

CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION ACT

SUMMARY DOCUMENT AND DISCLAIMER

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

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

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

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

Policyholders with additional questions should first contact their insurer or agent or may then contact:

The California Life and Health Insurance Guarantee Association

PO Box 17319

Beverly Hills CA 90209-3319

OR

Consumer Services Division

California Department of Insurance

300 South Spring St, South Tower

Los Angeles CA 90013

The state law that provides for this safety-net coverage is called the California Life and Health Guarantee Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Association.

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

Their insurer was not authorized to do business in this state when it issued the policy or contract;

Their policy was issued by a health care service plan (HMO, Blue Cross, Blue Shield), a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society;

They are eligible for protection under the laws of another state. This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.

The Guarantee Association also does not provide coverage for:

Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which guarantee rights to group contract holders, not individuals;

Employer or association plans, to the extent they are self-funded or uninsured;

Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

Any policy of reinsurance unless an assumption certificate was issued;

Interest rate yields that exceed an average rate;

Any portion of a contract that provides dividends or experience rating credits.

LIMITS ON AMOUNT OF COVERAGE

The Act limits the Association to pay benefits as follows:

LIFE AND ANNUITY BENEFITS

80% of what the insurance company would owe under a policy or contract up to \$100,000 in cash surrender values,

\$100,000 in present value of annuities, or

\$250,000 in life insurance death benefits.

A maximum of \$250,000 for any one insured life no matter how many policies and contracts there were with the same company, even if the policies provided different types of coverages.

HEALTH BENEFITS

A maximum of \$200,000 of the contractual obligations that the health insurance company would owe were it not insolvent. The maximum may increase or decrease annually based upon changes in the health care cost component of the consumer price index.

PREMIUM SURCHARGE

Member insurers are required to recoup assessments paid to the Association by way of a surcharge on premiums charged for health insurance policies to which the Act applies.

CALIFORNIA NOTICE OF COMPLAINT PROCEDURE

Should any dispute arise about your premium or about a claim that you have filed, write to the company that issued the group policy at:

**Standard Insurance Company
PO Box 2177
Portland, OR 97208-2177
(888) 937-4783**

If the problem is not resolved, you may also write to the State of California at:

**Department of Insurance
Consumer Services Division
300 S. Spring Street, 11th FL
Los Angeles, CA 90013
1-800-927-HELP (4357)**

This notice of complaint procedure is for information only and does not become a part or condition of this group policy/certificate.

STANDARD INSURANCE COMPANY

A Stock Life Insurance Company
900 SW Fifth Avenue
Portland, Oregon 97204-1282
(503) 321-7000

CERTIFICATE

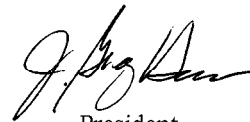
GROUP SHORT TERM DISABILITY INSURANCE

Policyholder:	City of Los Angeles
Policy Number:	630363-E
Effective Date:	January 1, 2011

The Group Policy has been issued to the Policyholder. We certify that you will be insured as provided by the terms of your Employer's coverage under the Group Policy. If the terms of this Certificate differ from the terms of your Employer's coverage under the Group Policy, the latter will govern. If your coverage is changed by an amendment to the Group Policy, we will provide the Employer with a revised Certificate or other notice to be given to you.

Possession of this Certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this Certificate.

"You" and "your" mean the Member. "We", "us" and "our" mean Standard Insurance Company. Other defined terms appear with the initial letters capitalized. Section headings, and references to them, appear in boldface type.



President

IMPORTANT NOTICE

To

Members insured under Group Policy 630363-E
issued to City of Los Angeles as Policyholder.

Effective January 1, 2011, the definition of Predisability Earnings in the section entitled **Predisability Earnings** has been amended to provide the following:

1. If the number of hours you work each biweekly pay period is reduced under Section 4.117 (Reduced Work Schedule) of the Los Angeles Administrative Code, your Predisability Earnings will be based on the earnings you would be receiving from the Employer if your work hours had not been reduced, including any cost of living increases.
2. If the number of hours you work is reduced under the Employer's mandated furlough program from January 1, 2011, through June 30, 2011, your Predisability Earnings for the period of that furlough program will be based on your Predisability Earnings that would have been in effect if your work hours had not been reduced, including any cost of living increases.

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COVERAGE FEATURES

This section contains many of the features of your short term disability (STD) insurance. Other provisions, including exclusions, limitations, and Deductible Income appear in other sections. Please refer to the text of each section for full details. The Table of Contents and the Index of Defined Terms help locate sections and definitions.

GENERAL POLICY INFORMATION

Group Policy Number: 630363-E
Policyholder: City of Los Angeles
Employer: City of Los Angeles
Group Policy Effective Date: January 1, 2011
Policy Issued in: California

Member means:

1. An active civilian employee of the Employer who is Actively At Work and regularly working at least 40 hours each pay period; or
2. An active half-time civilian employee of the Employer who is Actively At Work and regularly working at least 20 hours each pay period; and
3. One of the following:
 - a. A contributing member of the City Employees' Retirement System and not represented by an employee representation unit; or
 - b. Eligible for membership in one of the employee representation units for which an Employer-sponsored short term disability plan has been negotiated in a Memorandum Of Understanding (MOU); or
 - c. An active elected official or member of the Board of Public Works of the Employer.

For purposes of the Member definition, Actively At Work will include regularly scheduled days off, holidays, or vacation days, so long as the person is capable of Active Work on those days.

Member does not include: an employee classified by the Employer as a fire or police sworn employee who is not a LACERS member, or an employee of the Department of Water and Power; a part-time, intermittent, temporary or seasonal employee, or an employee in a similar position; or a full-time member of the armed forces of any country.

SCHEDULE OF INSURANCE

Eligibility Waiting Period: You are eligible on the later of:

1. The Group Policy Effective Date; and
2. The date you become a Member.

Eligibility Waiting Period means the period you must be a Member before you become eligible for insurance.

You may be insured under either Plan 1 or Plan 2, but not both. You will be insured under Plan 1 unless you are insured under Plan 2. If you cease paying premiums for Plan 2, you will automatically be insured under Plan 1.

Weekly STD Benefit:

Plan 1 (basic plan): 50% of the first \$1,384 of your weekly Predisability Earnings, reduced by Deductible Income.

Plan 2 (supplemental plan): 66 2/3% of the first \$4,157 of your weekly Predisability Earnings, reduced by Deductible Income.

Maximum weekly STD Benefit:

Plan 1: \$692 before reduction by Deductible Income.

Plan 2: \$2,771 before reduction by Deductible Income.

Minimum weekly STD Benefit:

\$15

Benefit Waiting Period:

The period for which you receive 100% or 75% sick leave pay under the Employer's sick leave plan.

Maximum Benefit Period:

180 days. However, STD Benefits will end on the date long term disability benefits become payable to you under a group plan provided by your Employer, even if that occurs before the end of the Maximum Benefit Period.

STD Benefits are paid weekly. However, if you are Disabled for less than one full week, we will pay one-seventh of the STD Benefit for each day of Disability.

PREMIUM CONTRIBUTIONS

Insurance is:

Plan 1: Noncontributory

Plan 2: Contributory; you and your Employer share the cost of coverage

The cost of insurance may be funded by contributions to an IRC Section 125 Cafeteria Plan.

INSURING CLAUSE

If you become Disabled while insured under the Group Policy, we will pay STD Benefits according to the terms of the Group Policy after we receive Proof Of Loss.

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WHEN YOUR INSURANCE BECOMES EFFECTIVE

A. Noncontributory Insurance

Subject to the Active Work Provisions, your Noncontributory insurance becomes effective on the later of (a) the date you become eligible, and (b) the date your enrollment form is received by Benefits Service Center, unless you become insured for Contributory insurance.

B. Contributory Insurance

You must apply in writing for Contributory insurance and agree to pay premiums. Subject to the Active Work Provisions, your Contributory insurance becomes effective on the later of (a) the date you become eligible, and (b) the following applicable date:

1. The date your enrollment form is received by Benefits Service Center, if it is received within 60 days after you become eligible.
2. The later of (a) the first day of the plan year following an Annual Enrollment Period during which you apply, and (b) the date we approve your Evidence Of Insurability.
3. The later of (a) the date of a Family Status Change, or (b) the date your enrollment form is received by Benefits Service Center, if it is received within 30 days after a Family Status Change.

Annual Enrollment Period means the period designated each year by your Employer when you may change insurance elections.

Family Status Change means:

1. Your marriage or divorce.
2. The beginning or ending of a domestic partner relationship.
3. Death of your Spouse/Domestic Partner.
4. Death of your dependent child or the dependent child of your Domestic Partner.
5. Birth or adoption of a dependent child.
6. Termination or commencement of employment for your Spouse/Domestic Partner.
7. A change from part-time to full-time employment status or from full-time to part-time employment status by you or your Spouse/Domestic Partner.
8. Taking of a leave of absence from employment by your Spouse/Domestic Partner.

The addition of Contributory coverage must be consistent with the nature of the Family Status Change.

C. Evidence Of Insurability Requirement

Evidence Of Insurability satisfactory to us is required:

- a. For late application for Contributory insurance (your enrollment form is received by Benefits Service Center more than 60 days after you become eligible). However, Evidence Of Insurability is not required if your enrollment form is received by Benefits Service Center within 30 days following a Family Status Change.

- b. To become insured for Contributory insurance if you were eligible under the Prior Plan for more than 60 days but were not insured (except as provided for a Family Status Change).
- c. For reinstatements if required.

Providing Evidence Of Insurability means you must:

1. Complete and sign our medical history statement;
2. Sign our form authorizing us to obtain information about your health;
3. Undergo a physical examination, if required by us (which may include blood testing); and
4. Provide any additional information about your insurability that we may reasonably require.

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ACTIVE WORK PROVISIONS

A. Active Work Requirement

You must be capable of Active Work on the day before the scheduled effective date of your insurance or your insurance will not become effective as scheduled. If you are incapable of Active Work because of Physical Disease, Injury, Pregnancy or Mental Disorder on the day before the scheduled effective date of your insurance, your insurance will not become effective until the day after you complete one full day of Active Work as an eligible Member.

Active Work and Actively At Work mean performing with reasonable continuity the Substantial And Material Acts of your Own Occupation at your Employer's usual place of business.

B. Changes In Insurance

This Active Work requirement also applies to any increase in your insurance.

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WHEN YOUR INSURANCE ENDS

Your insurance ends automatically on the earliest of:

1. The date the last period ends for which a premium contribution was made for your insurance, if your insurance is Contributory.
2. The date the Group Policy terminates.
3. The date your employment terminates. However, if your employment terminates because you retire, or because you are promoted to work for or are transferred to the City of Los Angeles Department of Water & Power, insurance ends on the last day of the calendar month in which you retire or are promoted/transferred to the City of Los Angeles Department of Water & Power.
4. The date you cease to be a Member or enter a non-pay status with the Employer. However, your insurance will be continued during the following periods when you are absent from Active Work, unless it ends under any of the above.
 - a. During the first 90 days of a temporary or indefinite administrative or involuntary leave of absence or sick leave, provided your Employer is paying you at least the same Predisability Earnings paid to you immediately before you ceased to be a Member. A period when you are absent from Active Work as part of a severance or other employment termination agreement is not a leave of absence, even if you are receiving the same Predisability Earnings.
 - b. During a leave of absence if continuation of your insurance under the Group Policy is required by a state-mandated family or medical leave act or law.

- c. During any other temporary leave of absence approved by your Employer in advance and in writing and scheduled to last 30 days or less. A period of Disability is not a leave of absence.
- d. During the first six months in which you are in a non-pay status, provided you pay premiums for the entire amount of your insurance continued during the period of your non-pay status (including premiums previously paid by the Employer) and you remain insured under the same Plan.
- e. During the Benefit Waiting Period and while STD Benefits are payable.

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REINSTATEMENT OF INSURANCE

If your insurance ends, you may become insured again as a new Member. However, the following will apply:

1. If you are insured for Noncontributory insurance, your insurance ends because you are in a non-pay status, and you return to a pay status with the Employer within the same calendar year, you will be required to provide Evidence Of Insurability if you wish to become insured for Contributory insurance.
2. If your insurance ends because you fail to make a required premium contribution, you must provide Evidence Of Insurability to become insured again.
3. If your insurance ends because you are on a federal or state-mandated family or medical leave of absence, and you become a Member again immediately following the period allowed, your insurance will be reinstated pursuant to the federal or state-mandated family or medical leave act or law.
4. In no event will insurance be retroactive.

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DEFINITION OF DISABILITY

You are Disabled if you meet either of the following definitions:

1. Definition of Total Disability; or
2. Definition of Partial Disability.

You are required to be Totally Disabled or Partially Disabled from your Own Occupation.

1. Total Disability Definition: You are Totally Disabled from your Own Occupation if, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder, you are unable to perform with reasonable continuity the Substantial And Material Acts necessary to pursue your Own Occupation and you are not working in your Own Occupation.
2. Partial Disability Definition: You are Partially Disabled from your Own Occupation if you are not Totally Disabled and you are actually working in your Own Occupation but, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder, you are unable to earn 80% or more of your Predisability Earnings.

Note: You are not Disabled from your Own Occupation merely because your right to perform your Own Occupation is restricted, including a restriction or loss of license. The loss of a professional license, occupational license, or certification does not, in itself, constitute Disability.

You may work in another occupation while you meet the definition of Disability. However, your Work Earnings may be Deductible Income and STD Benefits will end when your Work Earnings meet or exceed 80% of your Predisability Earnings. See **Return To Work Provisions, Deductible Income, and When STD Benefits End.**

Own Occupation may be interpreted to mean the employment, business, trade or profession that involves the Substantial And Material Acts of the occupation you are regularly performing for your Employer when Disability begins. Own Occupation is not necessarily limited to the specific job you perform for your Employer.

Substantial And Material Acts means the important tasks, functions and operations generally required by employers from those engaged in your Own Occupation that cannot be reasonably omitted or modified. In determining what Substantial And Material Acts are necessary to pursue your Own Occupation, we will first look at the specific duties required by your job. If you are unable to perform one or more of these duties with reasonable continuity, we will then determine whether those duties are customarily required of other individuals engaged in your Own Occupation. If any specific, material duties required of you by your job differ from the material duties customarily required of other individuals engaged in your Own Occupation, then we will not consider those duties in determining what Substantial And Material Acts are necessary to pursue your Own Occupation.

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RETURN TO WORK PROVISIONS

A. Return To Work Incentive

You may serve your Benefit Waiting Period while working if you meet the Definition of Disability.

You are eligible for the Return To Work Incentive on the first day you work after the Benefit Waiting Period if STD Benefits are payable on that date.

Your Work Earnings will be Deductible Income as determined in 1., 2. and 3:

1. Determine the amount of your STD Benefit as if there were no Deductible Income, and add your Work Earnings to that amount.
2. Determine 100% of your Predisability Earnings.
3. If a. is greater than b., the difference will be Deductible Income.

B. Work Earnings Definition

Work Earnings means your gross weekly earnings from work you perform while Disabled. Work Earnings includes:

1. Earnings from your Employer.
2. Any sick pay, vacation pay, annual or personal leave pay or other salary continuation earned or accrued while working.

Earnings from work you perform will be included in Work Earnings when you have the right to receive them. If you are paid in a lump sum or on a basis other than weekly, we will prorate your Work Earnings over the period of time to which they apply. If no period of time is stated, we will use a reasonable one.

In determining your Work Earnings we:

1. Will use the financial accounting method you use for income tax purposes, if you use that method on a consistent basis.
2. Will not be limited to the taxable income you report to the Internal Revenue Service.
3. May ignore expenses under section 179 of the IRC as a deduction from your gross earnings.
4. May ignore depreciation as a deduction from your gross earnings.
5. May adjust the financial information you give us in order to clearly reflect your Work Earnings.

If we determine that your earnings vary substantially from month to month, we may determine your Work Earnings by averaging your earnings over the most recent three-month period. STD Benefits will end on the date your average Work Earnings over the last three months equal or exceed 80% of your Predisability Earnings.

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TEMPORARY RECOVERY

You may temporarily recover from your Disability during the Maximum Benefit Period, and then become Disabled again from the same cause or causes, without having to serve a new Benefit Waiting Period. Temporary Recovery means you cease to be Disabled for no longer than the applicable allowable period. See **Definition Of Disability**.

A. Allowable Period

The allowable period of recovery during the Maximum Benefit Period is: a total of 30 days of recovery.

B. Effect Of Temporary Recovery

If your Temporary Recovery does not exceed the Allowable Period, the following will apply.

1. The Predisability Earnings used to determine your STD Benefit will not change.
2. The period of Temporary Recovery will not count toward your Maximum Benefit Period.
3. No STD Benefits will be payable for the period of Temporary Recovery.
4. No STD Benefits will be payable after benefits become payable to you under any other disability insurance plan under which you become insured through employment during your period of Temporary Recovery.
5. Except as stated above, the provisions of the Group Policy will be applied as if there had been no interruption of your Disability.

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WHEN STD BENEFITS END

Your STD Benefits end automatically on the earliest of:

1. The date you are no longer Disabled.
2. The date your Maximum Benefit Period ends.
3. The date you die.
4. The date you begin working for an employer other than your Employer, or become self-employed.
5. The date long term disability benefits become payable to you under a group long term disability policy, even if that occurs before the end of the Maximum Benefit Period.
6. The date benefits become payable to you under any other disability insurance plan under which you become insured through employment during a period of Temporary Recovery.
7. The date you fail to provide proof of continued Disability and entitlement to STD Benefits.
8. The date your Work Earnings equal or exceed 80% of your Predisability Earnings.

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PREDISABILITY EARNINGS

Your Predisability Earnings will be based on your earnings in effect on your last full day of Active Work. Any subsequent change in your earnings after that last full day of Active Work will not affect your Predisability Earnings.

Predisability Earnings means your weekly rate of earnings from your Employer, including:

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.
4. Bonuses as defined by the Los Angeles City Employees' Retirement System.

Predisability Earnings does not include:

1. Commissions.
2. Overtime pay.
3. Your Employer's contributions on your behalf to any deferred compensation arrangement or pension plan.
4. Any other extra compensation.

If you are paid on an annual contract basis, your weekly rate of earnings is one fifty-second (1/52nd) of your annual contract salary.

If you are paid hourly, your weekly rate of earnings is based on your hourly pay rate multiplied by the number of hours you are regularly scheduled to work per week, 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 during the preceding 52 weeks (or during your period of employment if less than 52 weeks), but not more than 40 hours.

If the number of hours you work each biweekly pay period is reduced under Section 4.117 (Reduced Work Schedule) of the Los Angeles Administrative Code, your Predisability Earnings will be based on the earnings you would be receiving from the Employer if your work hours had not been reduced.

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DEDUCTIBLE INCOME

Subject to **Exceptions To Deductible Income**, Deductible Income means:

1. Sick pay, annual or personal leave pay, severance pay, or other salary continuation, (but not vacation pay) paid to you by your Employer.
2. Your Work Earnings, as described in the **Return To Work Provisions**.
3. Any amount you receive or are entitled to receive because of your disability under a state disability income benefit law or similar law.
4. Any amount you receive because of your disability under any other group insurance coverage, as determined below:
 - a. Determine the amount of your STD Benefit as if there were no Deductible Income, add the amount you receive from any other insurance coverage because of your disability.

- b. Determine 80% of your Predisability Earnings.
 - c. If a. is greater than b., the difference will be Deductible Income.
5. Any amount you receive by compromise, settlement, or other method as a result of a claim for any of the above, whether disputed or undisputed.

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EXCEPTIONS TO DEDUCTIBLE INCOME

Deductible Income does not include:

- 1. Any cost of living increase in any Deductible Income other than Work Earnings, if the increase becomes effective while you are Disabled and while you are eligible for the Deductible Income.
- 2. Reimbursement for hospital, medical, or surgical expense.
- 3. Reasonable attorneys fees incurred in connection with a claim for Deductible Income.
- 4. Benefits from any individual disability insurance policy.
- 5. Group credit or mortgage disability insurance benefits.
- 6. Accelerated death benefits paid under a life insurance policy.

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RULES FOR DEDUCTIBLE INCOME

A. Weekly Equivalents

Each week we will determine your STD Benefit using the Deductible Income for the same weekly period, even if you actually receive the Deductible Income in another week.

If you are paid Deductible Income in a lump sum or by a method other than weekly, we will determine your STD Benefit using a prorated amount. We will use the period of time to which the Deductible Income applies. If no period of time is stated, we will use a reasonable one.

B. Your Duty To Pursue Deductible Income

You must pursue Deductible Income for which you may be entitled. We may ask for written documentation of your pursuit of Deductible Income. You must provide it within 60 days after we mail you our request.

C. Estimating and Deducting

For any item of Deductible Income that includes amounts you are entitled to receive, we may reduce your STD Benefit by the amount we estimate you would be entitled to receive if:

- 1. You have failed to pursue the Deductible Income with reasonable diligence;
- 2. We have a reasonable, good faith belief that you are entitled to the Deductible Income; and
- 3. We are able to reasonably estimate the amount that would be payable.

We will not estimate and deduct amounts with respect to a claim for Deductible Income that is pending, so long as you continue to pursue the claim with reasonable diligence.

D. Pending Deductible Income

We will not deduct pending Deductible Income until it becomes payable. You must notify us of the amount of the Deductible Income when it is approved. You must repay us for the resulting overpayment of your claim.

E. Overpayment Of Claim

We will notify you of the amount of any overpayment of your claim under any group disability insurance policy issued by us. You must immediately repay us. You will not receive any STD Benefits until we have been repaid in full. In the meantime, any STD Benefits paid, including the Minimum STD Benefit, will be applied to reduce the amount of the overpayment. We may charge you interest at the legal rate for any overpayment which is not repaid within 30 days after we first mail you notice of the amount of the overpayment.

ST.RU.CA.1X

BENEFITS AFTER INSURANCE ENDS OR IS CHANGED

During each period of continuous Disability, we will pay STD Benefits according to the terms of the Group Policy in effect on the date you become Disabled. Your right to receive STD Benefits will not be affected by:

1. Any amendment to the Group Policy that is effective after you become Disabled; or
2. Termination of the Group Policy after you become Disabled.

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EFFECT OF NEW DISABILITY

If a period of Disability is extended by a new cause while STD Benefits are payable, STD Benefits will continue while you remain Disabled. However, 1 and 2 below will apply.

1. STD Benefits will not continue beyond the end of the original Maximum Benefit Period.
2. All provisions of the Group Policy, including the **Disabilities Excluded From Coverage** and **Limitations** sections, will apply to the new cause of Disability.

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DISABILITIES EXCLUDED FROM COVERAGE

A. War

You are not covered for a Disability caused or contributed to by War or any act of War. War means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.

B. Intentionally Self-Inflicted Injury

You are not covered for a Disability caused or contributed to by an intentionally self-inflicted Injury, while sane or insane.

C. Work Related

You are not covered for a Disability arising out of or in the course of any employment for wage or profit.

(NONOCC) ST.XD.CA.1X

LIMITATIONS

A. Care Of A Physician

During the Benefit Waiting Period, you must be receiving care by a Physician which is appropriate for the condition or conditions causing the Disability. No STD Benefits will be paid for any period of Disability when you are not receiving care by a Physician which is appropriate for the condition

or conditions causing the Disability. Appropriate care is the treatment a patient would make a reasonable decision to accept after duly considering the opinions of medical professionals. This limitation will not apply after you reach your maximum point of recovery.

B. Occupational Benefits

No STD Benefits will be paid for any period when you are eligible to receive benefits for your Disability under a workers' compensation law or similar law. If your claim for these benefits is accepted, compromised or settled (whether disputed or undisputed), you must repay us for the full amount of any payments we make to you while your claim for occupational benefits is pending.

C. Working

No STD Benefits will be paid for any period: (a) when you are working for wage or profit for any employer other than your Employer; or (b) when you are self-employed. This limitation applies whether you are working in your own or another occupation

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CLAIMS

A. Notice of Claim

Written notice of claim must be provided to us within 60 days after the date you claim you became Disabled, or as soon thereafter as is reasonably possible.

B. Filing A Claim

Claims should be filed on our forms. If we do not provide our forms within 15 days after they are requested, you may submit your claim in a letter to us. The letter should include the date Disability began, and the cause and nature of the Disability. Subject to the time period for providing notice of claim, such letter will constitute notice and proof of claim.

C. Time Limits On Filing Proof Of Loss

You must give us Proof Of Loss within 90 days after the end of the Benefit Waiting Period. If your claim was closed, you must give us Proof of Loss within 90 days after the date STD Benefits ended. If you cannot do so, you must give it to us as soon as reasonably possible, but not later than one year after that 90-day period. If Proof Of Loss is filed outside these time limits, your claim will be denied. These limits will not apply while you lack legal capacity.

D. Proof Of Loss

Proof Of Loss means written proof that you are Disabled and entitled to STD Benefits. Proof Of Loss must be provided at your expense.

For claims of Disability due to conditions other than Mental Disorders, we may require proof of physical impairment that results from anatomical or physiological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. Examples of clinical and laboratory diagnostic techniques include but are not limited to actual observations upon physical examinations, blood tests, imaging studies (such as x-rays, MRIs and CT scans), electrocardiograms (EKG) and electroencephalograms (EEG).

E. Documentation

Completed claims statements, a signed authorization for us to obtain information, and any other items we may reasonably require in support of a claim must be submitted at your expense. If the required documentation is not provided within 45 days after we mail our request, your claim may be denied.

F. Investigation Of Claim

We may investigate your claim at any time.

At our expense, we may have you examined at reasonable intervals by specialists of our choice. We may deny or suspend STD Benefits if you fail to attend an examination or cooperate with the examiner.

G. Time Of Payment

We will pay STD Benefits within 60 days after you satisfy Proof Of Loss.

STD Benefits will be paid to you at the end of each week you qualify for them. STD Benefits remaining unpaid at your death will be paid to your estate.

H. Notice Of Decision On Claim

We will evaluate your claim promptly after you file it. Within 45 days after we receive your claim we will send you: (a) a written decision on your claim; or (b) a notice that we are extending the period to decide your claim for 30 days. Before the end of this extension period we will send you: (a) a written decision on your claim; or (b) a notice that we are extending the period to decide your claim for an additional 30 days. If an extension is due to your failure to provide information necessary to decide the claim, the extended time period for deciding your claim will not begin until you provide the information or otherwise respond.

If we extend the period to decide your claim, we will notify you of the following: (a) the reasons for the extension; (b) when we expect to decide your claim; (c) an explanation of the standards on which entitlement to benefits is based; (d) the unresolved issues preventing a decision; and (e) any additional information we need to resolve those issues.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

- a. The reasons for our decision.
- b. Reference to the parts of the Group Policy on which our decision is based.
- c. Reference to any internal rule or guideline relied upon in making our decision.
- d. A description of any additional information needed to support your claim.
- e. Information concerning your right to a review of our decision.

I. Review Procedure

If all or part of a claim is denied, you may request a review. You must request a review in writing within 180 days after receiving notice of the denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your request for review. There will be no charge for such copies. You may request the names of medical or vocational experts who provided advice to us about your claim.

The person conducting the review will be someone other than the person who denied the claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based on a medical judgment, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original medical judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request. Within 45 days after we receive your request for review we will send you: (a) a written decision on review; or (b) a notice that we are extending the review period for 45 days. If the extension is due to your failure to provide

information necessary to decide the claim on review, the extended time period for review of your claim will not begin until you provide the information or otherwise respond.

If we extend the review period, we will notify you of the following: (a) the reasons for the extension; (b) when we expect to decide your claim on review; and (c) any additional information we need to decide your claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may conclude our review of your claim based on the information we have received.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

- a. The reasons for our decision.
- b. Reference to the parts of the Group Policy on which our decision is based.
- c. A description of any additional information needed to support your claim.
- d. Information concerning your right to a review of our decision.

J. Assignment

The rights and benefits under the Group Policy are not assignable.

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TIME LIMITS ON LEGAL ACTIONS

No action at law or in equity may be brought until 60 days after you have given us Proof Of Loss. No such action may be brought after the expiration of three years after the date Proof of Loss is required to be given.

ST.TL.CA.1

INCONTESTABILITY PROVISIONS

A. Incontestability Of Insurance

Any statement you make to obtain or to increase insurance is a representation and not a warranty.

No misrepresentation will be used to reduce or deny a claim or contest the validity of insurance unless:

1. The insurance would not have been approved if we had known the truth; and
2. We have given you or any person claiming benefits a copy of the signed written instrument which contains your misrepresentation.

After insurance has been in effect for two years, during your lifetime, we will not use a misrepresentation by you to reduce or deny your claim, unless it was a fraudulent misrepresentation.

B. Incontestability Of The Group Policy

Any statement made by the Policyholder or Employer to obtain the Group Policy is a representation and not a warranty.

No misrepresentation by the Policyholder or your Employer will be used to deny a claim or to deny the validity of the Group Policy unless:

1. The Group Policy would not have been issued if we had known the truth; and
2. We have given the Policyholder or Employer a copy of a written instrument signed by the Policyholder or Employer which contains the misrepresentation.

The validity of the Group Policy will not be contested after it has been in force for two years, except for fraudulent misrepresentations.

ST.IN.CA.1

CLERICAL ERROR, AGENCY AND MISSTATEMENT

A. Clerical Error

Clerical error by the Policyholder, your Employer, or their respective employees or representatives will not:

1. Cause a person to become insured.
2. Invalidate insurance under the Group Policy otherwise validly in force.
3. Continue insurance under the Group Policy otherwise validly terminated.

B. Agency

The Policyholder and your Employer act on their own behalf as your agent, and not as our agent. The Policyholder and your Employer have no authority to alter, expand or extend our liability or to waive, modify or compromise any defense or right we may have under the Group Policy.

C. Misstatement Of Age

If a person's age has been misstated, we will make an equitable adjustment of premiums, benefits, or both. The adjustment will be based on:

1. The amount of insurance based on the correct age; and
2. The difference between the amount paid and the amount which would have been paid if the age had been correctly stated.

ST.CE.OT.1

TERMINATION OR AMENDMENT OF THE GROUP POLICY

The Group Policy may be terminated by us or the Policyholder according to its terms. It will terminate automatically for nonpayment of premium. The Policyholder may terminate the Group Policy in whole, and may terminate insurance for any class or group of Members, at any time by giving us written notice.

Benefits under the Group Policy are limited to its terms, including any valid amendment. No change or amendment will be valid unless it is approved in writing by one of our executive officers and given to the Policyholder for attachment to the Group Policy. If the terms of the certificate differ from the Group Policy, the terms stated in the Group Policy will govern. The Policyholder, your Employer, and their respective employees or representatives have no right or authority to change or amend the Group Policy or to waive any of its terms or provisions without our signed written approval.

We may change the Group Policy in whole or in part when any change or clarification in law or governmental regulation affects our obligations under the Group Policy, or with the Policyholder's consent.

Any such change or amendment of the Group Policy may apply to current or future Members or to any separate classes or groups of Members.

ST.TA.OT.1

DEFINITIONS

Benefit Waiting Period means the period you must be continuously Disabled before STD Benefits become payable. No STD Benefits are payable for the Benefit Waiting Period. See **Coverage Features**.

Contributory means insurance is elective and Members pay all or part of the premium for insurance.

Eligibility Waiting Period means the period you must be a Member before you become eligible for insurance. Your Eligibility Waiting Period is shown in the **Coverage Features**.

Employer means an employer (including approved affiliates and subsidiaries) for which coverage under the Group Policy is approved in writing by us.

Group Policy means the group STD insurance policy issued by us to the Policyholder and identified by the Group Policy Number.

Hospital means a legally operated hospital providing full-time medical care and treatment under the direction of a full-time staff of licensed physicians. Rest homes, nursing homes, convalescent homes, homes for the aged, and facilities primarily affording custodial, educational, or rehabilitative care are not Hospitals.

Injury means an injury to the body.

Maximum Benefit Period means the longest period for which STD Benefits are payable for any one period of continuous Disability, whether from one or more causes. It begins at the end of the Benefit Waiting Period. No STD Benefits are payable after the end of the Maximum Benefit Period, even if you are still Disabled. See **Coverage Features**.

Mental Disorder means any mental, emotional, behavioral, psychological, personality, cognitive, mood or stress-related abnormality, disorder, disturbance, dysfunction or syndrome, regardless of cause (including any biological or biochemical disorder or imbalance of the brain) or the presence of physical symptoms. Mental Disorder includes, but is not limited to, bipolar affective disorder, organic brain syndrome, schizophrenia, psychotic illness, manic depressive illness, depression and depressive disorders, anxiety and anxiety disorders.

Noncontributory means (a) insurance is nonelective and the Policyholder or Employer pay the entire premium for insurance; or (b) the Policyholder or Employer require all eligible Members to have insurance and to pay all or part of the premium for insurance.

Physical Disease means a physical disease entity or process that produces structural or functional changes in your body as diagnosed by a Physician.

Physician means a licensed medical professional, diagnosing and treating individuals within the scope of the license. The term includes a legally licensed physician, dentist, optometrist, podiatrist, psychologist or chiropractor. Physician does not include you or your Spouse/Domestic Partner, or the brother, sister, parent or child of either you or your Spouse/Domestic Partner.

Pregnancy means your pregnancy, childbirth, or related medical conditions, including complications of pregnancy.

Prior Plan means your Employer's group short term disability insurance plan in effect on the day before the effective date of your Employer's coverage under the Group Policy and which is replaced by the Group Policy.

Spouse/Domestic Partner means:

1. A person to whom you are legally married; or
2. Your Domestic Partner. Domestic Partner means an individual with whom you have completed an affidavit of declaration of domestic partnership, submitted that affidavit to the Employer, and filed that affidavit for public record if required by law; or an individual recognized as your domestic partner under California state law.

STD Benefit means the weekly benefit payable to you under the terms of the Group Policy.

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