your specific, written authorization:

- Use and disclosure of psychotherapy notes, except for your treatment, Company training programs, or to defend Company against litigation filed by you.
- Use and disclosure for marketing purposes, except for face to face communications with you.
- Use and disclosure that constitute the sale of your PHI. The Company does not sell the PHI of its customers.

Except as otherwise indicated in this notice, uses and disclosures of PHI will be made only with your written authorization subject to your right to revoke such authorization. You may revoke an authorization by submitting a written revocation to the Company at any time. If you revoke your authorization, the Company will no longer use or disclose your PHI under the authorization. However, any use or disclosure made in reliance of your authorization before its revocation will not be affected.

D. Uses and Disclosures Requiring Authorizations or Opportunity to Agree or Disagree Prior to the Use or Release

If you authorize in writing the Company to use or disclose your own PHI, the Company may proceed with such use or disclosure without meeting any other requirements and the use or disclosure shall be consistent with the authorization.

Disclosure of your PHI to family members, other relatives or your close personal friends is allowed if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

E. Uses and Disclosures for which Consent, Authorization or Opportunity to Object is Not Required

Use and disclosure of your PHI is allowed without your authorization or request under the following circumstances:

(1) When required by law.

(2) When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls and to conduct post-market surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

(3) When authorized by law to report information about abuse, neglect or domestic violence. In such case, the Company will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law where the parents or other representatives may not be given access to the minor's PHI.

(4) The Company may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

(5) The Company may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Company that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

(6) When required for law enforcement purposes (for example, to report certain types of wounds).

(7) For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Company's best judgment.

(8) When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent. The Company may also disclose your PHI to organ procurement organizations.

(9) The Company may use or disclose PHI for government-approved research, subject to conditions.

(10) When consistent with applicable law and standards of ethical conduct if the Company, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

(11) For certain government functions such as related to military service or national security.

(12) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

(13) That is "incident to" an otherwise permitted use or disclosure of PHI by the Company.

II. Rights of Individuals

A. Right to Request Restrictions on Use and Disclosure of PHI

You may request the Company to restrict its use and disclosure of your PHI to carry out treatment, payment or health care operations, or to restrict its use and disclosure to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Company may not be required to agree to your request, unless you have paid out of pocket in full for services, depending on the specific facts.

The Company will accommodate reasonable requests to receive communications of PHI by alternative means or alternative locations, such as a location other than your home. The Company will accommodate this request if you state in writing that you would be in danger from receiving communications through the normal means.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Such requests should be made to: Leslie Kaltenbach, Senior Privacy Officer & Compliance Manager, Chubb Group, 202 Hall's Mill Road, Whitehouse Station, NJ 08889, phone: 1-833-802-4822.

B. Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Company maintains the PHI.

"*Protected Health Information*" (PHI) includes all individually identifiable health information transmitted or maintained by the Company, regardless of form.

"*Designated Record Set*" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals.

Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Company is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to: Leslie Kaltenbach, Senior Privacy Officer & Compliance Manager, Chubb Group, 202 Hall's Mill Road, Whitehouse Station, NJ 08889, phone: 1-833-802-4822.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of Health and Human Services.

C. Right to Amend PHI

You have the right to request the Company to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Company has 60 days after the request to act on the request. A single 30-day extension is allowed if the Company is unable to comply with the deadline. If the request is denied in whole or part, the Company must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests for amendment of PHI in a designated record set should be made to: Leslie Kaltenbach, Senior Privacy Officer & Compliance Manager, Chubb Group, 202 Hall's Mill Road, Whitehouse Station, NJ 08889, phone: 1-833-802-4822.

You or your personal representative(s) will be required to complete a form to request amendment of the PHI in your designated record set.

D. Right to Receive an Accounting of PHI Uses and Disclosures

Upon your request, the Company will provide you with an accounting of disclosures by the Company of your PHI during the six (6) years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) prior to the compliance date; or (4) based upon your own written authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Company will charge a reasonable, cost-based fee for each subsequent accounting.

E. Right to Obtain a Paper Copy of This Notice Upon Request (Even if you have consented to receive this notice electronically)

To obtain a paper copy of this notice contact: Leslie Kaltenbach, Senior Privacy Officer & Compliance Manager, Chubb Group, 202 Hall's Mill Road, Whitehouse Station, NJ 08889, phone: 1-833-802-4822.

F. Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

The Company retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

III. The Company's Duties

The Company is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices and to notify affected individuals of a breach of unsecured PHI. The Company is required to abide by the terms of this notice.

The Company reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Company prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to all past and present participants and beneficiaries for whom the Company still maintains PHI. This notice and any revised version of this notice will be posted on the Company's internal website or mailed.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Company or other privacy practices stated in this notice.

A. "Minimum Necessary" Standard

When using or disclosing PHI, or when requesting PHI from another covered entity, the Company will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to the individual;
- Disclosures made to the Secretary of HHS;
- Uses or disclosures that are required by law; and
- Uses or disclosures that are required for the Company's compliance with legal regulations.

This notice does not apply to information that has been "de-identified." *De-identified information* is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. De-identified information is not individually identifiable health information.

In addition, the Company may use or disclose "summary health information" to a plan sponsor for obtaining premium bids or modifying, amending or terminating the Company, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom the Company Sponsor has provided health benefits under the Company; and from which identifying information has been deleted in accordance with HIPAA.

IV. Your Right to File a Complaint with the Company or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Company in care of: Leslie Kaltenbach, Senior Privacy Officer & Compliance Manager, Chubb Group, 202 Hall's Mill Road, Whitehouse Station, NJ 08889, phone: 1-833-802-4822.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

Your complaint must be submitted within 180 days of when you believe the violation occurred. The Company will not retaliate against you for filing a complaint.

V. Contact Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact: Leslie Kaltenbach, Senior Privacy Officer & Compliance Manager, Chubb Group, 202 Hall's Mill Road, Whitehouse Station, NJ 08889, phone: 1-833-802- 4822.

VI. Chubb Group Legal Entities

The following is a list of the Chubb Group of Companies located in the United States: ACE American Insurance Company, ACE Fire Underwriters Insurance Company, ACE Insurance Company of the Midwest, ACE Life Insurance Company, ACE Property and Casualty Insurance Company, Agri General Insurance Company, Atlantic Employers Insurance Company, Bankers Standard Insurance Company, Century Indemnity Company, Chubb Custom Insurance Company, Chubb Indemnity Insurance Company, Chubb Insurance Company of New Jersey, Chubb Lloyds Insurance Company of Texas, Chubb National Insurance Company, Executive Risk Indemnity Inc. Executive Risk Specialty Insurance Company, Federal Insurance Company, Great Northern Insurance Company, Illinois Union Insurance Company, Indemnity Insurance Company of North America, Insurance Company of North America, Pacific Employers Insurance Company, Pacific Indemnity Company, Penn Millers Insurance Company, Vigilant Insurance Company, Westchester Fire Insurance Company, Westchester Surplus Lines Insurance Company, Combined Insurance Company of America, and Combined Life Insurance Company of New York. These companies have designated themselves as *hybrid entities* and only those designated health care components identified by such companies are subject to HIPAA. In addition, these companies are legally separate affiliated companies under common ownership and have designated themselves as a *single covered entity* for purposes of HIPAA compliance.