Disability administration

Employer Manual | VACoRP Hybrid Disability Plan offered by Anthem Life Insurance Company (Anthem Life)

AnthemLife

VACORP

The contents of this manual should not be considered legal advice or recommendations. You should work with your company's attorney when interpreting your company's legal responsibility under your employee life and disability plan(s). You should also review applicable state and federal laws and regulations. The contents of this manual may change or be updated at any time.

114994VAEENLIC Rev. 7/20

Thank you for choosing Anthem Life. We have put together this manual to help you administer the Virginia Association of Counties Risk Pool (VACoRP) disability program. It has information about billing and claims, and samples of materials for your employees, such as helpful fliers, benefits summaries, and insurance contracts.

If you have questions about administration, please contact the representatives listed in the *Key contacts* in this manual. We are here to help you every step of the way.

VACoRP Table of contents

Program Overview

Key contacts

VACoRP

For questions related to administration:
Stephanie Heintzleman
Director of Member Services
sheintzleman@riskprograms.com
1-844-986-2705

For questions related to billing:
VACORP Hybrid Disability Billing
Billing-hybriddisability@riskprograms.com
1-844-986-2705

One Digital

For questions related to leave/benefits consulting:
Nancy Grasso
Principal
ngrasso@onedigital.com
1-804-762-7076

Carrie P. Bartlett
Senior Client Executive
cbartlett@onedigital.com
1-804-249-5152

Anthem Life Insurance Company

For questions related to plan enhancements:
Tiffany Sensabaugh
Specialty Account Manager
540-236-8338
Email questions to
vacorpservice@anthem.com

For questions related to claims:
Customer Service: 1-844-404-2111
Toll-free fax: 1-800-850-0017
Shared email: LDClaimsTeam@AnthemLife.com

Nanette Johnson
LTD Manager
Nanette.Johnson@Anthem.com
(470) 284-4546

Cheryl Flippo
LTD Team Lead
Cheryl.Flippo@Anthem.com
(470) 284-4513

Tricia Steele
LTD Disability Case Manager
Patricia.Steele@Anthem.com
(470) 284-4532

Chelsea Thomas
LTD Disability Case Manager
Chelsea.Thomas@Anthem.com
(470) 284-4536

STD Disability Claims Manager
Nicolle Jackson
Nicolle.Jackson@anthem.com
470-284-4023

STD Disability Claims Manager
Ton Albritton
Tondelayo.Albritton@anthem.com
470-284-4075

Roles and responsibilities

	VACoRP	Employer	Anthem Life
Sponsor Hybrid Disability Program	•		•
Be responsible for endorsements and program marketing	•		
Prepare and email monthly summary billing statements to the group	•		
Collect and remit applicable fees and premiums to Anthem Life	•		
Calculate and pay short-term disability (STD) benefits to employees		•	
Be bound by all long-term disability (LTD) insured policy terms and amendments		•	
Make coverage available to all present and future eligible employees		•	
Provide name, benefit amount, effective date, and premium of insured employees to Anthem Life, as needed for claims or administration review		•	
Make certificates available to each insured employee by posting or providing access		•	
Do not distribute material about Anthem Life unrelated to services provided, without Anthem Life's prior written consent		•	
Remit the cost of insurance to VACoRP on or before each premium due date		•	
Understand the LTD policy will terminate automatically on the date a group ceases to participate in the VACoRP-sponsored program, or if premium is not paid by the end of the grace period		•	
Comply with the terms of federal, state, and local laws and regulations governing employment relationships and the provision of fringe benefits to employees		•	
Indemnify and hold harmless Anthem Life, VACoRP, and any related entities from any liability that arises due to the individual employer's failure to comply with applicable laws	•	•	
Understand there are no producer commissions available for the individual employer's producer, from any of the programs available through Anthem Life under this agreement		•	
Understand that insurance under the LTD policy is not a substitute for coverage under workers' compensation law and does not relieve an individual employer of the obligation to provide such coverage		•	
Understand that the Pension Contribution Benefit (PCB) is a feature of the LTD policy and will be paid to the employer for remittance to Virginia Retirement System (VRS)		•	
Ensure that an employer contribution is properly made to VRS	•	•	
Consult with legal counsel to ensure that compliance obligations under §51.1-1131.1 are met		•	
Establish claims practices in accordance with the laws, rules, and regulations of the Commonwealth of Virginia			•
Investigate claims for benefits under the program, including whether a claimant is eligible for coverage; make initial claim decisions to approve, deny or close claims for benefits; and notify claimants and their employers in writing of decisions on claims			•
In the event of an appeal by the claimant, provide an independent review and notify claimant and employer in writing of Anthem's decision, subject to employer's right of final review and decision on all appeals			•
Provide copies of an employee's claim file, together with any necessary authorizations, at the request of the employer			•
Have medical and vocational examinations of claimants performed, as appropriate			•
Advise claimants concerning the need to apply for deductible income and periodically verify application for or receipt of deductible income			•
Provide program sponsor and employers with periodic listings of all payments made under the Hybrid Disability Program, upon written request			•

Billing Administration

Premium and billing

Billing method

Self-administered billing: Insured employees are summarized (not listed individually) for premium billing. You should prepare and initiate premium statements according to the number of employees insured under your group policy.

Premiums due

Premiums are due on or before the first calendar day of the period for which you are billed. This date is shown on the cover of your group policy. The policy specifies a grace period during which premiums must be paid.

Note: If your premium is not received within the grace period, your policy will lapse and your insurance coverage will be terminated. Timely payment is required for insurance to remain in force.

Reporting volume

Volume is the amount of coverage each employee has, according to your Long-Term Disability (LTD) Group Policy. Premiums for insurance are based on amounts reported to VRS in the LTD Schedule of Insurance provision of your group policy, up to a maximum benefit or earnings amount. Follow these guidelines to determine and pay premiums for the proper volume for your coverages:

- Report volume based on total creditable compensation and total number of employees in the Hybrid Plan.
- Do not report volume or pay premiums for earnings that exceed the maximum defined in your Group LTD Policy, or for coverage or amounts for which Evidence of Insurability is pending.
- Monitor and report changes in volume as of their effective date.

Paying premiums

Pay premiums according to these steps:

1. Update with current lives and LTD volumes for all insured under your plan.
2. Calculate the premium due by applying the appropriate rate(s) to current, total monthly volume as applicable for your insured population(s).
3. Forward billing documentation with total payment to VACoRP.

Employee adjustments

You are responsible for reporting and making billing adjustments related to employee additions and terminations, as well as LTD volume increases and decreases. These may result from changes in salary or other reasons as defined in your group policy.

For administrative ease, premium payments and adjustments are usually calculated as of the first of the month that coincides with or follows a change. To adjust your premiums for employee additions, terminations, and volume increases and decreases, follow these steps:

1. Input changes into your VRS tracking system.
2. Adjust the amount of premium and pay the amount due.
3. Send your billing documentation to VACoRP with your premium remittance.

Premiums during disability

To maintain group insurance coverage for eligible employees who are away from work because of disability, it is generally necessary to continue premium payments on their behalf. In certain cases, LTD insurance premiums may be waived for some period of time while an employee is disabled, according to the "When Insurance Ends" and "Waiver of Premium" provisions under your group policy and the directions that follow.

Note: Stop paying premiums when a disabled employee's insurance ends for any reason stated in your Group LTD Policy.

Premiums for long-term disability insurance

If an insured employee is away from work because of disability and a long-term disability claim is pending, follow these steps:

1. Continue paying premiums until you receive notification that the LTD claim is approved and benefits are payable and due, as long as the employee remains eligible for coverage.
2. After you receive notice of claim approval, report the changes for premiums.

Commonly asked questions

What is volume?

Volume is the total amount of LTD coverage each employee has, according to the contract provisions.

Why is an insured employee capped at a particular LTD volume level when the salary is higher than that?

An insured employee's LTD volume is limited by the LTD plan maximum.

How does Anthem Life calculate volume?

Insurance volume for VACoRP is calculated as follows for each individual covered:

- Volume equals the insured employee's LTD monthly pre-disability earnings.

Note the long-term disability examples below, and refer to your group policy for specific percentages, maximums and evidence requirements.

LTD examples:

- LTD benefit is 60% of the first $41,667 of pre-disability earnings
  - Pre-disability earnings = monthly earnings
  - $41,667 is the "cap," or maximum
  - Volume = capped pre-disability earnings (PDE)

Formula: volume x rate = premium

Employee	Monthly earnings	Volume	Sample rate(s)*	Premium
John Doe	$5,500	$5,500 (volume is monthly earnings, since it does not exceed the maximum $41,667)	0.37% pre-disability earnings	$5,500 x 0.37/100 = $30.80
Jane Doe	$50,000	$41,667 (volume is capped at the maximum PDE)	0.37% pre-disability earnings	$41,667 x 0.37/100 = $233.34

* 0.37% rate for demonstration purposes only; your actual rate(s) may be different.

Why do we have a charge/credit?

A charge or credit may be related to employee adjustments, payment not equaling the amount billed, or amendment changes. If you find a charge or credit you cannot verify, call 1-844-986-2705 and ask to speak with a representative of the Hybrid Disability Program.

Claims Administration

Claims: frequently asked questions

A recorded webinar to help you understand the claims process is available online in the *Hybrid Disability* section of the VACoRP website (no login needed): VACoRP.org/hybrid-disability/

Claims process with Anthem Life

- **When an employee has a disability claim, who should submit the claim?**
  - Either the employee or employer can report the claim. Either may call the dedicated telephone number or submit the claim online.
- **How can an employee file a disability claim?**
  - To report a claim, employees can call the dedicated claim line at 1-844-404-2111 **or**
  - Go to myspecialtyappsAnthemLife.com/Claims/ALIC, a secure site where the employee or employer can submit a claim.
- **As the payroll/benefits administrator, how will I know about disability claims that have been reported?**
  - An online employer portal is available to monitor claims activity for your entity. Updates are also provided by email.
  - Payroll and benefits administrators will need a secure login to access the online employer portal. To obtain your unique login, complete the *Anthem Life User Agreement* located here: http://www.vacorp.org/wp-content/uploads/2019/09/Anthem-Online-Claims-User-Agreement-Universal.pdf. Submission instructions are in the document.
- **How does Anthem Life verify an employee is a VRS Hybrid Disability Plan participant and meets the one-year eligibility requirement?**
  - At the time a disability claim is reported, both the employee and employer are asked the hire date. Anthem Life will verify the effective date of coverage for the employee and verify the employee is in the VRS Hybrid Plan.
- **How does the disability benefit payment to the employee work? Does Anthem Life pay the employee or does the employer pay the employee and receive reimbursement from Anthem Life?**
  - The short-term disability benefit is self-insured. Payment to employees with approved disability claims works the same as it has in the past. Anthem Life reviews the claim and determines whether a claim should be paid. During the short-term disability period, the entity is responsible for paying the determined disability benefit to the employee. Anthem Life does not reimburse the employer for this.
  - If the claim transitions to long-term disability, Anthem Life will then pay the employee.
- **Can Anthem Life provide a copy of the eligibility template that employers must provide as part of the claims process?**
  - The eligibility template is available on the VACoRP website: http://www.vacorp.org/wp-content/uploads/2019/10/Hybrid-Disability-Eligibility-Template-Anthem.pdf.
- **As payroll/benefits administrator, how do I know what information is missing and needed for Anthem Life to process the claim? Is this information available online?**
  - You should contact your dedicated Anthem Life Claims representative. Anthem Life is reviewing how to make this more accessible without direct outreach.

- **How does partial disability work?**
  - If an employee is disabled, yet could continue to work at some capacity, earning between 20% and 80% of their pre-disability earnings, the employee should report time missed and hours worked to Anthem Life for benefit determination. Anthem Life will also need to verify the employee's earnings. Intermittent leave with the Family Medical Leave Act (FMLA) may run concurrent with partial disability, if applicable.
- **What is the rehire provision for an employee with a disability claim?**
  - An employee who leaves covered employment, then returns to the same former position after a bona fide break in service, must satisfy a new, one-year waiting period for nonoccupational short-term disability coverage. A new, five-year eligibility period for higher-income replacement levels begins with the subsequent hire date.
  - A bona fide break in service is a break of at least one full calendar month, from the last day of employment that occurs over a period normally worked. Periods of leave with or without pay, and summer breaks, do not count toward satisfying this break in service.
- **We had an LTD claim prior to July 1, 2019, when we switched to Anthem Life. Who provides the W-2 to the employee on the LTD claim?**
  - The previous carrier will prepare the W-2s for claimants on long-term disability prior to July 1, 2019. Anthem Life will prepare W-2s for long-term disability claims incurred after July 1, 2019.
- **When Anthem Life sends claim notification emails, they are filtered to our spam/junk folder. What is the sender name for these notifications so we can add it to our safe sender list?**
  - Email notifications are sent from LDClaimsTeam@AnthemLife.com or the case manager's name (name@AnthemLife.com). We recommend that you add the @AnthemLife.com domain to your safe sender list.
- **What is included in the employer's email notification of claim?**
  - Anthem Life provides the following in the initial approval letter to the employer:
    - Elimination period dates
    - Benefit start date
    - Approval dates (dates the disability has been approved from and through)
    - Short-term disability benefit table showing income replacement percentage levels for nonoccupational disabilities, per § 51.1-1155

Questions specific to the Virginia Local Disability Program (VLDP)

- **Has anything changed in the legislation for the Hybrid program?**
  - No, the legislation has not changed.
- **Can you provide guidance on when an employee can be terminated from employment when they are out on LTD?**
  - FMLA offers job protection for 12 weeks. Entities are required to hold an employee's position for 12 weeks. VLDP requires employers to pay their contribution toward medical benefits and pay the employee's wages via the self-funded disability program for the 125 workdays of the short-term disability period.
  - Once an employee transitions to LTD, their creditable comp is reported to VRS, but shall not include salary increases awarded while the employee is on LTD.
  - This law does not supersede the Americans with Disabilities Act (ADA).
  - Please consult your attorney for issues related to terminating employees.
- **We have an employee who worked part time and is now in the Hybrid Disability Plan with the same entity. He purchased years of service from his employment with this entity. Does adding these years of purchased service qualify to increase his income replacement level on a disability claim?**
  - Virginia State Code § 51.1-1155 indicates that for the first 60 months after hire (or rehire) date, the employee is eligible for 60% income replacement. This means Hybrid Disability Plan employees cannot receive more than 60% disability benefit during the first five years. However, after 60 months of continuous employment with the same entity, the additional years would be included to determine the income replacement for this employee's disability claims. If, for example, they were able to buy five years of service, they would add five years to their Hybrid Disability income replacement level **after** the first 60 months of employment. With this purchase of service, they could qualify for the higher levels of income replacement after 60 months of continuous employment.
- **How does the Hybrid Plan interact with mandated use of sick leave, FMLA and workers' compensation?**
  - The Hybrid Disability benefit runs concurrently with the FMLA period. Virginia State Code (§§ 51.1-1100 through 51.1-1140) requires that schools, counties, and political subdivisions offer short- and long-term disability coverage to Hybrid employees. The plan begins to pay benefits once an employee is out of work for greater than seven consecutive calendar days due to a medical illness or injury. An employee can use sick leave during the first seven calendar days. Employees whose injuries or illnesses are deemed disabling should be granted disability payment on the eighth day of their disability.
  - Employers may not require employees who are disabled and receiving benefits to use sick leave in lieu of disability benefits. Employees who are absent from work due to an FMLA event for a family member may be required to use any or all of their accumulated sick leave.
  - The 12-week FMLA period is not impacted by the disability benefit. However, employers must continue to offer health insurance benefits and pay disability benefits to disabled employees beyond the 12-week FMLA period. There is no section of the code that prohibits an employer from terminating an employee after the FMLA period is exhausted. However, the employer must continue to pay disability benefits and offer health insurance to the terminated employee through the duration of the short-term disability. Health benefits must also be offered, with the employer contribution equal to the contribution offered prior to the disability.
  - Workers' compensation will be the first benefit to pay employees for work-related illness or injury. The Hybrid Disability Plan will pay benefits with the workers' compensation as an offset. Example: If an employee should receive 80% of pay for Hybrid Disability Plan benefits and the workers' compensation pays 66 and 2/3% of their income, the Hybrid Disability Plan will make up the difference by paying 13 and 1/3% of their income.
- **What date do we use when calculating 12 continuous months of service in the Hybrid Disability Plan?**
  - Per Virginia State Code § 51.1-1153 B, the effective date of participation in the Hybrid Disability Plan is their first day of employment or the effective date of their participation in the Hybrid Retirement Program described in § 51.1-169, whichever is later.

- **Should short-term disability claims be filed upon the expiration of the seven-calendar-day waiting period?**
  - Claims for short-term disability should be reported as soon as it is realized the claimant will be out of work more than five workdays (seven calendar days). Anticipatory claims, such as surgery, maternity, etc., should be reported approximately one month prior to the anticipated surgery, maternity due date or date of disability.
  - Except as provided in subsection B of § 51.1-1153 of the Virginia State Code, short-term disability benefits begin upon the expiration of a seven-calendar-day waiting period. The waiting period begins the first day of a disability or maternity leave. If an employee returns to work for one day or less during the seven-calendar-day waiting period but cannot continue to work, the periods worked shall not be considered to have interrupted the seven-calendar-day waiting period. Additionally, the seven-calendar-day waiting period shall not be considered to be interrupted if the employee works 20 hours or less during the waiting period. Short-term disability benefits payable as the result of a catastrophic disability or major chronic condition shall not require a waiting period.
  - Except as provided in § 51.1-1171, short-term disability coverage shall provide income replacement for (i) 60% of a participating employee's creditable compensation for the first 60 months of continuous participation in the program and (ii) thereafter, a percentage of a participating employee's creditable compensation during the periods specified below, based on the number of months of continuous participation in the program by an employee who is disabled, is on maternity leave, or takes periodic absences due to a major chronic condition as follows:

Months of continuous participation	Workdays of 100% replacement of creditable compensation	Workdays of 80% replacement of creditable compensation	Workdays of 60% replacement of creditable compensation
Fewer than 12	0	0	0
12 – 59	0	0	125
60 – 119	25	25	75
120 – 179	25	50	50
180 or more	25	75	25

- **Why do I need to provide the employee's 125th workday for a short-term disability claim? How will this be determined?**
  - This is needed to have an STD period end date in the system, which enables setting the necessary flags for claim review to determine whether the claim may roll to long-term disability. The 125th workday also represents the maximum benefit period (MBP) for STD benefits under the Hybrid Disability Plan. You begin counting the 125 workdays from the benefit payment start date.
  - **School divisions**: The 125-day STD period is "workdays," so the MBP for teachers and others with a nonworking summer period would **not** occur during the summer break period. If the MBP falls **after** the end of a contracted school year, the STD claim would close for the noncontracted time (that is, summer) and reopen when the contract is active again, if the claimant is still disabled. If an STD claimant's contract is nonrenewed, the 125th workday is still required, as they could become eligible for LTD. Contracted workdays, snow days, and paid holidays are counted as regular working days when counting an employee's 125th workday.

Schools

- **Are there sick-leave accumulation restrictions for school divisions? If so, can you provide more information on where this is located in the state code?**
  - There is no Virginia State Code restricting sick-leave accumulations for school divisions.
- **Where in the state code can I find the sick-leave requirements for teachers?**
  - The sick-leave requirement for teachers is found in the State Administrative Code and excerpted below:

    8VAC20-460-10 Allowances. Allowances shall be as follows:

    1. Each full-time teacher in the public free schools shall earn a minimum of 10 days each year.
    2. Earnings for less than a full year of full-time employment shall be at the rate of one day per month, or major fraction thereof. This provision applies to teachers who do not begin teaching at the start of the school term and to those who do not complete the full year.
    3. A teacher cannot claim any portion of earned leave unless he or she has actually reported for duty for the regular school term in accordance with the terms of the teacher's contract. If a teacher is unable, because of illness, to begin teaching when school opens in the fall, such teacher may be allowed to use accumulated leave, not to exceed the balance credited to him or her as of June 30 of the immediate preceding school year.
    4. School boards may, by resolution, permit teachers to anticipate sick-leave earnings for the current school year, provided adequate provision is made for a refund in the event the teacher terminates employment before such credit is earned.
- **Short-term disability benefits are payable for up to 125 workdays. Are snow days considered workdays?**
  - Yes, snow days are considered workdays. They are not considered an interruption in employment, so they count as workdays.

Legacy/Plan 1 and 2 disability coverage

- **Why should we consider offering STD and/or LTD benefits to the Plan 1 and 2 employees when they already have VRS disability?**
  - Plan 1 and 2 employees must meet Social Security requirements to be considered permanently disabled through VRS. This takes time, typically 2 to 4 years. Only those who are permanently disabled will be covered.
  - To provide equity for all employees who suffer disabilities, we recommend offering a disability plan to Plan 1 and 2 employees.

Billing questions

- If you have any questions regarding your VACoRP monthly invoice, please direct them to billing-hybriddisability@riskprograms.com or call 1-844-986-2705 and ask for Hybrid Disability billing.

Online Claims Manual:
Submitting Disability Claims Online

Filing a claim online

We're making it easier for you to do business with us. It's fast and convenient to submit claims online at anthemlife.com. You have control over claim information and accuracy, and the system guides you through the process step by step.

This section is a helpful resource as you file your claims.

If you have questions, we're here to help. Just call 1-844-404-2111 or your disability case manager.

You will see a different phone number on the system screens — remember 1-844-404-2111 is the dedicated VACoRP number.

Getting started

To submit claims online, go to **https://myspecialtyappsanthem.com/Claims/ALIC**. You'll select the type of claim you want to submit on the *Welcome* screen. You'll see a list of claim types:

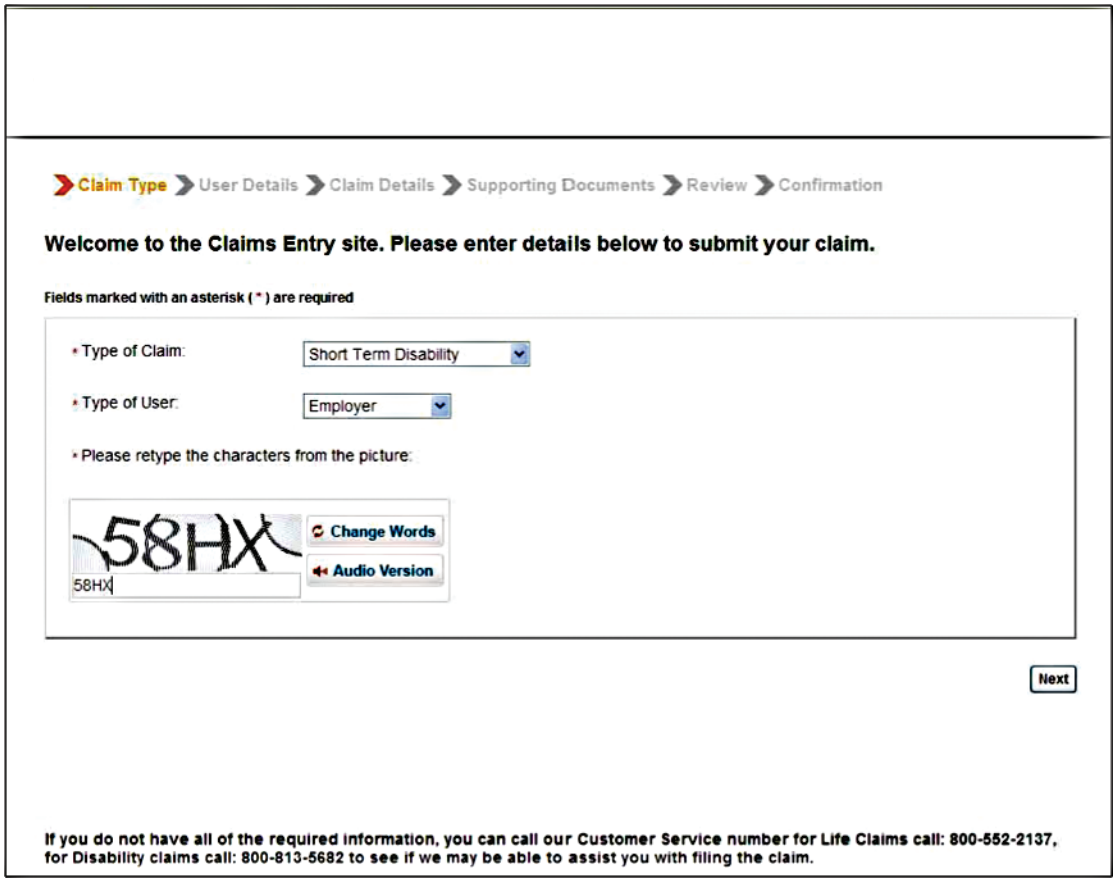
- Life*
- Accidental dismemberment*
- Living benefit*
- Life waiver of premium*
- Short-term disability
- Long-term disability

* These coverages are not included in the VACoRP plan. The VACoRP coverage is for short-term disability or long-term disability. Select one of those options.

Fields marked with an asterisk (*) are required.

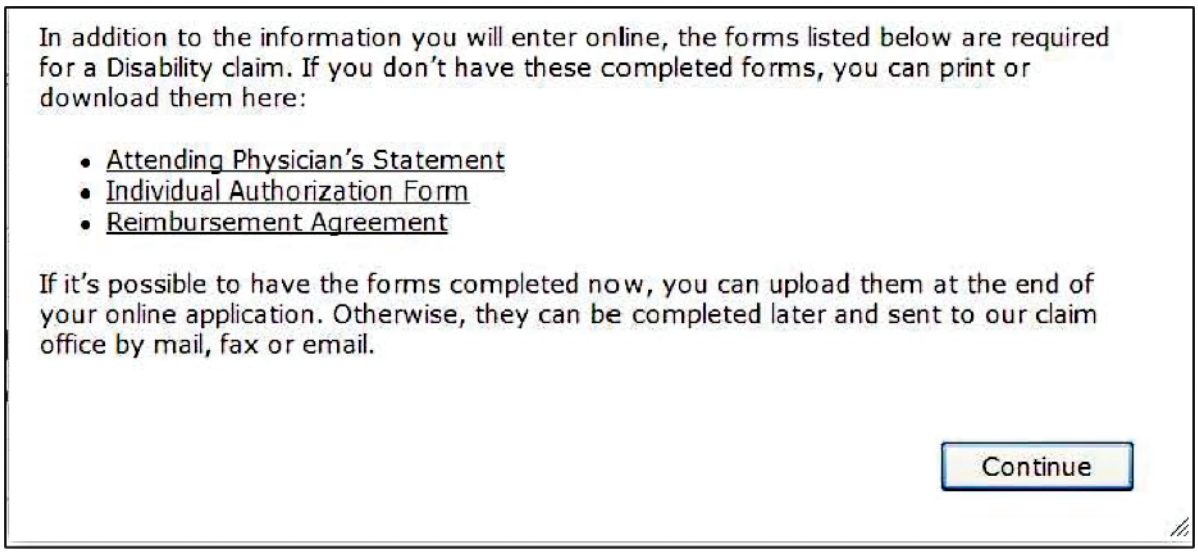
Submitting a short-term disability claim

Select **Short-Term Disability** in the *Type of Claim* field and **Employer** in the *Type of User* field. Enter the characters you see in the bottom box, then choose **Next**.

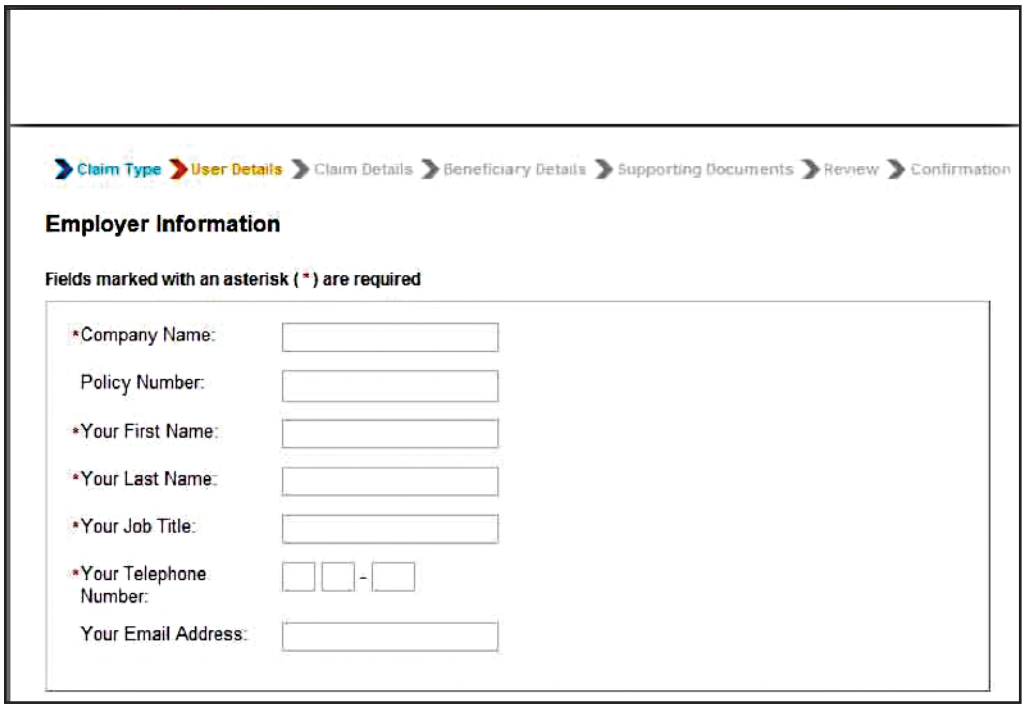


You can print the forms we need to process the short-term disability claim from this screen. Select the links to get fillable PDFs of the forms:

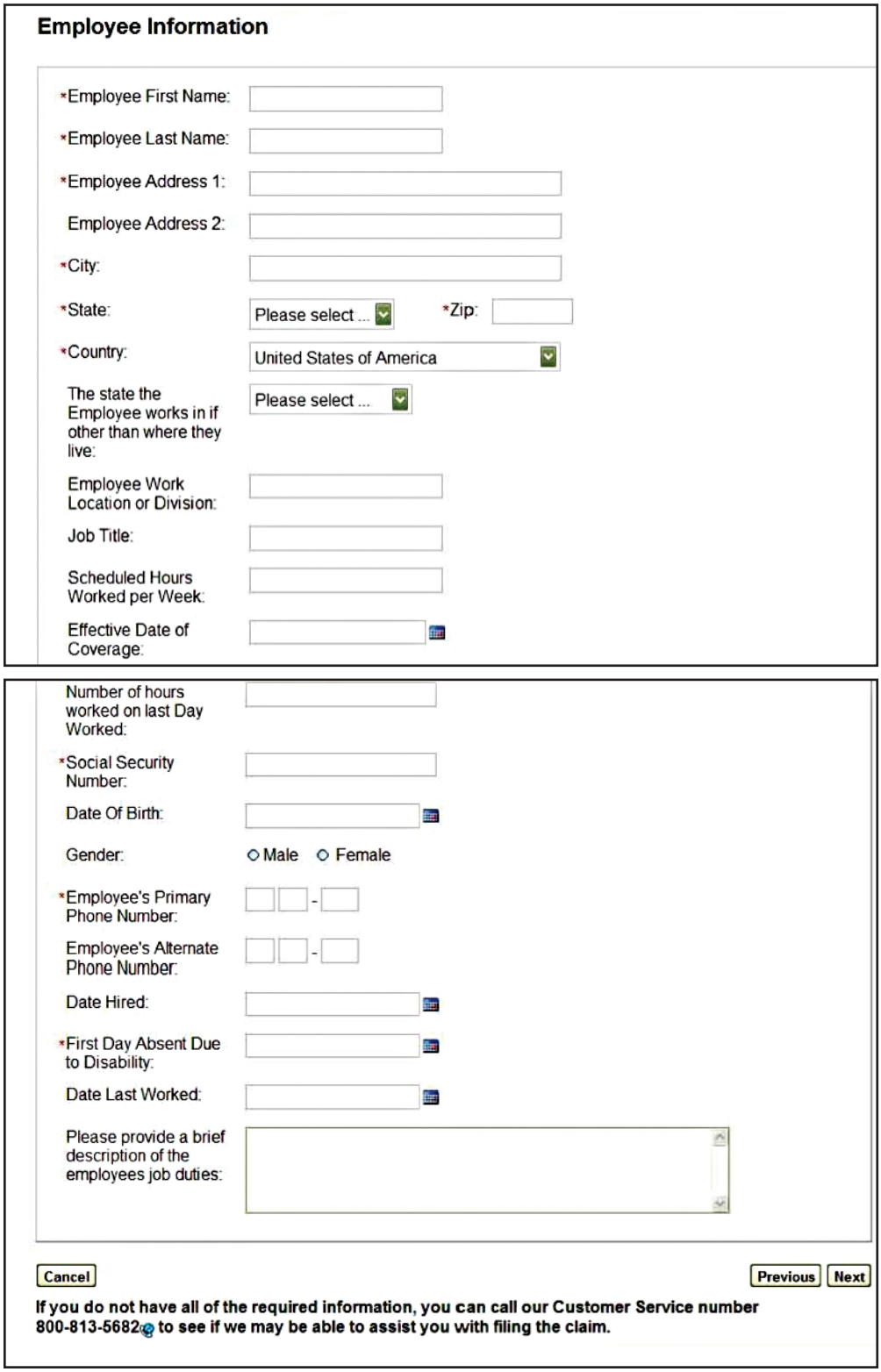
- *Attending Physician's Statement*
- *Individual Authorization Form*
- *Reimbursement Agreement*



Enter your contact information on the *Employer Information* screen.

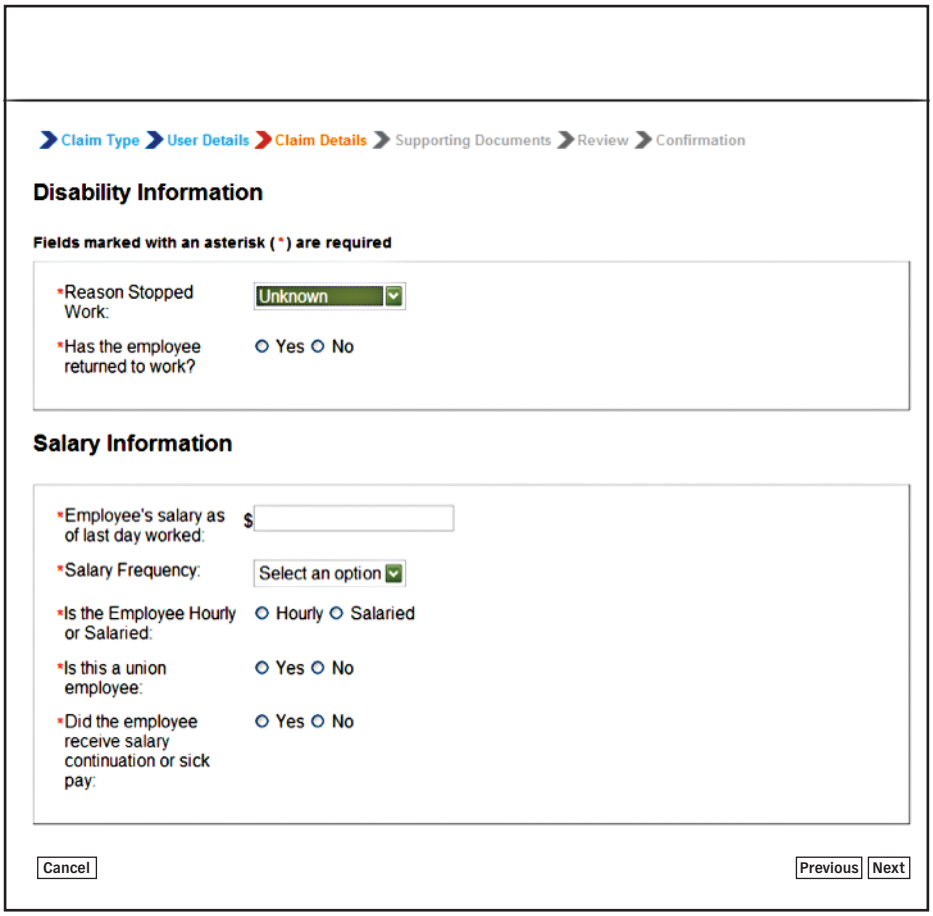


On the *Employee Information* screen, enter as much information as you have about the employee.



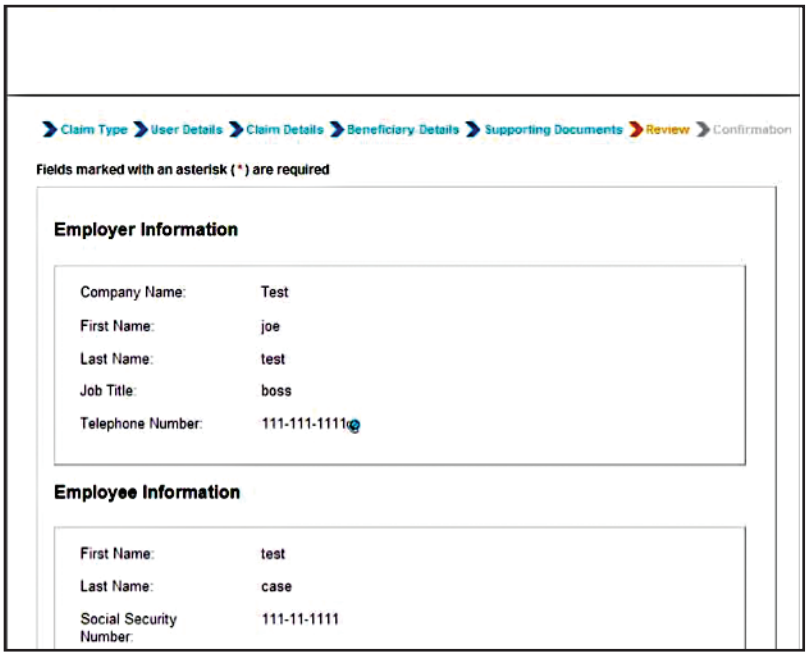
On the *Disability Information* screen, enter as much information as you can about the disabling condition. The questions will vary based on the reason the employee stopped work:

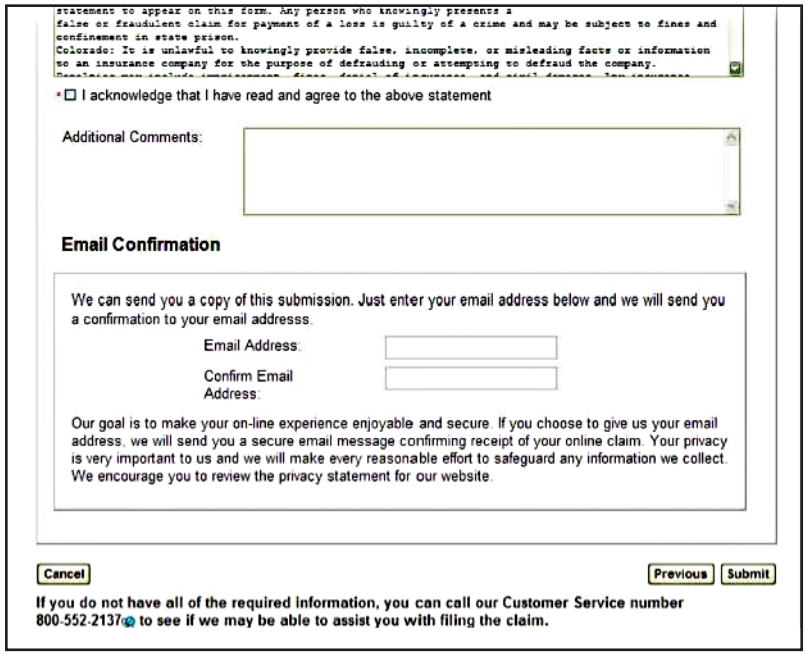
- Illness
- Injury
- Maternity
- Unknown



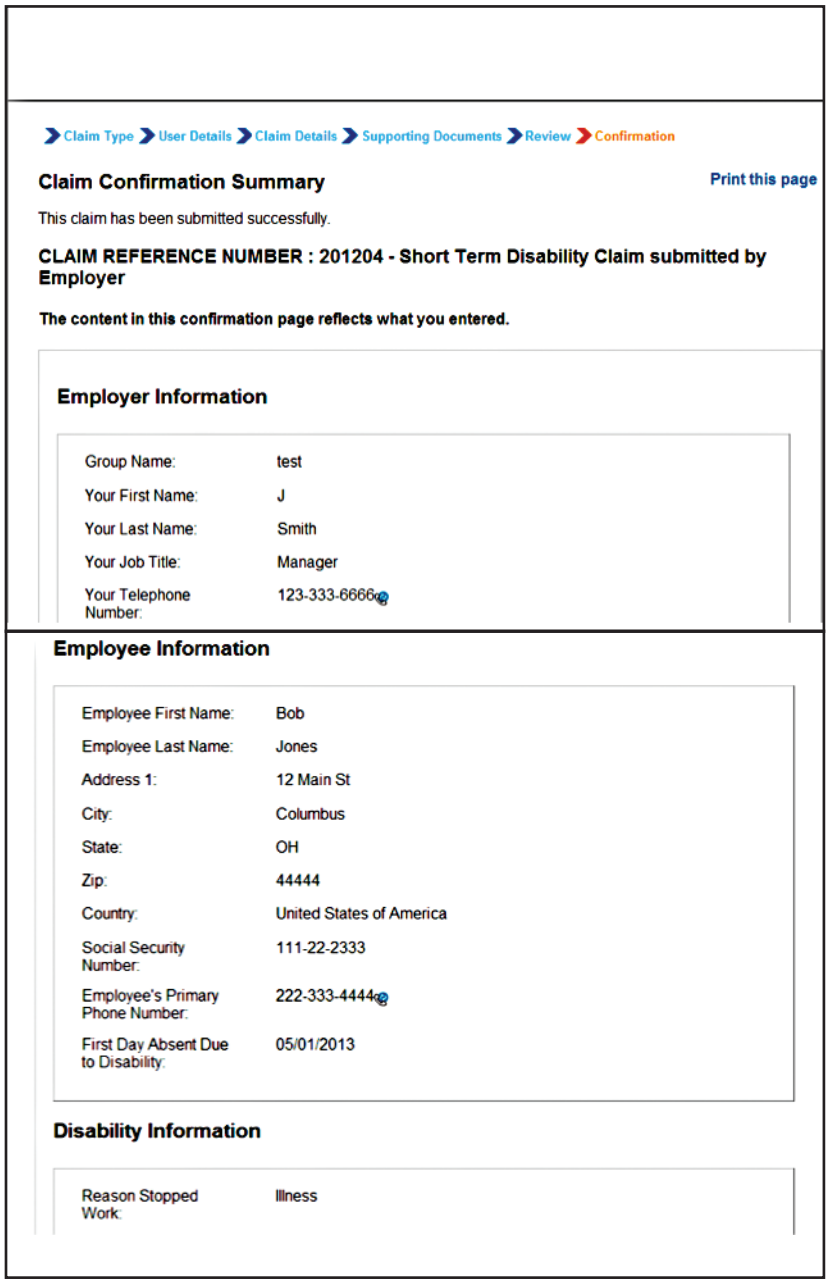
If you have completed forms at the time you enter the claim, such as the *Attending Physician's Statement*, the *Individual Authorization Form* or the *Reimbursement Agreement*, you can scan and attach them here.

Next, you'll get confirmation of the information you entered and agree to the legal statement so we can begin processing the claim. You can also enter your email address and we'll send you confirmation of all the information you entered.





Once the claim is complete, you'll receive a confirmation summary showing all the information you entered. If you entered your email address on the previous screen, you'll also get a confirmation summary by email.



Claim Type > User Details > Claim Details > Supporting Documents > Review > Confirmation

Claim Confirmation Summary Print this page

This claim has been submitted successfully.

CLAIM REFERENCE NUMBER : 201204 - Short Term Disability Claim submitted by Employer

The content in this confirmation page reflects what you entered.

Employer Information

Group Name:	test
Your First Name:	J
Your Last Name:	Smith
Your Job Title:	Manager
Your Telephone Number:	123-333-6666

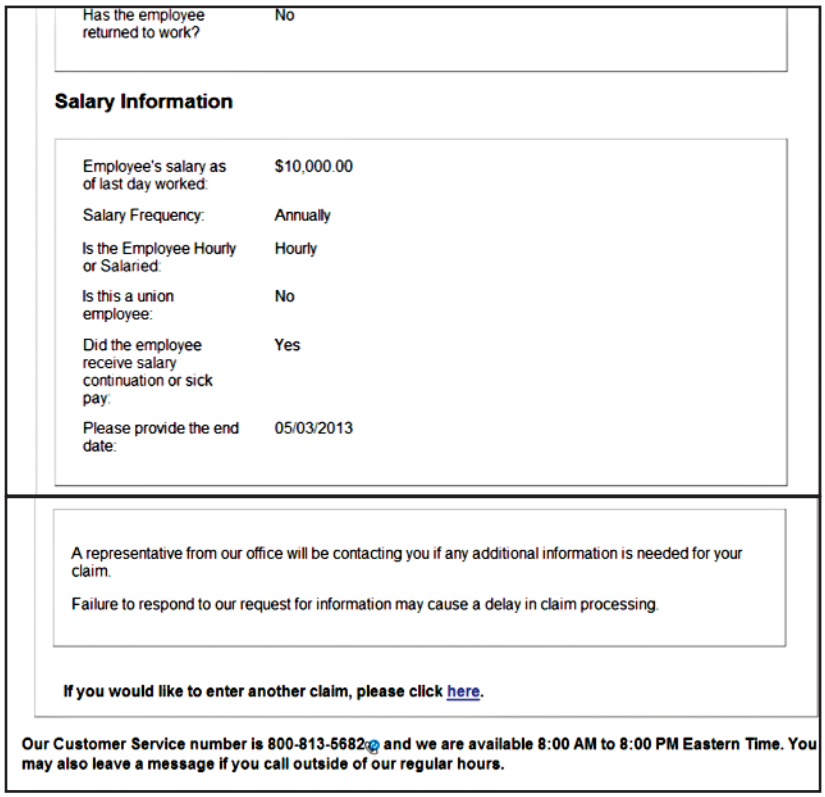
Employee Information

Employee First Name:	Bob
Employee Last Name:	Jones
Address 1:	12 Main St
City:	Columbus
State:	OH
Zip:	44444
Country:	United States of America
Social Security Number:	111-22-2333
Employee's Primary Phone Number:	222-333-4444
First Day Absent Due to Disability:	05/01/2013

Disability Information

Reason Stopped Work:	Illness

(Continued)



Has the employee returned to work?	No

Salary Information

Employee's salary as of last day worked:	$10,000.00
Salary Frequency:	Annually
Is the Employee Hourly or Salaried:	Hourly
Is this a union employee:	No
Did the employee receive salary continuation or sick pay:	Yes
Please provide the end date:	05/03/2013

A representative from our office will be contacting you if any additional information is needed for your claim.

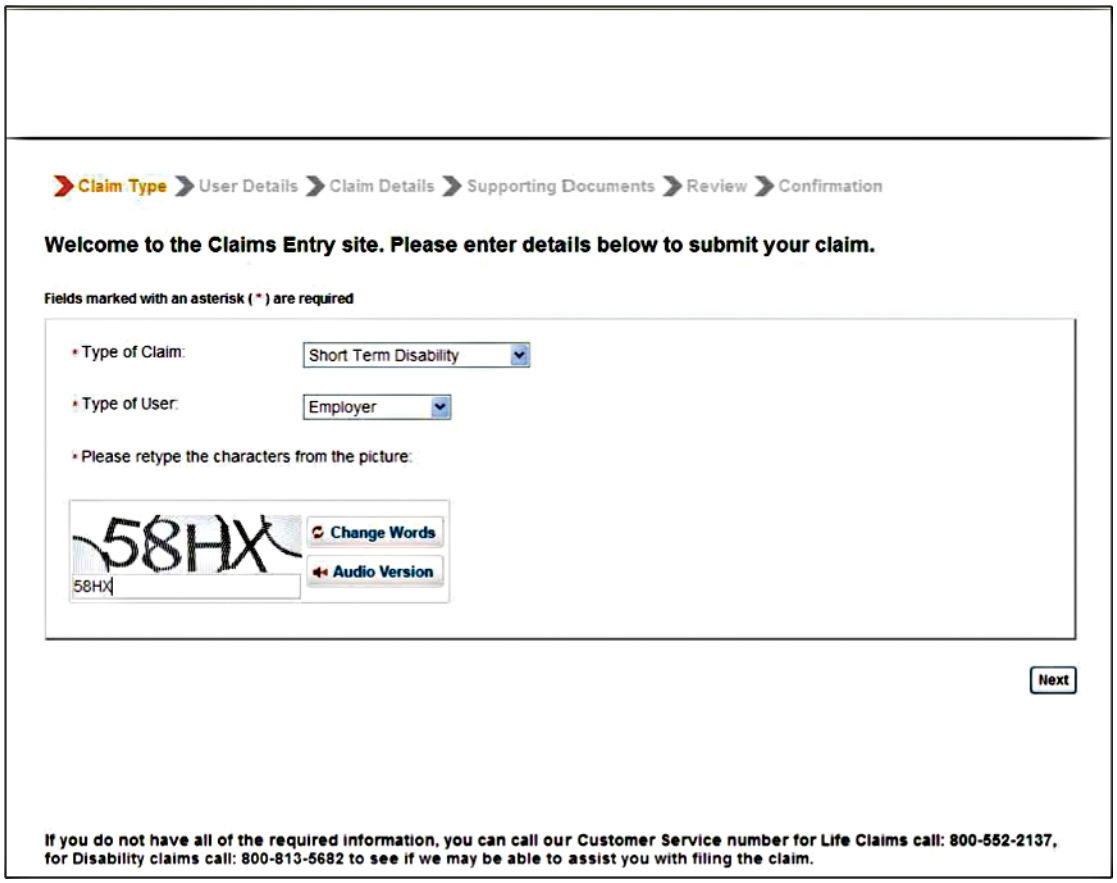
Failure to respond to our request for information may cause a delay in claim processing.

If you would like to enter another claim, please click here.

Our Customer Service number is 800-813-5682 and we are available 8:00 AM to 8:00 PM Eastern Time. You may also leave a message if you call outside of our regular hours.

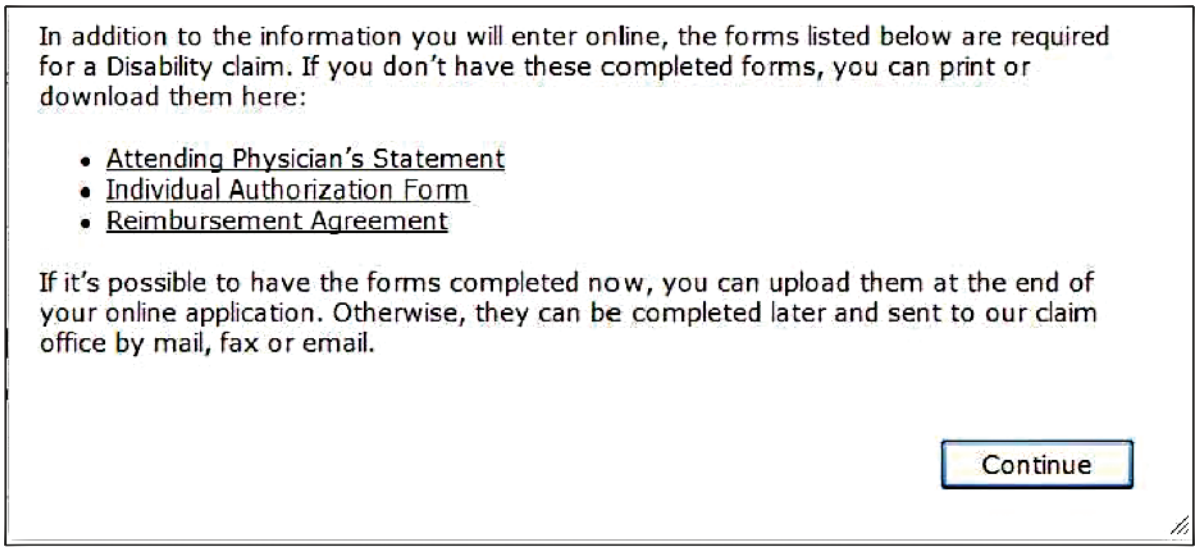
Submitting a long-term disability claim

Select **Long-Term Disability** in the *Type of Claim* field and **Employer** in the *Type of User* field. Enter the characters you see in the bottom box, then choose **Next**.

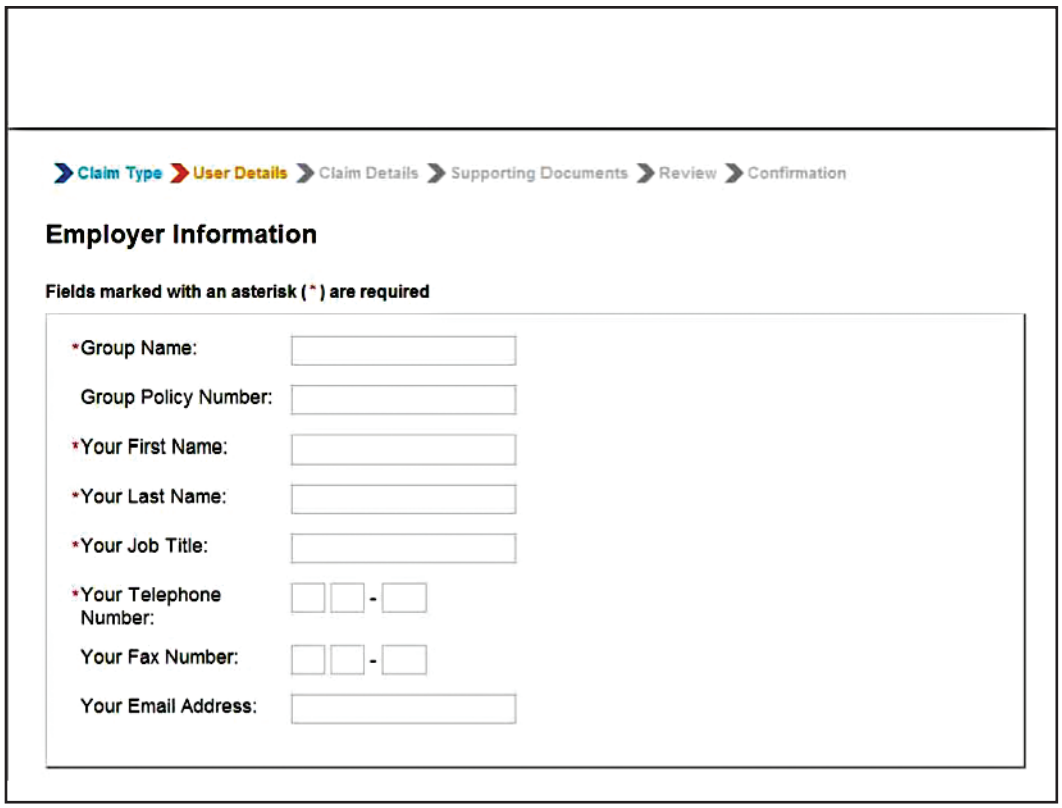


You can print the forms we need to process the long-term disability claim from this screen. Select the links to get fillable PDFs of the forms:

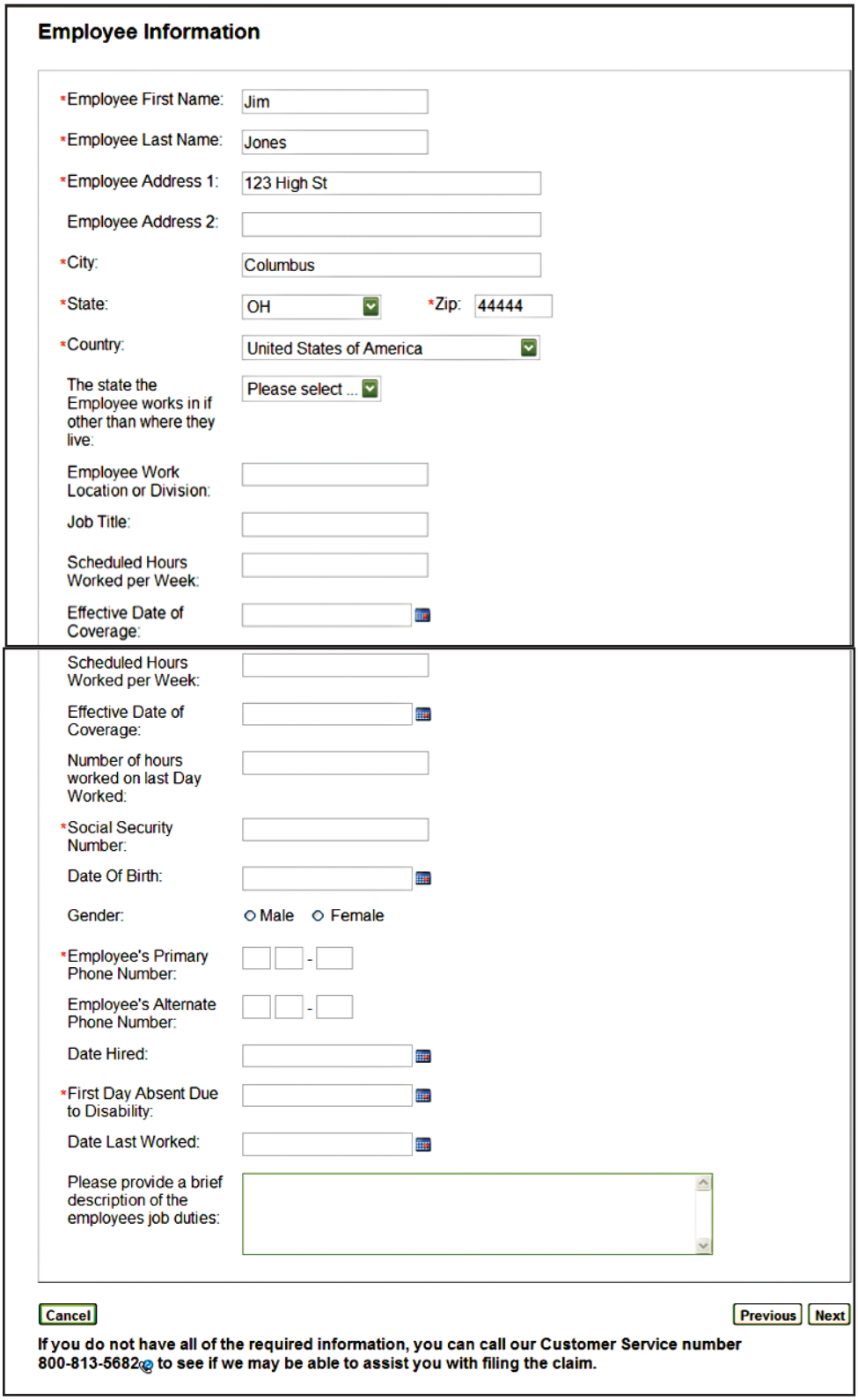
- *Attending Physician's Statement*
- *Individual Authorization Form*
- *Reimbursement Agreement*



Enter your contact information on the *Employer Information* screen.

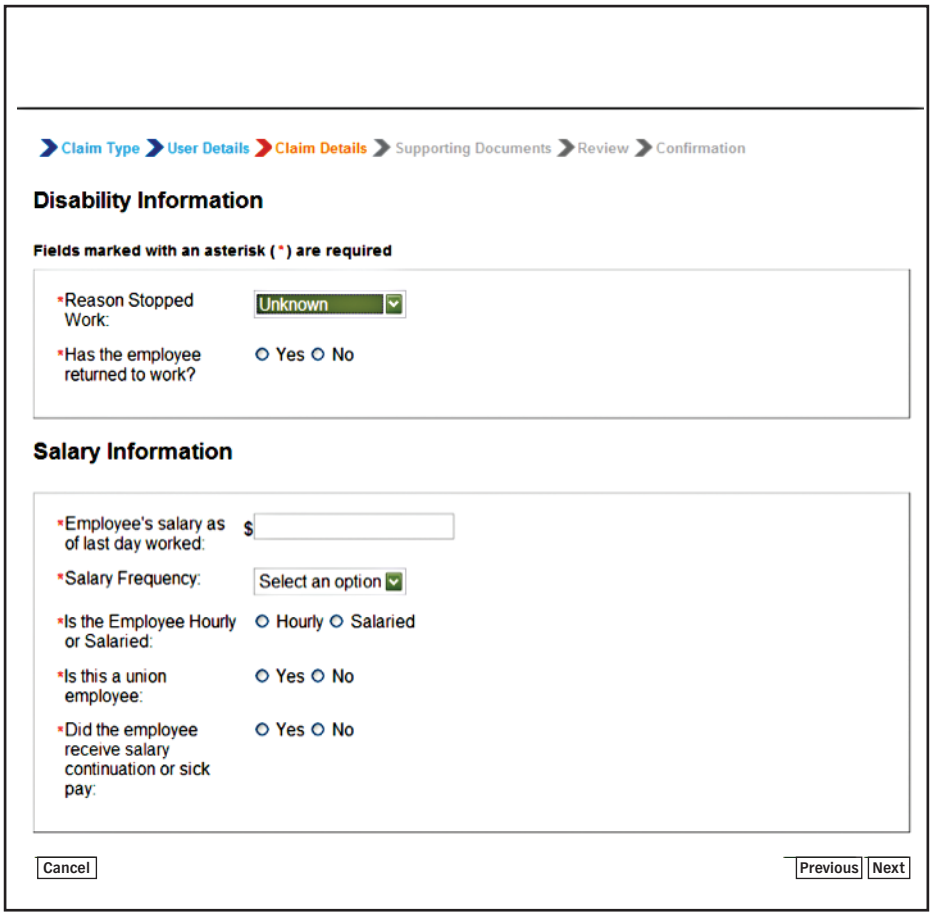


On the *Employee Information* screen, enter the employee's information.



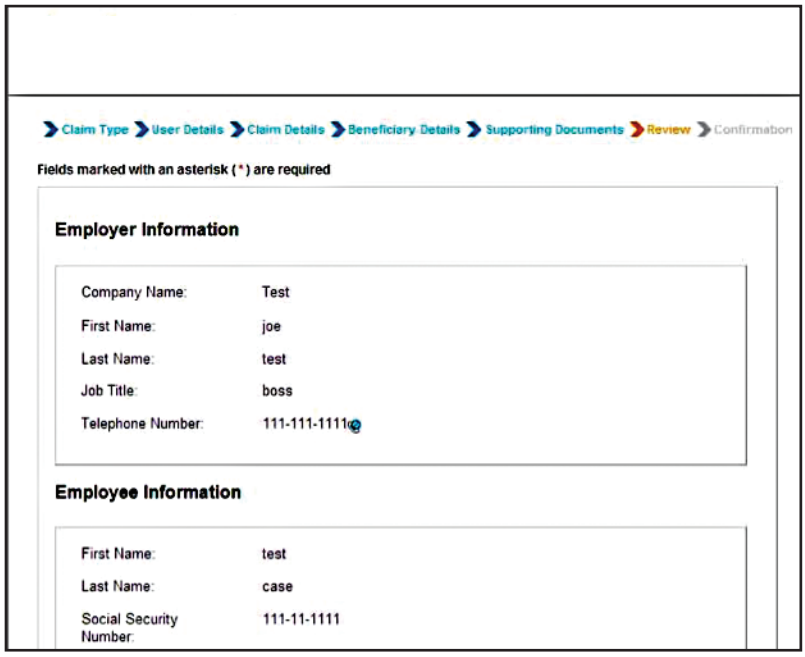
On the *Disability Information* screen, enter as much information as you can about the disabling condition. The questions will vary based on the reason the employee stopped work:

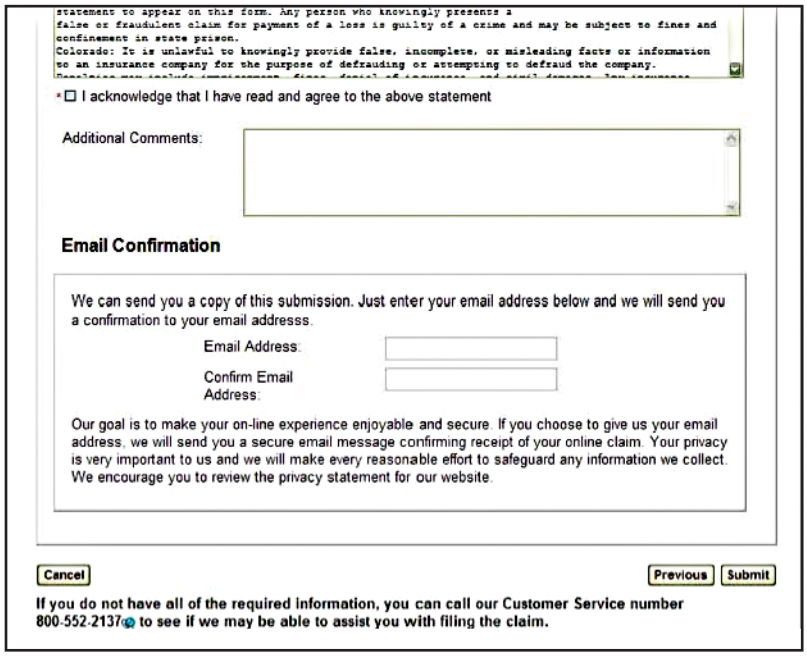
- Illness
- Injury
- Maternity
- Unknown



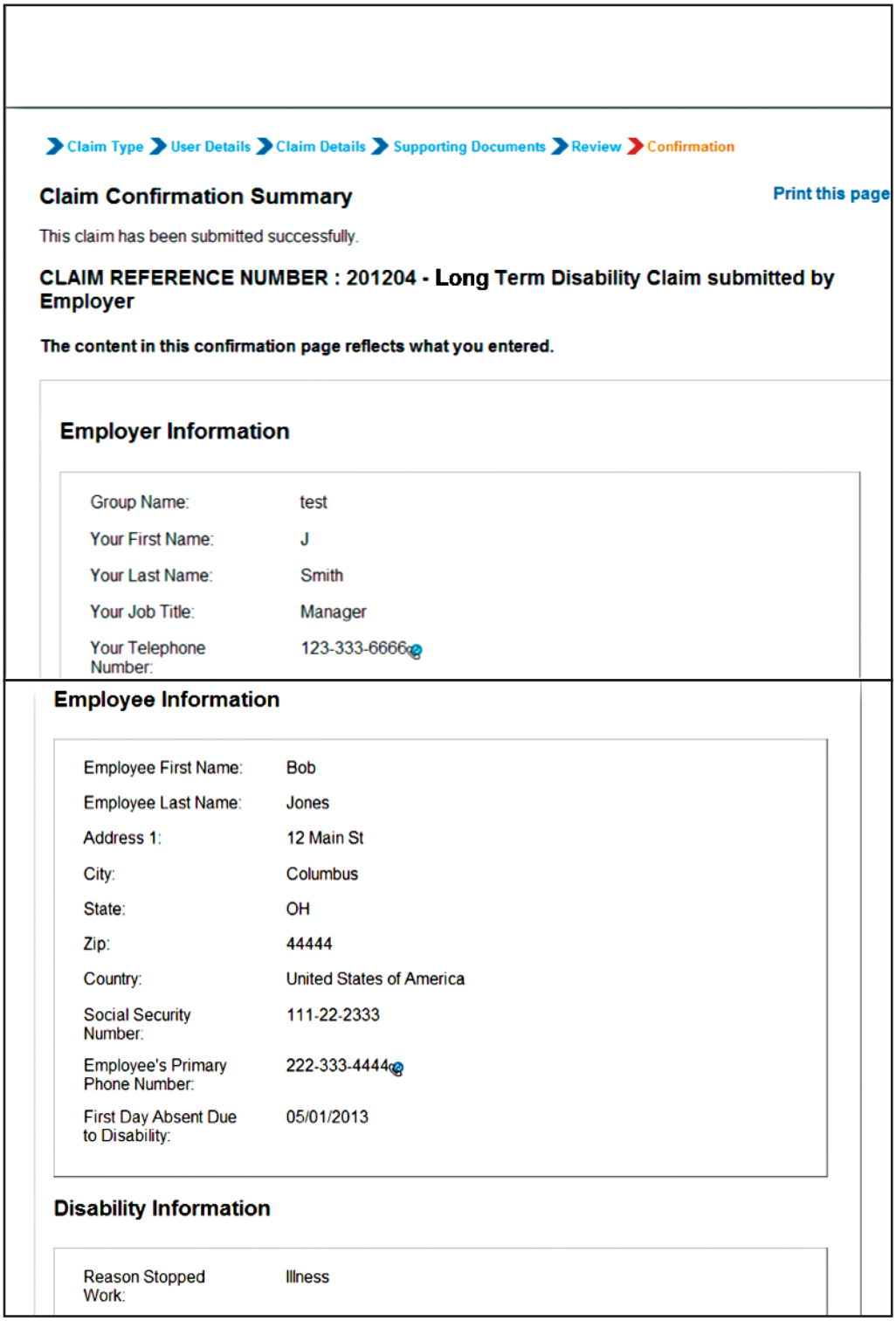
If you have completed forms at the time you enter the claim, such as the *Attending Physician's Statement*, the *Individual Authorization Form* or the *Reimbursement Agreement*, you can scan and attach them here.

Next, you'll get confirmation of the information you entered and agree to the legal statement so we can begin processing the claim. You can also enter your email address and we'll send you confirmation of all the information you entered.





Once the claim is complete, you'll receive a confirmation summary showing all the information you entered. If you entered your email address on the previous screen, you'll also get a confirmation summary by email.



Claim Type › User Details › Claim Details › Supporting Documents › Review › Confirmation

Claim Confirmation Summary

Print this page

This claim has been submitted successfully.

CLAIM REFERENCE NUMBER : 201204 - Long Term Disability Claim submitted by Employer

The content in this confirmation page reflects what you entered.

Employer Information

Group Name:	test
Your First Name:	J
Your Last Name:	Smith
Your Job Title:	Manager
Your Telephone Number:	123-333-6666

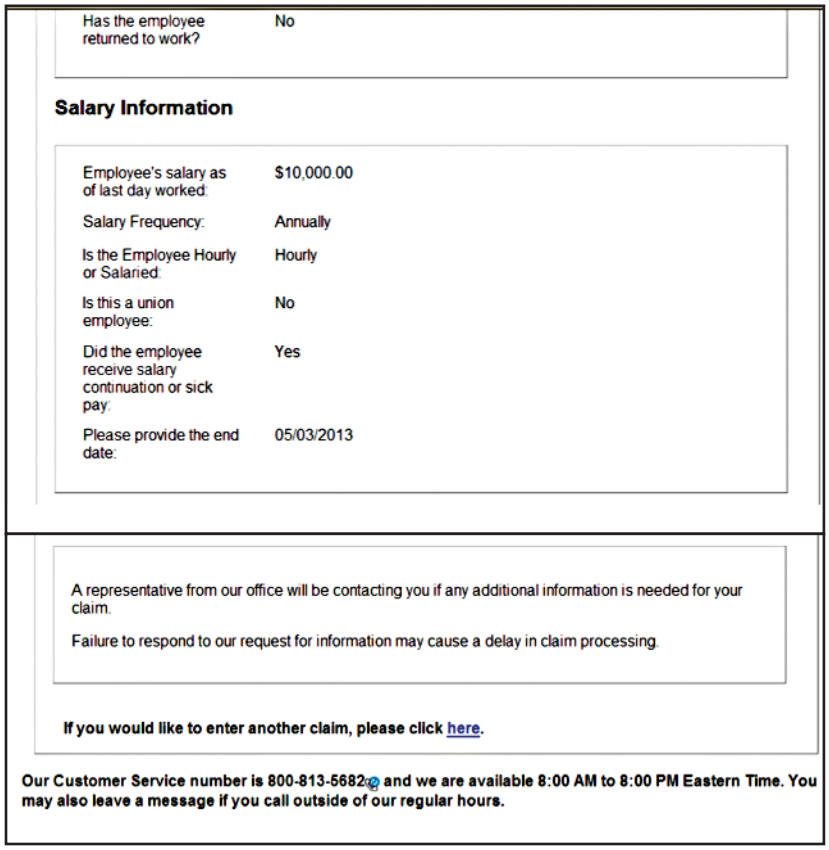
Employee Information

Employee First Name:	Bob
Employee Last Name:	Jones
Address 1:	12 Main St
City:	Columbus
State:	OH
Zip:	44444
Country:	United States of America
Social Security Number:	111-22-2333
Employee's Primary Phone Number:	222-333-4444
First Day Absent Due to Disability:	05/01/2013

Disability Information

Reason Stopped Work:	Illness

(Continued)



Has the employee returned to work?	No

Salary Information

Employee's salary as of last day worked:	$10,000.00
Salary Frequency:	Annually
Is the Employee Hourly or Salaried:	Hourly
Is this a union employee:	No
Did the employee receive salary continuation or sick pay:	Yes
Please provide the end date:	05/03/2013

A representative from our office will be contacting you if any additional information is needed for your claim.

Failure to respond to our request for information may cause a delay in claim processing.

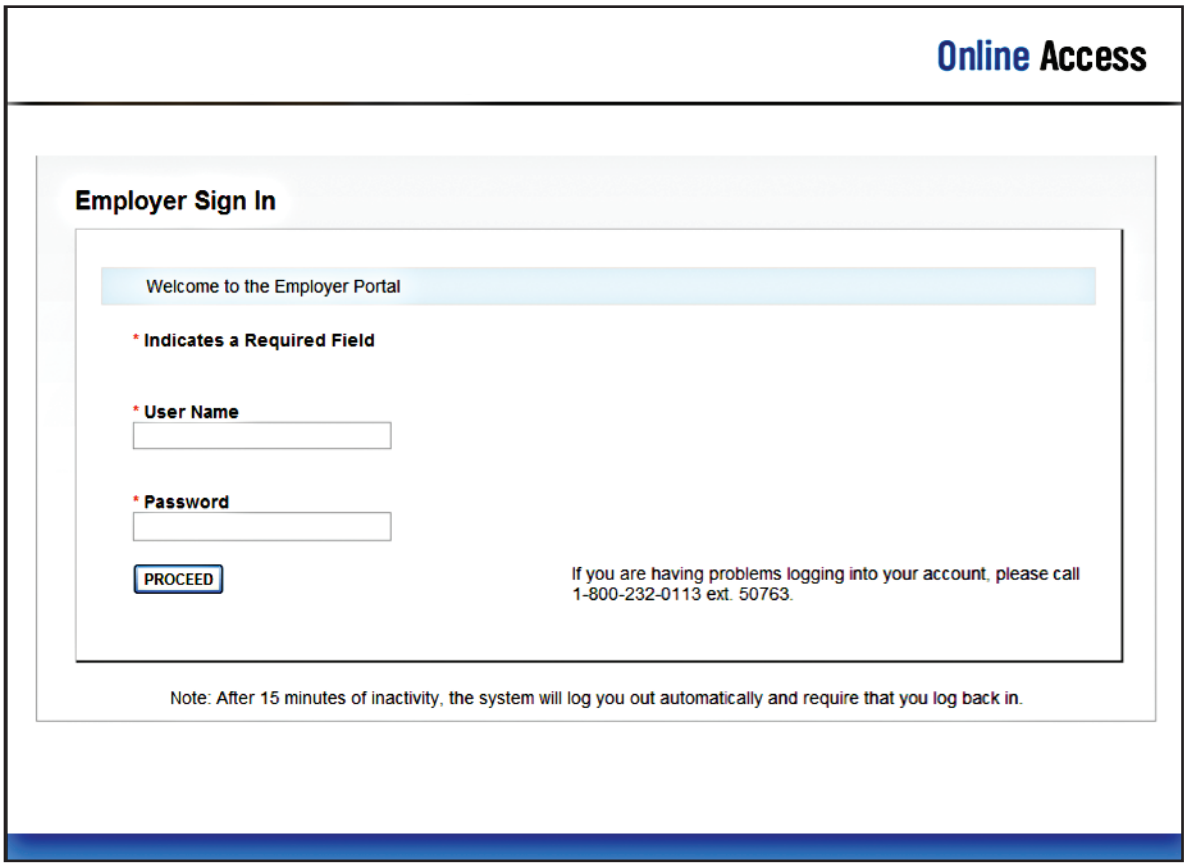
If you would like to enter another claim, please click here.

Our Customer Service number is 800-813-5682 and we are available 8:00 AM to 8:00 PM Eastern Time. You may also leave a message if you call outside of our regular hours.

Checking claim status

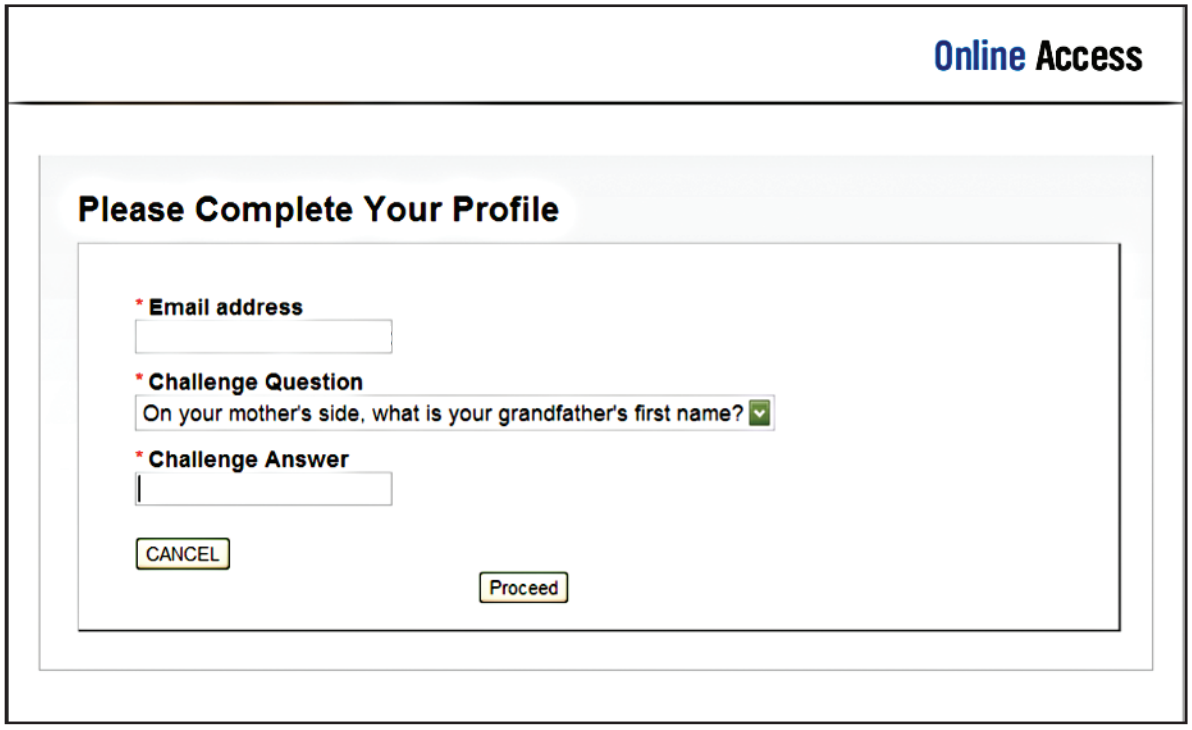
Using the secure website, you can check the status of claims submitted online. We'll provide a user name and temporary password for you.

Only a group administrator, or his or her designated representative can check claim status. Employees don't have access.

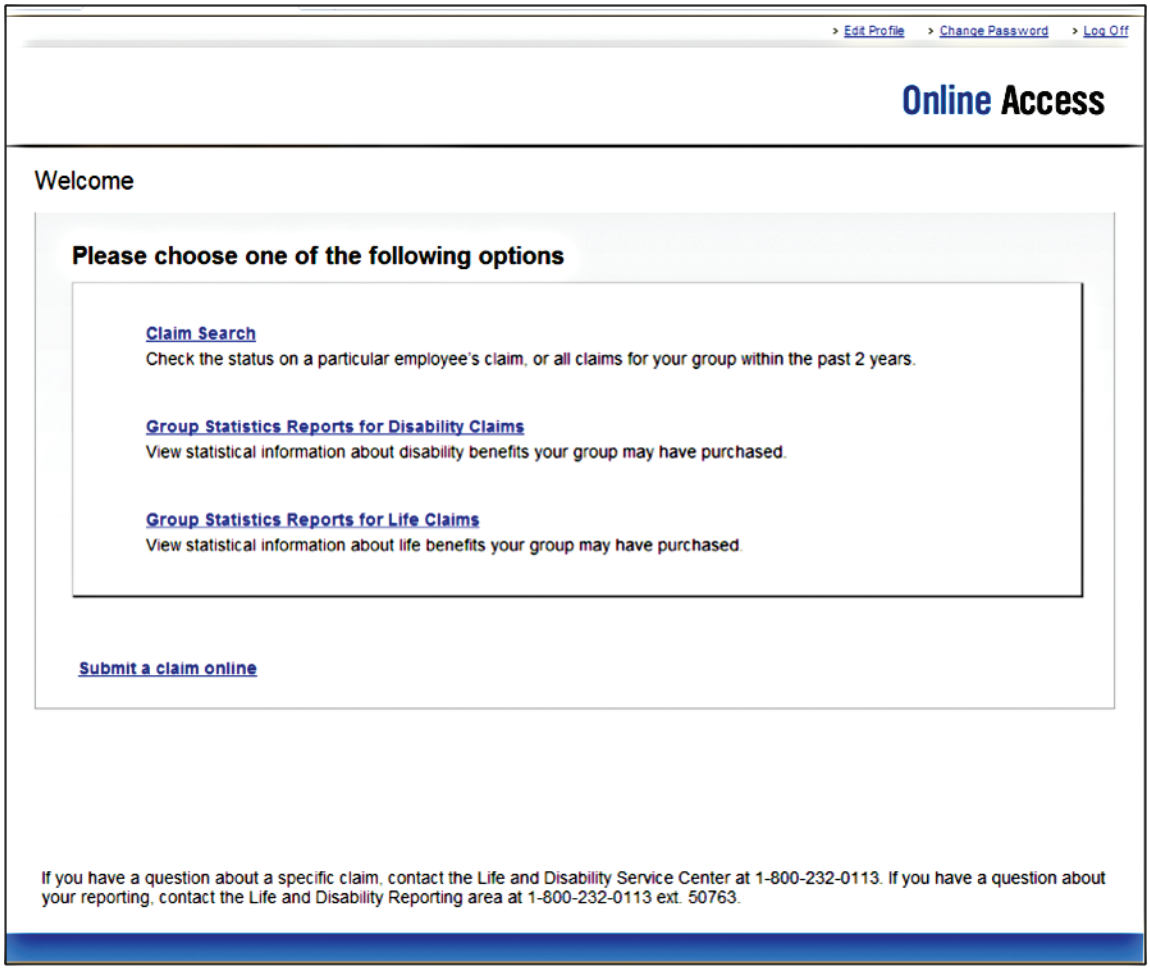


The first time you log on with your temporary password, you'll be prompted to change your password. You'll then get confirmation that your password was changed.

The first time you log on, you'll also need to complete your profile.



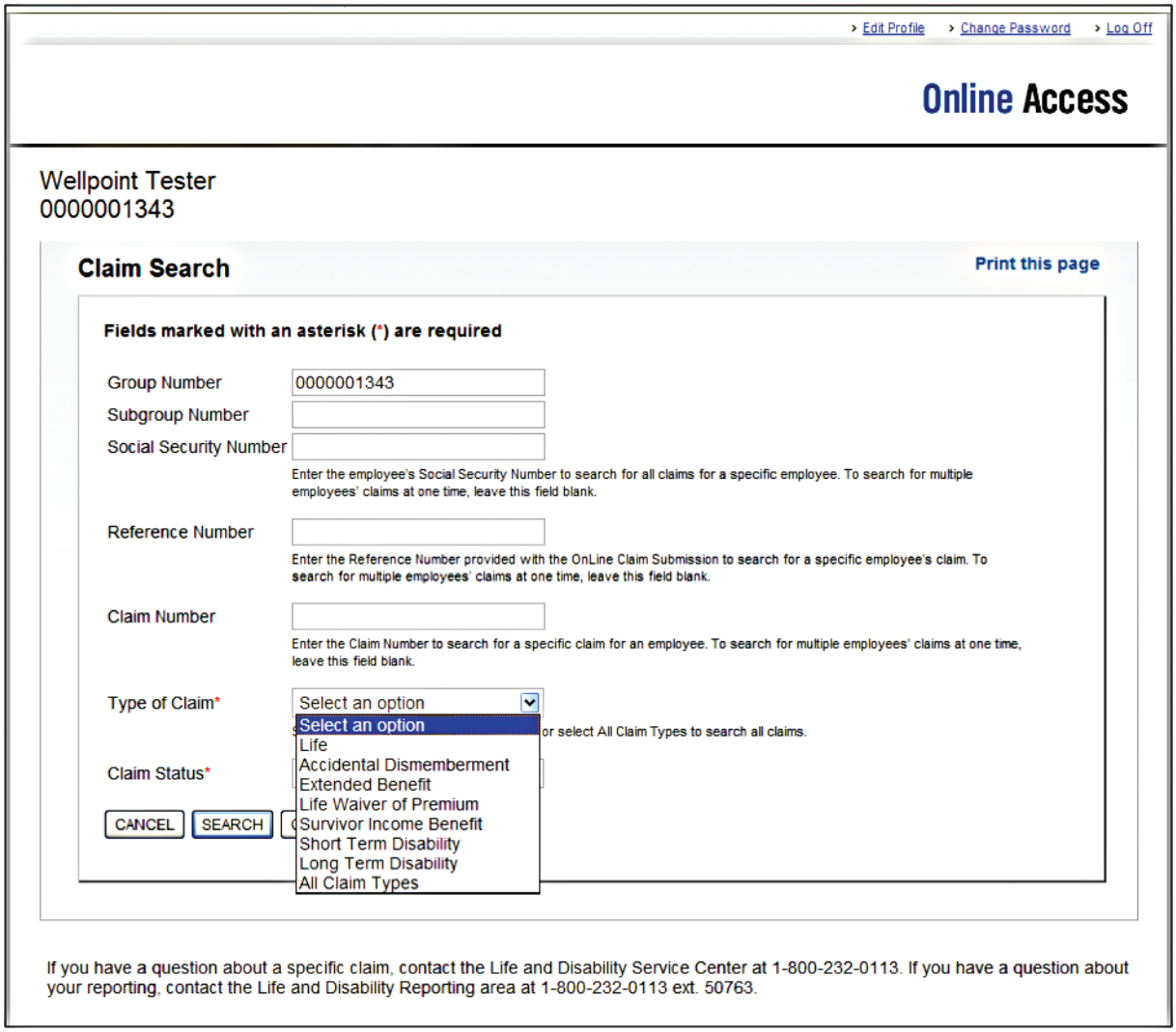
To check the status of submitted claims, select **Claim Search**.



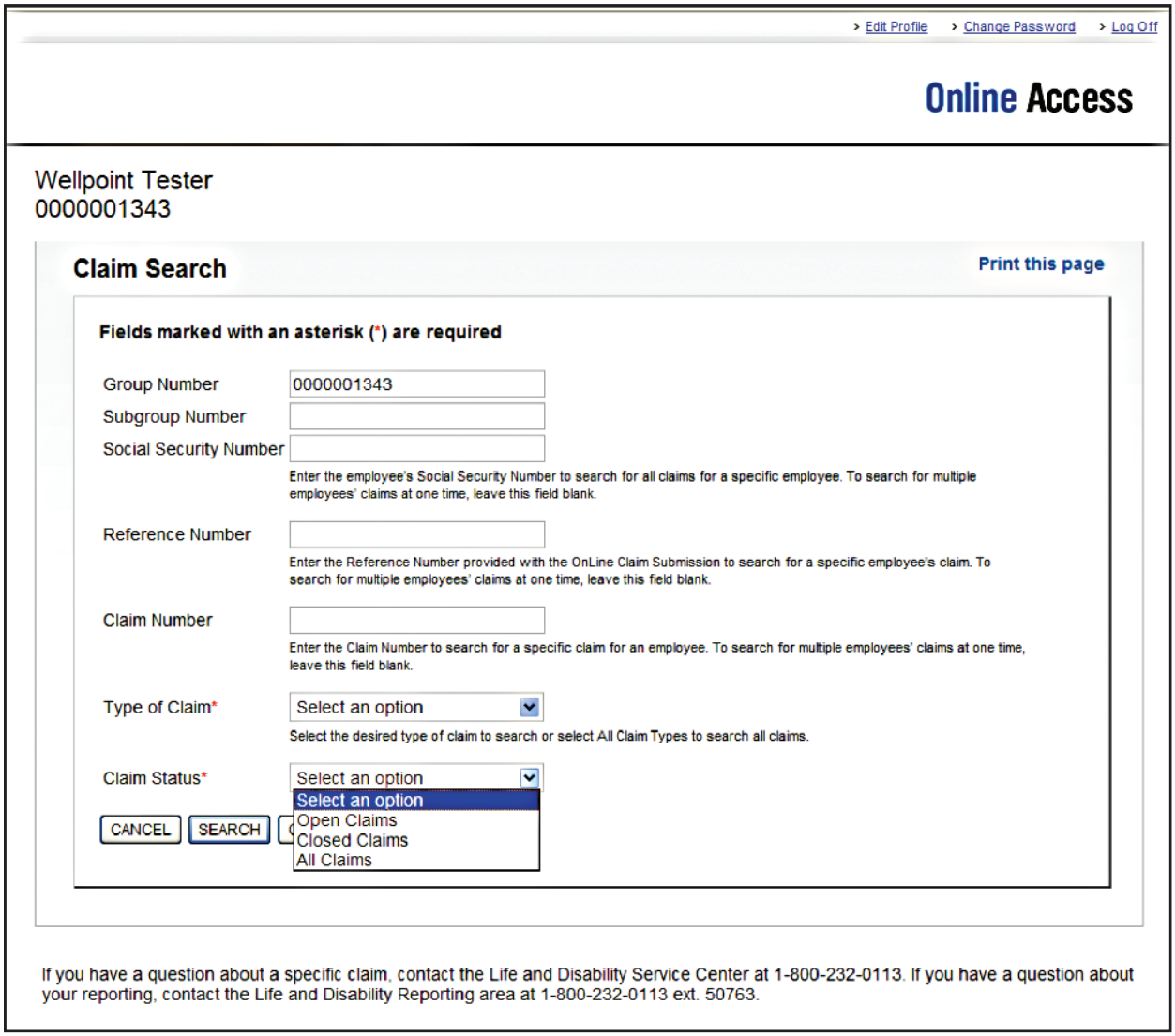
You can search for a claim by:

- Social Security number
- Reference number — the number provided when the claim was entered online
- Claim number — assigned by us
- Type of claim
- Claim status

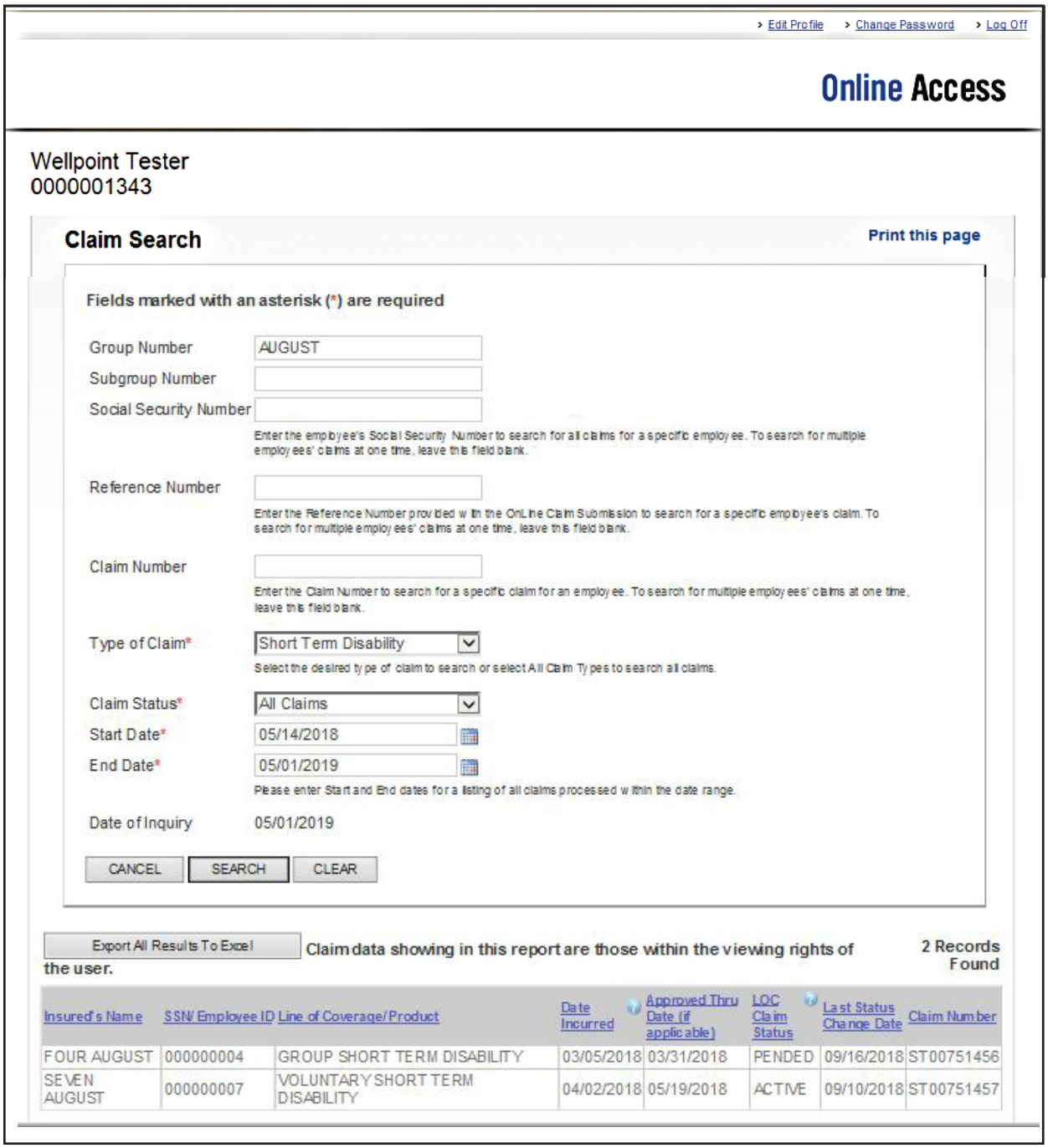
Only the *Type of Claim* and *Claim Status* fields are required.



You can search for open claims, closed claims or all claims for your group.



You can review claims online or export the claims report to Excel. To export the report to Excel, select the **Export All Results to Excel** button above the list of claims.

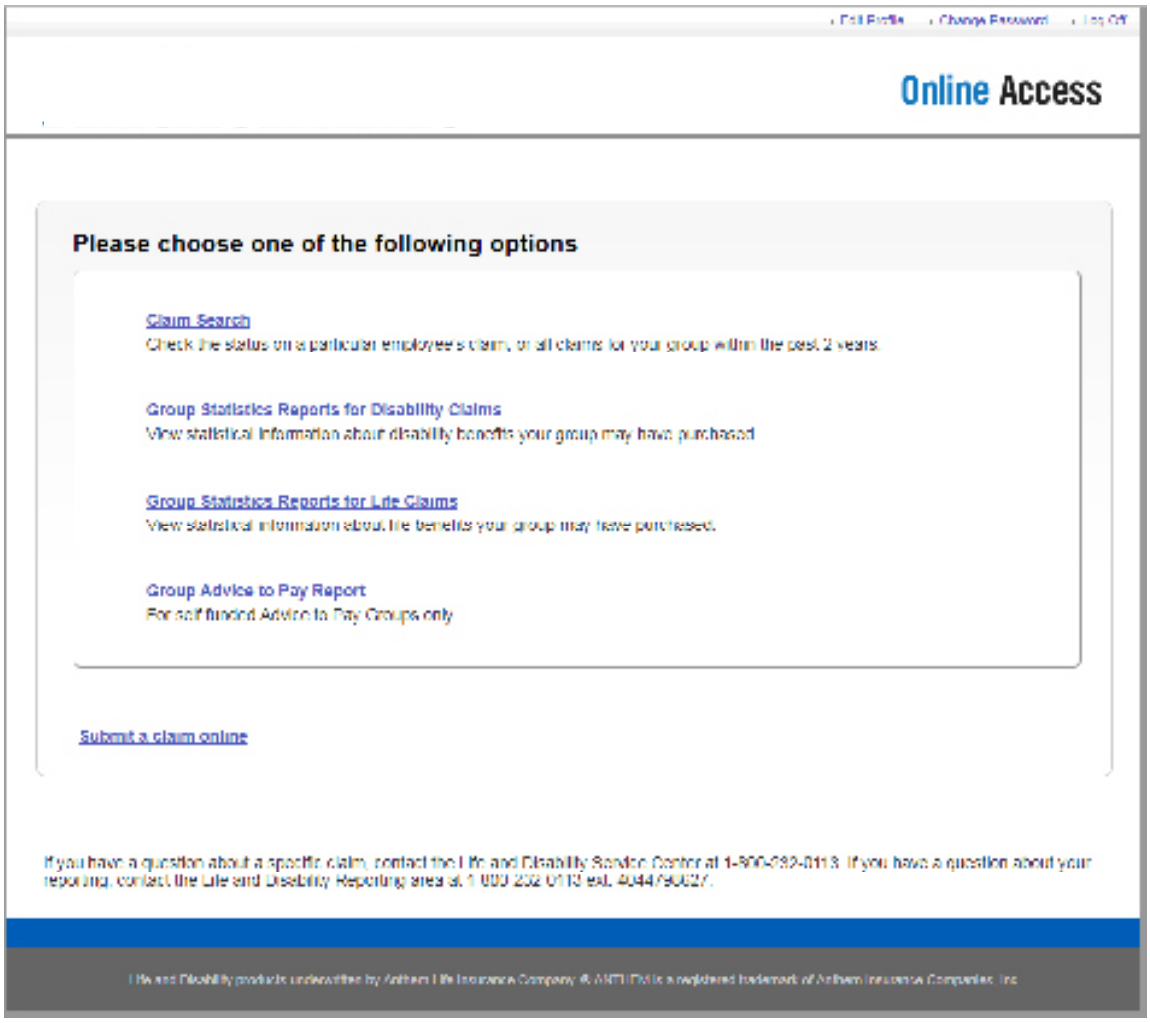


Getting reports

You can get reports of your group's disability claims. For groups with Administrative Services Only Short-Term Disability Advice to Pay or Financial Advice to Pay plans, you can also get your Advice to Pay claim reports.

Only group administrators or their designated representatives can access statistics reports. Employees don't have access.

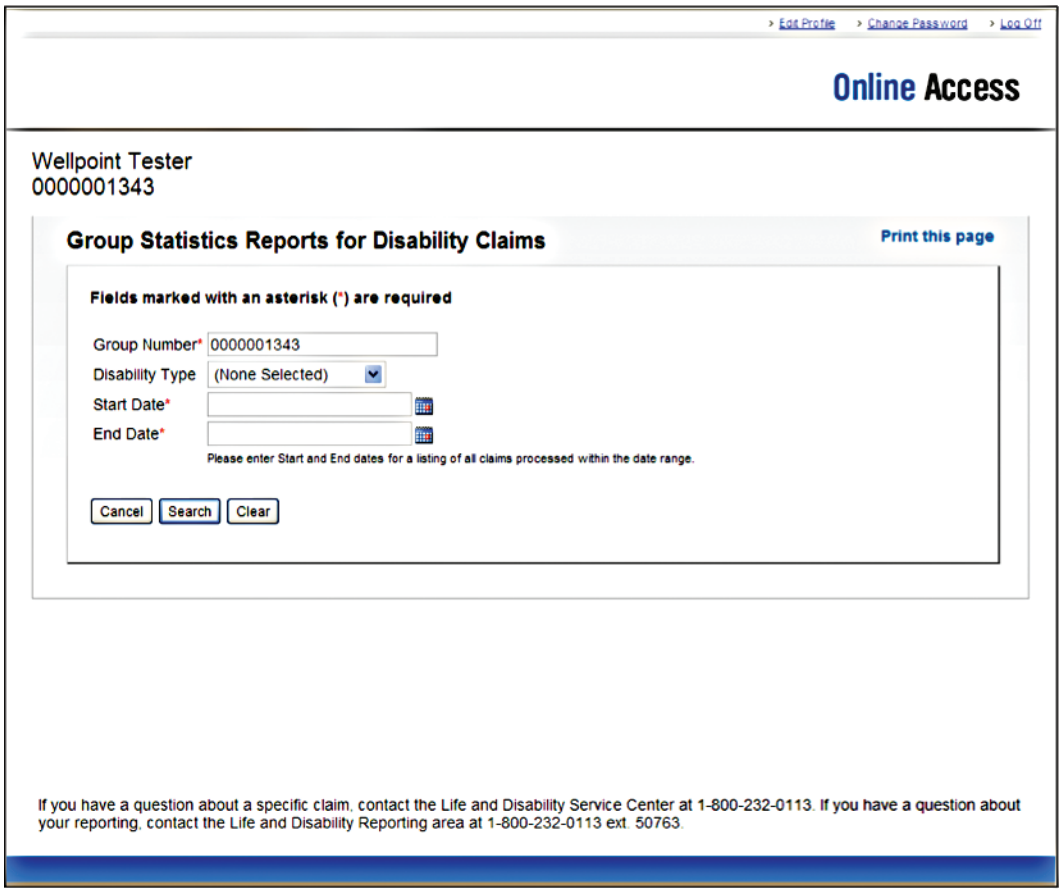
To access disability claims reports, select **Group Statistics Reports for Disability Claims**. For self-funded Advice to Pay groups only, to access Advice to Pay claim reports, select **Group Advice to Pay Report**.



To search the *Employee Disability Claims* status page:

- Enter the range of dates you'd like to search in the *Start Date* and *End Date* fields.
- Select **Search**.

Searches will display up to 12 months of results.



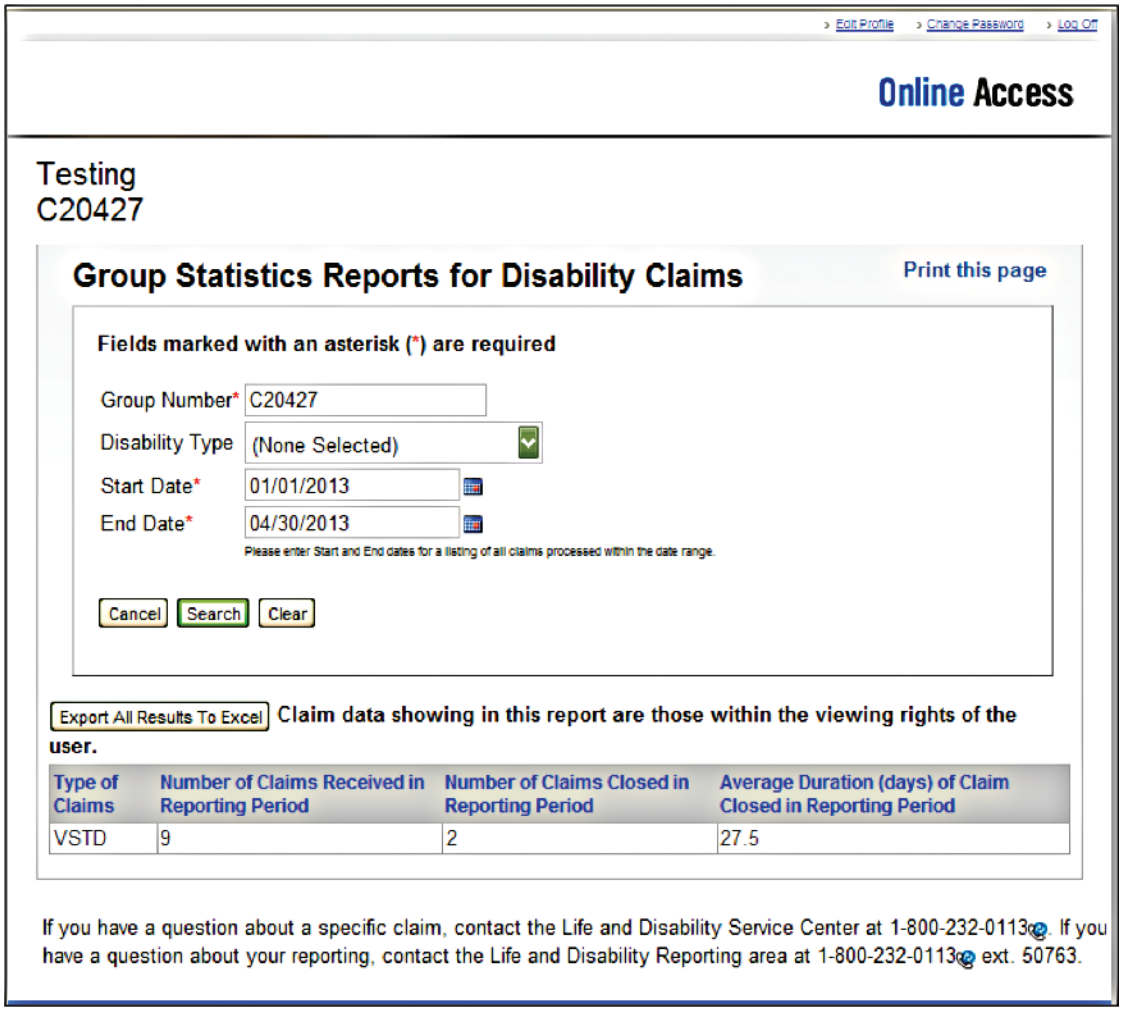
Select the claim type you want from the *Disability Type* drop-down box:

- Short-term disability
- Long-term disability

Enter the range of dates you'd like to search in the *Start Date* and *End Date* fields, then select **Search**.

You can review the report online or export the full report to Excel. To export it to Excel, select **Export All Results to Excel** above the list of claims.

Here's a sample group statistics report for disability claims.



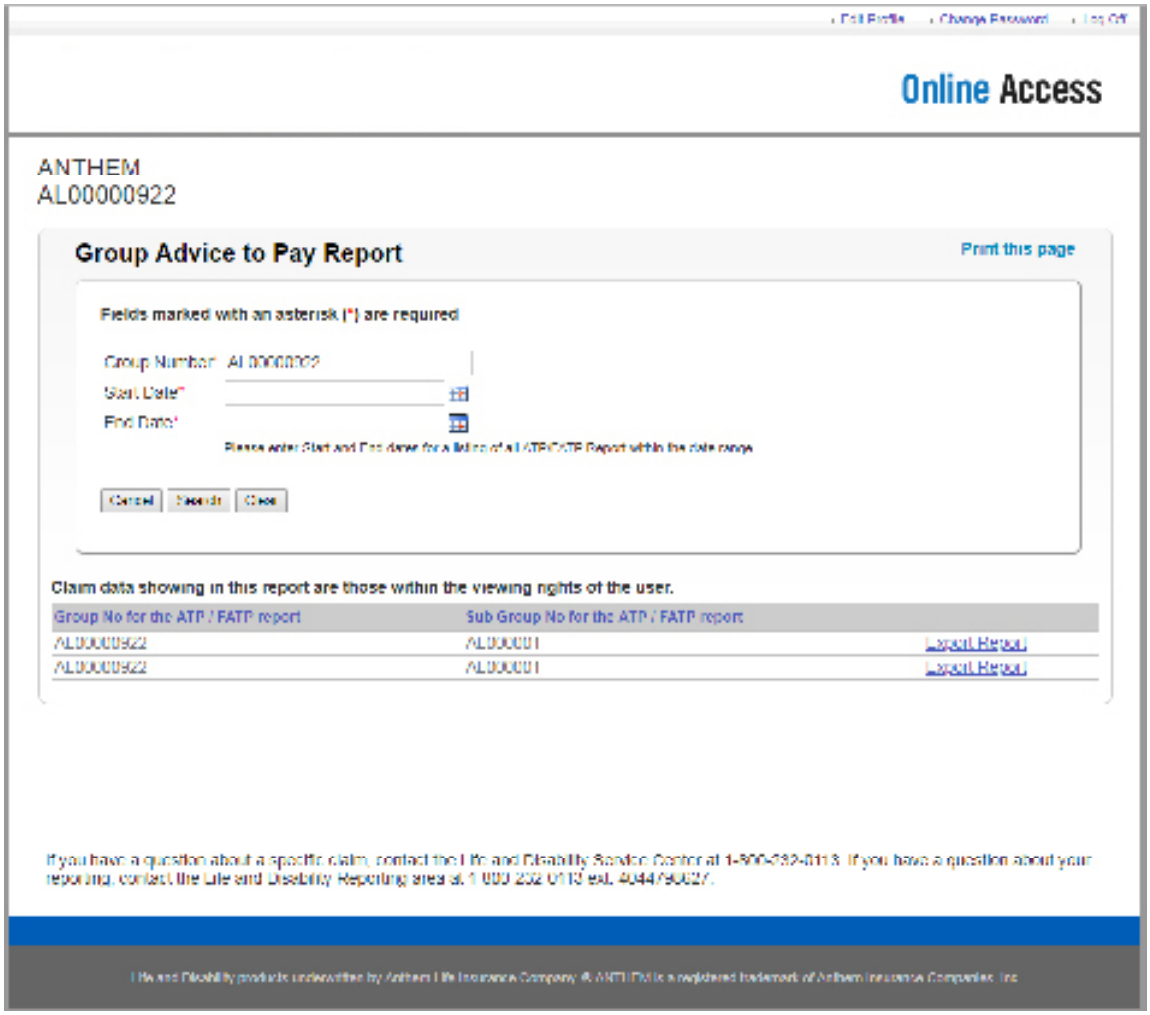
Advice to Pay groups only

For self-funded Advice to Pay groups only, to access Advice to Pay claim reports, select **Group Advice to Pay Report**.

Your current report and your recent reports are shown on this screen. You can view and export the full report to Excel by selecting **Export Report**.

If you'd like to recreate a report for a certain time period not shown:

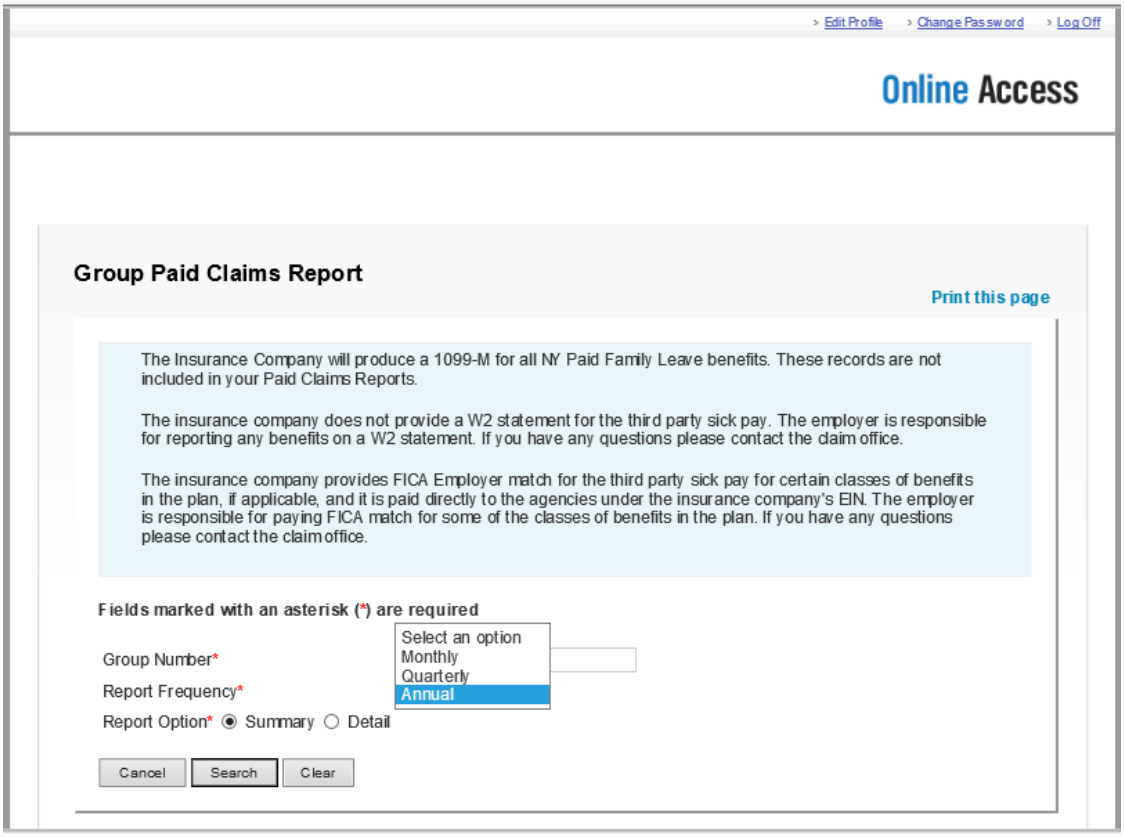
- Enter the range of dates you'd like to search in the *Start Date* and *End Date* fields.
- Select **Search**.



Group disability paid claims reports

You can view your paid disability claims reports monthly, quarterly or annually. You can also view a summary of paid disability claims or details of each claim.

Select the option you want to see. Also, enter your group number and choose Summary or Detail as the Report Option. Then, select Search.



Appendix - Program Policies and Summaries

Resource Advisor flier – for employees

Resource Advisor is here to help

Resource Advisor, a member assistance program that's included with your life and/or disability benefit, provides resources and services to support you and your household family members when you need it.

Counseling by phone, face-to-face or LiveHealth Online video chat

When you're feeling stressed, worried or having a tough time, you may want someone to talk to. You and your household family members can call Resource Advisor anytime, 24/7, and talk with a licensed counselor:

- **By phone**: Call **1-888-209-7840**.
- **In-person**: Call to set up face-to face sessions and then schedule with your counselor.
- **Video chat**: Talk with a counselor from the convenience of your home or wherever you have internet access and privacy using LiveHealth Online. To set up a LiveHealth Online visit, call Resource Advisor. We'll give you details about how to schedule a visit, along with a coupon code that gives you LiveHealth Online visits at no extra cost to you.

You can also review a therapist's background and qualifications to help choose one who's available and right for you. Whatever works for you — we're here to help with any concern, no matter how big or small.

You and your family members are eligible for up to three counselor visits for each issue or concern, at no cost to you.

Counselors can help with:

- Stress
- Parenting
- Anxiety
- Depression
- Any issue that affects your wellbeing
- Dealing with illness
- Relationship or family issues
- Finding child care
- Elder care issues and resources

Resource Advisor
1-888-209-7840

www.ResourceAdvisor.Anthem.com
(Log in with program name AnthemResourceAdvisor.)

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Anthem®

Anthem® Life

Support when you need it

Here are some services you can count on from Resource Advisor

Financial planning

Call Resource Advisor to set up one-on-one financial counseling with a certified professional financial planner. They can help with issues like retirement planning, saving for a child's education and more.

Legal services

With a call to Resource Advisor, you can get a consultation with an attorney over the phone at no charge. If you want to meet with an attorney in person, the legal consultant can set up an appointment at a discounted fee.

Identity theft recovery and monitoring

Resource Advisor has fraud resolution specialists who can help if your identity is stolen. They can work with creditors, collection agencies, law firms and credit reporting agencies for you for up to one year. You can sign up for ID monitoring, get credit report reviews and place fraud alerts on credit reports no matter how many times your identity is compromised.

Online tools to help with life's issues

The Resource Advisor website has tools to help with many of life's challenges, such as creating a will, parenting, aging, healthy living, household support, referrals, funeral planning and more. Visit www.ResourceAdvisor.Anthem.com and use the program name "AnthemResourceAdvisor" to access resources.

Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it's important that you seek help immediately. Please call **1-800-784-2433** (National Suicide Prevention Lifeline) or 911 and ask for help.

If your issue is an emergency, call 911 or go to your nearest emergency room. LiveHealth Online does not offer emergency services.

Appointments subject to availability of a therapist.

LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Anthem Blue Cross and Blue Shield.

Note about eligibility: This program is for active employees and their household family members. All benefits end at retirement.

Resource Advisor services are not a part of the certificate, policy or trust agreement and do not modify any insured benefits. Resource Advisor additional services are provided based on negotiated agreements between the insurance company and certain service providers. Although the insurance company endeavors to make these services available to all policyholders and certificateholders as described, modifications to our agreements with service providers may require that services be periodically modified or terminated. Such modification or termination of services may be made based on cost to the insurer, availability of services, or other business reasons at the discretion of the insurer or service providers.

Cut out this wallet card and keep it with you when you travel.

AnthemLife Anthem

Resource Advisor

Get support, advice and resources, 24/7.

1-888-209-7840

www.ResourceAdvisor.Anthem.com

Perks at Work discounts

Resource Advisor

Perks at Work

Discounts on things you use every day

Save on electronics, restaurant certificates, gym memberships, weight loss programs, glasses and contacts, nutritional supplements, travel, sporting events tickets — even on buying your next car. It's part of the Resource Advisor member assistance program that's included with your life and disability coverage from Anthem Life.

Perks at Work has discounts on goods and services you use every day like:

- Gym memberships, including FitReserve, LA Fitness, ClassPass, Active & Fit, GlobalFit and more
- Weight loss programs like Nutrisystem, Weight Watchers and more
- Vitamins and supplements, including GNC
- Vision supplies and services, including Glasses Shop, 1-800 CONTACTS, and LasikPlus
- Dozens of brands of hotels
- Flights and other vacation services
- TVs, computers, tablets, video games and more
- Six Flags amusement parks
- Movie tickets
- Employee car buying service
- Cell phones from Sprint, T-Mobile, Verizon and more
- Gift certificates from popular restaurants

Log on to Anthem Life's Resource Advisor website to check out all the savings — and to access discounts.

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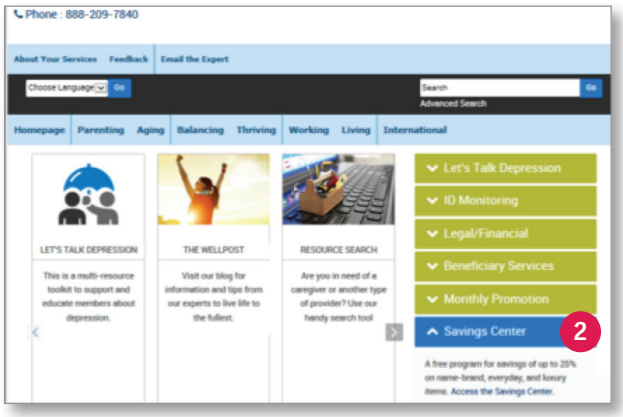
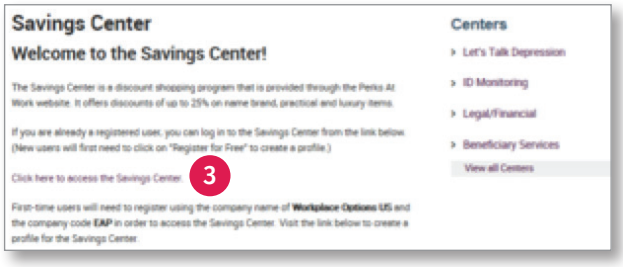
Anthem Life

To sign up for Perks at Work:

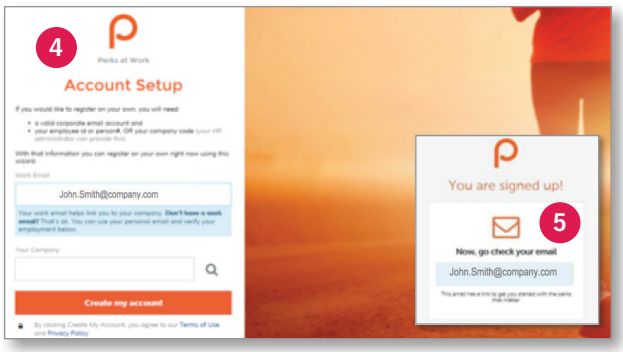
1. Go to www.ResourceAdvisor.anthem.com and sign in using the program name *AnthemResourceAdvisor*.
2. Choose **Savings Center** and then choose **Access the Savings Center**.



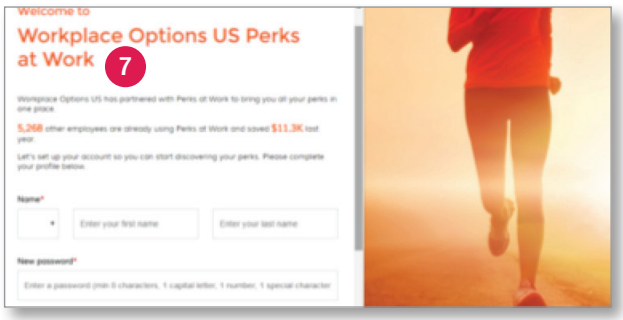
3. You'll see an overview of the *Savings Center*. To access *Perks at Work*, choose **Click here to access the Savings Center**.



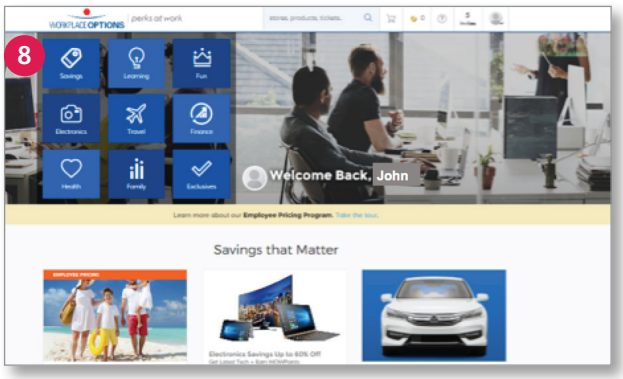
4. You'll be taken to the Perks at Work website. To set up your Perks at Work account, enter your work email. In the *Your Company* box, enter **Workplace Options US** and in the *Please enter your Company Code* box, enter **EAP**. Then, choose **Create my account**.
5. You'll get a confirmation.



6. Check your email for an email from Perks at Work. Click on the **Complete my profile** button in the email.
7. You'll be taken back to the Perks at Work website to set up your password.



8. You're now signed up for Perks at Work — time to start saving! Be sure to check Perks at Work often for new discounts.



Group Short-Term Disability Benefits At a Glance

Group Short Term Disability Program

Anthem Life

Virginia Association of Counties Group Self Insurance Risk Pool (VACORP)

Group # AL0006723

Effective date: July 1, 2019

Group Short Term Disability (STD) program provided for its participant by the Sponsor and administered by Anthem Life Insurance Company helps provide financial protection for covered members by promising to pay a weekly benefit in the event of a covered disability.

The cost of this program is paid by your Employer.

Employer means any unit of local government or other local agency, public entity, school, jail, department, board, or authority in the Commonwealth of Virginia which a) is eligible for and is participating in the Virginia hybrid retirement program described in §51.1-169 of the Code of Virginia, b) has signed a Participation Agreement with VACORP, and c) whose participation under the program has been approved in writing by the Policyholder.

Please refer to the plan summary document and your employee handbook, and for specific plan details, eligibility definitions, limitations, and exclusions

Eligibility

Definition of a Member: You are a member if you are:

1. an employee of the Employer who is participating in the Virginia hybrid retirement program described in §51.1-169 of the Code of Virginia.
2. a regular full-time or part-time employee of the Employer, working for pay on a scheduled normal week of at least 10 hours required per week; and
3. A citizen or resident of the United States.

You are not a member if you are a temporary or seasonal employee, full-time member of the armed forces, leased employee or an independent contractor.

Class Definition:

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

Eligibility Waiting Period:

None

Benefits

Group short term disability weekly benefit amount:

Work related disability

Months of continuous service	Work days @ 100% of Weekly Earnings	Work days @ 80% of Weekly Earnings	Work days @ 60% of Weekly Earnings
<60 months	0	0	125
60 - 119 months	85	25	15
120 months or more	85	40	0

Non-work related disability

Months of continuous service	Work days @ 100% of Weekly Earnings	Work days @ 80% of Weekly Earnings	Work days @ 60% of Weekly Earnings
0 – 12 months	0	0	0
13 – 59 months	0	0	125
60 - 119 months	25	25	75
120 - 179 months	25	50	50
180 months or more	25	75	25

Minimum Weekly Benefit

None

Benefit Waiting Period

Your weekly benefit becomes payable after you have been continuously disabled for 7 days for accident, 7 days day for illness.

Maximum Benefit Period

The maximum benefit period determines how long benefits will be paid. The maximum benefit period is 125 work days.

Definition of Disability

Disability means during the Elimination Period and thereafter because of your injury or illness, you are unable to do the material and substantial duties of your own occupation, or your disability work earnings, if any, are less than or equal to 80% of your weekly earnings.

Partial disability benefits

If you are able to return to work part-time, you may still receive a portion of your short term disability benefit to help fill the gap in your income.

Catastrophic Conditions

Additional 20% benefit if STD benefits are payable. When combined with the STD benefit, the total benefit amount cannot exceed 80% of creditable compensation.

Maternity benefit

Short term disability benefits for pregnancy are provided the same as for a disability caused by an illness.

Value Added Services

Resource Advisor

This value-added support program gives you and your family access to work/life resources, at no additional cost to you, including: face-to-face visits with a counselor or online visits via LiveHealth Online; identity monitoring and identity theft victim recovery services, legal and financial consultations; toll-free, 24/7 phone counseling from anywhere in the United States; and unlimited access to Resource Advisor online resources at www.resourceadvisor.anthem.com, program name “AnthemResourceAdvisor”. To access Resource Advisor call (888) 209-7840.

Virginia Association of Counties Group Self Insurance Risk Pool (Program Sponsor) has endorsed an employer-funded short term disability income benefit (Program) for certain employees of local public entities whose participation under the Program has been approved in writing by the Program Sponsor. Employers are solely responsible for payment of all risks, liabilities, benefits, and claims under this Program.

Anthem Life will perform certain administrative services for the Program, including advising and assisting Program Sponsor with preparation and revision of the Program. Anthem Life has no authority or obligation with respect to management or investment of the assets of the Program or Employer’s right of subrogation under the Program.

This is not a contract. It is a brief description of the STD benefit program endorsed by the Program Sponsor and administered by Anthem Life. The controlling provisions are in the Program Document adopted by the Program Sponsor. The Program Document contains a detailed description of the limitations, reductions in benefits, and exclusions. The Program document that describes the terms and conditions of the coverage is available for those who become covered according to its terms. For more complete details of the coverage, contact your human resources representative. This benefit overview is only one piece of your entire enrollment package. All benefits and services are subject to the conditions, limitations, exclusions and provisions listed in the contract documents: summary document, your employee handbook, and/or Trust Agreement for this product. In the event of a conflict between the contract documents and this benefits description, the contract documents will prevail. If you have any questions, please contact your Human Resources/Benefits manager.

Exclusions and limitations are listed in detail in the summary document, your employee handbook, or trust agreement that applies to this product.

The Value Added additional services are not a part of the summary document, your employee handbook, or trust agreement and do not modify any insured benefits. The Value Added additional services are provided based on negotiated agreements between the insurance company and certain service providers. Although the insurance company endeavors to make these services available to all policyholders and certificate holders as described, modifications to our agreements with service providers may require that services be periodically modified or terminated. Such modification or termination of services may be made based on cost to the insurer, availability of services, or other business reasons at the discretion of the insurer or service providers.

7/2019

Short-Term Disability Claim Form

Short Term Disability Claim Form

AnthemLife

Important notice to employee – Please read carefully: You or someone acting on your behalf should complete Section 1 and then have your employer complete Section 2. Have your physician complete Section 3. Also complete and sign the *Authorization for Release of Information*, *Communication Consent*, and *Reimbursement Agreement* forms. Submit the forms to us at the address or fax number listed to the right. Your cooperation will facilitate payments promptly when they are due.

Any person who knowingly, and with intent to defraud any insurance company, files a statement of claim containing any false, incomplete or misleading information may be subject to criminal penalties.

Anthem Life Insurance Company
Disability Claims Service Center
P.O. Box 105426
Atlanta, GA 30348-5426
Phone: 1-800-813-5682 Fax: 1-800-850-0017
Email: lifeanddisabilityclaims@anthem.com

Notice to customers regarding telephone service observance – To ensure our customers receive quality service, all of our phone calls are recorded. These calls, between our customers and employees, are evaluated by supervisors. This is to assure that prompt, consistent assistance, and accurate information is delivered in a professional manner. We have been properly licensed by the Georgia Public Service Commission to use such observing equipment.

Section 1: To be completed by the employee

Last name	First name	M.I.	Gender ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)

Social Security no.	Employee street address	City	State	ZIP code

Primary phone no.	Alternate phone no.	Fax no.	Email address

Marital status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	Employer name

Disability due to ☐ Illness ☐ Injury	Date you last worked due to your disability	Date you returned to work	If not yet returned, date you expect to return

If disability due to injury, what type? ☐ Auto ☐ Workers' Compensation ☐ Home ☐ Other: _____

Please provide complete details to accident, date and time. Attach a separate sheet if necessary.

_____

For New York residents, the following statement applies: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each violation.

I authorize the release to or by Anthem Life Insurance Company (Anthem Life) any medical or insurance information required to process my claim. I understand that any information obtained pursuant to this authorization will be used only to evaluate my claim and may be transferred to any organization or person employed by or representing Anthem Life to assist with this purpose. This authorization is valid for the duration of my claim. I understand I have a right to request and receive a copy of this authorization. A photocopy of this authorization is as valid as the original.

The above statements are true and complete to the best of my knowledge and belief. Your signature is required for benefit consideration.

Employee signature **X**	Date (MM/DD/YYYY)

Section 2: To be completed by the employer

Group policy no.	Date employed (MM/DD/YYYY)	Effective date of insurance	Occupation/job title

Employee Social Security no.	Employee no. (if applicable)	Employee benefit class ☐ Part-time ☐ Full-time	Standard no. of hours worked per week

Date employee last worked	No. of hours	Date employee scheduled to return to work	Date employee returned to work

Amount of weekly benefits	Employee's wage $ _____ per ☐ Hour ☐ Week ☐ Month ☐ Year	Employee's compensation ☐ Hourly ☐ Salaried

Did injury or illness arise out of or in course of employment for wages or profit? ☐ Yes ☐ No

Is claim being made for Workers' Compensation? ☐ Yes ☐ No

What percentage of the Short Term Disability premium does the employer pay? _____%

If the employee contributes to the premium, contributions are made: ☐ Pre-tax ☐ Post-tax

Is the employee receiving any compensation (sick pay, vacation, salary continuation)? ☐ Yes ☐ No Attach additional sheets if needed.
If so, please provide dates and amounts: _____

Group name	Branch or division address	Phone no.

Signature of employer representative **X**	Printed name of employer representative	Title	Date (MM/DD/YYYY)

Short Term Disability Claim Form
Attending Physician Statement

Anthem Life

Anthem Life Insurance Company
Disability Claims Service Center
P.O. Box 105426
Atlanta, GA 30348-5426
Phone: 1-800-813-5682 Fax: 1-800-850-0017
Email: lifeanddisabilityclaims@anthem.com

Section 3: To be completed by the physician

Note to physician: Completion of this form will assist your patient in presenting claim for group and/or individual disability benefits. Please complete all areas of the form; if a section is non-applicable, please enter N/A in the response area.

Patient last name	First name	M.I.	Birthdate (MM/DD/YYYY)

Patient street address	City	State	ZIP code

Current diagnosis: _____

ICD10/DSM5: _____

Subjective complaints: _____

Objective findings: _____

Has patient ever had same or similar condition? ☐ Yes ☐ No If yes, specify dates of treatment: _____

Did injury or illness arise out of or in course of employment for wages or profit? ☐ Yes ☐ No ☐ Unknown
If yes, please explain: _____

Is disability due to pregnancy? ☐ Yes ☐ No EDC: _____ Type of delivery: ☐ Vaginal ☐ C-section

Was patient hospitalized? ☐ Yes ☐ No If yes, please provide date of confinement: _____
Name of hospital/facility: _____

Nature of surgical procedure, if any. Date performed: _____
Describe in full: _____

Date patient first unable to work	Date of first visit	Date of last visit	Date of next visit

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other: _____

Treatment plan: _____

Functional impairments: _____

Current medications and dosages: _____

Patient released to return to work? ☐ Yes ☐ No
If yes: ☐ Full-time, no restrictions Date able to return to full duty: _____
☐ Light duty Date able to return to light duty: _____
Please specify restrictions, limitations, hours, graduated return to work schedule, etc.:
_____

Is this patient a suitable candidate for a rehabilitation program? ☐ Yes ☐ No

Is this patient competent to endorse checks and direct the proceeds thereof? ☐ Yes ☐ No

Printed physician name	Physician tax ID no.	Physician specialty

Physician street address	City	State	ZIP code

Physician phone no.	Physician fax no.	Physician email address

Physician signature	Date (MM/DD/YYYY)
X	

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Disability
Employee Authorization for Release of Information
(HIPAA compliant)

Anthem Life

To be signed and dated by the insured/claimant.

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, to give any and all such information to authorized representatives of Anthem Life Insurance Company (Anthem Life) and including, but not limited to any other mental or psychiatric records, medical, dental and hospital records (including psychiatric, alcohol, and drug abuse, and HIV/AIDS information) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by Anthem Life representatives to evaluate and adjudicate my current disability claim, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, employed by or representing Anthem Life solely to assist with the evaluation and adjudication of my current disability claim. Each such person or entity to whom this re-disclosure is made shall comply with the HIPAA Privacy Rule as regards any re-disclosed protected health information.

This authorization is valid during the pendency of my claim and shall expire on the date my claim finally ends. A photocopy of this authorization is as valid as the original. I understand that my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand that I have the right to revoke this authorization by notifying Anthem Life in writing, of my revocation. However, such revocation is not effective to the extent that Anthem Life have relied previously upon this authorization for the use or disclosure of my protected health information. In addition, I understand that my revocation of, or my failure to sign this authorization may impair Anthem Life's ability to evaluate my current disability claim and as a result may be a basis for denying that current disability claim for benefits.

If you reside in California, Connecticut or North Dakota: This authorization excludes the release of information about Human Immunodeficiency Virus (HIV).

If you reside in Maine: This authorization excludes disclosure of the result of a test for HIV if the applicant has tested positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the applicant has AIDS.

If you reside in Minnesota: This authorization excludes the release of information about HIV (AIDS VIRUS) tests.

If you reside in Vermont: This authorization EXCLUDES the release of any information about previously administered HIV-related tests, including but not limited to tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured is NOT AUTHORIZING ANTHEM LIFE to forward the results from any new test, requested by us, to any outside, non-affiliated company or entity not under specific contract with us to perform underwriting services, and ANTHEM LIFE shall comply, as applicable with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.

Claimant printed name	Birthdate (MM/DD/YYYY)
Claimant signature **X**	Date (MM/DD/YYYY)
Relationship of authorized person	Description of personal representative's authority, if applicable (If signed by authorized representative, attach verification of identity.)

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Send completed form to:

Anthem Life Insurance Company
Disability Claim Service Center
P.O. Box 105426
Atlanta, GA 30348-5426

For customer service:

Call: 1-800-813-5682
Fax: 1-800-850-0017

The laws of some states require us to provide you with the following information

Anthem Life

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Rhode Island, and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Delaware and Idaho: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing false, incomplete, or misleading information commits a felony.

Kansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia, and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps to commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. §638:20.

New Jersey: A person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: A person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each violation.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

General Fraud Warning: Any person who knowingly and with intent to defraud any insurance company, files a statement of claim containing any false, incomplete, or misleading information may be subject to criminal penalties.

Communication Consent

Anthem Life

Anthem Life Insurance Company
Disability Claims Service Center
P.O. Box 105426
Atlanta, GA 30348-5426
Phone: 1-800-813-5682 Fax: 1-800-850-0017
Email: lifeanddisabilityclaims@anthem.com

The Telephone Consumer Protection Act of 1991 (TCPA), the Federal Communications Commission's (FCC) regulations and interpretative orders implementing the TCPA, the Federal Trade Commission's (FTC) Telemarketing Sales Rule of 2003 (TSR), and parallel state laws (collectively referred to as the Telecommunications Laws) impose strict rules governing how Anthem Life Insurance Company (Anthem Life) may place outbound telephone calls and send text messages for Sales and Non-sales purposes to individuals.

In order to comply with the new federal regulation, please provide below what numbers we can contact you on in regard to your claim.

Phone number you wish to be contacted on: _____

This phone is: ☐ Cell phone
☐ Land line

Is this phone number registered on the National Do Not Call Registry? ☐ Yes ☐ No

Does Anthem Life have permission to contact you on this number? ☐ Yes ☐ No

Print your name: _____

Your signature: **X**_____

Date signed: |__|__|__|__|__|__|__|__| (MM/DD/YYYY)

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Reimbursement Agreement

Anthem Life

Anthem Life Insurance Company
Disability Claims Service Center
P.O. Box 105426
Atlanta, GA 30348-5426
Phone: 1-800-813-5682 Fax: 1-800-850-0017
Email: lifeanddisabilityclaims@anthem.com

Employee last name: _____ First: _____ M.I. ____

Social Security no.: |_ _ _ _ _ _ _ _ _|

First date absent: |_ _ _ _ _ _ _ _| (MM/DD/YYYY)

Employer: _____ Group no.: _____

I acknowledge that I am eligible for benefits under the disability plan sponsored by the above named employer whose claims for plan benefits are either insured by or administered on an employer self-funded basis by Anthem Life Insurance Company (hereinafter referred to as Anthem Life). I agree to reimburse Anthem Life 100% of the amount of benefits I receive, have received, or shall receive from any person or entity for loss wages incurred as a result of the occurrence which gave rise to my claim for payment of benefits from the disability plan. In the event that the 100% reimbursement provided in the preceding sentence is greater than the amount of my recovery, less attorney fees and other legal expenses I incurred in obtaining such recovery (my net recovery), I agree to reimburse Anthem Life the entire amount of my net recovery.

I agree to keep Anthem Life fully informed as to the status of my payment recovery so that Anthem Life may take whatever action it deems necessary to protect its interest. I also agree to authorize any person including, but not limited to, any insurance company, attorney, hospital, physician, surgeon or pharmacist to release to Anthem Life any information pertaining to this occurrence, or claim.

I also acknowledge that Anthem Life will have the right to recover any overpayment of benefits, either directly from me or by deduction of the amount of the overpayment from my future benefits payable under the disability plan, which are the result of error caused by or misinformation provided to Anthem Life.

Your signature: **X** _____

Date signed: |_ _ _ _ _ _ _ _| (MM/DD/YYYY)

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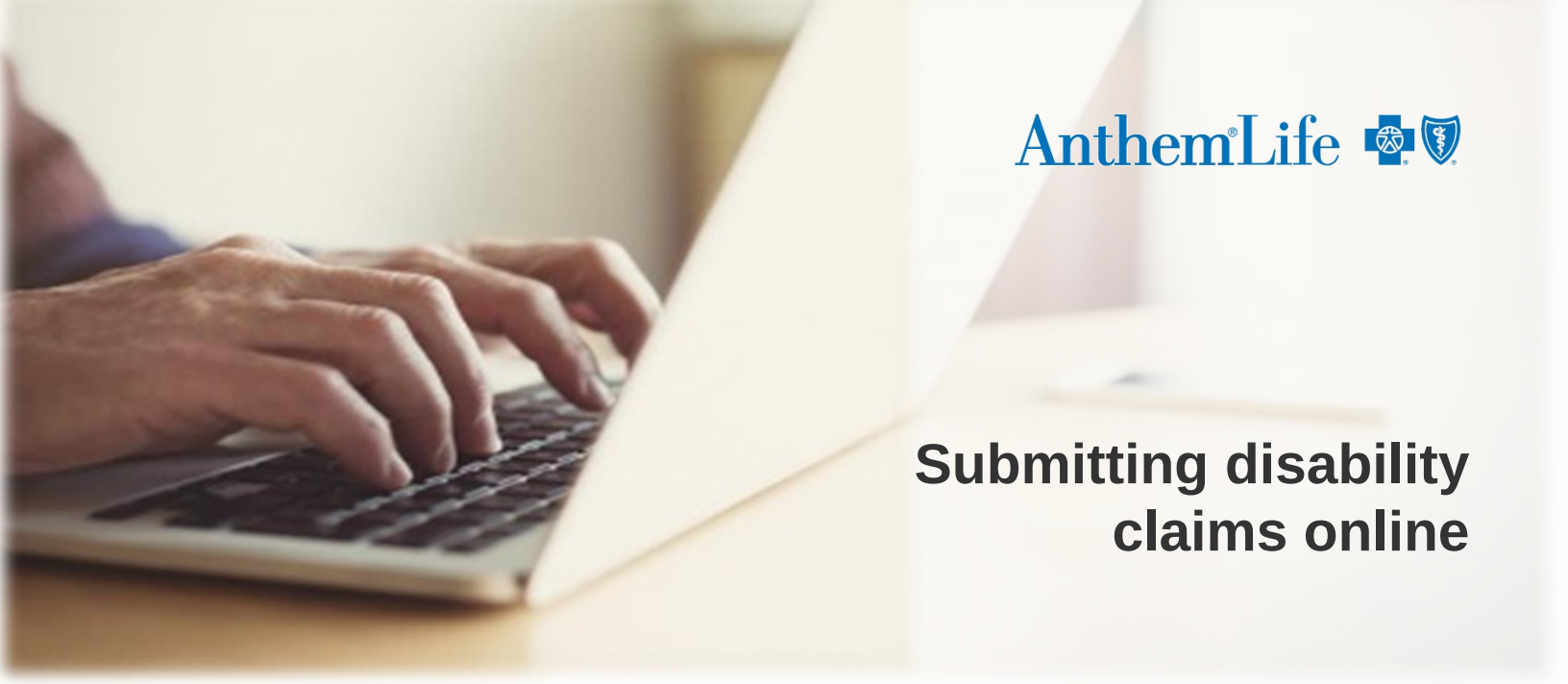
Submitting disability claims online



AnthemLife

Submitting disability claims online

It’s easy to submit a claim online

Our easy system lets you enter all the information we need to start your disability claim. Just go to https://myspecialtyappsanthem.com/claims/alic and follow the simple instructions to submit your claim:

- Choose **Short Term Disability** *or* **Long Term Disability** as the *Type of Claim,* then the *Type of User* field will appear
- Choose **Employee** for *Type of User*
- Enter the characters you see under “**Please retype the characters from the picture”** then click *Next*
- The system will guide you through all information you need to give us to get started on your claim.

During the claim submission process, you can download, fill out, scan, and upload the forms you need for your claim.

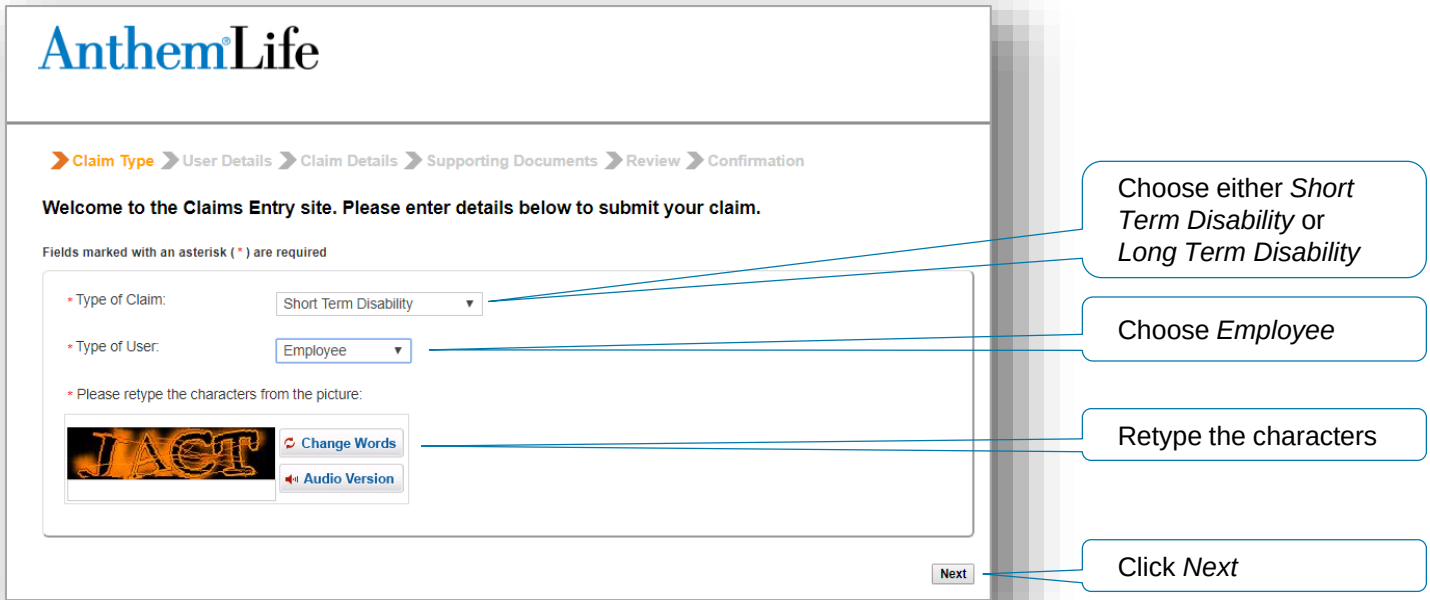
Once you submit your claim, you’ll receive a claim reference number and, if you give us your email address, you can also receive a confirmation email. Be sure to keep the claim reference number handy – we can help you faster if you have the claim reference number when you call us with questions.

Have questions?

If you have questions while you’re using the online claim system, call **1-800-813-5682**
Monday through Friday between 8:30 a.m. and 5:00 p.m. Eastern Time.
We can help you with any issues.

Here's an example

https://myspecialtyappsanthem.com/claims/alic



Online Employer Claims Reporting/Status Check Application Registration Form

Please forward completed form to:
dl-socerreporting@anthem.com and Sian.Ramsey@anthem.com

Online Employer Claims Reporting/Status Check Application Registration Form

EXECUTIVE CONTACT INFORMATION

Your Name:	
Your Title:	
E-mail Address:	
Daytime Phone No:	
Fax Number:	
Company Name:	VACORP / Entity Name:
Group Number(s):	AL00006723 / VACORP Member Number:
Address:	
City:	
State:	
Zip:	

Claim Contact (Name, Phone, Email)	

Please list additional users in your groups who will have access to Online Employer Claims Reporting and Status Check. (If the user should have limited access to a specific location or division please note the limitations):

Name:	E-mail:	Daytime Phone:
Name:	E-mail:	Daytime Phone:
Name:	E-mail:	Daytime Phone:
Name:	E-mail:	Daytime Phone:
Name:	E-mail:	Daytime Phone:

AnthemLife

User Agreement between Anthem and End User of Anthem Application

1. Definitions

1.1. Affiliate means any entity which owns or is owned by Anthem, Inc., directly or indirectly, and any entity which is under common ownership directly or indirectly, by or with Anthem Life Insurance Company and/or Anthem Life & Disability Insurance Company and/or Greater Georgia Life Insurance Company.

1.2. Agreement means this End User Agreement.

1.3. Application means any of the on-line claims reporting or status check services offered to Employers by Anthem to assist Employers in submitting, viewing or checking status on member claims information or similar functions.

1.4. Documentation means the Application(s)and the written and printed materials in all media pertaining to such Application.

1.5. End User means a Employer or their designated agent, who desires to access an Application pursuant to the terms of this Agreement.

1.6. Member means those individuals who are eligible to receive covered services under a group life and/or disability benefit plan issued or administered in whole or in part by Anthem or an Affiliate.

1.7. Operators means those individuals who are employees or agents or are otherwise acting exclusively on behalf of an End User accessing an Application(s).

1.8. Operator Keys means the security protocols of Anthem used to identify Operators and control access to an Application(s).

1.9. Designated Agents means those persons accessing an Application(s) for more than one End User (e.g., clearinghouses, practice management vendors or billing agents). A Designated Agent can be an individual or it can be a processing center employing several individuals, each of whom would be considered an Operator of the Designated Agent. Designated Agents must be separately designated by each End User on whose behalf the Designated Agent is accessing an Application.

1.10. Recognized Devices means those computers under the exclusive control of the End User (and/or its Designated Agent).

1.11. Site Administrators means those persons employed by, agents for or otherwise acting on behalf of the End User who are responsible for administration at the End User's site.

1.12. Anthem means Anthem, Inc.

2. Scope of Agreement

2.1. Parties. This Agreement is by and between Anthem (on behalf of itself and its Affiliates) and End User. Anthem grants End User a non-exclusive, non-transferable, revocable, limited-use license to access the Application(s)set forth in Exhibit A for End User's legitimate business purposes in providing services to Members. End User may request access for its Operators and/or its Designated Agents (e.g., clearinghouses, practice management vendors or billing agents), which access shall be provided and utilized in accordance with this Agreement.

2.2. Protecting Confidential Information. Member information, of any nature and in any format, along with all other sensitive or proprietary information obtained from Anthem is confidential information. End User represents and

warrants that it has implemented and will enforce adequate policies and procedures to protect the confidentiality of Confidential Information as required by applicable laws, rules, and regulations. End User shall not use or disclose any Confidential Information except as expressly authorized in this Agreement or as required by applicable law. End User further represents and warrants that it shall comply with all applicable privacy and confidentiality laws, regulations and rules pertaining to the use, disclosure and transmission of Confidential Information. End User must notify Anthem as soon as possible, but no later than the next business day, after learning of any unauthorized access to, disclosure of or use of any Confidential Information and cooperate with Anthem to regain possession of the information.

2.3. Restricting Access. End User (and/or its Designated Agent) shall, directly, or through its Designated Agent, if applicable, restrict access to an Application to its authorized Operators. End User (and/or its Designated Agent) shall ensure that each Operator has access to only those records of the End User which such Operator must access for legitimate business purposes of the End User in serving End User's Members/patients who are enrolled in a health care plan offered or administered by Anthem or one of its affiliates. Operators shall access an Application(s) solely on behalf of End User's Members/patients. Such access shall be on a need-to-know basis and only in accordance with this Agreement, applicable laws, rules, and regulations.

2.4. Internet Connectivity. End User must provide its own Internet Service connectivity directly, or through its Designated Agent.

2.5. Non-disclosure of Proprietary Information. End User acknowledges and agrees that Documentation is the proprietary and intellectual property of Anthem. Except for disclosure to Site Administrators and Operators necessary to the End User's use of an Application(s), End User shall not disclose, sell, use, reengineer or re-license the Documentation for any purpose. End User acknowledges and agrees that any unauthorized use or disclosure of Anthem's proprietary and intellectual property would cause Anthem irreparable harm that could not be fully remedied by monetary damages. End User, therefore, agrees that Anthem shall have the right to obtain such injunctive or other equitable relief as may be necessary to prevent unauthorized or unlawful action.

2.6. Appointment of Site Administrators. End User agrees to appoint one or more Site Administrator(s) as Anthem and End User mutually agree are necessary for the administration by End User. The initial Site Administrator(s) shall be specified on this Access Request Form. End User shall notify Anthem immediately when End User must change the initial Site Administrator(s) information by completing and submitting the applicable sections of the Access Change Form to Anthem. End User agrees to provide any information regarding Site Administrators reasonably requested by Anthem. End User represents that each Site Administrator shall have the authority to make decisions on behalf of the End User.

2.7. Responsibility of Site Administrator. End User acknowledges and agrees that, as between it and Anthem, End User is solely responsible for any and all actions of its Site Administrators, Operators and Designated Agent(s) and its/their Operators.

2.8. Canceling Operator Keys. End User shall ensure that the Site Administrator(s) notify Anthem in writing within two business days to cancel an Operator Key when the Operator to whom it was assigned has been dismissed, transferred, or is otherwise no longer authorized to access one or more Applications.

2.9. Notification of Change in Designated Agent/s. End User must promptly notify Anthem in writing upon appointing a Designated Agent, changing its Designated Agent or upon discontinuing its use of its Designated Agent, and must supply all information requested by Anthem pursuant to such appointment, change, or discontinuance.

2.10. Notice of Change in Operator, Site Administrator or Designated Agents. If at any time during the term of this Agreement the End User elects to: (a) change its Operator(s) (including hiring new employees who will be Operators or terminating one of its Operators or canceling the access of one of its Operators); (b) change any of its Site Administrator(s) information; or (iii) change its Designated Agent (including the retaining of a different Designated Agent or the cancellation of the Designated Agent), the End User must agree to the applicable portions of the User Agreement and notify Anthem. No Designated Agent may access an Application until such forms are accepted and approved by Anthem and all applicable Operator Keys are issued.

2.11. Proper Use and Non-Transferability of Operator Keys. End User acknowledges Operator Keys are unique to each individual Operator and agrees it must ensure proper use of all Operator Keys assigned to its Operators. Operator Keys are nontransferable. End User must request a separate Operator Key for each Operator by initially submitting an Access Request Form, Exhibit B to this Agreement, at the same time that this Agreement is submitted to Anthem. End User agrees to implement and enforce policies and procedures to ensure that Operator Keys are disclosed only to the individual Operator to whom such Operator Key is assigned. End User also shall implement policies and procedures to ensure that no person other than Site Administrators and Operators have access to an Application(s).

2.12. Use of Anthem Group Number. End User shall implement and enforce policies and procedures to ensure that all End User's transactions and all communications from End User to Anthem include the End User's Anthem Group Number(s). The End User's tax identification number(s) is/are set forth as part of this Agreement.

3. General Provisions

3.1. Assignment. This Agreement may not be assigned without Anthem's prior written consent. This Agreement is binding upon the parties, their successors and assignees if properly assigned in accordance with this section.

3.2. Termination. Anthem has the right to terminate access to an Application(s) by End User, any Operators, and/or End User's Designated Agent and its Operators immediately and without notice if Anthem reasonably believes that any of them breaches the terms of his or her respective agreements or if necessitated by concerns for the security of Application(s). Either party may otherwise terminate this Agreement upon 10 days' written notice. Any liabilities or obligations set forth in this Agreement that remain to be performed, or by their nature would be intended to be applicable following any such termination will survive termination of the Agreement.

3.3. Entire Agreement. This Agreement, together with all of the Forms and Attachments hereto, which are deemed incorporated by reference herein, represents the entire agreement between End User and Anthem and supersedes all prior and contemporaneous agreements or representations between the parties regarding the subject matter hereof.

3.4. Modifying the Agreement. This Agreement may be modified either (1) by written consent of both parties, or (2) by Anthem providing 15 days' notice to End User (Anthem may provide such notice by posting any modifications to this Agreement to its site, or by other written means); however, End User may notify Anthem within the 15 day period that such modifications are unacceptable, and Anthem will discontinue End User's access to Applications.

3.5. Governing Law. This Agreement will be construed in accordance with and governed by the laws of the Commonweath of Virginia without regard to its conflict of laws rules.

3.6. Waiver. All disputes arising from or relating to this Agreement shall be litigated in the United States District Court for either the Eastern District or Western District of Virginia. Anthem's waiver or failure to claim breach of any provision of this Agreement will not be a waiver of a breach of any other provision or subsequent breach of the same provision.

3.7. Descriptive Headings. The headings contained in this agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

3.8. Accuracy of Data. End User represents that all data submitted through the application is true and accurate to the best of their knowledge and understands that it is being relied on by Anthem in accepting, creating or updating membership information. Any misstatements or failure to report medical information prior to effective dates may result in a material change to coverage or premium rates. Any material misrepresentation or significant omission found may result in denial of benefits or rescission or cancellation of coverage.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement effective as of the day and year stated below.

ANTHEM LIFE INSURANCE COMPANY
ANTHEM LIFE & DISABILITY INSURANCE COMPANY

GREATER GEORGIA LIFE INSURANCE COMPANY	
Authorized Representative:	Kristan J. Andrews
Signature:	
Title:	Assistant Secretary
Date:	9/9/2019

Employer Group Name:	
Authorized Representative:	
Signature:	
Title:	
Date:	

3350 Peachtree Road, NE * Suite 700 * Atlanta * GA * 30326

Group Long-Term Disability Benefits At a Glance

Group Long Term Disability Insurance

AnthemLife

Virginia Association of Counties Group Self Insurance Risk Pool (VACORP)

Policy # AL0006723

Effective date: July 1, 2019

Group Long Term Disability (LTD) insurance from Anthem Life Insurance Company helps provide financial protection for insured members by promising to pay a monthly benefit in the event of a covered disability.

The cost of this insurance is paid by your Employer.

Employer means any unit of local government or other local agency, public entity, school, jail, department, board, or authority in the Commonwealth of Virginia which a) is eligible for and is participating in the Virginia hybrid retirement program described in §51.1-169 of the Code of Virginia, b) has signed a Participation Agreement with VACORP, and c) whose participation under the Group Policy has been approved in writing by the Policyholder.

Please refer to the plan summary document, your employee handbook, and Virginia Code Section § 51.1-1100 et. seq. for specific plan details, eligibility definitions, limitations, and exclusions

Eligibility

Definition of a Member: You are a member if you are:

1. A regular employee of the Employer who is participating in the Virginia hybrid retirement program described in §51.1-169 of the Code of Virginia.
2. a regular full-time or part-time employee of the Employer, working for pay on a scheduled normal week of at least 10 hours required per week; *and*
3. A citizen or resident of the United States.

You are not a member if you are a temporary or seasonal employee, full-time member of the armed forces, leased employee or an independent contractor.

Class Definition:

Class 1: Members participating in the VRS Hybrid Retirement Plan within their first 12 consecutive months of employment with their Employers.

Class 2: Members participating in the VRS Hybrid Retirement Plan with more than 12 consecutive months of employment with their Employers.

Eligibility Waiting Period: You are eligible on the latest of the following dates:

1. July 1, 2019
2. The effective date of your Employer's participation under the Group Policy
3. The first day as a Member that you are actively at work.

Benefits

Group long term disability benefit amount:

Class 1: Disability arising out of or in the course of employment with the Employer: 60% of monthly earnings up to a maximum monthly benefit of $30,000.

Disability not arising out of or in the course of employment with the Employer: None

Class 2: 60% of monthly earnings up to a maximum monthly benefit of $30,000.

Minimum monthly benefit is $100.

Elimination period

The number of days you must be unable to work due to an approved qualifying disability before benefits begin:

- Later of 125 work days or the end of the STD.

Note: Only work related disabilities are covered in Class 1.

Maximum Benefit period:

If you become disabled before age 60, LTD benefits may continue until Social Security Normal Retirement Age (SSNRA). If you become disabled at age 60 or older, the benefit duration is determined by your age when disability begins:

Age	Maximum Benefit Period
Less than age 60	To SSNRA
60 through 64	5 years
65 through 68	To age 70
69+	1 year

Social Security Normal Retirement Age (SSNRA) means your normal retirement age under the Federal Social Security Act, as amended.

See your certificate for specific maximum payment durations based on age at the time of disability. Benefits paid at the time of an approved qualifying disability may vary from the benefit duration period shown.

Definition of Disability

Disabled and **Disability** mean during the Elimination Period and the next 24 months because of Your Injury or Illness, *all* of the following are true:

- You are unable to do the Material and Substantial Duties of Your Own Occupation; *and*
- You are receiving Regular Care from a Physician for that Injury or Illness; *and*
- Your Disability Work Earnings, if any, are less than or equal to 80% of Your Indexed Monthly Earnings.

Thereafter, Disabled and Disability mean because of Your Injury or Illness *all* of the following are true:

- You are unable to do the duties of any Gainful Occupation for which You are or may become reasonably qualified by education, training, or experience; *and*
- You are receiving Regular Care from a Physician for that Injury or Illness; *and*
- Your Disability Work Earnings, if any, are less than or equal to 80% of Your Indexed Monthly Earnings.

Partial disability benefits

If you are able to return to work part-time, you may still receive a portion of your long term disability benefit to help fill the gap in your income.

Survivor benefit

If you pass away after receiving Long Term Disability benefits for at least 180 consecutive days, and are receiving benefits at the time of your death, a lump-sum payment benefit will be paid to your beneficiary. The Survivor Benefit is equal to three times your monthly benefit.

Vocational rehabilitation

We may provide services, such as vocational testing and training, job modifications and job placement to help you return to active employment if you suffer a disability.

Social Security assistance

If you are receiving long term disability benefits, we will help you apply for Social Security and, if necessary, offer guidance through the appeal process.

Lifetime Protection (if elected by your employer)

Allows payment of LTD benefits beyond the Maximum Benefit Duration subject to certain requirements. See certificate for complete details.

Pension Plan Contribution rider

1%, to a maximum benefit of $500.00 (monthly). See certificate for complete details.

Catastrophic Conditions

Included. An additional 20% of your Pre-disability Earnings not to exceed $5,000. See certificate for complete details.

Additional Benefits

- Vocational Rehabilitation
- Social Security Assistance
- Cost of Living Freeze
- Recurrent Disability
- Work Retention Assistance
- Waiver of Premium

Value Added Services

Resource Advisor

This value-added support program gives you and your family access to work/life resources, at no additional cost to you, including: face-to-face visits with a counselor or online visits via LiveHealth Online; identity monitoring and identity theft victim recovery services, legal and financial consultations; toll-free, 24/7 phone counseling from anywhere in the United States; and unlimited access to Resource Advisor online resources at www.resourceadvisor.anthem.com, program name “AnthemResourceAdvisor”. To access Resource Advisor call (888) 209-7840.

This is not a contract. It is a partial listing of benefits and services that is dependent on the Plan Options chosen. This benefit overview is only one piece of your entire enrollment package. All benefits and services are subject to the conditions, limitations, exclusions and provisions listed in the contract documents: the Certificate, Policy, and/or Trust Agreement for this product. In the event of a conflict between the contract documents and this benefits description, the contract documents will prevail. If you have any questions, please contact your Human Resources/Benefits manager.

Exclusions and limitations are listed in detail in the certificate, policy or trust agreement that applies to this product.

The Value Added additional services are not a part of the certificate, policy or trust agreement and do not modify any insured benefits. The Value Added additional services are provided based on negotiated agreements between the insurance company and certain service providers. Although the insurance company endeavors to make these services available to all policyholders and certificateholders as described, modifications to our agreements with service providers may require that services be periodically modified or terminated. Such modification or termination of services may be made based on cost to the insurer, availability of services, or other business reasons at the discretion of the insurer or service providers.

7/2019

ASO Short Term Disability Administrative Services Agreement

Advice to Pay Non-Financial (ATP)

ADMINISTRATIVE SERVICES AGREEMENT

(Agreement)

Between

Virginia Association of Counties Group Self Insurance Risk Pool (VACORP)
(Contractholder)

And

Anthem Life Insurance Company
(Company)

TABLE OF CONTENTS

Page Number

ADMINISTRATIVE SERVICES AGREEMENT
(Agreement)
between

Virginia Association of Counties Group Self Insurance Risk Pool (VACORP)
(Contractholder)

and

Anthem Life Insurance Company
(Company)

This Agreement becomes effective July 1, 2019 (the Agreement Effective Date), and will remain in effect for an initial term of 12 consecutive months (the Initial Term Year), subject to the provisions herein. In consideration of the mutual promises set out below, **Anthem Life Insurance Company** ("Company") and **Virginia Association of Counties Group Self Insurance Risk Pool (VACORP)** ("Contractholder") agree as follows:

This Plan is subject to ERISA: [ ] Yes [X] No

SECTION I: RECITALS

1.1 Contractholder wishes to fund the Plan, assume liability for payment of benefits described in the Plan and thereby act as Plan fiduciary. Company provides administrative services and does not assume any financial risk or obligation with respect to claims or the Plan.

1.2 Contractholder has requested that Company, which has expertise in the administration of certain group coverage programs providing disability and disability-related benefits, provide those administrative services set forth in this Agreement and Company is willing to do so in accordance with the terms of this Agreement.

1.3 Neither Contractholder nor Company intends this Agreement to confer any gain on any persons who are not parties to this Agreement.

1.4 Contractholder is the sponsor of a Plan that provides welfare benefits for certain employees. The terms of the Plan define, among other things, the benefits payable, any and all conditions applicable to or limiting payment of benefits, and the persons entitled to receive benefits (the Beneficiaries). A copy of the written description of the Plan shall be attached hereto as Attachment D, and is made a part of this Agreement for the limited purpose of defining the Plan.

SECTION II: DEFINITIONS

The following terms, when capitalized throughout the Agreement or any Attachments or Amendments thereto, shall have the meanings set forth below.

Beneficiaries shall mean the persons entitled to receive benefits under the Plan.

Designee shall refer to the subsidiary(ies), affiliates and independent contractors of Company to which Company has delegated responsibility for the provision of certain services described in Attachment A.

Employee shall mean an employee of the Employer who is covered for any benefits provided under the Plan.

Employer shall mean Contractholder.

Initial Term shall refer to the period beginning on the Agreement Effective Date.

Month shall refer to a calendar month.

Party shall refer to Contractholder or Company as the sense and context permits.

Parties shall refer to Contractholder and Company.

Plan refers to the self-funded employee welfare benefit Plan adopted by Contractholder for providing welfare benefits for certain employees.

For ERISA plans
Plan Document shall be the written instrument referred to in 29 U. S. C. 1102(a) by which the Plan is established.

For non-ERISA plans
Plan Document shall be the document that sets forth the terms of the Plan, and includes the Plan description.

Service Fees are the fees set forth in Attachment C, which Contractholder agrees to pay Company in compensation for services provided by Company under the Agreement.

Successive Terms shall refer to successive twelve-month terms, following the Initial Term, each of which shall begin on **July 1st.** Term shall refer to the Initial Term or any Successive Term.

Summary Plan Description refers to the written description of the benefits provided under the Plan as that term is defined in ERISA.

SECTION III: SERVICES PROVIDED BY Company

3.1 List of Provided Services. Company will furnish, on behalf of Contractholder and in accordance with the terms of this Agreement, the basic administrative services (Basic Services) and the Additional Services set forth in Attachment A which is hereby made a part of the Agreement.

3.2 Additional Services. Contractholder may desire that Company perform services not covered by or described in this Agreement, including, but not limited to, the development of programming to generate customized reports or the preparation or printing of special forms or special mailings. The performance of such Additional Services shall be subject to Contractholder's agreement to compensate Company the amount described in Attachment C for such service, or, if such additional fee is not included in Attachment C, the amount agreed upon by the Parties which shall be in excess of the Service Fees specified in this Agreement as described in Attachment C hereto.

SECTION IV: RELATIONSHIP OF THE PARTIES

4.1 Performance of Duties. Company agrees to use reasonable care and due diligence in the performance of its duties under this Agreement.

4.2 Recovery of Overpayments (applicable only to Full Service ASO Agreements)
If it is determined that any payment authorization has been made under this Agreement to an ineligible person, or if it is determined that more than a correct amount has been authorized for payment by Company, Company shall make a reasonable effort to recover any such overpayment made or to adjust the authorization and notify both the claimant and the Contractholder. If recovery is not secured either directly or, when appropriate, through offset in future benefits, notification shall be given to Contractholder.

4.3 Legal Actions.

A. Each Party shall promptly advise the other Party as to matters which come to its attention involving legal actions regarding the Plan.

B. Upon receipt from either Party of written notice of any claim or suit relating to the services provided hereunder, both Parties shall make available all books, records and documents relevant to the defense of any such claim or suit in its control or possession and shall cooperate fully to secure any necessary and relevant information or testimony which may be material to such claim or suit.

C. In the event of any claim or suit against Company or its Designee relating to the Plan, or to the services provided hereunder in connection with such Plan, Company shall, subject to Company's right to seek dismissal of or from any such claim or suit, refer the matter to Contractholder for further handling. Subject to Contractholder's rights under paragraph 4.7.A. hereof, Contractholder shall immediately undertake the defense thereof, cause itself to be substituted as a party in place of Company or its Designee, and obtain a full release of any liability or alleged liability of Company or its Designee for any such claim or suit under the Plan.

4.3 Legal Actions. (Continued)

D. In the event that Contractholder (i) does not immediately assume the defense of such claim or suit, (ii) has failed to cause Company or its Designee to be dismissed or released from any such claim or suit, (iii) has failed to cause itself to be substituted as a party in place of Company, or (iv) cannot intervene in any proceeding involving said claim or suit, Company shall consult with counsel for Contractholder in the handling of any such claim or suit. Nevertheless, in such event Company shall, as to any liability or alleged liability of Company, and subject to its rights under paragraph 4.7.B. hereof, have sole discretion (i) in determining whether any claim or suit be paid, compromised, litigated or appealed and (ii) as to all aspects of any litigation including matters of procedure, compromise, defense and appeal. In the event of claim or suit, Company shall not make any payment in excess of benefit expense from Contractholder's funds with respect to any such claim or suit.

E. **Applicable only to Full Service ASO Agreements:** Company shall not make any payment in excess of the benefit expense from Contractholder's funds with respect to any such claim or suit. Any payment made by Company from its own funds to compromise or settle any such lawsuit or to pay any judgment entered against it in such lawsuit shall be reimbursed to Company by Contractholder in accordance with paragraph 4.7.B., hereof.

F. Nothing contained herein shall operate to waive any privilege of Company or Contractholder with respect to any claim or suit.

4.4 Legal Advice. Contractholder herewith acknowledges that Company disclaims any intention or capacity to provide legal advice, legal opinions or other legal services relative to the establishment and maintenance of the Plan or relative to this Agreement. Company will make available its own legal counsel for consultation with Contractholder's legal counsel with respect to the legal aspects of the Plan and this Agreement, but Contractholder agrees that it will rely solely upon the advice of its own legal counsel in evaluating such legal aspects.

4.5 Dispute Resolution.

A. The Parties shall meet and confer in good faith to resolve any problem or dispute that may arise under this Agreement.

B. Unless otherwise mutually agreed in writing by the Parties, if the Parties cannot reach an amicable understanding regarding a difference or dispute, the Parties agree that any such problem or dispute concerning the terms of this Agreement that are not satisfactorily resolved shall be arbitrated under the Commercial Rules of the American Arbitration Association.

C. Arbitration shall be initiated by either Party making a written demand for arbitration on the other Party.

D. The cost of the arbitration shall be borne equally by the Parties, unless the arbitrator decides otherwise.

E. The written decision of the arbitrator shall be final and binding upon both Parties except to the extent that any applicable federal and/or state law provides for the

judicial review of arbitration proceedings. Judgment may be entered upon the final decision of the arbitrator in any court having jurisdiction.

4.6 Understandings of the Parties. It is understood and agreed that:

A. The Contractholder hereby acknowledges that it is the plan sponsor and, in its role as plan sponsor, has the specific authority under the Plan to make initial and subsequent benefit determinations. These determinations may differ from recommendations made by Company, as a result of the services performed by Company under this agreement. Claims for benefits shall be transmitted to Company in the manner agreed upon by Company and Contractholder. Claims shall be processed in accordance with the procedures described in Attachment A and any Amendments.

B, Contractholder has elected the claim submission method and Clinical Service Option(s) identified in Attachment B. The Clinical Service Option determines the degree of medical case management applied in the disability claim process.

C. The legal and tax status of the Plan under applicable law is a matter for determination by Contractholder and not by Company, which is not responsible for such determinations. Therefore, it is further understood that Company (i) is not the Administrator in connection with the Plan, (ii) does not insure benefits under the Plan, and (iii) has no liability or responsibility to provide funds for the payment of any benefit thereunder.

D. Contractholder has full and final authority and responsibility for the Plan and its operation. Company shall have no duty or power to act on behalf of Contractholder in connection with the Plan, except as expressly stated in this Agreement.

E. Company shall have no responsibility for the Plan's compliance with any applicable federal, state or local rule or law. Contractholder shall have the sole responsibility for, and shall bear the entire cost of, the Plan's compliance with all federal, state and local rules and laws, including, but not limited to, any licensing, filing, reporting and disclosure requirements as may apply to the Plan, and all costs, expenses and fees relating thereto.

F. Company shall have no responsibility for reporting under or compliance with any escheat or unclaimed property law of any jurisdiction. Contractholder shall be responsible for determining the applicability of any escheat or unclaimed property law and for any required compliance therewith.

G. Company shall not be liable for any loss resulting from any delay or errors in the performance of Company's duties hereunder caused by the failure of Contractholder to properly and adequately perform any of its duties hereunder in a timely manner.

H. Company is an independent contractor. Nothing in this Agreement shall create, or be construed to create, the relationship of employer and employee between Contractholder and Company, or as principal and agent; nor shall Contractholder's agents, officers, or employees be considered or construed to be the employees of Company for any purpose whatsoever; nor shall Company's agents, officers or

employees be considered or construed to be the employees of Contractholder for any purpose whatsoever.

4.7 Indemnification of the Parties:

A. **Indemnity in Favor of Contractholder.** Company agrees to indemnify, defend and hold Contractholder harmless against any claim, demand, loss, lawsuit, settlement, judgment or other liability, and all related expenses which may accrue including reasonable attorney's fees and expenses arising as a result of a claim or suit seeking the payment of a benefit under the Plan brought by an Employee with respect to which it is determined, first, that said benefit is payable under the Plan and, second, that it is shown that the claim or suit has directly resulted from or arisen from Company's or its Designee's gross negligence or from a fraudulent, dishonest, intentionally wrongful or criminal act or omission of Company's or Designee's employees, acting alone or in collusion with others and provided that such liability is not the direct result of any act or omission of Contractholder or its employees or agents. Notwithstanding the foregoing, it is understood and agreed that Company shall have no liability for any benefits found to be payable under the Plan. Company's obligation to indemnify Contractholder shall not exceed the amount of Service Fees paid by Contractholder to Company under this agreement.

B. **Indemnity in Favor of Company.** Contractholder agrees to indemnify and hold Company or its Designee harmless against any claim, demand, loss, lawsuit, settlement, judgment or other liability, and all related expenses which may accrue, including reasonable attorney's fees and expenses, arising from or in connection with the Plan or the performance by Company of any function under this Agreement, except to the extent it is shown that such liability is the direct consequence of Company's or Designee's gross negligence or from a fraudulent, dishonest, intentionally wrongful or criminal act or omission of Company's or Designee's employees, acting alone or in collusion with others.

C. **Determination of Liability.** If each Party claims and is entitled to indemnity from the other, the liability of each to the other shall be determined according to the principles of comparative fault.

SECTION V: DUTIES OF CONTRACTHOLDER

5.1 Providing Information to Company. Contractholder shall furnish in a timely manner to Company such information as may from time to time be required by Company for the performance of its duties, including, but not limited to, the following:

A. Prior to the effective date of this Agreement, Contractholder shall furnish to Company copies of the relevant Plan Document and all other pertinent Plan materials. The benefit provisions of the Plan with respect to which Company is to provide services shall be attached hereto and become a part hereof and Company shall provide services under this Agreement only with respect to the provisions set forth in the Plan. Contractholder agrees that Company may rely upon the accuracy and completeness of any information furnished by it, the Administrator, the Plan Sponsor, the Plan or the participant. Contractholder agrees to consult promptly with Company on any modifications or amendments to the Plan Document that relate to benefits under the Plan or that change or modify the rights or responsibilities of Company under this Agreement or the Plan. No such changes or modifications which affect the obligations of Company under this Agreement shall be made

without the prior written approval of Company, nor shall any such changes be effective with respect to Company until they have been agreed to in writing by Company. Contractholder shall afford Company a reasonable time to adjust to such agreed upon changes. Further, Contractholder agrees (i) that the use of Company's name in the Plan Document or other Plan materials is allowed only with Company's permission (which such permission shall not be unreasonably withheld), (ii) to remove Company's name from the Plan Document or any other materials pertinent to this Agreement as appropriate upon termination of services provided under this Agreement.

B. Contractholder shall provide adequate, accurate and complete eligibility information as may be necessary for Company to determine entitlement for Plan benefits.

Contractholder is responsible for retaining in auditable form complete eligibility documentation including but not limited to completed and signed enrollment forms, change forms, any written correspondence related to eligibility and declination forms. Contractholder agrees that it will obtain and retain a signed and legally valid authorization from each covered employee permitting disclosure by Company to the Contractholder of medical and other information regarding claims received and processed for the purposes of claim review, financial audit, and experience reporting.

5.2 Authorization and Distribution of Summary Plan Descriptions (ERISA plans) or Plan Descriptions (non-ERISA plans). Contractholder will be responsible for reviewing and approving any documents drafted by Company for use by Contractholder as Summary Plan Descriptions (SPDs) or Plan Descriptions. Approval/disapproval must be in writing and delivered to Company by the 31st day following the initial delivery of any such descriptions to the Contractholder, If Company does not receive a response from Contractholder by this date, the documents will be deemed approved by Contractholder. The distribution of such descriptions to employees shall be the responsibility of Contractholder.

5.3 Provision of Information to Beneficiaries. Contractholder shall answer all routine inquiries from employees seeking information concerning enrollment in the Plan and any other inquiries except those for which Company is responsible as provided in Attachment A. Contractholder shall conduct all enrollment activity and inquiries at its own expense, shall notify enrolled Beneficiaries of their right to apply for benefits and shall distribute to Beneficiaries the necessary claim forms and instructions to make application for benefits if applicable.

5.4 Liability for Claims. Contractholder agrees to assume full liability for all claims of Beneficiaries arising under the Plan, regardless of the date such claims are incurred.

For Full Service ASO Plans only: Notwithstanding any other provision under this ASO agreement, if the Contractholder fails to fund Claim Payment amounts, the Company shall have no obligation to process any Claims, and we will suspend performing all other obligations under the Agreement as of the date such funding ceased. The Agreement will be terminated effective as of the date claim funding ceased. Upon termination of this Agreement, the Contractholder shall remain liable for all payments due us under the terms of the ASO Agreement.

5.5 Costs to be Reimbursed

A. Contractholder agrees to reimburse Company in United States currency for all costs and expenses necessarily incurred by Company in any claim or suit in consequence of, or arising out of, the provision of services under this Agreement; such costs and expenses shall include the following items:

1. **For Full Service ASO Plans only:** all benefit payments and damages associated therewith that Company may sustain or become liable for or shall pay upon or in consequence of any liability or alleged liability arising out of the performance of its services under this Agreement, unless it is shown that Company has not exercised, with respect to its performance of services under this Agreement, the same care and skill that a similarly situated provider of like services would exercise following commonly accepted insurance industry practices.

2. all Service Fees, Additional Service Fees, or other fees set forth in Exhibit C or any other exhibit or amendment attached to this Agreement.

3. losses and expenses not compensated for by insurance or otherwise sustained by Company in connection with the services provided under this Agreement, unless it is shown that Company has not exercised, with respect to its performance of services under this Agreement, the same care and skill that a similarly situated provider of like services would exercise following commonly accepted insurance industry practices.

4. any payments made by Company from Company funds on Contractholder's behalf in connection with this Agreement.

B. Company agrees to reimburse Contractholder for all costs and expenses (including reasonable attorneys' fees but excluding any amount found to be payable under the Plan), not covered by insurance, necessarily incurred by Contractholder in any claim or suit seeking the payment of a benefit under the Plan brought by a covered employee with respect to which it is determined, first, that said benefit is payable under the Plan and, second, that the claim or suit has directly resulted or arisen from Company's failure to exercise, with respect to those services for which provision is specifically made under this Agreement, the same care and skill that a similarly situated provider of like services would exercise following commonly accepted insurance industry practices.

C. Reimbursement for any fees, costs and expenses to which Company and Contractholder are entitled in accordance with 5.5 A and B above shall be due within 30 days of presentation of appropriate written notice by one party to the other.

SECTION VI: COMPENSATION OF Company

6.1 Computation of Service Fees and Payment to Company.
In consideration of the performance of this Agreement, Contractholder agrees to make payments to Company as set forth in Attachment C hereto.

6.2 Change in Service Fees. In addition to any specific provision set forth in any Attachment to this Agreement, Company reserves the right to change required Contractholder payments set forth in Attachment C under this Agreement:

A. As of the beginning of any Successive Term by notice in writing to Contractholder, given at least thirty days prior to the beginning of such Term.

B. As of any date the terms of this Agreement or the Plan are changed so as to affect the cost and expense of services provided or to be provided by Company.

C. As of the first day of the Initial Term if the total number of Beneficiaries/Employees covered for disability benefits provided under this Agreement differs by 10% or more from the total number of Beneficiaries/Employees on which Company based the ASO fees presented in its proposal to the Contractholder.

D. As of the first day of any month during the Term that the total number of Beneficiaries/Employees covered for disability benefits provided under this Agreement differs by 10% or more from the total number of Beneficiaries/Employees covered for such benefits or services on the first day of the preceding month or by 10% or more from the total number of Employees covered for such benefits on the first day of the then current Term.

Company shall provide Contractholder pertinent data to support any change in fees as described herein.

SECTION VII: FORMS

7.1 Provision of Forms. Company shall provide Contractholder the forms described in Attachment A, if applicable.

7.2 Approval of Forms by Company. Company shall have the right to review and approve all printed materials provided to Beneficiaries or used to solicit participation in the Plan by Contractholder. Such review shall only be with regard to adequacy and legal effect of said materials on Company. Company makes, and will make no representation or warranty, express or implied, nor shall Company have any responsibility or liability with regard to the adequacy or legal effect of such material as to Contractholder or any other person or entity. Company will make every reasonable effort to review such materials and give Contractholder a response within a reasonable time period of receipt of the materials by Company.

SECTION VIII: TERM OF THE AGREEMENT

8.1 Agreement Effective Date. This Agreement shall become effective on the first day of the Initial Term and unless and until terminated as hereinafter provided shall continue in effect throughout the Initial and each Successive Term.

8.2 Renewal of the Agreement. After the completion of the Initial Term, this Agreement shall be renewed for one or more additional terms of twelve months each subject to (i) such changes regarding Company's compensation and other terms and conditions as Company may require and (ii) any other changes agreed upon by Contractholder and Company. Each renewal period is subject to the Termination of the Agreement provisions set forth below.

8.3 Termination of the Agreement. This Agreement may be terminated at the earliest time specified below:

A. The date of discontinuance of the Plan or the date Company determines that it cannot administer a change in Plan or a change in service proposed by Contractholder.

B. The date specified by Contractholder or Company following 30 days advance written notice to the other Party of its intent to terminate the Agreement.

C. The date the Contractholder makes a general assignment for the benefit of creditors, or petitions for reorganization or arrangement under the bankruptcy laws, or files a voluntary petition in bankruptcy, or the date a petition in bankruptcy is filed against the Contractholder, or the date of appointment of a receiver for the Contractholder for all or any part of the Contractholder's property or assets, or the date the Contractholder becomes insolvent.

D. Automatically if any amount payable by either Party hereto to the other remains unpaid 45 days after its due date, provided a follow-up notice of non-payment is furnished at least 10 days prior to the date of termination.

E. Upon 15 days' written notice if either Party commits any material breach (except as described above in paragraphs C and D herein) of this Agreement. Should the breaching Party completely cure, to the reasonable satisfaction of the other Party and within the 15-day notice period any particular default(s) or failure(s) of performance for which the other Party has provided notice of termination of the Agreement, this Agreement shall remain in force. However, the non-breaching Party may exercise its right to terminate the Agreement immediately, without a 15-day notice and cure period, if the breach is similar to, or of the same type or nature as, a previously cured breach, notwithstanding any cure by the breaching Party.

The foregoing remedies stated above in paragraphs C, D and E shall not be deemed exclusive, but shall be cumulative and shall be in addition to all the other remedies existing at law or in equity. Any waiver of the right to terminate this Agreement for cause shall extend only to the particular default and shall not operate as a waiver of any future default.

8.4 Notice of Termination to Beneficiaries. Contractholder agrees to promptly notify affected Beneficiaries of the termination of this Agreement at least 30 days prior to the effective date of such termination, except in the case of a termination of this Agreement for cause, in which case Contractholder shall immediately notify Beneficiaries of such termination.

8.5 Post-Termination Provisions. Upon termination of this Agreement, the following provisions will apply:

A. Provisions contained in this Agreement that by their sense and context are intended to survive completion of performance, termination or cancellation of this Agreement shall so survive.

B. Unless otherwise provided in an amendment to this agreement, upon termination of this Agreement, Company shall deny in its claim system all claims not processed by Company as of such termination date.

8.6 Final Settlement Upon Termination. In the event of termination of this Agreement, a final accounting and settlement shall be made taking into account the charges set forth in Attachment C and any other costs and expenses reimbursable by one Party to the other under this Agreement. Final settlement may be deferred at the option of either Party to this Agreement for no longer than 180 days following the later of (i) termination of this Agreement and (ii) completion by Company of any post-termination services provided by Company.

SECTION IX: EXTERNAL AUDITS

9.1 Audit by Contractholder. While this Agreement is in force, Contractholder, or a certified vendor, shall have the right, at Contractholder's expense, to conduct a statistically valid audit based on a random sampling methodology of Company's performance under this Agreement, subject to the following conditions:

A. Audits shall be limited to not more than one during any 12-month period. Notice shall be given in writing to Company of Contractholder's intent to conduct an audit. The notice shall state the purpose and scope of the audit; however, the audit shall not be broader than reasonably necessary to verify Company's performance under this Agreement. The audit shall not include the completion of extensive questionnaires but Contractholder's auditor will be provided with an operations walk-through, description and training on appropriate computer screens. Company shall provide, for audit sample selection purposes, an electronic listing of individual claim numbers ("Document Control Number") and amount paid for each claim for the period covered by the audit. In no event shall audit encompass data generated and/or claims processed by Company prior to the first day of the prior contract year. Any audit shall be conducted in accordance with, and subject to, the auditing standards of the American Institute of Certified Public Accountants, excluding any extrapolation standards.

B. Contractholder shall have the right to select an auditor of its choice, except that the auditor shall not be involved in, or be subsidiary to, a business engaged in activities competitive to Company or to subsidiaries or affiliates of Company. Contractholder's auditor must be bondable and show proof of such bond. Contractholder and Contractholder's auditor must execute an Audit Agreement which includes hold harmless and confidentiality provisions prepared by Company prior to the date such audit is undertaken.

C. The audit shall at all times be conducted in the presence of a representative appointed by Company and in accordance with written audit policy of Company, which shall be provided to the auditor. At the conclusion of the audit and prior to the drafting of the audit report, the auditor shall meet with such person or persons as Company may designate for an interview regarding the results of the audit.

D. Any claim authorization discrepancies discovered by the Contractholder's auditor during the course of the audit shall be resolved on a single case basis and shall not be extrapolated to other claims of the Contractholder. Contractholder's auditor shall provide Company with a copy of the draft audit report upon its completion. Company shall have the right, at least two weeks prior to the release of the audit report, to review the draft and to include in the final report its responses to issues raised by the report. Contractholder's auditor shall agree to provide Company with a copy of the final audit report upon its delivery to Contractholder.

E. Contractholder agrees to reimburse Company for all costs Company incurs in support of the audit. The amount of the reimbursement shall be (i) in addition to the fees described in Attachment C hereto, and (ii) due on the date indicated on the billing statement.

9.2 Audit by Company. Company will have the right at its expense to audit Contractholder's eligibility records that relate to the operation of this Agreement. Contractholder will have the right to review and comment on any audit report prior to said audit report being finalized.

9.3 Cooperation of the Parties. The Parties agree to fully cooperate with audit activities in connection with the subject matter of this Agreement and in accordance with the terms set forth in this Section.

SECTION X: RECORDS

10.1 Maintenance of Records. Company agrees that it shall maintain, in its standard format, adequate records of all transactions between itself, Contractholder and the Beneficiaries during the period this Agreement remains in force and for a period of seven years thereafter or any longer period of time required by law. Contractholder may request (i) a claim history listing in Company's standard format which is pertinent to the disbursement of benefits for each claim during the term of this Agreement and for up to 90 days thereafter, and (ii) reproductions of documents pertaining to the determination of a specific claim or specific claims during the term of this Agreement and for up to seven years thereafter to the extent Contractholder requires such information in responding to a claim or a suit for a benefit, provided that Contractholder shall pay any and all reasonable costs, as determined by Company, associated with preparing any such claim history listing and any such reproductions pertaining to a specific claim or specific claims.

10.2 Transfer of Records. In the event of the termination or failure to renew this Agreement, Company agrees to cooperate in the transfer of eligibility records and claims history data to Company's successor. Such information shall be provided in Company's standard format. Contractholder agrees to pay the actual costs for providing and shipping such material.

10.3 Confidentiality. The Parties agree that:

A. Company will use reasonable efforts, and take the same care as with its own information and data, to preserve the confidentiality of Contractholder's data or information.

B. Company acknowledges and agrees that all individually identifiable information regarding persons covered under the Plan, including, but not limited to, information pertaining to a person's health history, diagnosis or treatment, is confidential and shall be (i) used only in order to carry out the provisions of this Agreement (or in connection with any group insurance policy, or other services arrangement by and between Company and Contractholder) and (ii) disclosed only as otherwise provided in this Agreement or as required by law.

C. Contractholder acknowledges and agrees that all individually identifiable information regarding persons covered under the Plan and obtained from Company or Designee shall be used or disclosed only (i) for purposes of making eligibility and benefit determinations under the Plan (including, where appropriate, determinations under any medical case management program), (ii) as may otherwise be necessary in connection with administering the Plan, or (iii) as required by law.

D. Each Party to this Agreement reserves the right to control the use of the names, symbols, trademarks and service marks presently existing or hereafter established with respect to it or its subsidiary. Neither Party shall use the name, symbols, trademarks or service marks of the other Party (or its subsidiary) in advertising or promotional materials or otherwise, without the prior written consent of the other Party. Both Parties shall cease any and all usage immediately following the termination of this Agreement. In addition, the Contractholder agrees to protect the confidentiality of systems, procedures, materials and products utilized by Company and its Designees in providing services under this Agreement and to refrain from any unauthorized use of confidential or proprietary information regarding such systems, procedures, materials or products.

E. Company may use data collected in the course of providing services hereunder for statistical evaluation and research. If such data is ever released to a third party, it shall be released only in aggregate statistical form without identifying Contractholder, and in no event shall any data be released if Contractholder is the sole source of the aggregate data.

F. In the event new federal legislation or regulations are adopted regarding the confidentiality of medical and personal information relating to health benefit plans, Contractholder agrees that this Section X shall be amended by the Parties to satisfy the requirements of such legislation or regulations, and, pending execution of such amendment, this Section X shall be interpreted in a manner that conforms with the minimum requirements of such legislation or regulations.

SECTION XI: ASSIGNMENT/DELEGATION

11.1 Assignment of Rights. No assignment of any rights hereunder by Contractholder shall be valid without the prior written consent of Company. Any assignment made contrary to this provision shall be void.

11.2 Delegation. Company may delegate any obligations, as well as any rights to payment associated therewith, pertaining to this Agreement to another entity. It is understood that any delegation of obligations under this Agreement would not relieve Company from liability under this Agreement. Thus, to the extent that there is any delegation of obligations, the same standards of care would apply to those subcontractors, affiliates or subsidiaries as would apply to Company unless otherwise expressly provided in this Agreement.

SECTION XII: APPLICABLE LAW

This Agreement shall be construed, regulated and administered under the laws of the State of Indiana without regard to conflict of law principles that would result in the application of another jurisdiction, except as otherwise specifically required by federal law. The venue for any action or arbitration under this Agreement shall be the in the State of Indiana.

SECTION XIII: COMMUNICATIONS

Unless otherwise agreed to in writing, all notices required or permitted hereunder shall be in writing and shall be deemed to have been properly given on the day after such notice is deposited in the United States mail with First Class postage prepaid to the other Party at the following addresses:

If to Company -

For Claims:
Anthem Life Insurance Company
3350 Peachtree Road NE
Atlanta, GA 30326
Attention: Dorothy Tieslau

For Enrollment and Billing
Anthem Life Insurance Company
8940 Lyra Drive, Suite 300
Columbus, OH 43240

If to Contractholder-

Virginia Association of Counties Group Self Insurance Risk Pool (VACORP)
1819 Electric Road, Suite C
Roanoke, VA 24018

If the mail is not used, notice shall be deemed given on the date said notice is actually received by the party designated to receive said notice.

SECTION XIV: AUTHORITY OF THE PARTIES

Except as provided herein, Company shall have no power or authority on behalf of Contractholder to alter, modify or waive any terms or conditions of the Plan Document or any other Employer-sponsored benefit plan with respect to which services are provided under this Agreement, or to waive any breach of any such terms or conditions, or to bind Contractholder or to waive any of its rights by making any statement or by receiving at any time any notice or information.

Neither Company, nor Contractholder, shall have any power or authority to act for or on behalf of the other except as herein expressly granted, and no other or greater power or authority shall be implied by the grant or denial of power or authority specifically mentioned herein.

SECTION XV: ENTIRE AGREEMENT -- CHANGES/WAIVERS

15.1 Entire Agreement. This Agreement, together with its Attachments and Amendments, forms the entire contract between the Parties and supersedes any and all prior understandings or agreements between the Parties whether oral or in writing. No agent of either Party may change this Agreement or waive any of its contents, except as provided in paragraph 15.2 below.

SECTION XV: ENTIRE AGREEMENT -- CHANGES/WAIVERS (Continued)

15.2 Changes/Waivers. This Agreement may be changed in whole or in part by amendment. Any amendment to this Agreement shall only be effective, provided:

A. It is in writing; and

B. No modification or change in any provision of this Agreement shall be effective unless and until approved in writing by an authorized representative of Company and evidenced by an amendment attached to this Agreement. Any amendment produced by the Company to reflect a change shall only require signature by an officer of the Company. If a modification or change is proposed, the proposing Party shall provide written notice to the other at least thirty (30) days prior to the effective date of such change. The modification or change will be deemed accepted by the Parties unless a party receives written notice from the other party prior to the effective date that such change is unacceptable. If the Parties do not accept the proposed change, the Parties will meet and confer to reach agreement prior to implementation of such change.

Failure to enforce any term of this Agreement shall not be construed as a waiver thereof.

SECTION XVI: FORCE MAJEURE

Company shall not be liable for any failure to meet any of the obligations or provide any of the services specified or required under this Agreement where such failure to perform is due to any contingency beyond the reasonable control of Company, its employees, officers, or directors. Such contingencies include, but are not limited to, acts or omissions of any person or entity not employed by Company, its employees, officers, or directors, acts of God, fires, wars, accidents, labor disputes or shortages, and governmental laws, ordinances, rules or regulations, whether valid or invalid.

SECTION XVII: SURVIVAL

Provisions contained in this Agreement that by their sense and context are intended to survive completion of performance, termination or cancellation of this Agreement shall so survive.

SECTION XVIII: TITLES

Titles or headings are not part of this Agreement and shall have no effect on the construction or legal effect of this Agreement.

SECTION XIX: EFFECTIVE TIME

All periods begin and end at 12:01 A.M., standard time, at the Contractholder's address as reflected in Section XIII of this Agreement.

SECTION XX: AUTHORIZATION

IN WITNESS WHEREOF, the Parties hereto have duly executed this Agreement, including any amendments or attachments thereto, to be effective July 1, 2019.

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For Anthem Life Insurance Company

By: _____
Title: President _____
Date: 6-11-19 _____

For Virginia Association of Counties Group Self Insurance Risk Pool (VACORP)

By: _____

Title: **Administrator** _____

Date: **July 31, 2019** _____

ATTACHMENT A
LIST OF SHORT TERM DISABILITY SERVICES (ATP)

I. CLAIM PROCESSING

Unless otherwise provided in an amendment to this agreement, Company shall deny in its claim system claims for all disabilities preceding the Agreement effective date.

Company shall conduct eligibility evaluations on claims to determine whether coverage is available. This evaluation will be based upon Plan provisions and eligibility information provided by the Contractholder. Company will conduct an initial evaluation of claims through contact with appropriate parties, to determine whether disability benefits are payable. Dependent on the Clinical Services Option selected by the Contractholder, this evaluation may include review by medical personnel employed by Company or independent vendors when deemed appropriate by Company. Information gathering or verification will be performed by Company as needed for review of ongoing claims. Company shall be entitled to use its discretion in good faith and consistent with its respective standard and customary practices when processing claims under the Plan. Some claim processing procedures are described below.

Company shall advise the Contractholder on duration of disability for each claim, and identify the status of claims through regular reporting in accordance with the Contractholder's payroll cycle. This duration information is provided so that the Contractholder or its designee can issue benefit payments to claimants.

i. Initial processing of claims will include informing the claimant of action taken according to Contractholder's instructions and the Plan.
ii. Where the claimant under the Plan has also filed a claim or an appeal under any law applicable to benefit entitlement, such as workers' compensation, unemployment compensation, disability or cash sickness law of any state, Company will take appropriate action which may include holding the claim in a pending file and furnishing to the representative of the Plan designated by the Contractholder information relevant to such claim. Upon Contractholder's request, Company shall turn over any such claim to the representative of the Plan designated by the Contractholder for disposition by the Plan.
iii. With respect to issues not addressed in the provisions of the Plan or where provisions are ambiguous, including questions of eligibility for benefits, the Contractholder, the Administrator, or other fiduciary designated by the Contractholder, shall have final authority to make a determination with respect to such issues or such provisions.

II. CLAIM APPEAL

The Contractholder retains the right to review and override Company's denial decision. The Contractholder and Company acknowledge that pursuant to this Agreement, Contractholder will conduct a review of any claim denied or terminated in whole or in part upon receipt of such an appeal by a claimant. The Contractholder will determine whether the claim determination should be upheld or overturned. The Contractholder has retained the responsibility and discretionary

authority for providing the full and fair review of determinations concerning eligibility for Plan benefits and the interpretation of Plan terms in connection with the appeal of claims denied in whole or in part, required under ERISA Section 503 (2) where applicable and, therefore, Contractholder is the Named ERISA Claims Review Fiduciary for Plans subject to ERISA or the Claims Review fiduciary for Plans not subject to ERISA. Any determination or interpretation made by the Contractholder shall be given full force and effect and be binding on the claimant and Company.

i) Company will provide Contractholder with all information and documents within its control needed to facilitate the review of a claim on appeal.
ii) Contractholder will inform Company and claimant of its determination on appeal in accordance with its claim notification services.

III. BASIC CLAIM ADMINISTRATION SERVICES

Company shall:

a) Provide information and assistance to Beneficiaries concerning claims for benefits under the Plan.

b) Verify eligibility for benefits based on information provided to Company by Contractholder in an agreed upon format.

c) Process claims for benefits under this Agreement in accordance with the Plan utilizing claim procedures and standards established by Company and adopted by Contractholder.

d) Review each claim to:

(i) Confirm that a claimant is eligible for coverage and determine the plan of benefits under which the claimant is covered.
(ii) Examine claim proofs to verify that information is complete.
(iii) Request from the appropriate source any information necessary to process the claim.
(iv) Examine claim proofs for any apparent alteration.
(v) Determine Disability in accordance with the plan provisions and Contractholder's instructions.

e) Prepare weekly Advice to Pay Report

f) Perform appropriate internal claim audits based on Company's standard practices.

IV. LEGAL PROCEEDINGS

It is understood that performance of this Agreement by Company shall not require Company to appear at proceedings before departments or agencies of the United States, any state, or any subdivision thereof. It is further understood that performance of this Agreement shall not involve Company in the furnishing of legal advice or in any other function or activity prohibited to Company. However, Company will provide to Contractholder, claim files and any other records of action Company has taken with respect to any claim.

V. RECOVERY OF LIENS

Company agrees to use reasonable diligence to identify third-party liability liens or workers' compensation liens, and notify Contractholder so that Contractholder may take further action to pursue recovery.

VI. ELIGIBILITY

Contractholder shall establish and provide Company ongoing eligibility information in a format defined by Company and compatible to Company's system. Company shall have a reasonable period of time to input these additions and changes to the appropriate employee records file.

VII. FORMS/MATERIALS/PLAN DESCRIPTIONS

a) Company may prepare and print Plan text, including subsequent changes, based on benefit specifications agreed upon by Contractholder using Company's standard language and format for such text. Approval/disapproval must be in writing and delivered to Company by the 31st day following the initial delivery of the documents to the Contractholder, If Company does not receive a response from Contractholder by this date, the documents will be deemed approved by Contractholder. The distribution of such documents to employees shall be the responsibility of Contractholder. Preparation of forms shall not include preparation of any annual report or other form required to be furnished or made available to Beneficiaries pursuant to ERISA where applicable.

b) Contractholder must submit any non-standard enrollment materials and documents to Company for review and approval prior to printing. The cost of preparing and printing such materials shall be borne by Contractholder. The final documents must be acceptable to Company.

VIII. SUPPORT SERVICES

Company agrees to make its personnel available to Contractholder and its consultants on a day-to-day basis to make certain that the needs of Contractholder are being met.

IX. UNDERWRITING SERVICES

Company agrees to provide to Contractholder a renewal package not later than [30] days prior to the expiration of a Term Year which shall include:

a) Administrative fees for the following Term Year.
b) Documentation to support the change in fee.

X. REPORTS

Company shall provide to Contractholder the standard reports package pertinent to the services purchased by Contractholder.

ATTACHMENT B
CLAIM SUBMISSION AND CLINICAL SERVICE OPTION ELECTIONS
Effective July 1, 2019

Claim Submission Options

[X] Telephonic Claim Submission (standard): Disability claims submitted telephonically or on paper claim forms by employees or employer representatives. Basic intake of claim information and demographics is performed by Customer Service Representatives initially. Disability Case Managers then follow-up by phone with the employer, employee and attending physician to obtain any additional information necessary to make claim determinations.

Clinical Service Options

The Contractholder has elected Clinical Option 3.

Option 3: Company provides full case management approach. Claims are submitted telephonically. If appropriate, Company is notified of an absence concurrently with the supervisor or HR representative. An employee interview is conducted, if appropriate, and return-to-work expectations are set. Objective medical documentation (treatment notes, test results, surgical notes, etc.) is required to support and approve disability durations. Clinical information is collected telephonically whenever possible. All claims are evaluated against our standard duration guidelines. Both the clinical information and functional impairment are assessed, in conjunction with our duration guidelines, to determine total disability and appropriate claim duration. Claimants' job descriptions would play a major part in the duration of their claim. A heavy emphasis is placed on return to work at full capacity or in an alternate job function.

Productivity Solutions is included with Clinical Services Option 3. This integration of disability and medical programs focuses on the total productivity of employees. Employees covered by a Company health plan experiencing a serious disabling illness or injury are connected with a health coach, who is also a registered nurse, to serve as the employee's advocate throughout the claims and care management process. For an additional fee, health coaches work one-on-one with employees to help identify and resolve all issues that impact their ability to be productive. With this support, employees may return to work more quickly and in some cases, may be able to stay at work and avoid a disability claim altogether. Through coordination with the disability claim team, our internal staff of clinical professionals and other care management programs, such as EAP and disease management as needed, the health coaches ensure that the Company delivers a solution that best meets the employee's individual needs.

ATTACHMENT C
COMPUTATION OF ADMINISTRATION CHARGES
AND PAYMENT TO COMPANY
Effective July 1, 2019

Charges for services provided by Company and the method of payment by Contractholder shall be as described below.

I. SERVICE FEES

For services provided the Contractholder by Company during each Term described in this Agreement, any amounts described below, and any other amounts agreed upon in writing by Company and Contractholder, the fee for which shall be in addition to amounts payable as described below, Contractholder shall pay Company as follows:

Contractholder shall remit monthly service fees to Company and provide information regarding number of covered persons. Payment is due on the first of each month in arrears. However, we will allow the Sponsor a 90 day grace period to complete any payment or payment shortage. During this 90-day grace period, and notwithstanding any other provision under the ASO agreement, the Company shall continue performing all obligations under the Agreement. as of the due date. However, if the payment or any portion thereof is still not received by Company by the 90th day, and provided a follow-up notice of non-payment is furnished at least 10 days prior to the date of termination, the agreement will automatically terminate as of the end of the 90-day grace period and all our obligations under the Agreement will cease. Any outstanding fee payment prior to termination will still be owed to Company.

In order for Contractholder to receive credit for Service Fees paid for an ineligible person due to a correction or change in eligibility information, any such change or correction must be received by Company within 90 days of the date a Beneficiary ceases to be eligible under the Plan. In any event, the maximum retroactive credit for Service Fees paid for an ineligible person, whether or not benefits are actually provided for such person, shall not exceed 90 days.

II. FEES FOR ADDITIONAL SERVICES

In addition to the foregoing, Contractholder shall also pay Company for the following services:

A. Charges for External Medical Review, External Vocational Rehabilitation Vendor Services, Functional Capacity Evaluations, Independent Medical Examinations and Surveillance are subject to advance approval by Contractholder and are direct pass-through costs to Contractholder.

ATTACHMENT D
DESCRIPTION OF PLAN

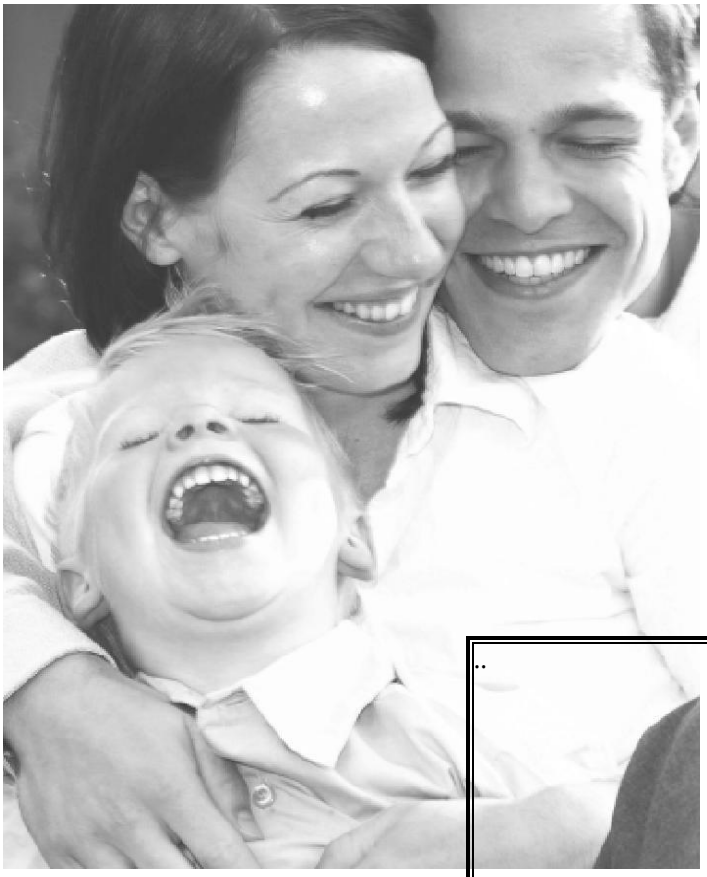
Plan consists of the benefit plans described in the following exhibits, which are attached to and a part of this Attachment D:

Plan	**July 1, 2019**
Exhibit I:	**Summary Plan Description**

A description of the Plan, furnished to Contractholder by Company or by Contractholder to Company, is intended to be included as part of this Attachment D and made a part of this Agreement.

ASO STD Summary Plan Description

Summary Plan Description



Short Term Disability Benefits Program

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A guide to your benefits

Plan Sponsor:	**Virginia Association of Counties Group Self Insurance Risk Pool ("VACORP")**
Participating Employer:	**Your Employer participating in VACORP**
Class:	**01**
Class Description:	**All Eligible Employees participating in the VRS Hybrid Retirement Plan**

Table of Contents

Short Term Disability Benefit Program

Introduction

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

The Plan Sponsor self-insures this Program. In this summary, Your employer is a participant of the Plan Sponsor and is referred to as "Employer" or "Participating Employer."
Anthem Life Insurance Company is the claims administrator for the Program, and does not underwrite or insure the Program. In this summary, the claims administrator is called "We" or "Us."

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

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

Schedule of Benefits for Short Term Disability Benefit Program

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

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

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

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

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

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

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

For a Non-work Related Disability:

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

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

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

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

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

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

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

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

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

Minimum Weekly Benefit None.

Elimination Period: Begins on the first day that You meet the definition of Disability and ends after:
- 7 days of injury; and/or
- 7 days of illness

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

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

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

Definitions

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

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

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

Eligible Employee means You meet all of the following:

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

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

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

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

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

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

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

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

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

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

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

Material and Substantial Duties means duties that:

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

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

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

Physician means:

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

Physician does not include:

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

- Grandparents
- Grandchildren
- In-Laws

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

Regular Care means:

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

Retirement Plan means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to employees and are not funded entirely by employee contributions.

We, Us, and Our means the claims administrator.

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

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

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

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

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

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

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

When Short Term Disability Benefits End

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

1. You are no longer Disabled under the terms of the Program; *or*
2. You are no longer receiving, accepting or following Regular Care from a Physician; *or*
3. The Maximum Benefit Period from the Schedule of Benefits ends; *or*
4. Preceding the date of Your death; *or*
5. We ask You for Proof that You are still Disabled, if We do not receive Proof of Disability within 31 days of Our request; *or*
6. We ask You for details about Your Deductible Sources of Income, including Your tax returns, if You do not give Us details within 31 days of Our request; *or*
7. We ask You to be examined by:
   - a Physician; *or*
   - health care professional

   If You do not reasonably cooperate with the examiner or if You unreasonably decline to be examined; *or*
8. Your Disability Work Earnings exceed the amount allowable under the Program; *or*
9. You cease to reside in the United States. If You are outside the United States for a total period of 6 months or more during any 12 consecutive months of Weekly Benefit Payments, You will be considered to have ceased to reside in the United States; *or*
10. You are confined to a penal or correctional institution; *or*
11. With respect to a mental illness, that You are not under the continuing Regular Care of a Physician specializing in psychiatric care; *or*
12. With respect to Alcoholism and Drug Addiction, that You are not being actively supervised by and receiving continuing treatment from a rehabilitation center or a designated institution approved for such treatment by an appropriate body in the governing jurisdiction, or, if none, by Us; *or*
13. You or Your Physician fail to submit any medical or psychiatric information requested by Us; *or*
14. You would be able to work in Your Own Occupation on a part-time basis earning 20% or more of Your Weekly Earnings, but choose not to do so; *or*
15. You would be able to increase Your current earnings to more than 80% of Your Weekly Earnings by increasing the number of hours worked or the number of duties performed in Your Own Occupation, but choose not to do so.

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

Termination of Coverage

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

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

Short Term Disability Income Coverage

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

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

Definition of Disability and Disabled for Short Term Disability

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

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

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

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

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

Short Term Disability Benefits

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

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

- We receive Proof of Your Disability.

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

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

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

Calculating Your Short Term Disability Benefit

We will calculate Your Weekly Benefit Payment as follows:

Part A

If You are Disabled and not working:

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

Part B (Work Incentive)

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

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

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

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

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

If Your Disability Work Earnings Fluctuate

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

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

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

Recurrent Disability Provision for Short Term Disability

If You have a Recurrent Disability, and after Your prior Disability ended, You return to work for Your Employer for 45 days or less, We will treat Your Disability as part of Your prior claim and You do not have to complete another Elimination Period.

Your Weekly Benefit Payment will be based on Your Weekly Earnings as of the date of Your initial claim.

Your Disability, as outlined above, will be subject to the same terms and conditions of the Program as Your prior claim.

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

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

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

Period of Disability extended by a new condition

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

Deductible Sources of Income

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

The following are Deductible Sources of Income:

1. The amount that You receive, or are eligible to receive, under:
   - a workers' compensation law; *or*
   - an occupational disease law; *or*
   - unemployment compensation law
   - any other Act or Law with similar intent.

2. The amount that You receive, or are eligible to receive, as disability income payments under any:
   - state compulsory benefit Act or Law; *or*
   - governmental retirement system as a result of Your employment with the Employer; *or*
   - Veteran's Administration or any other foreign or domestic governmental agency; *or*
   - automobile liability insurance policy; *or*
   - individual disability income plans which are wholly or partially paid for by the Employer; *or*
   - any plan or arrangement of disability coverage, whether insured or not, resulting from Your employment by or association with the Participating Employer or any other employer, or resulting from Your membership in or association with any group, association, union or other organization.

3a. The amount that You, Your spouse, and children receive, or are eligible to receive, as disability payments because of Your Disability under:
   - The United States Social Security Act; or
   - the Canada Pension Plan; or
   - the Quebec Pension Plan; or
   - any similar plan or act.

3b. The amount that You receive, or are eligible to receive, as retirement payments or the amount Your spouse and children receive as retirement payments because You are receiving retirement payments under:
   - The United States Social Security Act; or
   - the Canada Pension Plan; or
   - the Quebec Pension Plan; or
   - any similar plan or act.

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

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

5. The amount that You:

   - receive as disability payments under the Employer's Retirement Plan; *or*
   - voluntarily elect to receive as retirement payments under the Employer's Retirement Plan; *or*
   - are eligible to receive as retirement payments when You reach the later of age 62 or normal retirement age, as defined in the Employer's Retirement Plan.

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

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

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

6. The amount You receive as a result of any action brought under Title 46, United States Code Section 688 (The Jones Act).

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

8. The amount You receive under the mandatory portion of any "no fault" motor vehicle plan.

9. Commissions, severance allowance, sick pay or any similar employer sponsored paid time off plan where You receive income from the employer, vacation pay or any salary continuation plan. Any earnings from any work or employment may be used to reduce Your Weekly Benefit Payment unless otherwise specified by the terms of the Program.

10. Any amounts from partnership, proprietorship draws, or similar draws.

Lump Sum Payments

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

Non-Deductible Sources of Income

We will not subtract from Your Weekly Benefit Payment any income You receive from the following:

1. 401(k) plans;
2. profit sharing plans;
3. thrift plans;
4. tax sheltered annuities;
5. stock ownership plans;
6. credit or mortgage disability insurance;
7. non-qualified plans of deferred compensation;
8. pension plans for partners;
9. military pension and disability income plans;
10. individual disability plans paid by the Employee;
11. a retirement plan from another employer;
12. individual retirement accounts (IRA);
13. Accelerated death benefits paid from a life insurance policy
14. Keogh (HR-10) plan.
15. Reimbursement for hospital, medical or surgical expense

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

If You May Qualify for Deductible Income Benefits

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

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

Social Security Benefits

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

We may require You to:

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

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

Recovery of Overpayment

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

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

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

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

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

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

Adjustment for Underpayment

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

Proration

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

Additional Benefit for Vocational Rehabilitation Program

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

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

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

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

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

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

Vocational Rehabilitation Program (continued)

To qualify for these services, You must:

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

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

The written program will describe:

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

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

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

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

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

Additional Benefit for Work Retention Assistance

If You:

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

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

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

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

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

Additional Benefit for Catastrophic Conditions

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

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

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

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

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

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

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

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

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

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

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

Exclusions

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

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

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

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

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

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

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

General Provisions

Currency

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

Class Membership

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

Agency

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

Changes to Program

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

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

Enforcement of Program Terms

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

Claims

Notice of Claim

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

Claim Forms

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

Proof of Disability

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

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

Filing Claim Forms

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

Proof of Continuing Disability

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

Proof of Financial Loss

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

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

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

Payment of Claims

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

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

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

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

Notice of Claim Decisions

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

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

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

Reconsideration of a Denied Claim

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

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

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

Examinations

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

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

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

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

Discretionary Authority for Benefit Determination

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

Release of Information

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

Long Term Disability Policy

ANTHEM LIFE INSURANCE COMPANY

Group Insurance Policy

Plan Sponsor:	Virginia Association of Counties Group Self Insurance Risk Pool (VACORP)
Policy Number:	AL00006723
Policy Effective Date:	07/01/2019
Policy Anniversary Date:	07/01
Policy Situs:	Virginia

Anthem Life Insurance Company

"We," "Us," and "Our" means the insurer, Anthem Life Insurance Company

In consideration of the Plan Sponsor's application and payment of the first premium, Anthem Life Insurance Company agrees to insure those Employees and Dependents entitled to the insurance provided by this Group Insurance Policy, subject to its terms and conditions.

Payment of the premium indicates the Plan Sponsor's acceptance of this Policy.

This agreement is subject to the provisions on the attached pages, which together with this page and the Exhibits make up the Policy. The Schedule of Exhibits sets forth each Exhibit which is to be attached to and made a part of this Policy and to whom each such Exhibit applies.

All premiums must be paid on or before the date they are due. Signed for Anthem Life Insurance Company by:

Gregory G. Poulakos
President

Anthem Life Insurance Company
Administrative Office
P.O. Box 182361
Columbus, Ohio 43218-2361
1 (800) 551-7265

This is a legal contract between the Plan Sponsor and the Anthem Life Insurance Company.

Read Your Policy Carefully

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TABLE OF CONTENTS

ELIGIBLE EMPLOYERS

Associated Employers

An employer may be included as an Associated Employer if We and the Plan Sponsor so agree.

An employee of an Associated Employer will be deemed to be an employee of the Plan Sponsor for insurance purposes under the Policy.

All actions, agreements and notices between Us and the Plan Sponsor will be binding on all Associated Employers.

All the terms and conditions of the Policy and the Employer's Participation Agreement apply to an Associated Employer as of the date We and the Participating Employer agree. We will keep a list of accepted Associated Employers and the effective dates of coverage for each.

Eligible Classes

The Classes of employees eligible for insurance will be agreed upon between the Plan Sponsor and Us.

Additional eligibility, effective date, and termination provisions applicable to these eligible Classes are shown elsewhere in the Policy.

Policy Provisions

The Policy provisions for insurance will be as agreed upon between the Plan Sponsor and Us.

Additional Policy provisions with respect to any Eligible Employee are shown elsewhere in the Policy.

Contributions

This Policy may provide coverage for Eligible Employees and Eligible Dependents on a non-Contributory and/or Contributory basis as agreed upon between the Plan Sponsor and Us.

Employees may not contribute to non-Contributory coverage.

Any employee contributions may not exceed the premiums for the coverage.

Prior Service Credit

If a former employee leaves the Plan Sponsor's employ due to active service in the United States Armed Forces, then any prior service will be credited for the length of time required by any state or federal law.

PREMIUMS

Initial Premiums

We have set the initial premium rates. These rates are shown in the premium rate notice (within the Proposal) provided separately to the Plan Sponsor on or prior to the effective date of the Policy.

For the purpose of premium calculation and collection, We will determine the rates based upon the full, unreduced base amount of coverage.

Change in Monthly Premium Rates

We may set new premium rates with 31 days written notice, to become effective at any time after the initial guarantee period.

However, the initial premium rates may not remain in effect if:

1. the coverage, terms or provisions of the Policy are changed or amended; *or*
2. the volume of coverage or number of insured employees or dependents under the Policy change by 10% or more; *or*
3. there is a merger, acquisition or divestiture which affects the Plan Sponsor; *or*
4. there is a change in law or regulation that affects the Policy.

Factors that We may consider when setting new premium rates following the initial guarantee period include, but are not limited to:

1. change or amendment to the coverage, terms or provisions of the Policy; *or*
2. a change in law or regulation that affects the Policy; *or*
3. a change in the number of participants, or the participation level; *or*
4. claims experience; *or*
5. a change in Our operating expenses; *or*
6. a change in the size or demographics for the group; *or*
7. a change in the structure, finances or practices of the Plan Sponsor that affect the Policy.

We will give the Plan Sponsor a Written 31 day notice before changing the premium rates.

Any change in premium rates will be made according to the Change in The Group Policy provision herein.

Premium Payments

The Policy is issued in return for the payment by the Plan Sponsor of the required Premiums. Premiums are payable in advance of each premium due date. The Plan Sponsor's initial premium is due on the Plan Sponsor's Effective Date. The due date for subsequent premiums is the first day of each succeeding Policy month. On any due date, We may, at the Plan Sponsor's Written request, agree to change the frequency of premium due dates. This premium frequency may be annual, semi-annual, quarterly or monthly.

Any premium due will not be deemed paid unless the Plan Sponsor's total premium for all insurance in force has been paid on the due date subject to the Policy's Grace Period provision, the payment of premium due will not maintain insurance in force beyond the day prior to the next premium due date. Payment of premiums for a period before it is due will not guarantee the insurance for that period.

All premiums are due and payable at Our Home Office or to Our authorized agent in exchange for a receipt signed by an officer of Our company and countersigned by the agent. If any check, draft, money order, or other instrument is not honored when presented in the due course of business, the premium is considered unpaid.

If the Policy is terminated, the Plan Sponsor must pay to Us any adjustment premiums that are due and unpaid. The Plan Sponsor must also pay to Us a pro rata premium for the period (if any) elapsed from the date on which the last unpaid premium was due to the date on which the Policy terminated. In the event there is an overpayment of premium, We will return the unearned portion of premium paid.

Unless otherwise specifically stated by the Policy, We will not be required to accept the payment of any premium from anyone other than the Plan Sponsor.

Grace Period

We will allow the Plan Sponsor a 31 day grace period for the payment of all premiums subsequent to the initial premium payment. During this 31 day period, the Policy will stay in force. If the owed premium is not paid by the 31st day, the Policy will automatically terminate on the last day of the grace period.

Premiums are due for each day the insurance is in force.

Self-Administration

The Policy may be self-administered at the Plan Sponsor's request:

1. All documents and notices that would otherwise be sent to Our Home Office in accordance with the terms of the Policy will instead be held by the Plan Sponsor. This will not apply to any Proof of Insurability required by Us nor to any notice or claim forms required by Us to process any claim.
2. Whenever We request, the Plan Sponsor will furnish Us with all of the documents relating to an Insured which have been completed under the terms of the Policy, and which are being held in accordance with item 1. above.
3. We may inspect and examine the records which pertain to a person, in so far as records affect the person's insurance, or eligibility for insurance under the Policy.
4. Whenever We request, the Plan Sponsor will send to Us at Our Home Office a statement listing all of the following:
    a. Each person who is then insured; *and*
    b. The Class of each person insured; *and*
    c. The amount of earnings that apply to each person; *and*
    d. The date of birth of each person; *and*
    e. The occupation of each person, if applicable.

TERMINATION

Plan Sponsor's Request

The Plan Sponsor may terminate the Policy at any time by providing Us 31 days Written notice. Upon receipt of this notice, the Policy will terminate on the later of:

1. the date stated in the notice; or
2. the date the notice is received at Our Administrative Office.

Our Request

We may terminate the Policy on any anniversary date, or at any time by giving the Plan Sponsor 31 days Written notice.

In addition, We may terminate the Policy on:

1. the date premium is due but not paid by the Plan Sponsor, subject to the Policy's Grace Period provision; or
2. the date the number of Eligible Employees is less than those eligible for insurance under the Policy as listed:

Life/STD/LTD:	Non-Contributory – 100% of eligible employees. Contributory – 75% of eligible employees.
Optional Life/VSTD:	Greater of 10 individual or 20% of group eligible employees.
VLTD/VADD:	20% of eligible employees; *or*

3. the date the number of Eligible Employees insured for dependent insurance is less than 75% of those eligible for such insurance under the Policy; *or*
4. the date the Plan Sponsor fails to comply with contribution rules described in the Policy; *or*
5. the date the Plan Sponsor has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact in connection with the Policy; *or*
6. the date the Plan Sponsor does not promptly provide Us with information We reasonably require; *or*
7. the date that We cease to offer coverage for this type of insurance; *or*
8. the date We determine that there is a significant change in the size, occupation or age of the eligible Class(es) as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Plan Sponsor and/or its employees; *or*
9. for association groups, on the date the Plan Sponsor's membership in the association ceases.

We also reserve the right to review and terminate all Classes covered under the Policy if a Class or Classes cease to be covered.

The Plan Sponsor will be liable for any unpaid premium accrued while the Policy remains in force.

The Plan Sponsor is responsible for notifying all insured Eligible Employees about a cancellation of the Policy. Upon termination of the Policy, the Plan Sponsor must provide a list of Eligible Employees not Actively at Work on the cancellation date.

Termination by Us will not prejudice any claims incurred by a covered person prior to the effective date of the termination.

By Mutual Agreement

The Policy may be canceled on a date set by mutual agreement between the Plan Sponsor and Us.

The Plan Sponsor will be required to give each Eligible Employee at least 15 days Written notice prior to the date on which the Policy is to terminate. Failure to give Written notice within such 15 day period will not continue insurance in force with respect to a person beyond the time the Policy would otherwise have terminated.

GENERAL PROVISIONS

Entire Contract

The contract between the parties consists of the Policy, the applications if any, of each Eligible Employee or Eligible Dependent, and the attached listed Exhibits. A copy of the Plan Sponsor's application shall be attached to the Policy when issued.

Nonparticipation

This is a nonparticipating Policy. The Plan Sponsor shall not be entitled to share in any earnings.

Incontestability

The validity of the Policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue.

No statement made by any person insured under the Policy relating to his insurability or the insurability of his insured dependents shall be used in contesting the validity of the insurance with respect to which such statement was made:

- After the insurance has been in force prior to the contest for a period of two years during the lifetime of the person about whom the statement was made; and
- Unless the statement is contained in a written instrument signed by him.

This provision shall not preclude the assertion at any time of defenses based on the person's ineligibility for coverage under the Policy or upon other provisions of the Policy.

Misrepresentation

Any statement made by the Plan Sponsor, Associated Employers, and any insured person will be deemed a representation and not a warranty.

No statement will be used in any contest unless it is in Writing and a copy of it is given to the person who made it, or to his or her beneficiary or personal representative.

Information to be Furnished

The Plan Sponsor and any Associated Employers will give Us all information We need regarding matters pertaining to the insurance. At any reasonable time while the Policy is in force and for 24 months after that, We may inspect any of the Plan Sponsor's or Associated Employer's documents, books, or records which may affect the insurance or premiums of the Policy.

Misstatement of Fact

If the Plan Sponsor or any Associated Employer gives Us any incorrect information, the relevant facts will be determined to establish if insurance is in effect and in what amount.

No Eligible Employee or dependent will be deprived of insurance to which he or she is otherwise entitled or have insurance to which he or she is not entitled, because of any misstatement of fact by the Plan Sponsor or Associated Employer. Any required adjustment will not affect premiums paid or payable before the most recent Policy anniversary date.

Change in the Group Policy

No Change in the Policy may be made unless approved in Writing by the President, a Vice President, or a Secretary or Assistant Secretary of Our company. No other person may change or waive any part of the Policy. Any approved change will be documented in an amendment to the Policy.

Right to Amend

We may change any or all of the provisions under the Policy at the time of renewal.

After the Policy has been in force for 1 year, We may change any or all of the provisions under the Policy by notifying the Plan Sponsor. We must give the Plan Sponsor at least 31 days advance written notice of the change.

Notice

Any notice due from Us to the Plan Sponsor shall be deemed given on the day after such notice is deposited in the United States mail with first class postage prepaid and addressed the address of the Plan Sponsor appearing in Our records. Any notice due from the Plan Sponsor to Us shall be deemed given on the day after such notice is deposited in the United States mail with first class postage prepaid and addressed to Us at Our Home Office, or to such other address We designate in Writing.

Non-Waiver of Policy Terms

Our failure to insist upon compliance with any terms of the Policy, at any time or under any circumstance, will not operate to waive or modify these terms.

Certificate

We will give the Plan Sponsor an individual certificate for each Eligible Employee. The Plan Sponsor is responsible for distribution of certificates to the Eligible Employees.

We are not responsible and shall bear no liability for certificates not distributed or any materials used instead of, or in addition to, the certificates.

Claims Experience

We will provide the Plan Sponsor, upon request, with a complete record of claim experience. The record shall include all claims incurred for the lesser of : i) the period of time since the

Policy was issued; or ii) the period of time since the Policy was last renewed, reissued or extended, if already issued. The record will be made available promptly to the Plan Sponsor upon request made not less than 30 days prior to the date upon which the premiums or contractual terms of the Policy may be amended.

Time Period

All time periods begin and end at 12:01 A.M., standard time at the address of the administrative office of the Plan Sponsor.

Jurisdiction

This Group Policy is governed by the laws of Virginia.

Conformity with State Statutes

Any provision of the Policy which on the Policy effective date is in conflict with the statutes of the applicable Jurisdiction is amended to meet the minimum requirements of such statutes.

SCHEDULE OF POLICY EXHIBITS

The following documents are hereby incorporated into, and made part of, the Group Policy.

Exhibit Number	**Form/Document**	**Applicable to:**
1.	Group Insurance Application	All Employees
2.	Booklet Certificate Form Number LBO A 0105 C	All Covered Employees
and/or 3.	Booklet Certificate Form Number DLS A 0205 C	All Covered Employees

IMPORTANT INFORMATION
REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions, you may contact the insurance company issuing this insurance at the following address and telephone number:

Anthem Life Insurance Company
8940 Lyra Drive, Suite 300
Columbus, Ohio 43240
(866)-551-0326

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at P.O. Box 1157 Richmond, Virginia 23218-1157; (804) 371-9741 or (800) 552-7945 (VA only).

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

Anthem Life Insurance Company
Administrative Office
8940 Lyra Drive
Suite 300
Columbus, Ohio 43240
1 (614) 436-0688
1 (800) 551-7265

Long Term Disability Certificate with Additional Benefit for Lifetime Protection

Anthem Life

Long Term Disability Insurance

A guide to your benefits

You've made a good decision in choosing Anthem® Life

Plan Sponsor:	Virginia Association of Counties Group Self Insurance Risk Pool (VACORP)
Participating Employer:	Your Employer participating in VACORP
Policy:	AL00006723
Classes:	01and 02
Class Description:	Class 01: All Eligible Employees participating in the VRS Hybrid Retirement Plan within their first 12 consecutive months of employment with their Employers. Class 02: All Eligible Employees participating in the VRS Hybrid Retirement Plan with more than 12 consecutive months of employment with their Employers.

anthem.com

This Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding this policy constitutes a contract solely between this Group and Anthem Life Insurance Company, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Anthem Life Insurance Company to use the Blue Cross and/or Blue Shield Service Mark in Virginia and that Anthem Life Insurance Company is not contracting as the agent of the Association. This Group further acknowledges and agrees that it has not entered into this policy based upon representations by any person other than Anthem Life Insurance Company and that no person, entity, or organization other than Anthem Life Insurance Company shall be held accountable or liable to this Group for any of Anthem Life Insurance Company's obligations to the Group created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of Anthem Life Insurance Company other than those obligations created under other provisions of this agreement.

Contents

Section I.	Your Certificate of Coverage

Long Term Disability Insurance

Anthem Life Insurance Company
Post Office Box 182361
Columbus, Ohio 43218-2361
1 (800) 551-7265

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Introduction

Anthem Life Insurance Company certifies that it has issued a Group Policy insuring certain eligible employees of Employers participating in the Plan Sponsor.

This Certificate describes the benefits provided as of the effective date. For purposes of effective dates and ending dates under the Policy, all days begin at 12:01 a.m. and end at 12:00 midnight at the Plan Sponsor's address.

Certain terms of the Group Policy which affect Your insurance are contained in the following pages. Anthem Life has written this Certificate in plain English. However, a few terms and provisions are written as required by insurance law. Anthem Life urges You to read Your Certificate carefully and keep it in a safe place.

If the terms and provisions of the Certificate (issued to You) are different from the Policy (issued to the Plan Sponsor), the Policy will govern. Your coverage may be cancelled or changed in whole or in part under the terms and provisions of the Policy.

The Group Policy was issued in the Commonwealth of Virginia. Its laws and rules will govern in resolving any questions about the Group Policy, except to the extent that the Policy may be governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

While You remain insured, this booklet is Your Certificate of insurance. It replaces any prior booklet or Certificate given to You for the types of insurance described here. It is void and of no effect if You are not entitled to or have ceased to be entitled to the insurance coverage. Many of the provisions of this Certificate are interrelated, and You should read the entire Certificate to get a full understanding of Your coverage. This Certificate also contains exclusions, so please be sure to read this Certificate carefully.

Anthem Life Insurance Company
Administrative Office
P.O. Box 182361
Columbus, OH 43215-2361

Gregory G. Poulakos
President

Fraud: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

—TABLE OF CONTENTS—

Schedule of Benefits

About this Schedule

This Schedule of Benefits shows highlights of the coverage available under the Group Policy. Final interpretation of all provisions and coverages will be governed by the Group Policy on file with Anthem Life Insurance Company at its Administrative Office.

Your amount of insurance is determined by this schedule.

Your Long Term Disability Benefits help to protect You from loss of income due to a Disability as defined under the Policy. Your Long Term Disability Benefits are subject to any limitations, maximums, exclusions and reductions under the Policy, including any reductions by Your Deductible Sources of Income. Refer to the Long Term Disability Insurance Benefits section for details about how Your Monthly Benefit Payment is calculated.

Long Term Disability Benefit

For Class 01: All Eligible Employees participating in the VRS Hybrid Retirement Plan within their first 12 consecutive months of employment with their Employers:

> **For a Work-Related Disability,** meaning a Disability that is due to Your Injury or Illness that occurs because of Your job, the benefit is **60%** of Your Monthly Earnings in effect just prior to Disability, reduced by Deductible Sources of Income.
> **For a Non-work Related Disability,** there is **no benefit.**

For Class 02: All Eligible Employees participating in the VRS Hybrid Retirement Plan with more than 12 consecutive months of employment with their Employers:

> **For any Disability, whether Work-Related or not,** the benefit is 60% of Your Monthly Earnings in effect just prior to Disability, reduced by Deductible Sources of Income.

For all Class 01 and 02 Employees:

> **Maximum Monthly Benefit:** After benefit calculation, cannot exceed $30,000
>
> **Minimum Monthly Benefit:** After benefit calculation, cannot be less than $100.
>
> **Additional Benefit for Catastrophic Conditions:**
>
> For any Disability caused by Catastrophic Conditions as defined, and for which You are already receiving Monthly Benefit Payments under this Policy, the additional benefit is 20% of Your Monthly Earnings in effect just

prior to such Disability, unreduced by Deductible Sources of Income, and subject to a $5,000 monthly benefit maximum. See also the provision, Additional Benefit for Catastrophic Conditions, elsewhere in this Certificate for details.

Additional Benefit for Lifetime Security:

Your Employer has chosen this benefit for inclusion in its benefit plan. That means that We may pay LTD benefits beyond the end of Your Maximum Benefit Period if You remain Disabled, are not working, and you cannot perform at least 2 activities of Daily Living over an expected length of time, or have a certain degree of loss in intellectual capacity over an expected length of time. See also the provision, Additional Benefit for Lifetime Security, elsewhere in this Certificate for details.

Proof of Insurability means evidence satisfactory to Us of a person's health and other information related to insurability that We use which enables Us to determine whether the person can become insured, or is eligible for an increase in coverage.

Proof of Insurability is required for any amount for which application is received more than 31 days after the employee is initially eligible to purchase the insurance.

Eligibility Waiting Period:

There is no Eligibility Waiting period. You are eligible for insurance on the first day of being Actively at Work as a member in Class 01 or 02.

Elimination Period:

The period that expires upon the later to occur: the end of the 125th work day after disability begins, or the end of payment of any Employer sponsored short term disability benefits.

If You return to work for 45 or less consecutive days during the Elimination Period, those days will interrupt the Elimination Period. However, the Disability will be treated as continuous if it is from the same or a related condition. Only those days during which You are Disabled will be used to satisfy the Elimination Period. For example, one must complete an Elimination Period of 125 work days within a total period of not more than 125 work days plus 45 consecutive calendar days.

Maximum Benefit Period

For a disability which begins before You reach age 60, the Maximum Benefit Period will be until the Social Security Normal Retirement Age (SSNRA) as shown in the following table:

Year of Birth	***Social Security Normal Retirement Age**
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 Benefit Period will be determined according to the following table:

Your Age When Disability Begins	**Maximum Benefit Period**
Less than age 60	To Social Security Normal Retirement Age (see table immediately above)
Age 60 through 64	60 months
Age 65 through 68	To age 70
Age 69 or older	12 months

Premium Contributions:

Your coverage is Non-Contributory. This means Your Employer pays all of the premium for Your Long Term Disability Benefit coverage.

Additional Benefits:

- Survivor (Lump Sum)
- Vocational Rehabilitation with Additional Benefit for Work Incentive
- Social Security Assistance
- Workplace Modification Program
- Work Retention Assistance
- Additional Benefit for Catastrophic Conditions

- Additional Benefit for Lifetime Protection
- Pension Plan Contribution
- Additional Benefit for Rehabilitation Incentive

Specific information regarding the Policy and its terms may be obtained from the Plan Sponsor. The provisions, terms and conditions listed in any Policy document, including but not limited to this Certificate may be modified, amended, or changed at any time. Consent from any Insured or beneficiary is not required for such modification, amendment, or change.

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Definitions

Below, the definitions of the Policy are discussed. Where these terms are used in this Certificate, unless specified otherwise, they have the meaning explained here.

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

Act or Law means the original enactments of the Act or Law, and all amendments.

"**Actively at Work"** means reporting to the Participating Employer's regular place of employment and carrying out the regular duties of Your occupation for the number of hours required by the Employer, but in no case less than 10 hours a week. You will be considered Actively at Work on a day of paid vacation or on a regular non-work day provided You were Actively at Work for a full work day that was immediately prior to such a day.

Additional Benefit or Additional Provision means an addendum to the Policy which increases or limits coverage for a specified set of conditions. The provisions, limitations, and exclusions in the entire Policy will apply unless specifically stated otherwise in the Additional Benefit or Additional Provision.

Catastrophic Conditions means that due to the Disability for which You are receiving Monthly Benefit Payments, You lose the ability to safely and completely perform at least 2 Activities of Daily Living without another person's assistance or verbal cueing, or have a deteriation or loss in intellectual capacity and need another person's assistance or verbal cueing for Your protection or for the protection of others.

Certificate means this document which provides a description of the coverage available under the Policy.

Claimant means a person who has filed a claim for benefits under the Policy.

Class means a grouping of Insureds based on criteria agreed on between the Plan Sponsor and Us.

Contributory means that You pay all or a portion of the premium for the coverage.

Disabled and Disability are defined in the Coverage Provisions section of this Certificate.

Disability Work Earnings are defined in the Coverage Provisions section of this Certificate.

"Drug Addiction" means an addictive relationship or pattern of use of drugs, chemicals, or similar substances.

Eligible Employee means You meet all of the following:

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

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

Eligibility Waiting Period means the continuous length of time that You must serve in an eligible Class to reach Your eligibility date and begin Your coverage. There is no Eligibility Waiting period. You are eligible for insurance on the first day of being Actively at Work as a member in Class 01 or 02.

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

If You return to work for 45 or less consecutive days during the Elimination Period, those days will interrupt the Elimination Period. However, the Disability will be treated as continuous if it is from the same or a related condition. Only those days during which You are Disabled will be used to satisfy the Elimination Period. For example, one must complete an Elimination Period of 125 work days within a total period of not more than 125 work days plus 45 consecutive calendar days.

Employer and Participating Employer means Your Employer which is participating in VACORP (the Plan Sponsor). It is by reason of Your Employer's participation that insurance under the Group Policy is made available to You.

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

Gainful Occupation means an occupation that is or can be expected to provide You with an income within 12 months of Your return to work that exceeds 80% of Your Indexed Monthly Earnings.

Gross Monthly Benefit means Your gross Long Term Disability Benefit as calculated from the Schedule of Benefits, prior to any reductions for Deductible Sources of Income.

Guaranteed Issue Amount means an amount of insurance for which We do not require Proof of Insurability.

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

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

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

Independent Medical Exam means an examination by a Physician of the appropriate specialty for Your condition at Our expense. Such examination, scheduled by Us may be used for the purpose of determining eligibility for insurance or benefits, including eligibility under the Additional Benefits or Additional Provisions, if any, associated with the Policy.

Indexed Monthly Earnings means Your Monthly Earnings adjusted on each anniversary of Monthly Benefit Payments by the lesser of 7% or the current annual percentage increase of the Consumer Price Index. Your Indexed Monthly Earnings may increase or remain the same, but will never decrease.

The Consumer Price Index (CPI-U) is published by the U.S. Department of Labor. We reserve the right to use some other similar measurement if the Department of Labor changes or stops publishing the (CPI-U).

Indexing is only used to determine Your percentage of lost earnings while You are Disabled and working, and in the determination of Gainful Occupation.

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

Any Disability which begins more than 60 days after an Injury will be considered an Illness for the purpose of determining Long Term Disability benefits.

Insured means an individual covered under the Policy.

Leave of Absence means an arrangement where You and the Plan Sponsor agree that You will not be Actively at Work for a specific period of time and You are expected to be

Actively at Work at the end of that period. If You become Disabled while on a Leave of Absence, Benefit Payments will be based upon Earnings as last reported and premiums paid to Us immediately prior to the beginning of the Leave of Absence. Refer to *When Your Insurance Ends* to determine how long Your coverage can be continued during a Leave of Absence.

Long Term Disability Benefits are the monthly benefits provided under the terms of the Policy.

Material and Substantial Duties means duties that:

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

Mental Illness means any psychiatric or emotional illness or disease listed in the Diagnostic and Statistical Manual. Such conditions are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment. Mental Illness includes, but is not limited to, each of the following:

a) Neurotic disorders such as, but not limited to, anxiety, dissociative disorders, phobias, depression and obsessive compulsive disorders.
b) Psychotic disorders such as, but not limited to, schizophrenia, dementia, paranoid psychosis and affective disorders;
c) Personality disorders such as, but not limited to, sociopathic personality;
d) Syndromes such as, but not limited to, organic brain syndromes, amnesia syndromes and organic delusional or hallucinogenic syndromes.

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

"Monthly Earnings" is defined in one of the two following paragraphs that fits Your situation:

If You are paid on an annual contract basis, Your Monthly Earnings is Your monthly rate of creditable compensation based on one-twelfth (1/12th) of your annual contract salary received from the Employer, including any

1. Contributions you make through a salary reduction agreement with your Employer to:
   a. An Internal Revenue Code (IRC) Section 401(k), 403(b), 408(k), 408(p), or 457 deferred compensation arrangement; or
   b. An executive nonqualified deferred compensation arrangement.
2. Shift differential pay.

3. Amounts contributed to your fringe benefits according to a salary reduction agreement under an IRC Section 125 plan.

If You are paid hourly wages, Your Monthly Earnings is Your monthly rate of creditable compensation based on your hourly pay rate multiplied by the number of hours you are regularly scheduled to work per month by Your Employer, but not more than 173 hours. If you do not have regular work hours, your monthly rate of earnings is based on the average number of hours you worked per month for the Employer during the preceding 12 calendar months (or during your period of employment if less than 12 months), but not more than 173 hours. Monthly Earnings also includes:

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

In either case, Your amount of insurance will be calculated based on the lesser of Your Monthly Earnings as calculated above or the premium amount actually received by the Plan Sponsor on Your behalf from Your Employer, and in turn from the Plan Sponsor to Us.

Monthly Earnings will be determined according to the Employer's records.

Motorized Vehicle means any self-propelled vehicle or conveyance, including but not limited to automobiles, trucks, motorcycles, ATV's, snowmobiles, tractors, golf carts, motorized scooters, lawn mowers, heavy equipment used for excavating, boats, and person watercraft. Motorized Vehicle does not include a medically necessary motorized wheelchair.

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

Part-Time Basis means the ability to work and earn between 20% and 80% of Your Indexed Monthly Earnings. Ability is based on capacity and not market availability.

Physician means:

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

Physician does not include:

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

Plan Sponsor means the Virginia Association of Counties Group Self Insurance Risk Pool (VACORP), which is the entity that holds the Policy and in which Your Employer participates in order to make this coverage available to You.

Policy or **Group Policy** means the policy issued by Us and the Plan Sponsor and described in this Certificate.

Prior Plan means the plan providing similar Long Term Disability insurance benefits carried by the Plan Sponsor on the day before the Policy's effective date with Us.

Proof means evidence satisfactory to Us that the terms and provisions of the Policy have been met. Proof may include but is not limited to: questionnaires, physical exams, or Written documentation and records as required by Us. Proof must be received by Us at Our Administrative Office. All Proof must be given at Your expense (or that of Your representative or beneficiary), unless otherwise specifically provided by the terms of the Policy. If any additional Proof is reasonably required by Us, an Insured may be required to give Us authorization to obtain such additional Proof. The following are some specific types of Proof referenced under the Policy:

Proof of Claim or **Proof of Disability** means evidence satisfactory to Us that a person has satisfied the conditions and requirements for a benefit under the Policy. The Proof must establish:

- the nature and extent of the loss or condition; *and*
- our obligation to pay the claim under the Policy; *and*
- the Claimant's right to receive payment.

Proof of Insurability means evidence satisfactory to Us of a person's health and other information related to insurability which enables Us to determine whether the person can become insured, or is eligible for an increase in coverage.

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

Regular Care means:

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

Retirement Plan means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to employees and are not funded entirely by employee contributions.

Sign or **Signed** means the use by a person of a symbol or method with the present intention to authenticate a record. Such authentication may be executed and/or transmitted by paper or electronic media, provided it is acceptable to Us and consistent with applicable law.

We, **Us**, and **Our** mean the insurer Anthem Life Insurance Company

Wellness Programs include, but are not limited to appropriate programs for dietary and nutritional improvement, weight management, smoking cessation, abstention from excessive or illegal use of alcohol or narcotics, regular participation in exercise activities, stress management, pain management, behavioral therapy, coaching, and the regular taking of prescribed medications.

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

You and **Your** means an Eligible Employee.

Other terms are defined elsewhere under the Policy.

DLS A 0205 C2

When Insurance Begins and Ends

This section tells how You may become insured.

Obtaining Your Insurance

To obtain insurance under the Policy, You must be an Eligible Employee and be Actively at Work.

Specific information regarding the Group Policy and its terms may be obtained from the Plan Sponsor.

If You are an Eligible Employee on the effective date of the Policy, You are eligible for insurance on that date.

Enrollment

You do not contribute to the cost of Your coverage. Nevertheless, You must enroll for Your insurance within 31 days of becoming eligible for insurance. Your Employer must send Your completed enrollment to the Plan Sponsor.

Effective Date of Insurance

Once You have become eligible for insurance, this section tells when Your insurance will begin.

Your insurance begins on the first day You are Actively at Work following the date that You become an Eligible Employee. However, the enrollment form must be completed and given to Your Employer within 31 days of Your becoming eligible.

The Plan Sponsor must send Your completed enrollment to Us at our Administrative Office unless We and the Plan Sponsor have agreed that the Plan Sponsor will retain the applications.

Delayed Effective Date of Your Insurance

If You are not Actively at Work on the date Your insurance would otherwise begin, Your insurance begins on the date You are again Actively at Work.

Changes in Your Insurance

Change in Class or Earnings

The amount of Your insurance may change if:

- You become a member of a different Class; *or*

- The amount of Your Monthly Earnings changes.

If the change would *increase* Your amount of insurance, the increase takes effect on the first day You are Actively at Work following the *latest* of the date:

- The change occurs; *or*
- The Plan Sponsor tells Us in Writing about a change in Class or a change in the amount of Your Monthly Earnings.

When Insurance Ends

Your insurance coverage will end on the *earliest* of the following dates:

1. The date the Policy is canceled; *or*
2. The date on which You cease to be a member of a Class under the Policy; *or*
3. The date Your employment terminates. For the purpose of this provision, employment terminates when You are no longer Actively at Work, unless due to Disability; *or*
4. The date the Policy is changed to end the insurance for Your Class; *or*
5. The last day of the period for which premium was paid, if a premium is not paid within the Policy's grace period; *or*
6. Preceding the date of Your death; *or*
7. The date Your Monthly Benefit Payments end, if You are not again Actively at Work the following day; *or*
8. The date You cease to be an Eligible Employee as defined in the Definitions of the Policy; *or*
9. You request, in Writing, for Your insurance to be terminated; *or*
10. The date You cease to be Actively at Work. However, the Plan Sponsor may continue Your insurance unless it ends due to any of the above reasons during the following periods:
    a.) until the end of the 3rd month following the date You cease to be Actively at Work due to a temporary layoff; *or*
    b.) until the end of the 3rd month following the date You cease to be Actively at Work due to a Leave of Absence or due to Your being called to active duty as a reservist with the U.S. Armed Forces Reserve; or
    c.) during an absence from work due to a Leave of Absence that is in compliance with the Family Medical Leave Act of 1993 ("FMLA") or applicable state, family and medical leave law;) or
    d.) during the longest of the periods in above items (a), (b), and (c), if You cease to be Actively at Work due to Your being called to active duty as a reservist with the U.S. Armed Forces.

Any Leave of Absence must have been authorized in Writing by the Plan Sponsor. Unless otherwise specifically stated under the terms of the Policy, all premium required by the Policy must be paid in order for any continuance of insurance provision to be applicable.

If coverage is continued in accordance with the Leave of Absence provisions above, such continued coverage will cease immediately if any one or more of the following events occurs:

- the leave terminates prior to the agreed upon date; *or*
- the Policy terminates or Your employer ceases to be a associated employer with the Plan Sponsor; *or*
- You or the Plan Sponsor fail to pay premium when due; *or*
- the Policy no longer insures Your Class.

During the period that You are Disabled, Your Monthly Benefit Payments *will not* be affected by:

- termination or cancellation of the Plan Sponsor's Policy; *or*
- termination of Your coverage; *or*
- termination of Your employment; *or*
- any amendment to the Policy that becomes effective after the date You are Disabled.

Continuity of Coverage upon Transfer of Insurance Carriers

In order to prevent loss of coverage for You because of a transfer of insurance carriers, this provision will provide coverage for certain plan members as follows:

Failure to be in Active Employment Due to Injury or Illness

If You are not Actively at Work due to Injury, illness, leave of absence or temporary layoff on the date the Plan Sponsor changes insurance carriers to Anthem Life, and You were covered under the prior policy at the time the Anthem Life Policy became effective, We will provide continuity of coverage under the Anthem Life Policy. In order for this provision to apply, the prior policy must have provided similar coverage to the Anthem Life Policy.

If You are not Actively at Work due to injury, illness, leave of absence or temporary layoff on the effective date of the Anthem Life Policy, and You would otherwise be eligible to become insured under the Policy, We will provide limited coverage under the Anthem Life Policy. Coverage under this provision will begin on the Anthem Life Policy effective date and will continue until the earliest of:

- the end of the month following the date You return to active employment; *or*
- the end of any period of continuance or extension provided under the prior policy; *or*
- the date coverage would otherwise end, according to the provisions of the Anthem Life Policy.

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

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

If coverage ends under this provision, or if You were not covered under the prior policy on the date that policy terminated, the Effective Date of Insurance provision under the Anthem Life Policy will apply.

No Benefits are payable under this provision for any period of Disability:

- that begins prior to this Policy's effective date; *or*
- for which benefits are paid under the prior plan; *or*
- for which benefits would have been paid under the Prior Plan in the absence of this provision.

Coverage Provisions

Description of the Coverage

The pages of this section specify when Policy benefits will be paid. Conditions governing whether, and how much benefit is paid are also discussed in this section.

To receive Policy benefits, You must be insured under the terms of the Policy, and as described in the *When Insurance Begins and Ends* section. Then, Your amounts of insurance are as shown in the Schedule of Benefits, subject to the terms of the Policy.

Definition of Disability and Disabled for Long Term Disability Insurance

Disabled and **Disability** mean during the Elimination Period and the next 24 months because of Your Injury or Illness, *all* of the following are true:

- You are unable to do the Material and Substantial Duties of Your Own Occupation; *and*
- You are receiving Regular Care from a Physician for that Injury or Illness; *and*
- Your Disability Work Earnings, if any, are less than or equal to 80% of Your Indexed Monthly Earnings.

Thereafter, Disabled and Disability mean because of Your Injury or Illness *all* of the following are true:

- You are unable to do the duties of any Gainful Occupation for which You are or may become reasonably qualified by education, training, or experience; *and*
- You are receiving Regular Care from a Physician for that Injury or Illness; *and*
- Your Disability Work Earnings, if any, are less than or equal to 80% of Your Indexed Monthly Earnings.

Your Disability must start while You are insured under the Policy.

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

- Loss, suspension, restriction or failure to maintain a professional license, occupational license, permit or certification; *or*
- Loss of earnings due to economic factors such as, but not limited to, recession, job elimination, job restructuring, temporary layoffs, pay cuts and job-sharing; *or*
- The Plan Sponsor's work schedule that is inconsistent with the normal work schedule of Your Own Occupation; *or*

- Your relationship with the Plan Sponsor or other employees of the Plan Sponsor; *or*
- Failure or inability of the Plan Sponsor to maintain the workplace in a manner consistent with the normal physical environment of Your Own Occupation; *or*
- Your inability to work more than 40 hours per week in the occupation, even if You were regularly required to work more than 40 hours per week prior to Your Injury or Illness.

Disability Work Earnings means for Long Term Disability benefits, monthly earnings which You receive while You are Disabled and working.

DLS A 0205 C 4

Long Term Disability Insurance Benefits

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

- The Disability starts while You are insured under the Policy; *and*
- The Disability continues during and past the Elimination Period; *and*
- We receive Proof of Your Disability.

The Long Term Disability Benefit and the Maximum Benefit Period are shown in the Schedule of Benefits. The Long Term Disability Benefit may be reduced in accordance with the provisions of the Deductible Sources of Income section of the Policy. The Long Term Disability Benefit will not:

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

You will begin to receive payments when We approve Your claim, provided the Elimination Period has been met. We will send You a payment each month for Long Term Disability benefits for any period for which We are liable.

Calculating Your Long Term Disability Benefit

Part A.
If You are Disabled and not working, or Disabled and working and Your Disability Work Earnings are less than 20% of Your Indexed Monthly Earnings.

We will use the following process to calculate Your Monthly Benefit Payment:

1. Multiply Your Monthly Earnings by 60%.
2. The maximum benefit is $30,000 per month.
3. Compare the answer from Item 1 with the maximum benefit. The lesser of these two amounts is Your Gross Monthly Benefit.
4. Subtract from Your Gross Monthly Benefit any Deductible Sources of Income.

The amount calculated in Item 4 is Your Monthly Benefit Payment.

Part B.
If You are Disabled and working, and Your Disability Work 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 Monthly Benefit Payment plus Disability Work Earnings may be less than or equal to, but not more than 100% of Your Indexed Monthly Earnings. If the sum exceeds 100% of Your Indexed Monthly Earnings, We will reduce Your payment under the Policy by the excess amount.

To determine whether the sum of Your Monthly Benefit Payment plus Disability Work Earnings is less than or equal to or exceeds 100% of Your Indexed Monthly Earnings, We will use the following process:

1. Multiply Your Monthly Earnings by 60%.
2. The maximum benefit is $30,000 per month.
3. Compare the answer from Item 1. with the maximum benefit per month. The lesser of these two amounts is Your Gross Monthly Benefit.
4. Add Your Disability Work Earnings to Your Gross Monthly Benefit.

If the answer in Item 4 above is less than or equal to 100% of Your Indexed Monthly Earnings, Your Monthly Benefit Payment will be Your Gross Monthly Benefit minus any Deductible Sources of Income.

If the answer in Item 4 above is greater than 100% of Your Indexed Monthly Earnings, We will use the following process to calculate Your Monthly Benefit Payment.

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

The amount calculated in Item c is Your Monthly Benefit Payment.

After 12 months of Monthly Benefit Payments, You will receive payments based on the percentage of income You are losing due to Your Disability. We will use the following process to calculate Your Monthly Benefit Payment:

1. Subtract Your Disability Work Earnings from Your Indexed Monthly Earnings.
2. Divide the answer in Item 1 by Your Indexed Monthly Earnings. The result is Your percentage of lost earnings.
3. From Your Gross Monthly Benefit, subtract any Deductible Sources of Income.
4. Multiply the answer in Item 2 by the answer in Item 3.

The answer in Item 4 is Your Monthly Benefit Payment.

We may require You to send Proof of Your monthly Disability Work Earnings each month. We will adjust Your Monthly Benefit Payment based on Your monthly Disability Work Earnings.

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

Minimum Monthly Benefit: The minimum Monthly Benefit Payment is: $100

We may apply this amount toward an outstanding overpayment, as described in the Recovery of Overpayment provision.

If Your Disability Work Earnings Fluctuate

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

If We average Your Disability Work Earnings, We will not terminate Your claim unless:

- during the first 24 months of Monthly Benefit Payments, the average of Your Disability Work Earnings for a three month period exceeds 80% of Your Monthly Earnings; *or*
- beyond 24 months of Monthly Benefit Payments, the average of Your Disability Work Earnings for a three month period exceeds 80% of Your Monthly Earnings.

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

Cost of Living Freeze

After the first deduction for Social Security Benefits has been made to the Long Term Disability Benefit, the Monthly Benefit Payment will not be further reduced due to any cost of living increases for Social Security Benefits. This cost of living freeze does not apply to Disability Work Earnings or to any increases in income You earn from any form of employment.

Recurrent Disability Provision for Long Term Disability

If You have a Recurrent Disability, and after Your prior Disability ended, You return to work for the Plan Sponsor for 125 consecutive work days or less, We will treat Your Disability as part of Your prior claim and You do not have to complete another Elimination Period.

Your Monthly Benefit 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 and conditions of the Policy as Your prior claim.

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

- is unrelated to Your prior Disability; or
- after Your prior Disability ended, You returned to work for the Plan Sponsor for more than 125 consecutive work days.

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

If the Policy terminates You will not be eligible for benefits under this provision, unless You became Disabled due to the Recurrent Disability prior to the Policy termination.

Period of Disability extended by a new condition

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

When Long Term Disability Benefits End

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

1. You are no longer Disabled under the terms of the Policy; *or*
2. You are no longer receiving, accepting or following Regular Care from a Physician; *or*
3. The Maximum Benefit Period from the Schedule of Benefits ends; unless Your LTD benefits are continued by the Additional Benefit for Lifetime Protection; *or*
4. The period specified in the Long Term Disability Limitations provision of the Policy ends, if that section applies; *or*
5. Preceding the date of Your death; *or*
6. You take a refund of your member contributions and interest in the defined benefit component of your plan; or
6. We ask You for Proof that You are still Disabled, if We do not receive Proof of Disability within 31 days of Our request; *or*
7. We ask You for details about Your Deductible Sources of Income, including Your tax returns, if You do not give Us details within 31 days of Our request; *or*
8. We ask You to be examined by:
    - a Physician; *or*
    - a health care professional,

   if You do not reasonably cooperate with the examiner or if You unreasonably decline to be examined; *or*
9. You work, unless You are working as part of a Vocational Rehabilitation Program approved by Us; *or*
10. Your Disability Work Earnings exceed the amount allowable under the Policy; *or*
11. You cease to reside in the United States or Canada. If You are outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of Monthly Benefit Payments, You will be considered to have ceased to reside in the United States or Canada; *or*
12. You refuse to try or attempt work with the assistance of

- Modifications to Your work environment, functional job elements or work schedule; *or*
- Adaptive equipment or devices, that a qualified Physician has indicated will accommodate the limiting factors of the Injury or Illness for which You are claiming benefits under the Policy or will enable You to perform the Material and Substantial duties of an occupation from which the Policy requires You to be considered Disabled in order to receive benefits; *or*

13. You are confined to a penal or correctional institution; *or*
14. With respect to a Mental Illness, that You are not under the continuing Regular Care of a Physician specializing in psychiatric care; *or*
15. With respect to Alcoholism and Drug Addiction, that You are not being actively supervised by and receiving continuing treatment from a rehabilitation center or a designated institution approved for such treatment by an appropriate body in the governing jurisdiction, or, if none, by Us: *or*
16. You or Your Physician fail to submit any medical or psychiatric information requested by Us; *or*
17. You would be able to work in Your Own Occupation on a part-time basis earning 20% or more of Your Monthly Earnings, but choose not to do so; *or*
18. You would be able to increase Your current earnings to more than 80% of Your Monthly Earnings by increasing the number of hours worked or the number of duties performed in Your Own Occupation, but choose not to do so, *or*
19. You refuse to make a good faith effort to adhere to necessary Wellness Programs that your Physician has recommended and that are generally acknowledged by Physicians to cure, improve or reduce the disabling effect of the illness or Injury for which You are claiming benefits under the Policy. We will work with your treating Physician to determine the necessary Wellness Programs, if any, in accordance with generally accepted medical standards.

    We will give you 30 day's prior written notice of Our intent to apply these provisions for failure to adhere to Wellness programs to terminate Your benefits. During those 30 days You will have an opportunity to begin or resume reasonable efforts to adhere to the medically necessary Wellness Programs. We will not terminate benefits if there is no reasonable basis for believing that You will be able to return to productive employment in your Own Occupation or another Gainful Occupation on a full-time or part-time basis if You adhere to the recommended Wellness Programs.

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

Benefits after Policy Cancellation

Cancellation of the Policy does not by itself affect Your right to receive Long Term Disability Benefits for a Disability that begins while You are insured under the Policy. You must continue to comply with all requirements of the Policy. All terms and conditions of the Policy will apply.

Premium Waiver

With respect to Long Term Disability Benefits, We do not require premiums to be paid for the period during which You are receiving Monthly Benefit Payments. Premium payments will be required during the Elimination Period and after Your Monthly Benefit Payments end, if You continue to be insured under the Policy.

This premium waiver will begin on the premium due date that falls on or next follows the date You meet all of the conditions to qualify for premium waiver, as stated above.

We will continue to waive Your premiums until the premium due date that falls on or next follows the first of the following to occur:

- The date You are no longer Disabled; *or*
- the date Your Disability Work Earnings equal 20% or more of Your Monthly Earnings
- The end of the Maximum Benefit period from the Schedule of Benefits; *or*
- The date Your coverage under the Policy ends.

If You return to work and are an Eligible Employee on the date premium waiver ends, Your coverage will be continued subject to payment of the required premium. If You are not an Eligible Employee on the date premium waiver ends, Your coverage will end.

DLS A 0205 C5

Deductible Sources of Income

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

The following are Deductible Sources of Income:

1. The amount that You receive, or are eligible to receive, under:
   - A worker's compensation law; *or*
   - An occupational disease law; *or*
   - Unemployment compensation law; *or*
   - Any other Act or Law with similar intent.
2. The amount that You receive, or are eligible to receive, as disability income payments under any:
   - state compulsory benefit Act or Law; *or*
   - governmental retirement system as a result of Your employment with the Plan Sponsor; *or*
   - veteran's Administration or any other foreign or domestic governmental agency; *or*
   - other group insurance plan; *or*
   - any plan or arrangement of disability coverage, whether insured or not, resulting from Your employment by or association with the Plan Sponsor or any employer, or resulting from Your membership in or association with any group, association, union or other organization.

3a. The amount that You, Your spouse, and children receive, or are eligible to receive, as disability payments because of Your Disability under:
   - the United States Social Security Act; *or*
   - the Canada Pension Plan; *or*
   - the Quebec Pension Plan; *or*
   - any similar plan or act.

3b. The amount that You receive, or are eligible to receive, as retirement payments or the amount Your spouse and children receive as retirement payments because You are receiving retirement payments under:
   - the United States Social Security Act; or
   - the Canada Pension Plan; or
   - the Quebec Pension Plan; or
   - any similar plan or act.

4. The amount that You:
    - Receive as disability payments under the Plan Sponsor's Retirement Plan; *or*
    - Voluntarily elect to receive as retirement payments under the Plan Sponsor's Retirement Plan; *or*
    - are eligible to receive as retirement payments when You reach the later of age 62 or normal retirement age, as defined in the Plan Sponsor's Retirement Plan.

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

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

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

5. The amount You receive as a result of any action brought under Title 46, United States Code Section 688 (The Jones Act).
6. The amount You receive from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.
7. The amount You receive under any salary continuation or accumulated sick leave plans.
8. Commissions, severance allowance, sick pay or any similar employer sponsored paid time off where You receive income from the employer, vacation pay or any salary continuation plan.
9. Any amounts from partnership, proprietorship draws, or similar draws.

Lump Sum Payments

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

Non-Deductible Sources of Income

We will not subtract from Your Monthly Benefit Payment any income You receive from the following:

1. 401(k) plans;
2. vacation pay
3. profit sharing plans;
4. thrift plans;
5. tax sheltered annuities;

6. stock ownership plans;
7. credit or mortgage disability insurance;
8. non-qualified plans of deferred compensation;
9. pension plans for partners;
10. military pension and disability income plans;
11. individual disability plans;
12. franchise disability income plans;
13. a retirement plan from another plan sponsor;
14. individual retirement accounts (IRA);
15. automobile liability insurance policy;
16. Accelerated death benefits paid form a life insurance policy;
17. Keogh (HR-10) plan;
18. reimbursement for hospital, medical or surgical expense.

If You May Qualify for Deductible Income Benefits

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

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

Estimate and Deduction for Social Security Benefits

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

We will reduce the amount of Your Monthly Benefit Payments by the amount of Social Security benefits We estimate that You, Your spouse or children are eligible to receive because of Your Disability or retirement. We will start to do this after 24 months of Monthly Benefit Payments, unless We have received:

- Proof of the approval of Your claim for Social Security Benefits; *or*
- Proof of denial of Social Security Benefits, which shows that all levels of appeal have been exhausted.

However, within 6 months following the date You became Disabled; You must:

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

If You do not satisfy the above requirements, We will reduce Your Monthly Benefit Payments by such estimated Social Security benefits starting with the first Monthly Benefit Payment coincident with the date You were eligible to receive Social Security benefits.

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

Recovery of Overpayment

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

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

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

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

- Taking legal action;
- Stopping or reducing any future payments under the Policy, including the Minimum Weekly Benefit or any Additional Benefit or Additional Provision benefits, which might otherwise be payable to You or any other Claimant or payee.

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

Adjustment for Underpayment

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

Proration

Any Long Term Disability Benefit payable for less than a month will be prorated based on a 30 day month. The prorated amount may be less than the Minimum Monthly Benefit.

Awards of Damages and Right of Reimbursement

You will be required to reimburse Us for any benefits We pay to You if *both* of the following conditions are met:

1. Benefits are paid or payable under the Policy; *and*
2. You recover damages whether by action at law, settlement, or compromise from any person, organization, or legal entity that is or may be liable for any illness, Injury, or other event giving rise directly or indirectly, to the Disability for which benefits are payable.

The term damages will include all lump sum or periodic payments however designated You receive under paragraph number 2 above. The provisions of this section shall apply whether or not the person, organization, or legal entity admits liability.

If You receive damages in one or more lump sum payments instead of in monthly or weekly payments, the amount You must reimburse to Us will be based on the amount of the award pro-rated over the period benefits have been or will be paid. You must provide satisfactory Proof of the award to Us, or We will reasonably estimate the amount to be reimbursed. Our rights shall be to the first reimbursement out of all funds You, Your parents if You are a minor, or Your legal representative, is or was able to obtain under the conditions outlined above.

Your lawyer may represent Our rights of reimbursement. However, We reserve the right to:

1. Appoint another lawyer to act on Our behalf; *and*
2. Commence an action to pursue Our rights of reimbursement directly against a third party.

As an Insured, You must:

1. Agree to fully co-operate with Us in pursuing Our claim against the third party, including but not limited to the furnishing of any information, documents, or other assistance We may reasonably require.
2. Agree to notify Us of any action You have or bring against any third party.

DLS A 0205 C7

Additional Benefit for Survivor

We will pay a lump sum benefit to Your eligible survivor when Proof is received that You died:

- after Your Disability had continued for 180 or more consecutive days; *and*
- while You were receiving a Monthly Benefit Payment.

This Additional Benefit for Survivor will be an amount equal to three times the Last Monthly Benefit for Long Term Disability. Any Additional Benefit for Survivor will be applied first to reduce any outstanding overpayment.

We will pay the Additional Benefit for Survivor to Your legal spouse, if living. If Your spouse is not living, We will pay the Additional Benefit divided into equal shares to Your children. Children must be under age 21, unmarried, and dependent on You for support and maintenance. Children include step-children, adopted children, and foster children. If there is no person entitled to the Additional Benefit for Survivor living at the time of Your death, the Additional Benefit will be paid to Your estate. Our payment of Your estate discharges Us of all liability under this Additional Benefit to the extent of the payment, and shall be valid and effective against all claims by others representing or claiming to represent Your children. Benefits otherwise payable to a minor child may be made instead to an adult who submits Proof satisfactory to Us that he or she has assumed custody and support of the child.

Last Monthly Benefit means, for the purpose of this provision, the Gross Monthly Benefit amount paid to You immediately prior to Your death.

Additional Benefit for Vocational Rehabilitation Program

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

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

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

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

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

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

Vocational Rehabilitation Program (continued)

To qualify for these services, You must:

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

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

The written program will describe:

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

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

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

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

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

Additional Benefit for Work Incentive

If You participate in a Vocational Rehabilitation Program that is approved by Our Vocational Rehabilitation specialist, We may increase Your Gross Monthly Benefit Payment by **10**%, up to a maximum additional payment of **$750** per month, not to exceed the Maximum Monthly Benefit as shown in the Schedule of Benefits.

The Additional Benefit for Work Incentive will end on the earliest of the following dates:

- You cease to be paid a Gross Monthly Benefit Payment;
- 12 months of Additional Benefit for Work Incentive have been paid.
- You are no longer participating in a Vocational Rehabilitation Program; or
- We determine that You are no longer eligible to participate in a Vocational Rehabilitation Program;
- Any other requirement or condition of the Policy is not met, including but not limited to those listed in the *When Disability Benefits End* section.

Additional Benefit for Social Security Assistance

If You are receiving Monthly Benefit Payments from Us, We may provide advice to You about filing Your claim for Social Security disability benefits or appealing a denial of Your claim for Social Security disability benefits.

If You receive Social Security disability benefits, this may enable You to receive Medicare after 24 months of disability payments, protect Your Social Security retirement benefits, and Your family may also be eligible for Social Security benefits.

We can assist You in obtaining Social Security disability benefits by:

- helping You obtain medical and vocational evidence; *and*
- helping You find appropriate legal representation; *and*
- by reimbursing pre-approved case management expenses.

Additional Benefit for Workplace Modification

If You are Disabled and are receiving a Monthly Benefit Payment from Us, an Additional Benefit for Workplace Modification may be payable to the Plan Sponsor to accommodate You in returning to work. We may at our sole discretion, reimburse the Plan Sponsor for up to 100% of the reasonable costs the Plan Sponsor incurs through modifications to the workplace to accommodate Your return to work, and to assist You in remaining at work.

The amount We pay will not exceed $25,000.

To qualify for this reimbursement, You must:

1. be Disabled according to the terms of the Policy; *and*
2. have the reasonable expectation of returning to active employment and remaining in active employment with the assistance of the proposed workplace modification.

The Plan Sponsor must give us a written proposal of the planned workplace modification. This proposal must include:

1. input from the Plan Sponsor, 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 workplace modification.

We will reimburse the costs of the workplace modification when We:

1. approve the proposals in writing;
2. receive Proof from the Plan Sponsor that the Workplace modification is complete; and
3. receive Proof of the costs incurred by the Plan Sponsor for the workplace modification.

The Additional Benefit for Workplace Modification is available on a one time basis.

Additional Benefit for Work Retention Assistance

If You:

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

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

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

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

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

DLS A 0205 C AB

Additional Benefit for Catastrophic Conditions

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

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

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

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

An Activities of Daily Living loss that existed prior to Your effective date of coverage under the Policy will not be considered as a loss under this Additional Benefit.

The Additional Benefit for Catastrophic Conditions is 20% of pre-disability Monthly Earnings not to exceed $5,000 per month.

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

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

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

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

Additional Benefit for Lifetime Protection

We will pay LTD benefits beyond the date of your Maximum Benefit Period subject to all of the terms and limitations of the Policy and all of the following conditions:

1. LTD benefits will end solely because you have reached your Maximum Benefit Period; and
2. You continue to meet the Definition of Disability and You are not working in any occupation; and
    a. You are unable to safely and completely perform at least 2 Activities of Daily Living without another person's assistance or verbal cueing; or
    b. You have a deterioration or loss in intellectual capacity and need another person's assistance or verbal cueing for Your protection or for the protection of others.
3. The condition in 2a or 2b above is expected to last at least 90 days as certified by a physician.

The Lifetime Protection Benefit is an extension of Your Monthly Benefit Payments beyond the normal Maximum Benefit Period shown in the Schedule of Benefits. If you receive this extended benefit, no Pension Contribution will be paid and no survivor benefit will be paid if you die.

The Lifetime Protection Benefit will be payable for Your lifetime, as long as You meet conditions of Disability under this Lifetime Protection Benefit, and all other provisions of the Policy. This benefit will terminate on the earlier of:

a. The date you no longer meet the Definition of Disability.
b. The date LTD Benefits end under the terms of the Group Policy for any reason other than reaching the end of the Maximum Benefit Period.
c. The date you die.

Additional Benefit for Pension Plan Contribution

We will pay an Additional Benefit if You are receiving a Monthly Benefit Payment under the Policy and participated in the Plan Sponsor's pension plan for at least 3 months before You became Disabled.

The maximum amount of this Additional Benefit for Pension Plan Contribution is 1% of your Monthly Benefit to a maximum of $500. This benefit will be paid to the Plan Sponsor for deposit into the pension plan on Your behalf.

The Additional Benefit for Pension Plan Contribution will end on the earliest of the following dates:

1. You cease to be paid a Monthly Benefit Payment;
2. You return to full or part-time work in any occupation; *or*
3. You stop participating in the Plan Sponsor's pension plan; *or*
4. The date your employment is terminated by you or your Employer, unless your Employer's pension plan document allows continued contributions on your behalf after such date
5. You begin to receive benefits under the pension plan.
6. any other requirement or condition of the Policy is not met, including but not limited to those listed in the *When Disability Benefits End* section.

If the Pension Contribution Benefit Plan cannot accept contributions for You, this benefit may be paid into a flexible premium deferred annuity that is established and maintained by You.

Additional Benefit for Rehabilitation Incentive

If You participate in a Vocational Rehabilitation Program that is approved by Our Vocational Rehabilitation specialist, We may:

(a) increase Your Monthly Benefit Payment by **10%** not to exceed the Maximum Monthly Benefit as shown in the Schedule of Benefits; *or*
(b) reimburse You or pay directly at Our sole discretion for other expenses incurred in carrying out the Vocational Rehabilitation Program, such as but not limited to otherwise unreimbursed expenses for training, education, accommodation, travel or relocation.
(c) continue Your Monthly Benefit Payment for 3 months after the date You cease to be Disabled, to assist in Your transition to reenter the workforce, if You cease to be Disabled due to Your participation in a Vocational Rehabilitation Program.

The Rehabilitation Incentive will end on the earliest of the following dates:

1. You cease to be paid a Monthly Benefit Payment;
2. You are no longer participating in a Vocational Rehabilitation Program; or
3. We determine that You are no longer eligible to participate in a Vocational Rehabilitation Program;
4. any other requirement or condition of the Policy is not met, including but not limited to those listed in the When Disability Benefits End section.

The Rehabilitation Incentive is subject to the Total Benefit Cap provision of the Policy.

Exclusions

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

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

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

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

1. You are no longer receiving, accepting or following Regular Care from a Physician;
2. With respect to a mental disorder, any period during which You are not under the continuing Regular Care of a Psychiatrist specializing in psychiatric care.
3. With respect to Alcoholism and Drug Addiction, any period during with You are not being actively supervised by and receiving continuing treatment from a rehabilitation center or a designated institution approved for such treatment by an appropriate body in the governing jurisdiction, or, if not, by Us.
4. You have applied for benefits under fraudulent circumstances and these circumstances resulted in a conviction of fraud.
5. You unreasonably fail to submit to an Independent Medical Exam requested by Us.
6. You are confined to a penal or correctional institution.

7. Disability results from cosmetic or reconstructive surgery, except for complications arising from such surgery, or surgery necessary to correct a deformity caused by Illness or accidental Injury.
8. You or Your Physician fail to provide any medical or any psychiatric records which We request.
9. Any period that any other requirement or condition of the Policy is not met, including but not limited to those listed in the *When Disability Benefits Ends* section.

General Provisions

Assignment

You cannot assign Your rights or benefits under the Policy.

Currency

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

Class Membership

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

Misrepresentation

Any statement You make in an application to become insured is a representation and not a warranty. No representation made by You in an application to become insured will be used to reduce or deny Your claim or contest the validity of Your insurance unless:

- Your insurance would not have been approved except for Your misrepresentation; *and*
- Your misrepresentation is contained in a Written instrument Signed by You; *and*
- We give You or Your representative a copy of the Written instrument that contains Your misrepresentation.

Incontestability

No statement made by any person insured under the Policy relating to his or her insurability shall be used in contesting the validity of the insurance with respect to which such statement was made:

- After the insurance has been in force prior to the contest for a period of two years during the lifetime of the person about whom the statement was made; *and*
- Unless the statement is contained in a Written instrument signed by him or her.

This section does not prevent Us from using at any time a defense based on:

- Non-payment of premium; *or*
- Any other provision of the Policy; *or*
- Any other defense that is allowed by law.

Misstatement of Age or Other Facts

If Your age or any other fact was misstated, We will use the correct facts to determine whether You are insured and if so, for what amount and duration.

Errors

You must be properly insured under the Policy. An error or omission by the Plan Sponsor or by Us will not cause You to become insured. An error or omission by the Plan Sponsor or by Us will not cancel insurance that should continue nor continue insurance that should end. The requirements and conditions of the Policy must be properly met for any change in the amount of Your insurance to take effect. We have the right to full recovery of any overpayments made. Such reimbursement will be required regardless of whether the overpayment occurred due to an error by Us or by You, Your representative or beneficiary, or the Plan Sponsor.

Agency

The Plan Sponsor or employer and any administrator appointed by the Plan Sponsor or employer shall not be considered Our agents for any purpose. We are not liable for any of their acts or omissions.

Changes to Policy

The Policy including this Certificate may be amended at any time by Written agreement between the Plan Sponsor and Us, without the consent of or notice to any other individual. Any amendment must be in writing and attached to the Policy. The amendment must bear the signature or a reproduction of the signature of the President, a Vice President, or Secretary of Our company.

If You are not Actively at Work on the effective date of the amendment, the effective date with respect to You will be the date that You are again Actively at Work. However, if the amendment would reduce the amount of Your insurance, the effective date with respect to You will be the effective date of the amendment.

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

Enforcement of Policy Terms

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

DLS A 0205 C9

Claim and Payment Provisions

How to Claim Benefits

Due Written Proof of Claim is required in order to receive benefits under the Policy. Claim forms are available to You or Your beneficiary on request to the Plan Sponsor. For prompt payment, it is necessary that the claim form be completed in full. For a claim for loss of life, a certified copy of the death certificate must be provided to Us.

Notice of Claim

Notice of a claim must be given within 30 days after a covered loss starts, or as soon as reasonably possible. Written notice can be given to Us at Our home office or to Our agent. Reference to a "loss" merely means that an event occurred or an expense was incurred for which a benefit is payable under the Policy. The notice must identify You along with the Group Policy number shown in this Certificate.

For a claim for loss due to Disability, You must notify Us immediately if You return to work in any capacity.

Claim Forms

When We receive the notice of claim, We will send the Claimant forms for filing Proof of loss. The needed forms may also be obtained from the Plan Sponsor. If these forms are not given to the Claimant within 15 working days, the Claimant can meet the Proof of loss requirements by giving Us a Written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss section.

Proof of Disability or Other Loss

Due Written Proof of Disability or other loss must be given to Us within 90 days after such loss. Failure to furnish the Proof within that time shall not invalidate or reduce the claim if the Proof is given as soon as reasonably possible. But, unless delayed by the Claimant's legal incapacity, the required Proof must be furnished within 2 years of the specific time. If the Policy terminates, the Claimant must give written notice and Proof of Disability or loss for a Disability or loss that began or occurred before the Policy ended within 90 days after the Policy terminated.

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

Filing Claim Forms

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

Proof of Continuing Disability

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

Proof of Financial Loss

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

1. statements of Monthly Earnings and other written Proof of Your pre-disability income;
2. statements of income received from other sources while You are claiming benefits under the Policy;
3. evidence that due application has been made for all other available benefits;
4. tax returns and worksheets, tax statements, and accountant's statements; *and*
5. any other Proof that We may reasonably require.

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

Payment of Claims

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

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

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

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

Notice of Claim Decisions

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

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

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

Reconsideration of a Denied Claim

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

- Send Us written comments;
- Review any non-privileged information relating to Your claim; *and*

- Provide Us with other information or Proof in support of Your claim.

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

Legal Actions

There are time limits as to when legal action can be taken to obtain Policy benefits. No legal action can be taken until 60 days after Written Proof of Loss has been given as discussed above. No legal action can be taken more than 3 years after Written Proof of Loss was required by the above terms. Legal action with respect to a claim that has been denied, in whole or in part, shall be contingent upon having obtained Our reconsideration of that claim as explained in the above Reconsideration of a Denied Claim provision.

Examinations

We may require that You undergo an Independent Medical Exam as often as We may reasonably require during the pendancy of claim. No benefits will be paid beyond any date that:

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

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

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

Release of Information

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

Discretionary Authority for Benefit Determination

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

DLS A 0205 C 10

NOTICE OF
PROTECTION PROVIDED BY
VIRGINIA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policy holders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that a life, annuity or health insurance company licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values

- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability [income] insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits

- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000, except for hospital, medical and surgical insurance benefits, for which the limit is increased to $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Virginia law.

To learn more about the above protections, please visit the Association's website at www.valifega.org or contact:

NOTICE OF
PROTECTION PROVIDED BY
VIRGINIA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION

VIRGINIA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION
c/o APM Management Services, Inc.
8001 Franklin Farms Drive, Suite 235
Henrico, VA 23229
804-282-2240

STATE CORPORATION COMMISSION
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218-1157
804-371-9741
Toll Free Virginia only: 1-800-552-7945
http://www.scc.virginia.gov/boi/

Insurance companies and agents are not allowed by Virginia law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Virginia law, the Virginia law will control.

IMPORTANT INFORMATION
REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions, you may contact the insurance company issuing this insurance at the following address and telephone number:

Anthem Life Insurance Company
Post Office Box 182361
Columbus, Ohio 43218-2361
Toll-Free: (866)-551-0326

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

P.O. Box 1157
Richmond, Virginia 23218-1157

Toll Free inside Virginia: (800) 552-7945
Toll-free outside Virginia: 1-877-310-6560

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

Anthem Life Insurance Company
Administrative Office
8940 Lyra Drive
Suite 300
Columbus, Ohio 43240
1 (614) 436-0688
1 (800) 551-7265

Long Term Disability Certificate
No Additional Benefit for Lifetime Protection

Anthem Life

Long Term Disability Insurance

A guide to your benefits

You've made a good decision in choosing Anthem® Life

Plan Sponsor:	Virginia Association of Counties Group Self Insurance Risk Pool (VACORP)
Participating Employer:	Your Employer participating in VACORP
Policy:	AL00006723
Classes:	01and 02
Class Description:	Class 01: All Eligible Employees participating in the VRS Hybrid Retirement Plan within their first 12 consecutive months of employment with their Employers. Class 02: All Eligible Employees participating in the VRS Hybrid Retirement Plan with more than 12 consecutive months of employment with their Employers.

anthem.com

This Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding this policy constitutes a contract solely between this Group and Anthem Life Insurance Company, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Anthem Life Insurance Company to use the Blue Cross and/or Blue Shield Service Mark in Virginia and that Anthem Life Insurance Company is not contracting as the agent of the Association. This Group further acknowledges and agrees that it has not entered into this policy based upon representations by any person other than Anthem Life Insurance Company and that no person, entity, or organization other than Anthem Life Insurance Company shall be held accountable or liable to this Group for any of Anthem Life Insurance Company's obligations to the Group created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of Anthem Life Insurance Company other than those obligations created under other provisions of this agreement.

Contents

Section I.	Your Certificate of Coverage

Long Term Disability Insurance

Anthem Life Insurance Company
Post Office Box 182361
Columbus, Ohio 43218-2361
1 (800) 551-7265

DLS A 0205 C

Introduction

Anthem Life Insurance Company certifies that it has issued a Group Policy insuring certain eligible employees of Employers participating in the Plan Sponsor.

This Certificate describes the benefits provided as of the effective date. For purposes of effective dates and ending dates under the Policy, all days begin at 12:01 a.m. and end at 12:00 midnight at the Plan Sponsor's address.

Certain terms of the Group Policy which affect Your insurance are contained in the following pages. Anthem Life has written this Certificate in plain English. However, a few terms and provisions are written as required by insurance law. Anthem Life urges You to read Your Certificate carefully and keep it in a safe place.

If the terms and provisions of the Certificate (issued to You) are different from the Policy (issued to the Plan Sponsor), the Policy will govern. Your coverage may be cancelled or changed in whole or in part under the terms and provisions of the Policy.

The Group Policy was issued in the Commonwealth of Virginia. Its laws and rules will govern in resolving any questions about the Group Policy, except to the extent that the Policy may be governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

While You remain insured, this booklet is Your Certificate of insurance. It replaces any prior booklet or Certificate given to You for the types of insurance described here. It is void and of no effect if You are not entitled to or have ceased to be entitled to the insurance coverage. Many of the provisions of this Certificate are interrelated, and You should read the entire Certificate to get a full understanding of Your coverage. This Certificate also contains exclusions, so please be sure to read this Certificate carefully.

Anthem Life Insurance Company
Administrative Office
P.O. Box 182361
Columbus, OH 43215-2361

Gregory G. Poulakos
President

Fraud: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

—TABLE OF CONTENTS—

Schedule of Benefits

About this Schedule

This Schedule of Benefits shows highlights of the coverage available under the Group Policy. Final interpretation of all provisions and coverages will be governed by the Group Policy on file with Anthem Life Insurance Company at its Administrative Office.

Your amount of insurance is determined by this schedule.

Your Long Term Disability Benefits help to protect You from loss of income due to a Disability as defined under the Policy. Your Long Term Disability Benefits are subject to any limitations, maximums, exclusions and reductions under the Policy, including any reductions by Your Deductible Sources of Income. Refer to the Long Term Disability Insurance Benefits section for details about how Your Monthly Benefit Payment is calculated.

Long Term Disability Benefit

For Class 01: All Eligible Employees participating in the VRS Hybrid Retirement Plan within their first 12 consecutive months of employment with their Employers:

> **For a Work-Related Disability,** meaning a Disability that is due to Your Injury or Illness that occurs because of Your job, the benefit is **60%** of Your Monthly Earnings in effect just prior to Disability, reduced by Deductible Sources of Income.
> **For a Non-work Related Disability,** there is **no benefit.**

For Class 02: All Eligible Employees participating in the VRS Hybrid Retirement Plan with more than 12 consecutive months of employment with their Employers:

> **For any Disability, whether Work-Related or not,** the benefit is 60% of Your Monthly Earnings in effect just prior to Disability, reduced by Deductible Sources of Income.

For all Class 01 and 02 Employees:

> **Maximum Monthly Benefit:** After benefit calculation, cannot exceed $30,000
>
> **Minimum Monthly Benefit:** After benefit calculation, cannot be less than $100.
>
> **Additional Benefit for Catastrophic Conditions:**
>
> For any Disability caused by Catastrophic Conditions as defined, and for which You are already receiving Monthly Benefit Payments under this Policy, the additional benefit is 20% of Your Monthly Earnings in effect just

prior to such Disability, unreduced by Deductible Sources of Income, and subject to a $5,000 monthly benefit maximum. See also the provision, Additional Benefit for Catastrophic Conditions, elsewhere in this Certificate for details.

Proof of Insurability means evidence satisfactory to Us of a person's health and other information related to insurability that We use which enables Us to determine whether the person can become insured, or is eligible for an increase in coverage.

Proof of Insurability is required for any amount for which application is received more than 31 days after the employee is initially eligible to purchase the insurance.

Eligibility Waiting Period:

There is no Eligibility Waiting period. You are eligible for insurance on the first day of being Actively at Work as a member in Class 01 or 02.

Elimination Period:

The period that expires upon the later to occur: the end of the 125th work day after disability begins, or the end of payment of any Employer sponsored short term disability benefits.

If You return to work for 45 or less consecutive days during the Elimination Period, those days will interrupt the Elimination Period. However, the Disability will be treated as continuous if it is from the same or a related condition. Only those days during which You are Disabled will be used to satisfy the Elimination Period. For example, one must complete an Elimination Period of 125 work days within a total period of not more than 125 work days plus 45 consecutive calendar days.

Maximum Benefit Period

For a disability which begins before You reach age 60, the Maximum Benefit Period will be until the Social Security Normal Retirement Age (SSNRA) as shown in the following table:

Year of Birth	***Social Security Normal Retirement Age**
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 Benefit Period will be determined according to the following table:

Your Age When Disability Begins	**Maximum Benefit Period**
Less than age 60	To Social Security Normal Retirement Age (see table immediately above)
Age 60 through 64	60 months
Age 65 through 68	To age 70
Age 69 or older	12 months

Premium Contributions:

Your coverage is Non-Contributory. This means Your Employer pays all of the premium for Your Long Term Disability Benefit coverage.

Additional Benefits:

- Survivor (Lump Sum)
- Vocational Rehabilitation with Additional Benefit for Work Incentive
- Social Security Assistance
- Workplace Modification Program
- Work Retention Assistance
- Additional Benefit for Catastrophic Conditions
- Pension Plan Contribution
- Additional Benefit for Rehabilitation Incentive

Specific information regarding the Policy and its terms may be obtained from the Plan Sponsor. The provisions, terms and conditions listed in any Policy document, including but not limited to this Certificate may be modified, amended, or changed at any time. Consent from any Insured or beneficiary is not required for such modification, amendment, or change.

DLS A 0205 C 1

Definitions

Below, the definitions of the Policy are discussed. Where these terms are used in this Certificate, unless specified otherwise, they have the meaning explained here.

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

Act or Law means the original enactments of the Act or Law, and all amendments.

"**Actively at Work"** means reporting to the Participating Employer's regular place of employment and carrying out the regular duties of Your occupation for the number of hours required by the Employer, but in no case less than 10 hours a week. You will be considered Actively at Work on a day of paid vacation or on a regular non-work day provided You were Actively at Work for a full work day that was immediately prior to such a day.

Additional Benefit or Additional Provision means an addendum to the Policy which increases or limits coverage for a specified set of conditions. The provisions, limitations, and exclusions in the entire Policy will apply unless specifically stated otherwise in the Additional Benefit or Additional Provision.

Catastrophic Conditions means that due to the Disability for which You are receiving Monthly Benefit Payments, You lose the ability to safely and completely perform at least 2 Activities of Daily Living without another person's assistance or verbal cueing, or have a deteriation or loss in intellectual capacity and need another person's assistance or verbal cueing for Your protection or for the protection of others.

Certificate means this document which provides a description of the coverage available under the Policy.

Claimant means a person who has filed a claim for benefits under the Policy.

Class means a grouping of Insureds based on criteria agreed on between the Plan Sponsor and Us.

Contributory means that You pay all or a portion of the premium for the coverage.

Disabled and Disability are defined in the Coverage Provisions section of this Certificate.

Disability Work Earnings are defined in the Coverage Provisions section of this Certificate.

"Drug Addiction" means an addictive relationship or pattern of use of drugs, chemicals, or similar substances.

Eligible Employee means You meet all of the following:

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

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

Eligibility Waiting Period means the continuous length of time that You must serve in an eligible Class to reach Your eligibility date and begin Your coverage. There is no Eligibility Waiting period. You are eligible for insurance on the first day of being Actively at Work as a member in Class 01 or 02.

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

If You return to work for 45 or less consecutive days during the Elimination Period, those days will interrupt the Elimination Period. However, the Disability will be treated as continuous if it is from the same or a related condition. Only those days during which You are Disabled will be used to satisfy the Elimination Period. For example, one must complete an Elimination Period of 125 work days within a total period of not more than 125 work days plus 45 consecutive calendar days.

Employer and Participating Employer means Your Employer which is participating in VACORP (the Plan Sponsor). It is by reason of Your Employer's participation that insurance under the Group Policy is made available to You.

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

Gainful Occupation means an occupation that is or can be expected to provide You with an income within 12 months of Your return to work that exceeds 80% of Your Indexed Monthly Earnings.

Gross Monthly Benefit means Your gross Long Term Disability Benefit as calculated from the Schedule of Benefits, prior to any reductions for Deductible Sources of Income.

Guaranteed Issue Amount means an amount of insurance for which We do not require Proof of Insurability.

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

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

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

Independent Medical Exam means an examination by a Physician of the appropriate specialty for Your condition at Our expense. Such examination, scheduled by Us may be used for the purpose of determining eligibility for insurance or benefits, including eligibility under the Additional Benefits or Additional Provisions, if any, associated with the Policy.

Indexed Monthly Earnings means Your Monthly Earnings adjusted on each anniversary of Monthly Benefit Payments by the lesser of 7% or the current annual percentage increase of the Consumer Price Index. Your Indexed Monthly Earnings may increase or remain the same, but will never decrease.

The Consumer Price Index (CPI-U) is published by the U.S. Department of Labor. We reserve the right to use some other similar measurement if the Department of Labor changes or stops publishing the (CPI-U).

Indexing is only used to determine Your percentage of lost earnings while You are Disabled and working, and in the determination of Gainful Occupation.

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

Any Disability which begins more than 60 days after an Injury will be considered an Illness for the purpose of determining Long Term Disability benefits.

Insured means an individual covered under the Policy.

Leave of Absence means an arrangement where You and the Plan Sponsor agree that You will not be Actively at Work for a specific period of time and You are expected to be

Actively at Work at the end of that period. If You become Disabled while on a Leave of Absence, Benefit Payments will be based upon Earnings as last reported and premiums paid to Us immediately prior to the beginning of the Leave of Absence. Refer to *When Your Insurance Ends* to determine how long Your coverage can be continued during a Leave of Absence.

Long Term Disability Benefits are the monthly benefits provided under the terms of the Policy.

Material and Substantial Duties means duties that:

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

Mental Illness means any psychiatric or emotional illness or disease listed in the Diagnostic and Statistical Manual. Such conditions are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment. Mental Illness includes, but is not limited to, each of the following:

a) Neurotic disorders such as, but not limited to, anxiety, dissociative disorders, phobias, depression and obsessive compulsive disorders.
b) Psychotic disorders such as, but not limited to, schizophrenia, dementia, paranoid psychosis and affective disorders;
c) Personality disorders such as, but not limited to, sociopathic personality;
d) Syndromes such as, but not limited to, organic brain syndromes, amnesia syndromes and organic delusional or hallucinogenic syndromes.

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

"Monthly Earnings" is defined in one of the two following paragraphs that fits Your situation:

If You are paid on an annual contract basis, Your Monthly Earnings is Your monthly rate of creditable compensation based on one-twelfth (1/12th) of your annual contract salary received from the Employer, including any

1. Contributions you make through a salary reduction agreement with your Employer to:
   a. An Internal Revenue Code (IRC) Section 401(k), 403(b), 408(k), 408(p), or 457 deferred compensation arrangement; or
   b. An executive nonqualified deferred compensation arrangement.
2. Shift differential pay.

3. Amounts contributed to your fringe benefits according to a salary reduction agreement under an IRC Section 125 plan.

If You are paid hourly wages, Your Monthly Earnings is Your monthly rate of creditable compensation based on your hourly pay rate multiplied by the number of hours you are regularly scheduled to work per month by Your Employer, but not more than 173 hours. If you do not have regular work hours, your monthly rate of earnings is based on the average number of hours you worked per month for the Employer during the preceding 12 calendar months (or during your period of employment if less than 12 months), but not more than 173 hours. Monthly Earnings also includes:

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

In either case, Your amount of insurance will be calculated based on the lesser of Your Monthly Earnings as calculated above or the premium amount actually received by the Plan Sponsor on Your behalf from Your Employer, and in turn from the Plan Sponsor to Us.

Monthly Earnings will be determined according to the Employer's records.

Motorized Vehicle means any self-propelled vehicle or conveyance, including but not limited to automobiles, trucks, motorcycles, ATV's, snowmobiles, tractors, golf carts, motorized scooters, lawn mowers, heavy equipment used for excavating, boats, and person watercraft. Motorized Vehicle does not include a medically necessary motorized wheelchair.

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

Part-Time Basis means the ability to work and earn between 20% and 80% of Your Indexed Monthly Earnings. Ability is based on capacity and not market availability.

Physician means:

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

Physician does not include:

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

Plan Sponsor means the Virginia Association of Counties Group Self Insurance Risk Pool (VACORP), which is the entity that holds the Policy and in which Your Employer participates in order to make this coverage available to You.

Policy or **Group Policy** means the policy issued by Us and the Plan Sponsor and described in this Certificate.

Prior Plan means the plan providing similar Long Term Disability insurance benefits carried by the Plan Sponsor on the day before the Policy's effective date with Us.

Proof means evidence satisfactory to Us that the terms and provisions of the Policy have been met. Proof may include but is not limited to: questionnaires, physical exams, or Written documentation and records as required by Us. Proof must be received by Us at Our Administrative Office. All Proof must be given at Your expense (or that of Your representative or beneficiary), unless otherwise specifically provided by the terms of the Policy. If any additional Proof is reasonably required by Us, an Insured may be required to give Us authorization to obtain such additional Proof. The following are some specific types of Proof referenced under the Policy:

Proof of Claim or **Proof of Disability** means evidence satisfactory to Us that a person has satisfied the conditions and requirements for a benefit under the Policy. The Proof must establish:

- the nature and extent of the loss or condition; *and*
- our obligation to pay the claim under the Policy; *and*
- the Claimant's right to receive payment.

Proof of Insurability means evidence satisfactory to Us of a person's health and other information related to insurability which enables Us to determine whether the person can become insured, or is eligible for an increase in coverage.

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

Regular Care means:

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

Retirement Plan means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to employees and are not funded entirely by employee contributions.

Sign or **Signed** means the use by a person of a symbol or method with the present intention to authenticate a record. Such authentication may be executed and/or transmitted by paper or electronic media, provided it is acceptable to Us and consistent with applicable law.

We, **Us**, and **Our** mean the insurer Anthem Life Insurance Company

Wellness Programs include, but are not limited to appropriate programs for dietary and nutritional improvement, weight management, smoking cessation, abstention from excessive or illegal use of alcohol or narcotics, regular participation in exercise activities, stress management, pain management, behavioral therapy, coaching, and the regular taking of prescribed medications.

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

You and **Your** means an Eligible Employee.

Other terms are defined elsewhere under the Policy.

DLS A 0205 C2

When Insurance Begins and Ends

This section tells how You may become insured.

Obtaining Your Insurance

To obtain insurance under the Policy, You must be an Eligible Employee and be Actively at Work.

Specific information regarding the Group Policy and its terms may be obtained from the Plan Sponsor.

If You are an Eligible Employee on the effective date of the Policy, You are eligible for insurance on that date.

Enrollment

You do not contribute to the cost of Your coverage. Nevertheless, You must enroll for Your insurance within 31 days of becoming eligible for insurance. Your Employer must send Your completed enrollment to the Plan Sponsor.

Effective Date of Insurance

Once You have become eligible for insurance, this section tells when Your insurance will begin.

Your insurance begins on the first day You are Actively at Work following the date that You become an Eligible Employee. However, the enrollment form must be completed and given to Your Employer within 31 days of Your becoming eligible.

The Plan Sponsor must send Your completed enrollment to Us at our Administrative Office unless We and the Plan Sponsor have agreed that the Plan Sponsor will retain the applications.

Delayed Effective Date of Your Insurance

If You are not Actively at Work on the date Your insurance would otherwise begin, Your insurance begins on the date You are again Actively at Work.

Changes in Your Insurance

Change in Class or Earnings

The amount of Your insurance may change if:

- You become a member of a different Class; *or*

- The amount of Your Monthly Earnings changes.

If the change would *increase* Your amount of insurance, the increase takes effect on the first day You are Actively at Work following the *latest* of the date:

- The change occurs; *or*
- The Plan Sponsor tells Us in Writing about a change in Class or a change in the amount of Your Monthly Earnings.

When Insurance Ends

Your insurance coverage will end on the *earliest* of the following dates:

1. The date the Policy is canceled; *or*
2. The date on which You cease to be a member of a Class under the Policy; *or*
3. The date Your employment terminates. For the purpose of this provision, employment terminates when You are no longer Actively at Work, unless due to Disability; *or*
4. The date the Policy is changed to end the insurance for Your Class; *or*
5. The last day of the period for which premium was paid, if a premium is not paid within the Policy's grace period; *or*
6. Preceding the date of Your death; *or*
7. The date Your Monthly Benefit Payments end, if You are not again Actively at Work the following day; *or*
8. The date You cease to be an Eligible Employee as defined in the Definitions of the Policy; *or*
9. You request, in Writing, for Your insurance to be terminated; *or*
10. The date You cease to be Actively at Work. However, the Plan Sponsor may continue Your insurance unless it ends due to any of the above reasons during the following periods:
    a.) until the end of the 3rd month following the date You cease to be Actively at Work due to a temporary layoff; *or*
    b.) until the end of the 3rd month following the date You cease to be Actively at Work due to a Leave of Absence or due to Your being called to active duty as a reservist with the U.S. Armed Forces Reserve; or
    c.) during an absence from work due to a Leave of Absence that is in compliance with the Family Medical Leave Act of 1993 ("FMLA") or applicable state, family and medical leave law;) or
    d.) during the longest of the periods in above items (a), (b), and (c), if You cease to be Actively at Work due to Your being called to active duty as a reservist with the U.S. Armed Forces.

Any Leave of Absence must have been authorized in Writing by the Plan Sponsor. Unless otherwise specifically stated under the terms of the Policy, all premium required by the Policy must be paid in order for any continuance of insurance provision to be applicable.

If coverage is continued in accordance with the Leave of Absence provisions above, such continued coverage will cease immediately if any one or more of the following events occurs:

- the leave terminates prior to the agreed upon date; *or*
- the Policy terminates or Your employer ceases to be a associated employer with the Plan Sponsor; *or*
- You or the Plan Sponsor fail to pay premium when due; *or*
- the Policy no longer insures Your Class.

During the period that You are Disabled, Your Monthly Benefit Payments *will not* be affected by:

- termination or cancellation of the Plan Sponsor's Policy; *or*
- termination of Your coverage; *or*
- termination of Your employment; *or*
- any amendment to the Policy that becomes effective after the date You are Disabled.

Continuity of Coverage upon Transfer of Insurance Carriers

In order to prevent loss of coverage for You because of a transfer of insurance carriers, this provision will provide coverage for certain plan members as follows:

Failure to be in Active Employment Due to Injury or Illness

If You are not Actively at Work due to Injury, illness, leave of absence or temporary layoff on the date the Plan Sponsor changes insurance carriers to Anthem Life, and You were covered under the prior policy at the time the Anthem Life Policy became effective, We will provide continuity of coverage under the Anthem Life Policy. In order for this provision to apply, the prior policy must have provided similar coverage to the Anthem Life Policy.

If You are not Actively at Work due to injury, illness, leave of absence or temporary layoff on the effective date of the Anthem Life Policy, and You would otherwise be eligible to become insured under the Policy, We will provide limited coverage under the Anthem Life Policy. Coverage under this provision will begin on the Anthem Life Policy effective date and will continue until the earliest of:

- the end of the month following the date You return to active employment; *or*
- the end of any period of continuance or extension provided under the prior policy; *or*
- the date coverage would otherwise end, according to the provisions of the Anthem Life Policy.

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

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

If coverage ends under this provision, or if You were not covered under the prior policy on the date that policy terminated, the Effective Date of Insurance provision under the Anthem Life Policy will apply.

No Benefits are payable under this provision for any period of Disability:

- that begins prior to this Policy's effective date; *or*
- for which benefits are paid under the prior plan; *or*
- for which benefits would have been paid under the Prior Plan in the absence of this provision.

Coverage Provisions

Description of the Coverage

The pages of this section specify when Policy benefits will be paid. Conditions governing whether, and how much benefit is paid are also discussed in this section.

To receive Policy benefits, You must be insured under the terms of the Policy, and as described in the *When Insurance Begins and Ends* section. Then, Your amounts of insurance are as shown in the Schedule of Benefits, subject to the terms of the Policy.

Definition of Disability and Disabled for Long Term Disability Insurance

Disabled and **Disability** mean during the Elimination Period and the next 24 months because of Your Injury or Illness, *all* of the following are true:

- You are unable to do the Material and Substantial Duties of Your Own Occupation; *and*
- You are receiving Regular Care from a Physician for that Injury or Illness; *and*
- Your Disability Work Earnings, if any, are less than or equal to 80% of Your Indexed Monthly Earnings.

Thereafter, Disabled and Disability mean because of Your Injury or Illness *all* of the following are true:

- You are unable to do the duties of any Gainful Occupation for which You are or may become reasonably qualified by education, training, or experience; *and*
- You are receiving Regular Care from a Physician for that Injury or Illness; *and*
- Your Disability Work Earnings, if any, are less than or equal to 80% of Your Indexed Monthly Earnings.

Your Disability must start while You are insured under the Policy.

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

- Loss, suspension, restriction or failure to maintain a professional license, occupational license, permit or certification; *or*
- Loss of earnings due to economic factors such as, but not limited to, recession, job elimination, job restructuring, temporary layoffs, pay cuts and job-sharing; *or*
- The Plan Sponsor's work schedule that is inconsistent with the normal work schedule of Your Own Occupation; *or*

- Your relationship with the Plan Sponsor or other employees of the Plan Sponsor; *or*
- Failure or inability of the Plan Sponsor to maintain the workplace in a manner consistent with the normal physical environment of Your Own Occupation; *or*
- Your inability to work more than 40 hours per week in the occupation, even if You were regularly required to work more than 40 hours per week prior to Your Injury or Illness.

Disability Work Earnings means for Long Term Disability benefits, monthly earnings which You receive while You are Disabled and working.

DLS A 0205 C 4

Long Term Disability Insurance Benefits

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

- The Disability starts while You are insured under the Policy; *and*
- The Disability continues during and past the Elimination Period; *and*
- We receive Proof of Your Disability.

The Long Term Disability Benefit and the Maximum Benefit Period are shown in the Schedule of Benefits. The Long Term Disability Benefit may be reduced in accordance with the provisions of the Deductible Sources of Income section of the Policy. The Long Term Disability Benefit will not:

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

You will begin to receive payments when We approve Your claim, provided the Elimination Period has been met. We will send You a payment each month for Long Term Disability benefits for any period for which We are liable.

Calculating Your Long Term Disability Benefit

Part A.
If You are Disabled and not working, or Disabled and working and Your Disability Work Earnings are less than 20% of Your Indexed Monthly Earnings.

We will use the following process to calculate Your Monthly Benefit Payment:

1. Multiply Your Monthly Earnings by 60%.
2. The maximum benefit is $30,000 per month.
3. Compare the answer from Item 1 with the maximum benefit. The lesser of these two amounts is Your Gross Monthly Benefit.
4. Subtract from Your Gross Monthly Benefit any Deductible Sources of Income.

The amount calculated in Item 4 is Your Monthly Benefit Payment.

Part B.
If You are Disabled and working, and Your Disability Work 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 Monthly Benefit Payment plus Disability Work Earnings may be less than or equal to, but not more than 100% of Your Indexed Monthly Earnings. If the sum exceeds 100% of Your Indexed Monthly Earnings, We will reduce Your payment under the Policy by the excess amount.

To determine whether the sum of Your Monthly Benefit Payment plus Disability Work Earnings is less than or equal to or exceeds 100% of Your Indexed Monthly Earnings, We will use the following process:

1. Multiply Your Monthly Earnings by 60%.
2. The maximum benefit is $30,000 per month.
3. Compare the answer from Item 1. with the maximum benefit per month. The lesser of these two amounts is Your Gross Monthly Benefit.
4. Add Your Disability Work Earnings to Your Gross Monthly Benefit.

If the answer in Item 4 above is less than or equal to 100% of Your Indexed Monthly Earnings, Your Monthly Benefit Payment will be Your Gross Monthly Benefit minus any Deductible Sources of Income.

If the answer in Item 4 above is greater than 100% of Your Indexed Monthly Earnings, We will use the following process to calculate Your Monthly Benefit Payment.

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

The amount calculated in Item c is Your Monthly Benefit Payment.

After 12 months of Monthly Benefit Payments, You will receive payments based on the percentage of income You are losing due to Your Disability. We will use the following process to calculate Your Monthly Benefit Payment:

1. Subtract Your Disability Work Earnings from Your Indexed Monthly Earnings.
2. Divide the answer in Item 1 by Your Indexed Monthly Earnings. The result is Your percentage of lost earnings.
3. From Your Gross Monthly Benefit, subtract any Deductible Sources of Income.
4. Multiply the answer in Item 2 by the answer in Item 3.

The answer in Item 4 is Your Monthly Benefit Payment.

We may require You to send Proof of Your monthly Disability Work Earnings each month. We will adjust Your Monthly Benefit Payment based on Your monthly Disability Work Earnings.

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

Minimum Monthly Benefit: The minimum Monthly Benefit Payment is: $100

We may apply this amount toward an outstanding overpayment, as described in the Recovery of Overpayment provision.

If Your Disability Work Earnings Fluctuate

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

If We average Your Disability Work Earnings, We will not terminate Your claim unless:

- during the first 24 months of Monthly Benefit Payments, the average of Your Disability Work Earnings for a three month period exceeds 80% of Your Monthly Earnings; *or*
- beyond 24 months of Monthly Benefit Payments, the average of Your Disability Work Earnings for a three month period exceeds 80% of Your Monthly Earnings.

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

Cost of Living Freeze

After the first deduction for Social Security Benefits has been made to the Long Term Disability Benefit, the Monthly Benefit Payment will not be further reduced due to any cost of living increases for Social Security Benefits. This cost of living freeze does not apply to Disability Work Earnings or to any increases in income You earn from any form of employment.

Recurrent Disability Provision for Long Term Disability

If You have a Recurrent Disability, and after Your prior Disability ended, You return to work for the Plan Sponsor for 125 consecutive work days or less, We will treat Your Disability as part of Your prior claim and You do not have to complete another Elimination Period.

Your Monthly Benefit 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 and conditions of the Policy as Your prior claim.

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

- is unrelated to Your prior Disability; or
- after Your prior Disability ended, You returned to work for the Plan Sponsor for more than 125 consecutive work days.

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

If the Policy terminates You will not be eligible for benefits under this provision, unless You became Disabled due to the Recurrent Disability prior to the Policy termination.

Period of Disability extended by a new condition

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

When Long Term Disability Benefits End

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

1. You are no longer Disabled under the terms of the Policy; *or*
2. You are no longer receiving, accepting or following Regular Care from a Physician; *or*
3. The Maximum Benefit Period from the Schedule of Benefits ends; *or*
4. The period specified in the Long Term Disability Limitations provision of the Policy ends, if that section applies; *or*
5. Preceding the date of Your death; *or*
6. You take a refund of your member contributions and interest in the defined benefit component of your plan; or
6. We ask You for Proof that You are still Disabled, if We do not receive Proof of Disability within 31 days of Our request; *or*
7. We ask You for details about Your Deductible Sources of Income, including Your tax returns, if You do not give Us details within 31 days of Our request; *or*
8. We ask You to be examined by:
    - a Physician; *or*
    - a health care professional,

   if You do not reasonably cooperate with the examiner or if You unreasonably decline to be examined; *or*
9. You work, unless You are working as part of a Vocational Rehabilitation Program approved by Us; *or*
10. Your Disability Work Earnings exceed the amount allowable under the Policy; *or*
11. You cease to reside in the United States or Canada. If You are outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of Monthly Benefit Payments, You will be considered to have ceased to reside in the United States or Canada; *or*
12. You refuse to try or attempt work with the assistance of

- Modifications to Your work environment, functional job elements or work schedule; *or*
- Adaptive equipment or devices, that a qualified Physician has indicated will accommodate the limiting factors of the Injury or Illness for which You are claiming benefits under the Policy or will enable You to perform the Material and Substantial duties of an occupation from which the Policy requires You to be considered Disabled in order to receive benefits; *or*

13. You are confined to a penal or correctional institution; *or*
14. With respect to a Mental Illness, that You are not under the continuing Regular Care of a Physician specializing in psychiatric care; *or*
15. With respect to Alcoholism and Drug Addiction, that You are not being actively supervised by and receiving continuing treatment from a rehabilitation center or a designated institution approved for such treatment by an appropriate body in the governing jurisdiction, or, if none, by Us: *or*
16. You or Your Physician fail to submit any medical or psychiatric information requested by Us; *or*
17. You would be able to work in Your Own Occupation on a part-time basis earning 20% or more of Your Monthly Earnings, but choose not to do so; *or*
18. You would be able to increase Your current earnings to more than 80% of Your Monthly Earnings by increasing the number of hours worked or the number of duties performed in Your Own Occupation, but choose not to do so, *or*
19. You refuse to make a good faith effort to adhere to necessary Wellness Programs that your Physician has recommended and that are generally acknowledged by Physicians to cure, improve or reduce the disabling effect of the illness or Injury for which You are claiming benefits under the Policy. We will work with your treating Physician to determine the necessary Wellness Programs, if any, in accordance with generally accepted medical standards.

    We will give you 30 day's prior written notice of Our intent to apply these provisions for failure to adhere to Wellness programs to terminate Your benefits. During those 30 days You will have an opportunity to begin or resume reasonable efforts to adhere to the medically necessary Wellness Programs. We will not terminate benefits if there is no reasonable basis for believing that You will be able to return to productive employment in your Own Occupation or another Gainful Occupation on a full-time or part-time basis if You adhere to the recommended Wellness Programs.

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

Benefits after Policy Cancellation

Cancellation of the Policy does not by itself affect Your right to receive Long Term Disability Benefits for a Disability that begins while You are insured under the Policy. You must continue to comply with all requirements of the Policy. All terms and conditions of the Policy will apply.

Premium Waiver

With respect to Long Term Disability Benefits, We do not require premiums to be paid for the period during which You are receiving Monthly Benefit Payments. Premium payments will be required during the Elimination Period and after Your Monthly Benefit Payments end, if You continue to be insured under the Policy.

This premium waiver will begin on the premium due date that falls on or next follows the date You meet all of the conditions to qualify for premium waiver, as stated above.

We will continue to waive Your premiums until the premium due date that falls on or next follows the first of the following to occur:

- The date You are no longer Disabled; *or*
- the date Your Disability Work Earnings equal 20% or more of Your Monthly Earnings
- The end of the Maximum Benefit period from the Schedule of Benefits; *or*
- The date Your coverage under the Policy ends.

If You return to work and are an Eligible Employee on the date premium waiver ends, Your coverage will be continued subject to payment of the required premium. If You are not an Eligible Employee on the date premium waiver ends, Your coverage will end.

DLS A 0205 C5

Deductible Sources of Income

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

The following are Deductible Sources of Income:

1. The amount that You receive, or are eligible to receive, under:
   - A worker's compensation law; *or*
   - An occupational disease law; *or*
   - Unemployment compensation law; *or*
   - Any other Act or Law with similar intent.
2. The amount that You receive, or are eligible to receive, as disability income payments under any:
   - state compulsory benefit Act or Law; *or*
   - governmental retirement system as a result of Your employment with the Plan Sponsor; *or*
   - veteran's Administration or any other foreign or domestic governmental agency; *or*
   - other group insurance plan; *or*
   - any plan or arrangement of disability coverage, whether insured or not, resulting from Your employment by or association with the Plan Sponsor or any employer, or resulting from Your membership in or association with any group, association, union or other organization.

3a. The amount that You, Your spouse, and children receive, or are eligible to receive, as disability payments because of Your Disability under:
   - the United States Social Security Act; *or*
   - the Canada Pension Plan; *or*
   - the Quebec Pension Plan; *or*
   - any similar plan or act.

3b. The amount that You receive, or are eligible to receive, as retirement payments or the amount Your spouse and children receive as retirement payments because You are receiving retirement payments under:
   - the United States Social Security Act; or
   - the Canada Pension Plan; or
   - the Quebec Pension Plan; or
   - any similar plan or act.

4. The amount that You:
    - Receive as disability payments under the Plan Sponsor's Retirement Plan; *or*
    - Voluntarily elect to receive as retirement payments under the Plan Sponsor's Retirement Plan; *or*
    - are eligible to receive as retirement payments when You reach the later of age 62 or normal retirement age, as defined in the Plan Sponsor's Retirement Plan.

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

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

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

5. The amount You receive as a result of any action brought under Title 46, United States Code Section 688 (The Jones Act).
6. The amount You receive from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.
7. The amount You receive under any salary continuation or accumulated sick leave plans.
8. Commissions, severance allowance, sick pay or any similar employer sponsored paid time off where You receive income from the employer, vacation pay or any salary continuation plan.
9. Any amounts from partnership, proprietorship draws, or similar draws.

Lump Sum Payments

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

Non-Deductible Sources of Income

We will not subtract from Your Monthly Benefit Payment any income You receive from the following:

1. 401(k) plans;
2. vacation pay
3. profit sharing plans;
4. thrift plans;
5. tax sheltered annuities;

6. stock ownership plans;
7. credit or mortgage disability insurance;
8. non-qualified plans of deferred compensation;
9. pension plans for partners;
10. military pension and disability income plans;
11. individual disability plans;
12. franchise disability income plans;
13. a retirement plan from another plan sponsor;
14. individual retirement accounts (IRA);
15. automobile liability insurance policy;
16. Accelerated death benefits paid form a life insurance policy;
17. Keogh (HR-10) plan;
18. reimbursement for hospital, medical or surgical expense.

If You May Qualify for Deductible Income Benefits

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

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

Estimate and Deduction for Social Security Benefits

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

We will reduce the amount of Your Monthly Benefit Payments by the amount of Social Security benefits We estimate that You, Your spouse or children are eligible to receive because of Your Disability or retirement. We will start to do this after 24 months of Monthly Benefit Payments, unless We have received:

- Proof of the approval of Your claim for Social Security Benefits; *or*
- Proof of denial of Social Security Benefits, which shows that all levels of appeal have been exhausted.

However, within 6 months following the date You became Disabled; You must:

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

If You do not satisfy the above requirements, We will reduce Your Monthly Benefit Payments by such estimated Social Security benefits starting with the first Monthly Benefit Payment coincident with the date You were eligible to receive Social Security benefits.

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

Recovery of Overpayment

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

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

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

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

- Taking legal action;
- Stopping or reducing any future payments under the Policy, including the Minimum Weekly Benefit or any Additional Benefit or Additional Provision benefits, which might otherwise be payable to You or any other Claimant or payee.

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

Adjustment for Underpayment

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

Proration

Any Long Term Disability Benefit payable for less than a month will be prorated based on a 30 day month. The prorated amount may be less than the Minimum Monthly Benefit.

Awards of Damages and Right of Reimbursement

You will be required to reimburse Us for any benefits We pay to You if *both* of the following conditions are met:

1. Benefits are paid or payable under the Policy; *and*
2. You recover damages whether by action at law, settlement, or compromise from any person, organization, or legal entity that is or may be liable for any illness, Injury, or other event giving rise directly or indirectly, to the Disability for which benefits are payable.

The term damages will include all lump sum or periodic payments however designated You receive under paragraph number 2 above. The provisions of this section shall apply whether or not the person, organization, or legal entity admits liability.

If You receive damages in one or more lump sum payments instead of in monthly or weekly payments, the amount You must reimburse to Us will be based on the amount of the award pro-rated over the period benefits have been or will be paid. You must provide satisfactory Proof of the award to Us, or We will reasonably estimate the amount to be reimbursed. Our rights shall be to the first reimbursement out of all funds You, Your parents if You are a minor, or Your legal representative, is or was able to obtain under the conditions outlined above.

Your lawyer may represent Our rights of reimbursement. However, We reserve the right to:

1. Appoint another lawyer to act on Our behalf; *and*
2. Commence an action to pursue Our rights of reimbursement directly against a third party.

As an Insured, You must:

1. Agree to fully co-operate with Us in pursuing Our claim against the third party, including but not limited to the furnishing of any information, documents, or other assistance We may reasonably require.
2. Agree to notify Us of any action You have or bring against any third party.

DLS A 0205 C7

Additional Benefit for Survivor

We will pay a lump sum benefit to Your eligible survivor when Proof is received that You died:

- after Your Disability had continued for 180 or more consecutive days; *and*
- while You were receiving a Monthly Benefit Payment.

This Additional Benefit for Survivor will be an amount equal to three times the Last Monthly Benefit for Long Term Disability. Any Additional Benefit for Survivor will be applied first to reduce any outstanding overpayment.

We will pay the Additional Benefit for Survivor to Your legal spouse, if living. If Your spouse is not living, We will pay the Additional Benefit divided into equal shares to Your children. Children must be under age 21, unmarried, and dependent on You for support and maintenance. Children include step-children, adopted children, and foster children. If there is no person entitled to the Additional Benefit for Survivor living at the time of Your death, the Additional Benefit will be paid to Your estate. Our payment of Your estate discharges Us of all liability under this Additional Benefit to the extent of the payment, and shall be valid and effective against all claims by others representing or claiming to represent Your children. Benefits otherwise payable to a minor child may be made instead to an adult who submits Proof satisfactory to Us that he or she has assumed custody and support of the child.

Last Monthly Benefit means, for the purpose of this provision, the Gross Monthly Benefit amount paid to You immediately prior to Your death.

Additional Benefit for Vocational Rehabilitation Program

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

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

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

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

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

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

Vocational Rehabilitation Program (continued)

To qualify for these services, You must:

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

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

The written program will describe:

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

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

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

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

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

Additional Benefit for Work Incentive

If You participate in a Vocational Rehabilitation Program that is approved by Our Vocational Rehabilitation specialist, We may increase Your Gross Monthly Benefit Payment by **10**%, up to a maximum additional payment of **$750** per month, not to exceed the Maximum Monthly Benefit as shown in the Schedule of Benefits.

The Additional Benefit for Work Incentive will end on the earliest of the following dates:

- You cease to be paid a Gross Monthly Benefit Payment;
- 12 months of Additional Benefit for Work Incentive have been paid.
- You are no longer participating in a Vocational Rehabilitation Program; or
- We determine that You are no longer eligible to participate in a Vocational Rehabilitation Program;
- Any other requirement or condition of the Policy is not met, including but not limited to those listed in the *When Disability Benefits End* section.

Additional Benefit for Social Security Assistance

If You are receiving Monthly Benefit Payments from Us, We may provide advice to You about filing Your claim for Social Security disability benefits or appealing a denial of Your claim for Social Security disability benefits.

If You receive Social Security disability benefits, this may enable You to receive Medicare after 24 months of disability payments, protect Your Social Security retirement benefits, and Your family may also be eligible for Social Security benefits.

We can assist You in obtaining Social Security disability benefits by:

- helping You obtain medical and vocational evidence; *and*
- helping You find appropriate legal representation; *and*
- by reimbursing pre-approved case management expenses.

Additional Benefit for Workplace Modification

If You are Disabled and are receiving a Monthly Benefit Payment from Us, an Additional Benefit for Workplace Modification may be payable to the Plan Sponsor to accommodate You in returning to work. We may at our sole discretion, reimburse the Plan Sponsor for up to 100% of the reasonable costs the Plan Sponsor incurs through modifications to the workplace to accommodate Your return to work, and to assist You in remaining at work.

The amount We pay will not exceed $25,000.

To qualify for this reimbursement, You must:

1. be Disabled according to the terms of the Policy; *and*
2. have the reasonable expectation of returning to active employment and remaining in active employment with the assistance of the proposed workplace modification.

The Plan Sponsor must give us a written proposal of the planned workplace modification. This proposal must include:

1. input from the Plan Sponsor, 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 workplace modification.

We will reimburse the costs of the workplace modification when We:

1. approve the proposals in writing;
2. receive Proof from the Plan Sponsor that the Workplace modification is complete; and
3. receive Proof of the costs incurred by the Plan Sponsor for the workplace modification.

The Additional Benefit for Workplace Modification is available on a one time basis.

Additional Benefit for Work Retention Assistance

If You:

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

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

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

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

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

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Additional Benefit for Catastrophic Conditions

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

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

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

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

An Activities of Daily Living loss that existed prior to Your effective date of coverage under the Policy will not be considered as a loss under this Additional Benefit.

The Additional Benefit for Catastrophic Conditions is 20% of pre-disability Monthly Earnings not to exceed $5,000 per month.

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

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

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

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

Additional Benefit for Pension Plan Contribution

We will pay an Additional Benefit if You are receiving a Monthly Benefit Payment under the Policy and participated in the Plan Sponsor's pension plan for at least 3 months before You became Disabled.

The maximum amount of this Additional Benefit for Pension Plan Contribution is 1% of your Monthly Benefit to a maximum of $500. This benefit will be paid to the Plan Sponsor for deposit into the pension plan on Your behalf.

The Additional Benefit for Pension Plan Contribution will end on the earliest of the following dates:

1. You cease to be paid a Monthly Benefit Payment;
2. You return to full or part-time work in any occupation; *or*
3. You stop participating in the Plan Sponsor's pension plan; *or*
4. The date your employment is terminated by you or your Employer, unless your Employer's pension plan document allows continued contributions on your behalf after such date
5. You begin to receive benefits under the pension plan.
6. any other requirement or condition of the Policy is not met, including but not limited to those listed in the *When Disability Benefits End* section.

If the Pension Contribution Benefit Plan cannot accept contributions for You, this benefit may be paid into a flexible premium deferred annuity that is established and maintained by You.

Additional Benefit for Rehabilitation Incentive

If You participate in a Vocational Rehabilitation Program that is approved by Our Vocational Rehabilitation specialist, We may:

(a) increase Your Monthly Benefit Payment by **10%** not to exceed the Maximum Monthly Benefit as shown in the Schedule of Benefits; *or*
(b) reimburse You or pay directly at Our sole discretion for other expenses incurred in carrying out the Vocational Rehabilitation Program, such as but not limited to otherwise unreimbursed expenses for training, education, accommodation, travel or relocation.
(c) continue Your Monthly Benefit Payment for 3 months after the date You cease to be Disabled, to assist in Your transition to reenter the workforce, if You cease to be Disabled due to Your participation in a Vocational Rehabilitation Program.

The Rehabilitation Incentive will end on the earliest of the following dates:

1. You cease to be paid a Monthly Benefit Payment;
2. You are no longer participating in a Vocational Rehabilitation Program; or
3. We determine that You are no longer eligible to participate in a Vocational Rehabilitation Program;
4. any other requirement or condition of the Policy is not met, including but not limited to those listed in the When Disability Benefits End section.

The Rehabilitation Incentive is subject to the Total Benefit Cap provision of the Policy.

Exclusions

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

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

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

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

1. You are no longer receiving, accepting or following Regular Care from a Physician;
2. With respect to a mental disorder, any period during which You are not under the continuing Regular Care of a Psychiatrist specializing in psychiatric care.
3. With respect to Alcoholism and Drug Addiction, any period during with You are not being actively supervised by and receiving continuing treatment from a rehabilitation center or a designated institution approved for such treatment by an appropriate body in the governing jurisdiction, or, if not, by Us.
4. You have applied for benefits under fraudulent circumstances and these circumstances resulted in a conviction of fraud.
5. You unreasonably fail to submit to an Independent Medical Exam requested by Us.
6. You are confined to a penal or correctional institution.

7. Disability results from cosmetic or reconstructive surgery, except for complications arising from such surgery, or surgery necessary to correct a deformity caused by Illness or accidental Injury.
8. You or Your Physician fail to provide any medical or any psychiatric records which We request.
9. Any period that any other requirement or condition of the Policy is not met, including but not limited to those listed in the *When Disability Benefits Ends* section.

General Provisions

Assignment

You cannot assign Your rights or benefits under the Policy.

Currency

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

Class Membership

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

Misrepresentation

Any statement You make in an application to become insured is a representation and not a warranty. No representation made by You in an application to become insured will be used to reduce or deny Your claim or contest the validity of Your insurance unless:

- Your insurance would not have been approved except for Your misrepresentation; *and*
- Your misrepresentation is contained in a Written instrument Signed by You; *and*
- We give You or Your representative a copy of the Written instrument that contains Your misrepresentation.

Incontestability

No statement made by any person insured under the Policy relating to his or her insurability shall be used in contesting the validity of the insurance with respect to which such statement was made:

- After the insurance has been in force prior to the contest for a period of two years during the lifetime of the person about whom the statement was made; *and*
- Unless the statement is contained in a Written instrument signed by him or her.

This section does not prevent Us from using at any time a defense based on:

- Non-payment of premium; *or*
- Any other provision of the Policy; *or*
- Any other defense that is allowed by law.

Misstatement of Age or Other Facts

If Your age or any other fact was misstated, We will use the correct facts to determine whether You are insured and if so, for what amount and duration.

Errors

You must be properly insured under the Policy. An error or omission by the Plan Sponsor or by Us will not cause You to become insured. An error or omission by the Plan Sponsor or by Us will not cancel insurance that should continue nor continue insurance that should end. The requirements and conditions of the Policy must be properly met for any change in the amount of Your insurance to take effect. We have the right to full recovery of any overpayments made. Such reimbursement will be required regardless of whether the overpayment occurred due to an error by Us or by You, Your representative or beneficiary, or the Plan Sponsor.

Agency

The Plan Sponsor or employer and any administrator appointed by the Plan Sponsor or employer shall not be considered Our agents for any purpose. We are not liable for any of their acts or omissions.

Changes to Policy

The Policy including this Certificate may be amended at any time by Written agreement between the Plan Sponsor and Us, without the consent of or notice to any other individual. Any amendment must be in writing and attached to the Policy. The amendment must bear the signature or a reproduction of the signature of the President, a Vice President, or Secretary of Our company.

If You are not Actively at Work on the effective date of the amendment, the effective date with respect to You will be the date that You are again Actively at Work. However, if the amendment would reduce the amount of Your insurance, the effective date with respect to You will be the effective date of the amendment.

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

Enforcement of Policy Terms

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

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Claim and Payment Provisions

How to Claim Benefits

Due Written Proof of Claim is required in order to receive benefits under the Policy. Claim forms are available to You or Your beneficiary on request to the Plan Sponsor. For prompt payment, it is necessary that the claim form be completed in full. For a claim for loss of life, a certified copy of the death certificate must be provided to Us.

Notice of Claim

Notice of a claim must be given within 30 days after a covered loss starts, or as soon as reasonably possible. Written notice can be given to Us at Our home office or to Our agent. Reference to a "loss" merely means that an event occurred or an expense was incurred for which a benefit is payable under the Policy. The notice must identify You along with the Group Policy number shown in this Certificate.

For a claim for loss due to Disability, You must notify Us immediately if You return to work in any capacity.

Claim Forms

When We receive the notice of claim, We will send the Claimant forms for filing Proof of loss. The needed forms may also be obtained from the Plan Sponsor. If these forms are not given to the Claimant within 15 working days, the Claimant can meet the Proof of loss requirements by giving Us a Written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss section.

Proof of Disability or Other Loss

Due Written Proof of Disability or other loss must be given to Us within 90 days after such loss. Failure to furnish the Proof within that time shall not invalidate or reduce the claim if the Proof is given as soon as reasonably possible. But, unless delayed by the Claimant's legal incapacity, the required Proof must be furnished within 2 years of the specific time. If the Policy terminates, the Claimant must give written notice and Proof of Disability or loss for a Disability or loss that began or occurred before the Policy ended within 90 days after the Policy terminated.

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

Filing Claim Forms

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

Proof of Continuing Disability

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

Proof of Financial Loss

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

1. statements of Monthly Earnings and other written Proof of Your pre-disability income;
2. statements of income received from other sources while You are claiming benefits under the Policy;
3. evidence that due application has been made for all other available benefits;
4. tax returns and worksheets, tax statements, and accountant's statements; *and*
5. any other Proof that We may reasonably require.

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

Payment of Claims

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

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

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

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

Notice of Claim Decisions

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

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

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

Reconsideration of a Denied Claim

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

- Send Us written comments;
- Review any non-privileged information relating to Your claim; *and*

- Provide Us with other information or Proof in support of Your claim.

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

Legal Actions

There are time limits as to when legal action can be taken to obtain Policy benefits. No legal action can be taken until 60 days after Written Proof of Loss has been given as discussed above. No legal action can be taken more than 3 years after Written Proof of Loss was required by the above terms. Legal action with respect to a claim that has been denied, in whole or in part, shall be contingent upon having obtained Our reconsideration of that claim as explained in the above Reconsideration of a Denied Claim provision.

Examinations

We may require that You undergo an Independent Medical Exam as often as We may reasonably require during the pendancy of claim. No benefits will be paid beyond any date that:

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

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

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

Release of Information

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

Discretionary Authority for Benefit Determination

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

DLS A 0205 C 10

NOTICE OF
PROTECTION PROVIDED BY
VIRGINIA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policy holders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that a life, annuity or health insurance company licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values

- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability [income] insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits

- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000, except for hospital, medical and surgical insurance benefits, for which the limit is increased to $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Virginia law.

To learn more about the above protections, please visit the Association's website at www.valifega.org or contact:

NOTICE OF
PROTECTION PROVIDED BY
VIRGINIA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION

VIRGINIA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION
c/o APM Management Services, Inc.
8001 Franklin Farms Drive, Suite 235
Henrico, VA 23229
804-282-2240

STATE CORPORATION COMMISSION
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218-1157
804-371-9741
Toll Free Virginia only: 1-800-552-7945
http://www.scc.virginia.gov/boi/

Insurance companies and agents are not allowed by Virginia law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Virginia law, the Virginia law will control.

IMPORTANT INFORMATION
REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions, you may contact the insurance company issuing this insurance at the following address and telephone number:

Anthem Life Insurance Company
Post Office Box 182361
Columbus, Ohio 43218-2361
Toll-Free: (866)-551-0326

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

P.O. Box 1157
Richmond, Virginia 23218-1157

Toll Free inside Virginia: (800) 552-7945
Toll-free outside Virginia: 1-877-310-6560

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

Anthem Life Insurance Company
Administrative Office
8940 Lyra Drive
Suite 300
Columbus, Ohio 43240
1 (614) 436-0688
1 (800) 551-7265

AnthemLife

anthemlife.com