COUNTY OF HENRICO
DEPARTMENT OF FINANCE
PURCHASING DIVISION
CONTRACT EXTRACT
NOTICE OF AWARD/RENEWAL

DATE:	October 30, 2023
CONTRACT COMMODITY/SERVICE: *(include contracting entity if cooperative)*	Group Short-Term Disability and Long-Term Disability Program for VRS Hybrid Participants
CONTRACT NUMBER:	2530A
COMMODITY CODE:	953.37
CONTRACT PERIOD:	October 30, 2023 through December 31, 2026
RENEWAL OPTIONS:	Two one-year renewal options through 2028
USER DEPARTMENT:	Human Resources
Contact Name:	Lauren Taylor (Gen Gov't) / Tina Brooks (Schools)
Phone Number:	804.501.4302 / 804.652.3625
Email Address:	tay151@henrico.us / tmbrooks@henrico.k12.va.us
HENRICO COOPERATIVE TERMS INCLUDED:	Yes
SUPPLIER: Name:	Standard Insurance Company
Address:	1100 SW 6th Avenue
City, State:	Portland, Oregon 97204
Contact Name:	Stephen Lovings
Phone Number:	804.980.6031
Email address:	slovings@standard.com
ORACLE SUPPLIER NUMBER:	153441
BUSINESS CATEGORY:	Non-SWAM
PAYMENT TERMS:	Per Contract
DELIVERY:	As Required
FOB:	Destination
BUYER: Name:	Oscar Knott, CPP, CPPO, VCO
Title:	Purchasing Director
Phone:	804.501.5649
Email:	kno008@henrico.us

This contract is the result of a competitive solicitation issued by the Department of Finance, Purchasing Division. A requisition must be generated for all purchases made against this contract and the requisition must reference the contract number.

PRICE SCHEDULE – CONTRACT NO. 2530A

Employee Group	Rate: % of Creditable Compensation
Henrico County General Government	0.50
Henrico County Public Schools – Professionals *(Professionals means all Henrico County Public Schools teachers, administrators, and administrative support staff.)*	0.23
Henrico County Public Schools – Non-Professionals *(Non-Professionals means all Henrico County Public Schools employees other than Professionals)*	0.50

COMMONWEALTH OF VIRGINIA

County of Henrico

Non-Professional Services Contract
Contract No. 2530A

This Non-Professional Services Contract (this "Contract") entered into this 30th of October 2023, by Standard Insurance Company (the "Contractor") and the County of Henrico, Virginia (the "County").

WHEREAS the County has awarded the Contractor this Contract pursuant to Request for Proposals No. 23-2530-5JOK, as modified by Addendum No. 1 (the "Request for Proposals"), for group short-term disability ("STD") and long-term disability ("LTD") program for VRS hybrid participants.

WITNESSETH that the Contractor and the County, in consideration of the mutual covenants, promises and agreements herein contained, agree as follows:

SCOPE OF CONTRACT: The Contractor shall provide the services to the County as set forth in the Contract Documents.

COMPENSATION: The compensation the County will pay to the Contractor under this Contract shall be pursuant to Exhibit B and C and summarized in the below table:

Employee Group	Rate: % of Creditable Compensation
Henrico County General Government	0.50
Henrico County Public Schools – Professionals *(Professionals means all Henrico County Public Schools teachers, administrators, and administrative support staff.)*	0.23
Henrico County Public Schools – Non-Professionals *(Non-Professionals means all Henrico County Public Schools employees other than Professionals)*	0.50

CONTRACT TERM: The Contract term shall be from Contract execution through December 31, 2026. Implementation of the STD and LTC program shall commence upon execution of the Contract to prepare for STD and LTD program commencement on January 1, 2024. The County may renew the Contract for up to two one-year terms giving 30 days' written notice before the end of the term unless Contractor has given the County written notice that it does not wish to renew at least 90 days before the end of the term.

CONTRACT DOCUMENTS: This Contract hereby incorporates by reference the documents listed below (the "Contract Documents") which shall control in the following descending order:

1. This Non-Professional Services Contract between the County and Contractor.
2. The Negotiated Modifications (Exhibit A).
3. The General Contract Terms and Conditions included in the Request for Proposals.
4. Contractor's Best and Final Offer dated August 31, 2023 (Exhibit B).
5. Contractor's Original Proposal dated June 2023 (Exhibit C).
6. Contractor's Application for Group Insurance (LTD) and STD Self-Funding Plan Application (Exhibit D).
7. Contractor's Group Long Term Disability Insurance Policy (Exhibit E).

8. Contractor's Disability Program Administrative Services Agreement (Exhibit F).
9. Contractor's Program Document – Short Term Disability Income Benefit Program (Exhibit G).
10. The Scope of Services included in the Request for Proposals.

IN WITNESS WHEREOF, the parties have caused this Contract to be duly executed intending to be bound hereby.

Standard Insurance Company
1100 SW 6th Avenue
Portland, OR 97204

Kathleen Quetel
Signature

Kathleen Quetel, 2nd VP, Underwriting
Printed Name and Title

10/27/2023
Date

County of Henrico, Virginia
P.O. Box 90775
Henrico, VA 23273-0775

Signature

Oscar Knott, CPP, CPPO, VCO
Purchasing Director

10/30/23
Date

APPROVED AS TO FORM:

Assistant County Attorney

10-30-23
Date

Exhibit A

NEGOTIATED MODIFICATIONS TO AGREEMENT DOCUMENTS FOR CONTRACT NO. 2530A

These Negotiated Modifications are hereby incorporated into Contract No. 2530A (the "Contract") for Group Short-Term and Long-Term Disability Program for VRS Hybrid Participants as of the effective date of the Contract.

WHEREAS, the County and Contractor desire to agree in writing to modify the final terms and conditions of the Contract.

THEREFORE, in consideration of the Recital set forth above and good and valuable consideration as set forth in the Contract, the parties agree that the Contract Documents are modified as follows as of the date of the Contract:

1. Section V – General Contract Terms and Conditions, Item A, shall be revised to read as follows:

   A. Annual Appropriations

   The contract resulting from this procurement ("Contract") shall be subject to annual appropriations by the Henrico County Board of Supervisors. Should the Board fail to appropriate funds for this Contract, the Contract shall be terminated when existing funds are exhausted. The Successful Offeror ("Successful Offeror" or "Contractor") shall not be entitled to seek redress from the County or its elected officials, officers, agents, employees, or volunteers should the Board of Supervisors fail to make annual appropriations for the Contract. The Successful Offeror shall have no continuing obligation to provide insurance coverage, and the County will be responsible for all premiums due and payable up to the date of termination of the policy.

2. Section V – General Contract Terms and Conditions, Item D, shall be revised to read as follows:

   D. Compensation

   The Successful Offeror must submit a complete invoice for services that are performed under the Contract. The County shall pay the Successful Offeror for satisfactory compliance with the Contract within forty-five (45) days after receipt of a proper invoice.

3. Section V – General Contract Terms and Conditions, Item E, shall be revised to read as follows:

   E. Controlling Law and Venue

   The Contract will be made, entered into, and shall be performed in the County and shall be governed by the applicable laws of the Commonwealth of Virginia without regard to its conflicts of law principles. Any dispute arising out of the Contract, its interpretations, or its performance shall be litigated only in the Henrico County General District Court or the Circuit Court of the County of Henrico, Virginia. Provided, however, the portion of this section regarding venue shall not be interpreted to apply to disputes arising from an adverse benefit determination under the Successful Offeror's group insurance policies.

4. Section V – General Contract Terms and Conditions, Item F, shall be revised to read as follows:

   F. Termination by County

   1. The County may terminate the Contract for cause or for convenience.

   2. Termination for Cause

a. *If the Successful Offeror fails to perform the Contract, in whole or in part, the County shall give the Successful Offeror written notice of the default and the opportunity to cure it by a stated deadline.*
b. *If the Successful Offeror fails to cure its default by the deadline, then the County may terminate the contract, in whole or in part, by providing written notice of termination to the Successful Offeror. The notice of termination shall state the effective date of termination. A partial termination shall set forth the nature and scope of the termination.*
c. *Unless the notice of termination states otherwise, the Successful Offeror shall stop performing the Contract when it receives the notice of termination.*
d. ~~*An equitable adjustment in the Contract price shall be made for unpaid services satisfactorily rendered and goods satisfactorily delivered before the date the Successful Offeror receives the notice of termination minus the County's cost to complete the Successful Offeror's work. The Successful Offeror shall not be entitled to payment for services rendered or goods delivered after the date the Successful Offeror receives the notice of termination or for reimbursement of any cost the Successful Offeror incurs after the date the Successful Offeror receives the notice of termination. If the County's cost to complete the Successful Offeror's work exceeds the unpaid balance due to the Successful Offeror, the County will not owe the Successful Offeror any money; instead, the Successful Offeror shall pay to the County the difference between the unpaid balance due and the County's cost to complete the work.*~~
e. *Unless the parties expressly agree in writing otherwise, the County may transmit notices of default and termination for cause by email, USPS First-Class Mail®, or courier or overnight delivery service. The Successful Offeror shall be deemed to be in receipt of any notice emailed on the day the County sends it. The Successful Offeror shall be deemed to be in receipt of any notice the County sends by USPS First-Class Mail® three business days after the date shown in the postmark. The Successful Offeror shall be deemed to be in receipt of any notice the County sends by courier or overnight delivery service on the date of delivery as confirmed by the courier or overnight delivery service.*
f. *If the Successful Offeror receives two notices of default, the County shall not be obligated to give the Successful Offeror the opportunity to cure any subsequent defaults but may terminate the contract in accordance with this section.*
g. *If it is determined that the Successful Offeror knowingly made a false certification in violation of the Responsible Offeror Certification section of this RFP, the County may terminate the contract for cause. In terminating the contract for this cause, the County shall not be obligated to give the Successful Offeror the opportunity to cure.*
h. *If any act or omission of the Successful Offeror (including the Successful Offeror's employees, agents, subcontractors, and assigns) arising out of the performance of the contract causes any person to suffer bodily injury that involves substantial risk of death, extreme physical pain, protracted and obvious disfigurement, or protracted loss or impairment of the function of a bodily member, organ, or mental faculty, then the County shall not be obligated to give the Successful Offeror the opportunity to cure its default but may terminate the contract in accordance with this section.*
i. *Any remedies this section affords to the County are non-exclusive, and the County may enforce any remedy available at law or in equity in connection with any default of the Successful Offeror. Termination of the Contract for cause does not relieve the Successful Offeror of liability for damages the County sustains because of the Successful Offeror's breach.*

3. *Termination for Convenience*
   a. *The County may terminate the Contract, in whole or in part, whenever the Purchasing Director determines that such termination is in the County's best interest.*

b. *The County must give the Successful Offeror written notice of a termination for convenience. The notice must specify the extent to which the Contract is terminated and the effective termination date. The effective termination date shall be at least seven calendar days after the date the County issues the notice of termination for convenience.*

c. ~~*An equitable adjustment in the Contract price shall be made for unpaid services satisfactorily rendered and goods satisfactorily delivered before the date the Successful Offeror receives the notice of termination. The Successful Offeror shall not be entitled to payment for services rendered or goods delivered after the date the Successful Offeror receives the notice of termination, and the Successful Offeror shall not be entitled to payment for any costs it incurs after the date it receives the notice of termination.*~~

d. *Unless the County's notice specifies otherwise, the Successful Offeror must stop work on the date it receives the notice of termination.*

e. *Unless the parties expressly agree otherwise, the County may transmit notices of termination for convenience by email, USPS First-Class Mail®, or courier or overnight delivery service. The Successful Offeror shall be deemed to be in receipt of any notice emailed on the day the County sends it. The Successful Offeror shall be deemed to be in receipt of any notice sent by USPS First-Class Mail® three business days after the date shown in the postmark. The Successful Offeror shall be deemed to be in receipt of any notice the County sends by courier or overnight delivery service on the date of delivery as confirmed by the courier or overnight delivery service.*

f. *The policyholder may terminate the group policy at any time by giving the Successful Offeror written notice. The effective date of termination will be the later of*
   1. *The date stated in the notice; or*
   2. *The Date the notice is received by the Successful Offeror.*

g. *The policyholder will be responsible for all premiums due and payable up to the date of termination of the policy.*

h. *The Successful Offeror may terminate the group policy as follows:*
   1. *If premium is not paid by the end of the grace period, the group policy will terminate automatically at the end of the grace period.*
   2. *On any premium due date if the number of persons insured is less than the minimum participation shown in the Coverage Features of the group policy.*
   3. *On any premium due date if the Successful Offeror determines that the policyholder has failed to promptly furnish any necessary information requested by the Successful Offeror or has failed to perform any other obligations relating to the group policy.*

   For Items 2 and 3 above, the minimum advance notice of termination by the Successful Offeror shall be 31 days.

   The Successful Offeror shall not be responsible for payment of replacement coverage (the difference between the Contract and purchase price) or the cost to obtain replacement coverage. Charges shall not be deducted from the existing premium due.

   The County shall be responsible for all premiums due and payable up to the date of termination of the policy.

4. Section V – General Contract Terms and Conditions, Item L, shall be revised to read as follows:

L. <u>Testing and Inspection</u>

The County reserves the right to conduct any test/inspection it may deem advisable to assure service conform to the specifications.

The Successful Offeror will permit the County or an agreed-upon, third-party auditor (not a competitor) to perform audits or inspections of pertinent books and records. Audits shall be conducted at one of the Successful Offeror's primary business locations and may be subject to applicable privacy and confidentiality laws and the Successful Offeror's internal privacy and confidentiality policies and procedures. Access to claim records required written authorization from the insured.

Prior to the audit or inspection, the Successful Offeror will hold a discussion between all parties (the County, third-party auditor/inspector and the Successful Offeror) to determine the desired process, as well as the amount of staff time required. If the third-party auditor/inspector anticipates a charge for time based on the audit request, parties will discuss these fees and agree to terms prior to any audit.

5. Section V – General Contract Terms and Conditions, Item M, shall be revised to read as follows:

M. <u>Assignment of Contract</u>
A contract shall not be assignable by the Successful Offeror in whole or in part without written consent of the County. To the extent the Successful Offeror proposes to enter into a subcontracting relationship soley and exclusively for the purpose of providing group insurance coverage to the County, the Successful Offeror shall seek prior consent.

6. Section V – General Contract Terms and Conditions, Item N, shall be revised to read as follows:

N. <u>Indemnification</u>
The Successful Offeror agrees to indemnify, defend, and hold harmless the County (including Henrico County Public Schools), and the County's officers, agents, and employees ("Indemnified Parties") from any damages, liabilities, and costs, including attorneys' fees, arising from any claims, demands, actions, or proceedings made or brought against one or more of the Indemnified Parties by any person, including any employee of the Successful Offeror, related to the provision of any services, the failure to provide any services, or the use of any services or materials furnished (or made available) by the Successful Offeror, provided that such liability is not attributable to the sole negligence of the County.

Individuals selected by the Policyholder or by the County to secure coverage under the Group Policy or to perform their administrative function under it, represent and act on behalf of the person selecting them, and do not represent or act on behalf of the Successful Offeror. The Policyholder, County and such individuals have no authority to alter, expand or extend the Successful Offerors liability or to waive, modify or comprise any defense or right the Successful Offeror may have under the Group Policy. The Policyholder hereby release, hold harmless and indemnify the Successful Offeror from any liability arising from or related to any negligence, error, omission, misrepresentation or dishonesty of any of them or their representatives, agents or employees.

7. Section V – General Contract Terms and Conditions, Item R, shall be revised to read as follows:

R. <u>Ownership of Deliverable and Related Products</u>
1. *The County shall have all rights, title, and interest in or to all specified or unspecified interim and final products, work plans, project reports and/or presentations, data, documentation, computer programs and/or applications, and documentation developed or*

generated during the completion of this project, including, without limitation, unlimited rights to use, duplicate, modify, or disclose any part thereof, in any manner and for any purpose, and the right to permit or prohibit any other person, including the Successful Offeror, from doing so. To the extent that the Successful Offeror may be deemed at any time to have any of the foregoing rights, the Successful Offeror agrees to irrevocably assign and does hereby irrevocably assign such rights to the County. On fully insured plans, the Successful Offeror owns all proprietary business records created in the course of administering the group insurance policy, including, but not limited to, underwriting, sales and claim files. Subject to applicable law and the Successful Offeror's confidentiality policies and procedures, the Successful Offeror may provide copies of records to the County for a reasonable charge.

2. *The Successful Offeror is expressly prohibited from receiving additional payments or profit from the items referred to in this paragraph, other than that which is provided for in the general terms and conditions of the Contract.*
3. *This shall not preclude Offerors from submitting proposals, which may include innovative ownership approaches, in the best interest of the County.*

8. Section V – General Contract Terms and Conditions, Item S, shall be revised to read as follows:

S. <u>Record Retention and Audits</u>

1. *The Successful Offeror shall retain, during the performance of the Contract and for a period of five years from the completion of the Contract, all records pertaining to the Successful Offeror's proposal and any Contract awarded pursuant to this Request for Proposal. Such records shall include but not be limited to all paid vouchers including those for out-of-pocket expenses; other reimbursement supported by invoices, including the Successful Offeror's copies of periodic estimates for partial payment; ledgers, cancelled checks; deposit slips; bank statements; journals; Contract amendments and change orders; insurance documents; payroll documents; timesheets; memoranda; and correspondence. Such records shall be available to the County on demand and without advance notice during the Successful Offeror's normal working hours.*
2. *County personnel may perform in-progress and post-audits of the Successful Offeror's records as a result of a Contract awarded pursuant to this Request for Proposals. Files would be available on demand and without notice during normal working hours.*
3. *The Successful Offeror shall retain records pursuant to applicable insurance laws and the Successful Offeror's record retention policy. This section shall not apply to proprietary records created in the ordinary course of the Successful Offeror's business, including, but not limited to, claim, sales and underwriting files. Subject to applicable privacy laws and regulations and the Successful Offeror's privacy and confidentiality policies, the Successful Offeror may provide the County copies of requested records with a reasonable charge for copying and shipping.*

9. Section V – General Contract Terms and Conditions, Item JJ, shall be revised to read as follows:

JJ. <u>Cooperative Procurement</u>

This procurement is being conducted by the County in accordance with the provisions of Section 2.2-4304 of the Code of Virginia. Except for contracts for architectural and engineering services, if agreed to by the contractor, other public bodies may utilize this Contract. The Contractor shall deal directly with any public body it authorizes to use the

Contract. The County, its officials, and its employees are not responsible for placement of orders, invoicing, payments, contractual disputes, or any other transactions between the Contractor and any other public body, and in no event shall the County, its officials, or its employees be responsible for any costs, damages or injury resulting to any party from another public body's cooperative use of a County contract. The County assumes no responsibility for any notification of the availability of the Contract for use by other public bodies, but the Contractor may conduct such notification.

The Contractor reserves the right to individually underwrite each group.

10. Attachment E – County of Henrico Insurance Specifications, Professional Liability additional requirement shall be revised to read as follows:

☒ ***Professional Liability - $2,000,000 Per Claim (or limit in accordance with Statute for Medical Professional)***
*Required if the Scope includes providing advice or consultation including but not limited to**;** lawyers, bankers, physicians, programming, design (including construction design), architects & engineers and others who require extensive education and/or licensing to perform their duties.*

By signing the Contract, the parties thereto have approved these Negotiated Modifications.

Exhibit B

August 31, 2023

Oscar Knott, CPP, CPPO, VCO
County of Henrico, Purchasing Director
8600 Staples Mill Rd., PO Box 90775
Henrico, Va. 23273-0775

RE: RFP# 23-2530-5JOK

Dear Mr. Knott,

We are pleased to provide our best and final financial response to the RFP for Group Short-Term and Long-Term Disability Program for VRS Hybrid participants for the County of Henrico General Government and Public Schools. Standard Insurance Company (The Standard) is excited to have the opportunity to continue our existing ten-year relationship with the County. The Standard ranks as one of the top insurance carriers in the nation and has earned a reputation for providing quality insurance products, personalized service, and strong financial performance.

We have included a revised proposal with lower rates for the next 3 years.

- General Government and Economic Development Authority rate reduced from .53 to .50.
- School's nonprofessional employees rate reduced from .53 to .50.
- School's professional employees rate reduced from .24 to .23.

Throughout our proposals and presentations, we have demonstrated our experience and consistency administering the Hybrid Disability insurance program with costs that have only reduced over the last 10 years.

We look forward to continuing and expanding our partnership with the County in building a secure future for your members.

Sincerely,

Stephen Lovings

Stephen Lovings
Sr. Employee Benefits Consultant
Stephen.Lovings@standard.com
Henrico Va. 23059

Employee Benefits

Proposal And Cost Summary

Presented by:
The Standard

Prepared for:
Henrico County, Virginia

January 1, 2024

- **Group STD Advice to Pay**
- **Group Long Term Disability Insurance**

Standard Insurance Company

How The Standard's Focused Expertise Can Benefit Your Business

At Standard Insurance Company, group Life and Disability insurance aren't add-ons. They're our primary business. For you, our focused expertise means people who understand your needs and employee benefits that work harder to support your goals.

From fast, responsive claims handling to flexible plan designs that help you control costs, we're here to partner with you for the long term. Our proactive approach and solutions can help reduce the workload for your HR team and help you maintain a more efficient and productive workplace.

Key Reasons To Choose The Standard	
Partnership Focus	With The Standard's 40-plus fully-staffed sales and service offices across the country, you can count on a smooth, hassle-free transition, local account resources and personal, responsive service. We're here to minimize your administrative burden and simplify claim management. With access that works the way you work – online, phone or in person – we're easy to reach and quick to follow through.
Long-Term Perspective	We've tailored this proposal to address your needs, today and for the long-term. Need more options? Just ask. We offer millions of possible plan design combinations. We also emphasize giving you the "right rate" from the beginning to avoid a big increase later.
Proactive Approach	We focus on helping employers prevent disabilities, increase employee well-being and maintain a more productive workplace through innovative solutions that deliver measurable results, including: • Industry-leading Workplace Possibilities℠ program • Exclusive partnership with Health Advocate™ • Employee Assistance Program included with our LTD plans • Comprehensive Absence Management services • Flexible Dental and Vision plans

We Keep Our Promises

At The Standard, doing the right thing for our customers is in our DNA. More than 100 years of history and our long track record of financial strength back up our commitment to you and your employees.

STD Plan – Advice to Pay (ATP)

Covered Members

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

Plan

STD Weekly Benefit

Months of Continuous Service	Workdays at 100% Replacement	Workdays at 80% Replacement	Workdays at 60% Replacement
Less than 12	0	0	0
13 - 59	0	0	125
60 - 119	25	25	75
120 - 179	25	50	50
180 or more	25	75	25

Accident/Sickness Benefits begin on day	8
Major/Catastrophic Conditions Benefits begin on day	1
Maximum Benefit Period	125 work days

Features

- All other provisions of the existing Policy #649721 remain unchanged.

LTD Plan

Covered Members

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

Class 1: Members with fewer than 12 months continuous participation in the Virginia hybrid retirement program described in § 51.1-169 of the Code of Virginia

Class 2: Members with at least 12 months continuous participation in the Virginia hybrid retirement program described in § 51.1-169 of the Code of Virginia

Plan

LTD Income Benefit	60%
Creditable Compensation	$41,667
Maximum Monthly Benefit	$25,000
Minimum Monthly Benefit	$100
Benefit Waiting Period	The period for which benefits are payable under the Employer's short term disability benefits program, including any benefit waiting period under that plan
Maximum Benefit Period	59 or younger…To age 65 SSNRA 60 through 64…5 years 65 through 68…To age 70 69 or older…….1 year
Own Occupation Period	24 Months
Guarantee Issue (benefit)	Full Benefit
Eligibility Waiting Period	One year of continuous employment for non work related disabilities
Employer Contribution	100%
Benefit Taxation	100% Taxable

Features

- All other provisions of the existing Policy #649720 remain unchanged.

Employee Benefits Proposal and Cost Summary

Prepared for: Henrico County, Virginia
Proposed Effective Date of January 1, 2024

Presented By: The Standard

Cost:

	Lives	Volume (Creditable Comp)	x	*Rate: % of Creditable Comp	=	Monthly Premium
Henrico County	1,820	$6,444,880		0.500		$32,224.40
Henrico County Public Schools – Professionals	2,645	$6,229,044		0.230		$14,326.80
Henrico County Public Schools – Non-Professionals	17	$21,290		0.500		$106.45
				Total:		$46,657.65

*Rate is inclusive of LTD and STD ATP fee

- Rates are guaranteed until January 1, 2027.

Producer Compensation Disclosure

We recognize the valuable role of Insurance advisors, consultants and brokers ("producers") in helping their clients design an employee benefits program, and we support reasonable and fair compensation for these services. Producers may be eligible to receive compensation from The Standard. Any questions regarding the compensation connected with this proposal should be directed to the producer. Please visit our website at **www.standard.com/compensation/eb/** to view our normal commission scales. If this proposal is quoted with a non-standard scale or override it is noted below. An override if noted is compensation paid in addition to or in lieu of commissions. Please consult with your producer for details.

Non-standard commission scale: **Rates are net of commission**
Override: **N/A**

Unless participation is declined by the producer or client, contingent compensation is additional compensation that may also be paid and is contingent on the satisfaction of one or more minimum requirements, such as a specified amount of new premium volume or persistency in connection with the producer's block of business. For information about our customary producer rewards program visit **www.standard.com/compensation/eb/**. Some producers may have a contingent compensation arrangement that differs from our customary program. Please consult with your producer for additional details.

Additionally, fees for administrative, marketing or consulting services may apply. If applicable, fees are noted below.

Fees:

We appreciate the opportunity to provide you with this benefit and cost summary proposal from The Standard. This document outlines certain important features of the group insurance coverages available. This is not a contract or an offer to contract for such coverages. Detailed information about other important features of the coverage proposed is available on request. Just ask your broker/consultant or Standard representative.

A completed application must be submitted before a group can be considered for coverage. Insurance will be effective after the application is accepted by The Standard. If approved, we will issue a contract containing our customary language. It will not duplicate existing policy language, if any. The group contract will contain provisions and defined terms not described in this Benefit and cost summary proposal. The group contract will control if there are discrepancies between it and this proposal.

The proposed premium rate and plan design for each coverage are based on the underwriting data received by The Standard. Final premium rates and plan provisions will be determined by The Standard on the basis of: applicable state laws, policyholder contributions, confirmation of occupations, the actual composition of the group of persons who will become insured, and our current underwriting rules and practices.

This benefit and cost summary proposal expires on December 31, 2023, unless replaced or withdrawn by The Standard.

Exhibit C

County of Henrico

Group STD and LTD Program for VRS Hybrid Participants

RFP No. 23-2530-5JOK

June, 2023

Employee Benefits

Introduction and Signed Forms

June 6, 2023

Oscar Knott, Purchasing Director
County of Henrico
8600 Staples Mill Rd; PO Box 90775
Henrico, Va. 23273-0775

RE: RFP No. 23-2530-5JOK

Dear Oscar,

Standard Insurance Company (The Standard) is excited to offer to continue our relationship providing disability coverage to members of the Hybrid retirement system. The Standard ranks as one of the top insurance carriers in the nation and has earned a reputation for providing quality insurance products, personalized service and strong financial performance. We appreciate the past 9 year partnership with the County for its Hybrid Disability program and look forward to extending the relationship for the next 5 years.

We are uniquely qualified to compose a tailored package to help you achieve your financial and coverage goals, while also offering innovative options. Your customized plan includes:

- Competitive and affordable pricing, based upon The Standard's substantial experience in effectively underwriting risk.
- Our unique, proactive Workplace Possibilities^{SM} program that helps keep employees at work by quickly addressing and reducing the causes of disability.
- Streamlined and technologically advanced claims intake, administration and management for The County of Henrico, Henrico County Public Schools and its employees.

Throughout our proposal, we have demonstrated our capabilities and competitive strengths.

We look forward to partnering with you in building a secure future for your members.

Sincerely,

CrisDee Plambeck

CrisDee Plambeck
AVP, Product & Strategy Support
Portland, OR 97204
CrisDee.Plambeck@standard.com

Stephen Lovings
Sr. Benefits Consultant
Henrico, VA 23233
804.980.6031

ATTACHMENT A
PROPOSAL SIGNATURE SHEET

My signature certifies that the proposal as submitted complies with all requirements specified in this Request for Proposal ("RFP") No. 23-2530-5JOK – Group Short-Term and Long-Term Disability Program for VRS Hybrid Participants – County of Henrico Government and Public Schools.

My signature also certifies that by submitting a proposal in response to this RFP, the Offeror represents that in the preparation and submission of this proposal, the Offeror did not, either directly or indirectly, enter into any combination or arrangement with any person or business entity, or enter into any agreement, participate in any collusion, or otherwise take any action in the restraining of free, competitive bidding in violation of the Sherman Act (15 U.S.C. Section 1) or Sections 59.1-9.1 through 59.1-9.17 or Sections 59.1-68.6 through 59.1-68.8 of the Code of Virginia.

I hereby certify that I am authorized to sign as a legal representative for the business entity submitting this proposal.

LEGAL NAME OF OFFEROR (DO NOT USE TRADE NAME):
Standard Insurance Company
ADDRESS:
1100 SW 6th Ave.
Portland, OR 97204
FEDERAL ID NO: 93-0242990
SIGNATURE: CrisDee Plambeck
NAME OF PERSON SIGNING (PRINT): CrisDee Plambeck
TITLE: AVP Product & Strategy Support
TELEPHONE: n/a
FAX: n/a
EMAIL ADDRESS: CrisDee.Plambeck@standard.com
DATE: 06/06/2023

ATTACHMENT B
BUSINESS CATEGORY CLASSIFICATION FORM

Company Legal Name: Standard Insurance Company

This form completed by: Signature: Cristine Plambeck Title: AVP Product & Strategy Support

Date: 06/06/2023

PLEASE SPECIFY YOUR BUSINESS CATEGORY BY CHECKING THE APPROPRIATE BOX(ES) BELOW.

(Check all that apply.)

- ☐ **SMALL BUSINESS**
- ☐ **WOMEN-OWNED BUSINESS**
- ☐ **MINORITY-OWNED BUSINESS**
- ☐ **SERVICE-DISABLED VETERAN**
- ☐ **EMPLOYMENT SERVICES ORGANIZATION**
- ☒ **NON-SWaM (Not Small, Women-owned or Minority-owned)**

SUPPLIER REGISTRATION – The County of Henrico encourages all suppliers interested in doing business with the County to register with eVA, the Commonwealth of Virginia's electronic procurement portal, http://eva.virginia.gov.

eVA Registered? ☒ **Yes** ☐ **No**

If certified by the Virginia Minority Business Enterprises (DMBE), provide DMBE certification number and expiration date.

_____ **NUMBER** _____ **DATE**

DEFINITIONS

For the purpose of determining the appropriate business category, the following definitions apply:

"Small business" means a business, independently owned and controlled by one or more individuals who are U.S. citizens or legal resident aliens, and together with affiliates, has 250 or fewer employees, or annual gross receipts of $10 million or less averaged over the previous three years. One or more of the individual owners shall control both the management and daily business operations of the small business.

"Women-owned business" means a business that is at least 51 percent owned by one or more women who are U.S. citizens or legal resident aliens, or in the case of a corporation, partnership, or limited liability company or other entity, at least 51 percent of the equity ownership interest is owned by one or more women who are U.S. citizens or legal resident aliens, and both the management and daily business operations are controlled by one or more women.

"Minority-owned business" means a business that is at least 51 percent owned by one or more minority individuals who are U.S. citizens or legal resident aliens, or in the case of a corporation, partnership, or limited liability company or other entity, at least 51 percent of the equity ownership interest in the corporation, partnership, or limited liability company or other entity is owned by one or more minority individuals who are U.S. citizens or legal resident aliens, and both the management and daily business operations are controlled by one or more minority individuals.

"Minority individual" means an individual who is a citizen of the United States or a legal resident alien and who satisfies one or more of the following definitions:

1. "African American" means a person having origins in any of the original peoples of Africa and who is regarded as such by the community of which this person claims to be a part.

2. "Asian American" means a person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands, including but not limited to Japan, China, Vietnam, Samoa, Laos, Cambodia, Taiwan, Northern Mariana Islands, the Philippines, a U.S. territory of the Pacific, India, Pakistan, Bangladesh, or Sri Lanka and who is regarded as such by the community of which this person claims to be a part.

3. "Hispanic American" means a person having origins in any of the Spanish-speaking peoples of Mexico, South or Central America, or the Caribbean Islands or other Spanish or Portuguese cultures and who is regarded as such by the community of which this person claims to be a part.

4. "Native American" means a person having origins in any of the original peoples of North America and who is regarded as such by the community of which this person claims to be a part or who is recognized by a tribal organization.

"Service disabled veteran business" means a business that is at least 51 percent owned by one or more service disabled veterans or, in the case of a corporation, partnership, or limited liability company or other entity, at least 51 percent of the equity ownership interest in the corporation, partnership, or limited liability company or other entity is owned by one or more individuals who are service disabled veterans and both the management and daily business operations are controlled by one or more individuals who are service disabled veterans.

"Service disabled veteran" means a veteran who (i) served on active duty in the United States military ground, naval, or air service, (ii) was discharged or released under conditions other than dishonorable, and (iii) has a service-connected disability rating fixed by the United States Department of Veterans Affairs.

"Employment services organization" means an organization that provides community-based employment services to individuals with disabilities that is an approved Commission on Accreditation of Rehabilitation Facilities (CARF) accredited vendor of the Department of Aging and Rehabilitative Services.

ATTACHMENT C
Virginia State Corporation Commission (SCC)
Registration Information

The Offeror:

☒ is a corporation or other business entity with the following SCC identification number: F1014606 **-OR-**

☐ is not a corporation, limited liability company, limited partnership, registered limited liability partnership, or business trust **-OR-**

☐ is an out-of-state business entity that does not regularly and continuously maintain as part of its ordinary and customary business any employees, agents, offices, facilities, or inventories in Virginia (not counting any employees or agents in Virginia who merely solicit orders that require acceptance outside Virginia before they become contracts, and not counting any incidental presence of the Bidder in Virginia that is needed in order to assemble, maintain, and repair goods in accordance with the contracts by which such goods were sold and shipped into Virginia from Bidder's out-of-state location) **-OR-**

☐ is an out-of-state business entity that is including with this bid/proposal an opinion of legal counsel which accurately and completely discloses the undersigned Bidder's current contracts with Virginia and describes why those contracts do not constitute the transaction of business in Virginia within the meaning of §13.1-757 or other similar provisions in Titles 13.1 or 50 of the Code of Virginia.

Please check the following box if you have not checked any of the foregoing options but currently have pending before the SCC an application for authority to transact business in the Commonwealth of Virginia and wish to be considered for a waiver to allow you to submit the SCC identification number after the due date for bids: ☐

ATTACHMENT D

PROPRIETARY/CONFIDENTIAL INFORMATION IDENTIFICATION

NAME OF OFFEROR: Standard Insurance Company

Not applicable. The Standard's proposal does not contain any proprietary information.

Trade secrets or proprietary information submitted by an Offeror shall not be subject to public disclosure under the Virginia Freedom of Information Act; however, the Offeror must invoke the protections of Va. Code § 2.2-4342(F) in writing, either before or at the time the data or other materials are submitted. The Offeror must specifically identify the data or materials to be protected including the section(s) of the proposal in which it is contained and the pages numbers, and state the reasons why protection is necessary. A summary of trade secrets and proprietary information submitted shall be submitted on this form. The proprietary or trade secret material submitted must be identified by some distinct method such as highlighting or underlining and must indicate only the specific words, figures, or paragraphs that constitute trade secret or proprietary information. Va. Code § 2.2-4342(F) prohibits an Offeror from classifying an entire proposal, any portion of a proposal that does not contain trade secrets or proprietary information, line item prices, or total proposal prices as proprietary or trade secrets. If, after being given reasonable time, the Offeror refuses to withdraw such classification(s), the proposal will be rejected.

SECTION/TITLE	PAGE NUMBER(S)	REASON(S) FOR WITHHOLDING FROM DISCLOSURE

County of Henrico General Government and Public Schools

DIRECT CONTACT WITH STUDENTS

Name of Bidder/Offeror: Standard Insurance Company

Pursuant to Va. Code § 22.1-296.1(E), as a condition of awarding a contract for the provision of services that require the contractor or employees of the contractor to have direct contact with students on school property during regular school hours or during school-sponsored activities, the contractor shall provide certification of whether any individual who will provide such services has been convicted of any violent felony set forth in the definition of barrier crime in subsection A of Va. Code § 19.2-392.02; any offense involving the sexual molestation, physical or sexual abuse, or rape of a child, or the solicitation of any such offense; or any crime of moral turpitude.

Any individual making a materially false statement regarding any such offense is guilty of a Class 1 misdemeanor and, upon conviction, the fact of such conviction is grounds for the revocation of the contract to provide such services and, when relevant, the revocation of any license required to provide such services. School boards shall not be liable for materially false statements regarding the certifications required by Va. Code § 22.1-296.1(E),.

Va. Code § 22.1-296.1(E), shall not apply to a contractor or his employees providing services to a school division in an emergency or exceptional situation, such as when student health or safety is endangered or when repairs are needed on an urgent basis to ensure that school facilities are safe and habitable, when it is reasonably anticipated that the contractor or his employees will have no direct contact with students.

For purposes of this certification, “services” means any work performed by an independent contractor wherein the service rendered does not consist primarily of acquisition of equipment or materials, or the rental of equipment, materials and supplies.

The contractor is responsible for affirming certification information for his subcontractors.

Pursuant to Va. Code § 22.1-296.1(F), no school board shall award a contract for the provision of services that require the contractor or his employees to have direct contact with students on school property during regular school hours or during school-sponsored activities when any individual who provides such services has been convicted of any violent felony set forth in the definition of barrier crime in subsection A of § 19.2-392.02 or any offense involving the sexual molestation, physical or sexual abuse, or rape of a child, or the solicitation of any such offense.

Pursuant to Va. Code § 22.1-296.1(G), any school board may award a contract for the provision of services that require the contractor or his employees to have direct contact with students on school property during regular school hours or during school-sponsored activities when any individual who provides such services has been convicted of any felony or crime of moral turpitude that is not set forth in the definition of barrier crime in subsection A of § 19.2-392.02 and does not involve the sexual molestation, physical or sexual abuse, or rape of a child, or the solicitation of any such offense, provided that in the case of a felony conviction, such individual has had his civil rights restored by the Governor.

As part of this submission, the contractor certifies the following:

☒ **None of the individuals who will be providing services that require direct contact with students on school property during regular school hours or during school-sponsored activities have been convicted of a violent felony set forth in the definition of "barrier crime" in Va. Code § 19.2-392.02(A) or an offense involving the sexual molestation, physical or sexual abuse, or rape of a child, or the solicitation of any such offense;**

And (select one of the following)

☒ **None of the individuals who will be providing services that require direct contact with students on school property during regular school hours or during school-sponsored activities have been convicted of any felony or any crime of moral turpitude.**

or

☐ **One or more individuals who will be providing services that require direct contact with students on school property during regular school hours or during school-sponsored activities has been convicted of a felony or crime of moral turpitude that is not set forth in the definition of "barrier crime" in Va. Code § 19.2-392.02(A) and does not involve the sexual molestation, physical or sexual abuse, or rape of a child, or the solicitation of any such offense. (In the case of a felony conviction meeting these criteria, the contractor must submit evidence that the Governor has restored the individual's civil rights.).**

10/11/2023

Signature of Authorized Representative

Jill Schlofer, 2nd VP, Implementation & Enrollment

Printed Name of Authorized Representative

Standard Insurance Company

Printed Name of Vendor
(if different than Representative)

COMMONWEALTH OF VIRGINIA
County of Henrico

DEPARTMENT OF FINANCE
Oscar Knott, CPP, CPPO, VCO
Purchasing Director

Addendum No. 1

Date:	June 1, 2023
Request for Proposal:	23-2530-5JOK – Group Short-Term and Long-Term Disability Program for VRS Hybrid Participants – County of Henrico Government and Public Schools
Receipt Date/Time:	June 8, 2023 / 11:00 a.m.
Subject:	Revision and Question/Answer

Ladies/Gentlemen,
Please make the following corrections, deletions and/or additions to the above referenced Request for Proposal:

1. Section IV, Anticipated Procurement Schedule – Replace in its entirety with the following:

The following represents the timeline of the process currently anticipated by the County:

Request for Proposal Distributed	*May 12, 2023*
Questions Due by	*May 30, 2023*
Receive Written Proposals by	*11:00 a.m. on June 8, 2023*
Conduct Oral Interviews with Offerors	*July 2023*
Negotiations Completed	*July/August 2023*
Award Contract	*September 2023*
Implementation of STD and LTD Program	*September – December 2023*
Benefits begin	*January 1, 2024*

2. Please outline the following regarding the ASO request:
   a. Please confirm whether the incumbent provider requires medical record retrieval preapproval from the employer (initial & appeal) and if the responding proposer should in the future.
   Answer: No.
   b. Please confirm whether the incumbent provider requires IME/FCE/Peer Review Preapproval from the employer (Initial & Appeal) and if the responding proposer should in the future.
   Answer: No.
   c. Please confirm whether the group requires the Decision Letter(s) to be sent to the employee.
   Answer: Yes, The Standard sends the employee notice of decision on their claim as well as the employer contact (according to entity – schools, government or economic development authority).
   d. Please confirm whether the group requires the incumbent provider to calculate both the benefit and payment and if the responding proposer should in the future.
   Answer: Henrico County calculates the benefit and payment for the employee. Standard provides support the duration of disability, but Henrico calculates and issues the benefit payment to the employee.

e. Please confirm whether the group currently has telephonic claims service on ASO/ATP.
Answer: Confirmed.

3. Please provide occupations on the census.
Answer: Column "Organization Name" and can be used to reference or cross-reference occupation.

4. Please provide current rates.
Answer:

Business Unit	**STD-ATP & LTD Combined Rates**
Henrico County Government	0.53% insured earnings
Henrico County Economic Development Authority	0.53% insured earnings
Henrico County Public Schools: Professionals	0.24% insured earnings
Henrico County Public Schools: Non-Professionals	0.53% insured earnings

5. Please explain the jump in lives on the LTC Incurred Exhibit from 2021 (1,793 lives) to 2022 (4,312 lives).
Answer: Prior to 2022 the Henrico County Schools was not included in the enrollment billing report even though premium was. Starting in 2022 the Schools employee count was included with the Government.

All other specifications and General Terms and Conditions shall remain the same.

Offerors must take due notice and be governed accordingly. Failure to acknowledge this addendum may result in your proposal being declared non-responsive.

Sincerely,

Oscar Knott, CPP, CPPO, VCO
Purchasing Director
Kno008@henrico.us

ACKNOWLEDGEMENT:

Signature: CrisDee Plambeck

Print Name: CrisDee Plambeck

Company: Standard Insurance Company

Date: 6/6/2023

Statement of Scope

Response to Section II. Scope of Services

II. SCOPE OF SERVICES

The Scope of Services is intended to establish Minimum Services and Additional Specific Conditions the Successful Offeror shall meet to fulfill the County's intent as stated in Section I of this RFP.

A. Minimum Services

The Successful Offeror shall:

1. Provide STD and LTD plans which meet or exceed the VRS-mandated "comparable" benefit requirement. The comparable plan must include STD and LTD coverage only, not long-term care.

   Confirmed. As the incumbent, the plans will continue to run as they have been.

2. Provide and/or make available necessary, appropriate and high-quality income protection benefits and services to each employee.

   Our Group Disability insurance isn't an add-on, it's our primary business. Our knowledge and experience covers the full spectrum of disability. From underwriting, plan design and claims handling to worksite and job analysis and rehabilitation. For you, that means having distinct advantages that work harder to support you, your employees and your goals.

   Innovative Workplace Possibilities℠ Program
   Our customers get much more than a product with our Group Disability insurance. They get a proactive, whole-person approach focused on helping employees stay at work or return sooner. The Workplace Possibilities approach:

   - Treat the whole person – We do more than pay claims. Our approach looks at the range of factors that can delay an employee's recovery from a physical or behavioral condition. Then we customize a plan to help the individual return to work quickly and safely.
   - Focus on stay at work – Our on-site consultants work proactively with employees.* We coach managers on hot to spot employees who need support and refer them to our program. Early intervention helps keep employees from missing work, so they can stay productive and keep receiving a full paycheck.
   - Bring expertise right to you – It starts with integrating into an organization's culture and making a personal connection with employees. Employers can have local or on-site support. This includes working directly with employees, coordinating the programs and services available, and providing help with ADAAA accommodations.** All these efforts may help reduce the burden on HR.

     ** This type of local, on-site support will vary depending on employer size and plan design. In all cases, a consultant is available to you for calls and visits. Contact us to talk about the options available to you.*
     *** Consultants provide this assistance for employers using ADAAA Accommodation Services.*

   Reasonable Accommodation Expense Benefit
   The Standard may cover up to $25,000 of approved expenses toward: worksite modifications; assistive devices; training; other assistance that results in the covered employee staying at work or returning to work after a disability

   Mental Health & Musculoskeletal Outreach

At The Standard, all mental health and musculoskeletal cases receive clinical case management. Our team of eight mental health case managers averages more than 20 years of experience. They review claims each week to identify claimants who may benefit from assistance. They help employees follow through with medical providers' treatment recommendations. They can make referrals to available services, such as the employer's EAP.

1:6–7 Ratio of Nurses/Vocational Case Managers to Analysts
Our best practices model reflects a 1:7 (or less) ratio of clinical and vocational resources to claim-paying staff. This means that our nurse case managers – averaging 27 years of experience – and vocational case managers – averaging 26 years of experience – are readily accessible to our benefit examiners and analysts. Employees benefit from our integrated support and continuous case management.

Flexible Plan Designs – Our policies are flexible enough to meet the demands of employers with special requirements or those looking to match the benefits of their existing plans, including: Family Care Expense Adjustment; Dependent Education Benefit; Lifetime Security Benefit; Annuity Contribution Benefit.

Public employers have unique needs. These include: special administrative requirements; reporting needs; integration with other benefits and programs; union representation; employee classification; funding requirements; budget concerns.

Public Experience
The Standard is a leading provider of employee benefit products serving the public sector for more than 70 years. Our very first policyholder was a public entity. We are proud to say that we still have them insured today.

Long-term relationships are a primary goal of our organization. Most of our public employers maintain relationships with us that average nearly 9 years per policyholder. We provide Life or Disability coverage to more than 4,900* public entities.

*Standard Insurance Company internal data as of March 31, 2023.

3. Ensure disability claims are managed effectively, efficiently, and consistent with the Code of Virginia requirements.

   Confirmed. The County's designated claims team will continue to manage claims.

4. Provide high quality, efficient program administration and services, including but not limited to:
   a. Maintaining accurate payment records.

      Our premium billing system is self-administered. This means that the policyholder maintains eligibility and census information. They only need to provide aggregate information each month. Premium statements will reflect the prior month's:
      - Aggregate number of lives.
      - Insurance volume.
      - Current in-force rate for each coverage.

      The policyholder adjusts the statement to reflect any changes. They will add or subtract lives and insurance volume. Premium is then remitted based on the new aggregate numbers.

Billing statements are generated and mailed about 11 to 13 days before the due date. The first statement will reflect the census information provided when coverage was first applied for. The policyholder is then responsible for updating these figures before sending payments.

b. Providing state-of-the-art data tracking and claims payment services.

The Standard's STD, state disability claims and LTD claims are stored, assessed, and tracked in a paperless online system.

We use a claims adjudication and payment system that provides online transaction processing to support immediate customer inquiries.

Our claims processing system:

- automates all benefit calculations
- claims payment
- tax
- benefit contribution deductions
- offset withholding and reporting
- overpayment calculation
- claims reserving
- creates standard correspondence and reports

Additionally, the County can pull a variety of claims data through our Reports OnlineSM system. Reports OnlineSM provides benefit managers with ready access to disability claims status, payment, and experience data. You'll be able to quickly confirm when The Standard has issued benefits.

c. Providing plan utilization, claims, enrollment, and premium data to the County General Government and Public Schools on at minimum at quarterly basis.

The Standard will provide a customized financial and claim utilization reports based on the County's needs. We not only provide the reports, but we will be consultative in walking through the data and providing recommendations for changes and improvements.

We have provided samples of our reporting package in Tab 9.

As demonstrated in our sample reporting package in Tab VII, The Standard provides a full suite of financial and claim utilization reports that includes benchmarking to our public block of business and the leading research organization in health and productivity, Integrated Benefits Institute. If additional reporting is needed, The Standard is able to create ad hoc reporting based on data points collected in our claim system and/or provided in an eligibility file from Henrico County.

In addition, to make pertinent disability claims information readily available to employers, The Standard offers Reports Online[SM], our web-based claims management reporting system. Reports include:

Daily Reports

- Disability claim status
- Disability claims payment detail
- Benefit Calculation Report (LTD only)
- Waiver claims detail

Quarterly Reports

- Disability benefits paid by diagnosis and occupation
- Disability claim duration by diagnosis and closure reason

The Standard provides online access to:

- **Daily FICA Tax Activity Report:** This tells employers when we make a FICA Tax deduction from a claims payment. It also shows the Social Security and Medicare tax withheld. We can report this information by employer location or affiliate with different taxpayer identification numbers (if requested).

In addition to the information available through Reports Online[SM], we print and mail the following Disability reports to a designated contact at the County for fully-insured plans:

- **Group Benefits Activity Report:** This details disability payments and claim determinations made during the previous month. We generate the report monthly and can report in aggregate or by employer location or affiliate.
- **Disability Income Report:** This shows yearly total benefit payments per claim and tax withholding for each employee who received disability benefits from The Standard during the calendar year. This also shows when The Standard has prepared a W-2 for the employee. We generate this report for all disability plans.

We can also provide the following reports, as needed, for fully-insured plans:

- **Experience Report:** We produce this at renewal. It shows the current policy year and all years' experience, including ASO fees and paid claims, if applicable.
- **Claim Experience Report:** This printout lists the individual claims that were active during the time period requested. The information includes benefits paid as well as beginning and ending reserves. We can produce this by group office for any time period from the policy effective date through the last full month.

d. Maintaining separate accounts or subgroups as required by the County.

We can separate billing, claims, and experience by various accounts or subgroups within the County. For example, we can provide claim utilization reports by separate policies and by sub-groups such as government entities versus school entities.

5. Provide administrative support services that simplify the work input and administrative time of General Government and Public Schools' benefits staff.

We are a leader in the industry for disability claims management. We have tenured claims staff and robust medical and vocations resources to manage claims effectively and fairly while providing best in class customer service. In addition, our telephonic intake service streamlines the process for employers and employees.

6. Maintain a local or toll-free customer service number for covered employees and General Government and Schools' benefits staff.

   We can confirm that there is a toll-free customer service number available to covered employees and benefits staff.

   Moreover, The Standard implemented a Telephone intake service for Short Term Disability claims with Henrico for the Hybrid Disability plan. For both employers and employees, claims are reported to The Standard's Customer Contact Center.

7. Designate a single point of contact (account manager) responsible for resolving issues, answering claims, administrative, and billing inquiries, and expediting services related to the overall performance of the Contract.

   Our approach to account management is to provide our customers with a single, dedicated point of contact for whom they can trust.

   Kim Haines, Account Manager, will continue to serve as the County's point of contact. Account managers pride themselves on being your advocate, representing your interests and providing you with timely responses.

8. Provide an account team chart which lists contacts in relevant, functional areas (with phone numbers, email addresses, departments, and titles) that will be updated as changes occur.

   We have included a team chart in Tab 9. We confirm that we will provide updates as they occur.

9. Provide specific performance guarantees that include financial penalties for non-performance. (See **Attachment I)**

   Our policyholders decide what aspects of service are most important to them through the Performance Guarantee Program. They do this by rating their satisfaction based on those criteria. The Standard promises to make every effort to meet those overall service expectations.

   If we fail to meet expectations, we will refund five percent (5%) of the previous quarter's plan administration expenses, excluding commission, premium tax, and risk charges.

10. Meet with the County 15 days after the Contract award date to review the disability program, to present the proposed employee communication material, and to jointly establish a preliminary implementation plan and schedule.

    As the incumbent carrier, implementation is not necessary. Service will continue without disruption.

11. Work with the benefits staff of the General Government and County Schools to develop employee communications materials.

    Communication materials already exist. If changes are needed, we will be happy to work with the County.

12. Work with the benefits staff of the General Government and County Schools to develop a benefits booklet (or booklets) for employees to include a summary of benefits, plan limitations, exclusions, and claims appeal procedures. This booklet proof must be provided to the County on a timely basis, but not later than November 1, 2023. The General Government and Schools shall review and approve the booklet(s) prior to distribution. Booklets must be reprinted if changes are required at no additional cost to the County.

    Benefit summaries have been provided. If more communications are needed, we will be happy to work with the County on a timely basis.

13. Provide the County with contractual documents necessary to this coverage, no later than December 1, 2023.

    The Policy will continue to be in place unless we receive notice of termination from the County pursuant to the terms and conditions of the policy in place. We will work with the County contract team to finalize any agreements needed by the purchasing department. The Standard does not require any additional documents to continue the coverage on January 1, 2024.

14. Provide a detailed renewal underwriting analysis each July 1 (or earlier if requested by the County) for the upcoming January 1 renewal. Detailed utilization data comparing current and prior years (if applicable) must be provided.

    Confirmed.

B. Additional Specific Conditions

The Successful Offeror shall transfer all data and records necessary to administer the disability program upon the termination or expiration of the Contract within 30 days of the County's request. Such transfer may be accomplished either electronically or by paper based upon the mutual agreement between the Successful Offeror and the County.

The Standard will share and/or transfer data and records consistent with applicable law.

Default, Termination and Barred Certification Statement

Response to Section VI, L(3), L(4), L(5)

The Standard certifies the following:

(i) that it has not defaulted on any government contract in the last five years,

(ii) that no government has terminated a contract with the Offeror for cause in the last five years, and

(iii) that neither it nor any of its officers, directors, partners, or owners is currently barred from participating in any procurements by any federal, state, or local government body.

Description of Proposed Plan Design

Presented by:

The Standard

Proposal And Cost Summary

Prepared for:

Henrico County, Virginia

- **Group STD Advice to Pay**
- **Group Long Term Disability Insurance**

How The Standard's Focused Expertise Can Benefit Your Business

aren't They're we're

Key Reasons To Choose The Standard

Partnership Focus	Standard's 40 resources and personal, responsive service. We're here to minimize your we're easy to reach
Long-Term Perspective	We've tailored this proposal to address your needs, today and for the long combinations. We also emphasize giving you the "right rate" from the
Proactive Approach	• ™

We Keep Our Promises

STD Plan – Advice to Pay (ATP)

Covered Members

[illegible]

Plan

STD Weekly Benefit

Months of Continuous Service	[illegible]	[illegible]	[illegible]
Less than 12	[illegible]	[illegible]	[illegible]
13 - 59	[illegible]	[illegible]	[illegible]
60 - 119	[illegible]	[illegible]	[illegible]
120 - 179	[illegible]	[illegible]	[illegible]
180 or more	[illegible]	[illegible]	[illegible]

Accident/Sickness Benefits begin on day	[illegible]
Major/Catastrophic Conditions Benefits begin on day	[illegible]
Maximum Benefit Period	[illegible]

Features

- [illegible]

LTD Plan

Covered Members

Plan

LTD Income Benefit	
Creditable Compensation	
Maximum Monthly Benefit	
Minimum Monthly Benefit	
Benefit Waiting Period	Employer's short term disability benefits program,
Maximum Benefit Period	59 or younger…To age 65 SSNRA 60 through 64…5 years through 68…To age 70 69 or older…….1 year
Own Occupation Period	
Guarantee Issue (benefit)	
Eligibility Waiting Period	
Employer Contribution	
Benefit Taxation	

Features

[illegible]

[illegible]

[illegible]

ATTACHMENT H
DEVIATIONS FROM REQUESTED PLAN DESIGN

Effective Date: 1/1/2024

Name of Offeror: Standard Insurance Company

Plans Offered to Match Current Benefits:
(Check below the plans offered in your proposal)

__X__ VLDP Comparable STD Plan (ASO)

__X__ VLDP Comparable LTD Plan (Fully-Insured)

Please list any deviations to requested benefit designs or funding arrangements below:

N/A

ATTACHMENT I
PERFORMANCE GUARANTEES

Effective Date: January 1, 2024 – December 31, 2026

Name of Offeror: Standard Insurance Company

Performance Guarantees Apply to the Following Plan(s): STD and LTD

(Provide separate Performance Guarantee Exhibits if guarantees vary by plan or by funding arrangement)

For each performance category, please insert a financial penalty in the "Financial Penalty" column or insert "N/A" in that column if you cannot guarantee performance in that area. Insert the measure(s) that you intend to use to determine if the minimum standard has been met (Performance Measure column), provide information about how performance in each category will be reported and the frequency of the reports (Performance Reporting column), and indicate whether each of the performance categories will be measured based upon your book of business or if they will be measured for Henrico (Book of Business or Henrico Specific column).
Offerors are free to modify any of the minimum standards shown below, but should clearly highlight any modification so that it may be easily identified.

Our policyholders decide what aspects of service are most important to them through the Performance Guarantee Program. They do this by rating their satisfaction based on those criteria. The Standard promises to make every effort to meet those overall service expectations.

If we fail to meet expectations, we will refund five percent (5%) of the previous quarter's plan administration expenses, excluding commission, premium tax, and risk charges.

Performance Category	Minimum Standard	Performance Measure	Performance Reporting	Frequency of Reports (Reporting Period)	Book of Business or Henrico Specific	Financial Penalty
Claim Payment Accuracy	98% of all STD and LTD claims dollars paid accurately.					
Claims Processing Accuracy	98% of all STD and LTD claims processed correctly.					
Claim Turnaround Time	98% of all STD and LTD claims processed within 5 business days.					

ATTACHMENT I
PERFORMANCE GUARANTEES

Effective Date: January 1, 2024 – December 31, 2026

Name of Offeror: Standard Insurance Company

Performance Guarantees Apply to the Following Plan(s): STD and LTD

(Provide separate Performance Guarantee Exhibits if guarantees vary by plan or by funding arrangement)

For each performance category, please insert a financial penalty in the "Financial Penalty" column or insert "N/A" in that column if you cannot guarantee performance in that area. Insert the measure(s) that you intend to use to determine if the minimum standard has been met (Performance Measure column), provide information about how performance in each category will be reported and the frequency of the reports (Performance Reporting column), and indicate whether each of the performance categories will be measured based upon your book of business or if they will be measured for Henrico (Book of Business or Henrico Specific column).
Offerors are free to modify any of the minimum standards shown below, but should clearly highlight any modification so that it may be easily identified.

Performance Category	Minimum Standard	Performance Measure	Performance Reporting	Frequency of Reports (Reporting Period)	Book of Business or Henrico Specific	Financial Penalty
Customer Services Telephone Response Time ***Average Speed to Answer***	Average speed of answer 25 seconds or less					
Customer Services Telephone Response Time ***Average Abandonment Rate***	2% or fewer callers to customer service representative or center abandon the call					
Account Management Satisfaction (Survey to be provided to Benefits Managers)	100% of all Benefits Managers surveyed respond satisfied or very satisfied					

ATTACHMENT I
PERFORMANCE GUARANTEES
Effective Date: January 1, 2024 – December 31, 2026

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Performance Guarantees Apply to the Following Plan(s): STD and LTD

(Provide separate Performance Guarantee Exhibits if guarantees vary by plan or by funding arrangement)

For each performance category, please insert a financial penalty in the "Financial Penalty" column or insert "N/A" in that column if you cannot guarantee performance in that area. Insert the measure(s) that you intend to use to determine if the minimum standard has been met (Performance Measure column), provide information about how performance in each category will be reported and the frequency of the reports (Performance Reporting column), and indicate whether each of the performance categories will be measured based upon your book of business or if they will be measured for Henrico (Book of Business or Henrico Specific column).
Offerors are free to modify any of the minimum standards shown below, but should clearly highlight any modification so that it may be easily identified.

Performance Category	Minimum Standards	Performance Measure	Performance Reporting	Frequency of Reports (Reporting Period)	Book of Business or Henrico Specific	Financial Penalty
Account Management Responsiveness (to be rated by Benefits Managers)	All calls and emails from the County and Schools will be returned within 1 business day					
Satisfaction with Member Services and Claim Administration (Survey to be Provided to Employees/Claimants)	90% of all survey responses will be rated satisfied or very satisfied					
Implementation of Plan	Survey of Benefits Managers results in 100% satisfied or very satisfied					
Total $ at Risk						

ATTACHMENT K
PLAN DESIGN GRID

(Place a check mark in the column to the right of the Code to indicate that your proposed plan matches the provision or include comments to show any deviations to a particular provision. A check mark or comments should be included in the right column for each plan provision.)

LTD Plan Design Comparison **(Indicate any provisions requiring filing with VA Bureau of Insurance)**

Plan Provision	Current Plan Provision	Confirm with a √ or Include a Deviation
Benefit Waiting Period 51.1-1157	LTD benefits will begin upon the expiration of the maximum period for which the employee receives STD benefits.	✓
Income Replacement Percentage 51.1-1157(B)	60% of a participating employee's creditable compensation.	✓
Maximum Benefit Period 51.1-1161	**Age At Date Of Disability** — **Maximum Benefit Period** 59 or younger — To Social Security Normal Retirement Age (SSNRA) 60 through 64 — 5 years 65 through 68 — To age 70 69 or older — 1 year	✓
Maximum Benefit	None	$25,000 month
Minimum Benefit	None	$100 month
Taxability	Non-work related benefits are fully taxed since the employer will pay premiums for the insurance. Work-related benefits – Non taxable	✓
Catastrophic Condition Benefit 51.1-1171	If the insured is unable to perform two or more activities of daily living without hands-on assistance or requires substantial supervision for their health or safety due to severe cognitive impairment, the benefit percentage will be at least 80% of the insured's pre-disability earnings.	✓
Own Occupation – Definition Of Total Disability 51.1-1150: Definitions	24-month Own Occupation period; the insured is disabled if he or she is unable to perform the essential duties of their own occupation.	✓
Any Occupation – Definition Of Total Disability 51.1-1150: Definitions	After the first 24 months of benefit payment, the employee is disabled if he or she is unable to perform any occupation for which he or she is reasonably educated, trained and experienced to perform and he or she continues to suffer a loss of at least 20% of pre-disability earnings.	✓
Definition Of Partial Disability 51.1-1150: Definitions	The insured is partially disabled if he or she is working in an occupation but is unable to earn 80% or more of pre-disability earnings.	✓
Successive Periods Of Long Term Disability/Recurrent Disabilities 51.1-1158	The insured may temporarily recover from disability and then become disabled again from the same cause or causes without having to serve a new benefit waiting period. During the benefit waiting period, an insured is allowed 45 consecutive days of recovery before a new waiting period is required. During the maximum benefit period, an insured is allowed 125 consecutive workdays for each period of recovery before a new benefit waiting period is required.	✓
Military Disability Benefits Offset 51.1-1159(F)	The Standard will not offset LTD benefits for any military disability benefits received.	✓
Social Security Offset 51.1-1159(A)(3)	Social Security benefits payable to the insured or to the dependents of the insured will be considered deductible.	✓

LTD Plan Design Comparison (Indicate any provisions requiring filing with VA Bureau of Insurance)

Plan Provision	Current Plan Provision	Confirm with a √ or Include a Deviation
Workers' Compensation Benefit Offset 51.1-1159(A)(5)	Any amount received by the insured from workers' compensation, including amounts for partial or total disability, will reduce the LTD benefit.	✓
Group Insurance Disability Offset 51.1-1159(A)(4)	Any amount received from another group disability plan provided by the employer will reduce LTD benefits from The Standard.	✓
Cost-Of-Living Adjustments (COLA) Increases To Other Benefits 51.1-1159(C)	If a cost-of-living adjustment increases a deductible income benefit amount, The Standard will not increase the offset amount and will continue to offset the initial award amount.	✓
Return-To-Work Incentive 51.1-1159(A)(1)-(2)	For the first 12 months after returning to work, the employee's LTD benefit will be reduced by 60% of the employee's return-to-work earnings. After the first 12 months, the employee's LTD benefit will be reduced by 70% of the employee's return-to-work earnings.	1st 12 months- Only amount above 100% of Pre-disability earnings will be offset. After 12 months- Reduce benefit by 50% of work earnings.
Substance Abuse/Alcohol Use And Drug Use Limitation 51.1-1176(B)	No benefits will be payable unless an employee is actively receiving treatment, and, in the judgment of the case manager, is fully complying with the treatment plan.*	✓
Commission Of A Felony 51.1-1176(A)	Benefits are not payable for disabilities resulting from the commission of a felony, or during any period when an employee is confined for any reason in a penal or correctional institution.	✓
Return-To-Work Responsibility 51.1-1160	Failure to cooperate with a prescribed rehabilitation program will reduce benefits payable to an employee by 50%.*	
Mental Disorder Limitation	Mental disorders are not limited by the policy.	✓
Subjective Conditions Limitation	Subjective conditions are not limited by the policy.	✓
Reasonable Accommodation Expense Benefit	None	Included- $25,000 per disability
Rehabilitation Plan Provision 51.1-1160	Disability benefits payable to a participating employee who fails to cooperate with a rehabilitation program prescribed for them shall be decreased by 50% of the amounts otherwise payable to such employee.	Confirmed- We may provide training, education, family care, work or job searches during an approved rehabilitation plan.
Rehabilitation Incentive	Disability benefits payable to a participating employee who fails to cooperate with a rehabilitation program prescribed for them shall be decreased by 50% of the amounts otherwise payable to such employee.	Confirmed. Standard also includes an additional 10% benefit while participating in an approved rehabilitation plan.
Waiver Of Premium	None	Included
Survivors Benefit	None	Included- 3 months lump sum gross LTD benefit after 180 days continuous disability.
Employer Contributions to the Defined Contribution Plan	Mandatory employer contributions to the defined contribution component of the hybrid retirement program pursuant to subdivision B 2 of 51.1-169 on behalf of a participating employee shall be made for each employee who is permanently and totally disabled (as defined in 22(e)(3) of the Internal Revenue Code). The calculation of such contributions shall be covered by such plan during periods of absence covered by LTD benefits.	Included

STD Plan Design Comparison

Plan Provision	Current Plan Provision	Confirm with a √ or Include a Deviation
Participation Requirements 51.1-1153	Non-contributory coverage = 100% of eligible employees	✓
Income Replacement For Non-Work-Related Disabilities 51.15-1155	Months Of Continuous Service / Workdays Of Income Replacement At 100% / Workdays Of Income Replacement At 80% / Workdays Of Income Replacement At 60% Less than 12: 0 / 0 / 0 13-59: 0 / 0 / 125 60-119: 25 / 25 / 75 120-179: 25 / 50 / 50 180 or more: 25 / 75 / 25	✓
Income Replacement For Work-Related Disabilities 51.1-1163	Months Of Continuous Service / Workdays Of Income Replacement At 100% / Workdays Of Income Replacement At 80% / Workdays Of Income Replacement At 60% Fewer than 60: 0 / 0 / 125 60-119: 85 / 25 / 15 120 or more: 85 / 40 / 0	✓
Benefit Waiting Period 51.1-1155	Seven calendar days. However, the waiting period will be waived for catastrophic or chronic conditions.	✓
Maximum Benefit Period 51.1-1155	125 work days	✓
Own Occupation Definition Of Disability 51.1-1150: Definitions	The insured is disabled if he or she is unable to perform the essential duties of their own occupation.	✓
Partial Disability 51.1-1150: Definitions	The insured is partially disabled if he or she is working in an occupation but is unable to earn 80% or more of their pre-disability earnings.	✓
Non-Occ Or 24-Hour Coverage 51.1-1162	24-hour coverage	✓
Preexisting Condition Limitation	Not included	✓
Return To Work Responsibility 51.1-1160	Failure to cooperate with a prescribed rehabilitation program will reduce benefits payable to an employee by 50%.	✓
Successive Periods Of Short Term Disability (51.1-1156	The employee does not have to serve a new benefit waiting period if the period of recovery is less than 45 consecutive calendar days.	✓
Catastrophic Condition Benefit 51.1-1171	If the insured is unable to perform two or more activities of daily living without hands-on assistance or requires substantial supervision for their health or safety due to severe cognitive impairment, the benefit percentage will be at least 80% of the insured's pre-disability earnings.	✓

Questionnaire

ATTACHMENT J
QUESTIONNAIRE

The following questionnaire will assist the County in evaluating the quality of care and benefits being offered to employees as well as assist in the evaluation of the financial and administrative information requested of the Offeror. An Offeror's evaluation score will not be adversely impacted if a specific question does not apply.

INSTRUCTIONS

1. Each question and response must be provided in Tab 5 as instructed in Section VII. **An electronic copy of your responses is also requested in Microsoft Word format.**

2. Answer all questions fully, clearly and concisely unless a specific question is inapplicable to the service you are proposing to provide. Graphics/visuals are discouraged in your responses, **just the facts**.

3. Each response must immediately follow the respective question. The question as well as the answer shall be typed. All questions and responses shall be numbered/labeled exactly as in this Questionnaire.

4. If the Offeror is unable to answer a question or the question does not apply, the Offeror shall indicate why.

5. If the Offeror is unwilling to disclose particular information asked in a question, the Offeror shall indicate why.

6. Samples of documents requested in the Questionnaire should be labeled with the corresponding question number and submitted in Tab 5 of your proposal as specified in Section VII of the RFP.

GENERAL INFORMATION

1. Type in the following information:

Point of Contact:	Stephen Lovings
Title:	Senior Employee Benefits Consultant
Company:	Standard Insurance Company
Address:	Glen Allen, Va. 23059
Telephone:	804-980-6031
E-Mail:	Stephen.Lovings@standard.com

2. Have the proposal requirements been fully met as requested in this RFP (see Attachment K for specific contract requirements)?

   [X] Yes [ ] No

   If not, please summarize all deviations and include the summary in Tab 4 as requested in Section VII.

3. Provide background information and a **brief** description of your organization. Include any pertinent information relative to the size and organizational structure of your company.

Standard Insurance Company was founded in 1906 as Oregon Life Insurance Company. It was the first life insurance company in the Pacific Northwest. In 1929, we converted to a mutual company and updated our name to Oregon Mutual Life Insurance Company. In 1931, the company began promoting its bond portfolio of non-callable, high-interest, long-term bonds. The bonds paid returns of 4-5 percent through the worst years of the Great Depression. This provided rare financial security for investors.

As the company expanded, we gained recognition for our customer-centric approach, as well as for product quality and financial strength. In 1946, the company's name changed to Standard Insurance Company. In 1951, Standard Insurance Company wrote its first Group Life insurance policy. It is still in force today. This is a testament to our commitment to building lasting customer relationships.

The Standard is a nationally recognized provider of group Disability insurance today. We provide insurance to approximately 26,500 groups covering more than 7.7 million employees nationwide (based on internal data developed by The Standard as of March 2023). For more than 100 years, we have been dedicated to our core purpose: to help people achieve financial well-being and peace of mind. We have earned a national reputation for quality products and superior service. We are always striving to do what is right for our customers.

4. Please provide pertinent financial data that demonstrates your organization's ability to successfully perform this contract. Include a copy of the most recent annual report. (Include in Tab 7 of your proposal.) Please provide your most recent ratings by each of the following:

Please see Tab 7 of this proposal for our Annual Report as well as the "Our Financial Strength" brochure.

Company	Rating	Date of Rating	Legal Name of Company to Which Rating Applies
Fitch	The Standard actively participates in the ratings process with A.M. Best, Moody's, and Standard & Poor's. We believe we receive a balanced perspective on our mix of business and our investments. We do not subscribe to the Duff and Phelps (Fitch) rating system.	Not applicable	Not applicable
Standard & Poor's	A+, "Strong"	June 2023	StanCorp Financial Group Inc.
Moody's	A1, "Good"	June 2023	Standard Insurance Company
A.M. Best	A, "Excellent"	June 2023	Standard Insurance Company

5. Report any restraining or disciplinary action taken against you by any regulatory body within the last three (3) years.

Our business operates in a heavily regulated industry. Our main regulator is the State of Oregon Insurance Division. Other states also regularly conduct examinations of all insurers operating within their state. These market conduct examinations review an insurer's entire operations in that state.

These examinations bear out a strong record of regulatory compliance. The Standard, like other insurers, has been subject in the past to small regulatory fines in the normal course of business. We are not currently the subject of any disciplinary action, restraints on our license in any jurisdiction or any compliance orders.

In March 2023 we did settle via consent resolution a matter with the Washington Insurance Commission concerning technical rate and form filing procedures unique to that state. The underlying matter applies to the entire industry, not just The Standard, but we chose to settle amicably in exchange for payment of $500,000. Upon conclusion, the Commission sent a similar compliance demand out to all carriers.

6. Please identify all subcontractors (including consultants, advisors, network managers and suppliers) to be used and describe specific responsibilities, qualifications, and background experience of all key personnel. Include financial ratings for each major subcontractor, consultant, or advisor.

Consistent with industry best practices, The Standard contracts with outside partners to help perform certain subprocesses in support of our products and services. Our decisions are driven by a commitment to continuously improve the value we deliver to our customers.

All Coverages

- Health Advocacy Services – Health Advocate
- Electronic Data Transfers – GXS
- Telephonic Translation Services – Lionbridge
- Back-office processes, administrative tasks and simple transactional requests related to the administration of group policies and portal support. – Genpact Limited (Genpact).

Disability

The Standard has established the following partnerships for our disability coverages:

- Employee Assistance Program – Health Advocate
- Social Security Assistance – Allsup Incorporated, Doherty Cella Keane, LLP
- Back-Office Administrative Tasks – Genpact
- Assistance with Medical Record Copies – ReleasePoint
- Claim set-up and claim status inbound calls; adjudication of routine short term disability claims; back-office administrative tasks – Genpact

7. Provide pertinent references. Specifically**, three active and three terminated accounts** (other than mergers), within the last three years. Please provide group name, contact person, telephone number, email address, effective date and termination date.

The Standard does not give references during the initial proposal process. This is a courtesy to our customers. If we are selected as a finalist, we would then provide you with contact information for references from current policyholders. We have partnered with the County to provide disability coverage for over seven years, and we believe that this partnership has demonstrated our ability to provide exceptional results.

If this does not meet your needs, we would be happy to discuss potential solutions with you.

8. Identify the number of groups for which you expect to provide VLDP opt-out STD and LTD plans in 2024.

The Standard provides VLDP opt out coverage to 60 Virginia localities including neighboring City of Richmond Public Schools and Chesterfield County and Schools.

ENROLLMENT/ELIGIBILITY AND ADMINISTRATION

1. What is the location of the claims office that will be processing claims and providing general administration for this account? Indicate if locations are different for STD and LTD or based upon funding arrangement (i.e., ASO, ATP, and fully-insured). Identify service center locations for each of the following functions:

Function	Service Center Location
Claims Processing	Altavista, VA
Eligibility	Altavista, VA
Billing	Portland, OR
Claims Management & Reporting	Altavista, VA
Accounting	Portland, OR
Underwriting	Portland, OR
Account Management	Washington D.C.
Contract Generation	Portland, OR

2. Provide an implementation schedule (in Tab 6 of your proposal) detailing specific activities, target dates, data requirements, and responsibilities for completion. Detail any expenses involved and whether these expenses are included in your pricing.

As the incumbent carrier, implementation is not necessary. The County's services will continue without disruption.

3. What on-line services are available to members?

Employees can initiate a disability claim via our website any time, day or night. The web submission starts with an overview of the process and the information the employee needs to begin. The employee is then guided through a series of claim-related questions. If the employer has provided a data feed, some information (e.g., name and address) will pre-populate. After submitting their information, employees are provided with a confirmation and any remaining forms necessary to complete the claim. Employees also have the option to save their submission and continue it at another time.

The Standard offers a secure, flexible, web-based solution that streamlines the enrollment process, handling the initial setup to create a tailored enrollment process for each employee, based on individual eligibility.

Ready Enroll, The Standard's online enrollment system, is an electronic eligibility and enrollment tool. It streamlines enrollment, beneficiary management and the benefit-education process for Standard Insurance products. Ready Enroll offers a secure, flexible, web-based service. The Standard handles the initial setup and creates a tailored enrollment process for each employee.

Ready Enroll is available for one time enrollment or recurring annual enrollment activity. For customers with over 1000 benefit eligible, Ready Enroll may remain available year-round to manage enrollment activity throughout the year, such as, new employees and life-event updates. This requires regular enrollment files.

For Employees:

- Awareness and appreciation of the benefits available to them
- Information to help make an informed buying decision
- Peace of mind that The Standard will help them meet their financial needs

4. What on-line services are available to benefit administrators?

Conducting enrollments and administering benefit plans can be a burden for employers. The Standard offers a secure, flexible, web-based solution that streamlines the enrollment process, handling the initial setup to create a tailored enrollment process for each employee, based on individual eligibility.

Ready Enroll, The Standard's online enrollment system, is an electronic eligibility and enrollment tool. It streamlines enrollment, beneficiary management and the benefit-education process for Standard Insurance products. Ready Enroll offers a secure, flexible, web-based service. The Standard handles the initial setup and creates a tailored enrollment process for each employee. Employers can use the system's robust reporting options to get the information they need in real time.

Ready Enroll is available for one time enrollment or recurring annual enrollment activity. For customers with over 1000 benefit eligible, Ready Enroll may remain available year-round to manage enrollment activity throughout the year, such as, new employees and life-event updates. This requires regular enrollment files.

A well-designed enrollment strategy will help to meet these objectives.

For Administrators:

- Enhanced employee understanding of the value of their benefits
- Increased confidence in the professional, proven approach
- More efficient delivery of information to individuals, with less disruption in the workplace
- Improved risk results by enrolling a larger portion of your eligible population

To assist you in managing your employee benefits program, we offer our secure, online AdminEASE plan administration tools. The services are customized to the group insurance products purchased with The Standard. AdminEASE[SM] displays a combination of real-time and daily updated data.

The AdminEASE Advantage:

- Reduce paperwork, increase the security of your data, and speed up plan administration from initiating claims to distributing forms
- Access contract and policy documents, view historical billing statements, billing and payment information, pay premium for Life, LTD and STD coverage, initiate and monitor claims, get administrative forms and download reports
- Control user access privileges to services
- Ease-of-use with intuitive site layout, navigation and tools

Billing

- Access current premium details and billing statement by billing division (daily)
- View up to 24 months of historical billing and payment information (daily)
- Select a particular due date to view detailed billing information by coverage (daily)
- Pay premium for Life, LTD and STD coverage

Claims Management

- Initiate the employer portion of LTD and STD claims for insured and self-funded plans
- View daily claims status and payment information for STD, LTD and statutory Disability
- Evaluate Disability claim trends and expenses (daily) with case management reports (quarterly)
- Download claim data for further analysis (daily)

Medical Evidence (real-time)

- Monitor and track the status of medical evidence applications
- Download details on insurance coverage approvals and benefit amount
- Provide employees a tool with step-by-step instructions for quick and easy completion of state-specific Evidence of Insurability applications

Contract Documents (real-time)

- Get fast access to group policies, certificates, amendments and notices
- Print, email or post group certificates to company intranet

Forms (real-time)

- Access a library of customized administrative and claim forms specific to an employer's coverage and provide links for employee to fill out form online and print
- If printed materials are preferred, you can order paper forms using the convenient, online order form.

Daily Reports

- Disability (STD, LTD and Statutory) claim status
- Disability claims payment detail
- Claims-to-pay and claims in non-pay status (for self-funded STD and Statutory only)

Quarterly Reports

- Disability benefits paid by diagnosis and occupation
- Disability claim duration by diagnosis and closure reason
- Paid claims (insured and self-funded STD and Statutory only)

5. Do you provide automated, interactive telephone service? Is there always an option to default to a customer service representative? During what hours is a customer service representative available to take calls?

Yes. All incoming calls flow through our integrated voice response (IVR) system. The IVR offers two options to the caller:

- Transfer to a Spanish representative
- Transfer to the directory to enter an extension or name to speak to a specific individual

The Standard's IVR is natural language. This means the IVR asks the caller "How may I help you" versus giving options.

Employees can access their claim information 24 hours a day, seven days a week. With proper identification, IVR provides:

- Information on STD and LTD claim status
- The date last benefit payment was issued
- Amount of last benefit payment issued
- Payment history
- Fax number and address for claim form submission

Employees with Absence services may report an absence. Our IVR is natural language and captures the caller's intent. The IVR asks – "How may I help you today?" It then offers prompts – "You may say, new claim, claim status, claim payment, report an absence, etc."

The caller can opt out at any time. The caller just has to say Operator, Agent or Representative. Intelligent Call Routing delivers the call to the contact center representative who is best qualified to handle the call. The system finds the person with the specialized skills or experience required to meet the caller's needs.

Our normal business hours are Monday through Friday, 8 a.m. to 8 p.m. Eastern Time. Telephone calls received after normal business hours are directed through the IVR system.

6. Do the customer service representatives have the authority to resolve problems immediately? What is the percentage of problems that are resolved during the initial call?

Contact Center Representatives have the authority to immediately resolve many caller issues. However, we do not track First Contact Resolution.

7. Do you have the capability of accepting eligibility records electronically? Please provide a sample file format compatible with Oracle HRMS.

There is a data feed in production today supporting Telephonic Claim Intake for the STD and LTD products. This file feed can stay in place to support these products.

8. To what extent will the County be allowed to customize the enrollment and communication materials that will be provided to members? What additional costs will be associated with customization?

We have prepared custom materials for the County in the past. If additional materials are needed, we would be happy to discuss. There is not an additional cost for the communication materials.

9. How are claim disputes handled? Please describe your appeal process for a fully-insured plan. What is your turnaround time for response to claim disputes?

The Standard handles all claim decisions carefully. When we must decide to limit, close or deny a claim, we give the employee the chance to appeal. Employees are notified of:

- Their right to request a review of the decision within 180 days of the decision letter
- The reasons for limitation, denial or closure
- Additional information that may be helpful if he or she requests a review, including the decision from the Social Security Administration, if applicable
- Our policy of reviewing all information the employee submits
- Any internal guideline used in in evaluating the claim
- Notice of the right to receive relevant documents without charge
- Notice of Important Language Information

Employees must submit requests for review in writing. They are not required to submit more information to exercise their review rights. The employee (or the employee's authorized representative) has the right to review relevant claim documents and to submit comments in writing for The Standard to review.

Additionally, The Standard provides a second STD appeal within 90 days of the initial appeal review. With self-insured claims, Henrico County has the ultimate authority as the plan sponsor and will be consulted in the final determination. Additionally, Henrico County may request information regarding and contained in the claim file.

If a review is requested, the Benefits Examiner or Benefits Analyst immediately refers the claim file to the Administrative Review Unit (ARU) for an independent review. An ARU Benefits Review Specialist analyzes the claim facts and conduct a full investigation, if needed. If the original claim involved a Physician Consultant, we consult with a different Physician Consultant during the appeal. The ARU Benefits Review Specialist informs the employee at least every 15 days about the claim's review and investigation status and informs the employee in writing about the results of the independent review.

10. Will your company provide assistance with claims disputes for a self-insured plan where you are providing ATP? If so, is this included in the standard fees?

Yes, The Standard provides an independent review of an adverse claim decision upon receipt of a request for review from the claimant within 180 days. Additionally, The Standard provides a second STD appeal within 90 days of the initial appeal review. With self-insured claims, Henrico County has the ultimate authority as the plan sponsor and will be consulted in the final determination. Additionally, Henrico County may request information regarding and contained in the claim file. This is included in the fees.

11. What tax-related services (W-2s, withholding and remittance of FICA, etc.) can be provided to the County for the STD and LTD plans? Please break these services out for ATP and fully-insured funding and indicate if any of the services are included in premiums/administrative fees and which are optional. Outline the applicable pricing for any optional tax-related services.

The County provides the claim payment and any required taxation or reporting to the employee for ATP-STD claims.

For the LTD, we:

- Calculate and pay the employer's FICA liability for taxable benefits
- Report employer FICA/Tier 1 taxes withheld on IRS Form 941 quarterly for taxable benefits
- Prepare and Transmit IRS W-3 form
- Prepare W-2 forms to all claimants who received LTD benefits during the tax year

We do not require LTD policyholders to reimburse The Standard for the employer's portion of Social Security and Medicare taxes (FICA) paid to the IRS on their behalf.

As documentation of our tax withholding services, we provide policyholders with:

- Monthly Group Benefits Activity reports
- Annual Disability Income Report (DIR)

The Group Benefits Activity report includes a monthly summary of FICA/Tier 1 and other deductions withheld from benefits. The DIR, mailed in first working week in January, provides yearly totals for benefit payments and taxes withheld and adjusted during the previous year. The DIR also serves as an official record that The Standard is preparing the annual W-2s on the LTD plan.

12. Please provide a detailed list of all services that will be included as standard in your fee for ATP.

All self-insured services include the following:

- Claim intake, review and adjudication
- Duration and Plan management services
- Our plan document
- Specialty examinations, such as FCEs and IMEs included in fees if deemed necessary by The Standard

We also manage appeals for STD for the County.

13. Please provide a detailed list of STD ATP services that are optional for the County to purchase and the associated fee/charge.

There are no additional STD ATP services that we offer.

14. Please provide a list of the standard management reports (claims, etc.) that are included in your fully-insured premium rates and ATP fees.

Reports Online[SM], our web-based claims management reporting system, provides employers access to claims information. Reports include:

Daily Reports

- Disability claim status
- Disability claims payment detail (LTD only)
- Claims-to-pay and claims in non-pay status (for self-funded STD and statutory only. Not available for LTD)
- Benefit Calculation Report (LTD only)

Quarterly Reports

- Disability benefits paid by diagnosis and occupation
- Disability claim duration by diagnosis and closure reason
- Paid claims (insured and self-funded STD and statutory only – not available for LTD)

15. Does your company offer the capability of reporting short-term disability claims telephonically or online? If so, please describe the process, including any charges/fees that would apply.

Yes. We currently have a telephonic intake program implemented with the County and Schools for the Hybrid Disability Plan.

Employers and employees submit all disability claims to The Standard's Customer Contact Center. Employees can choose telephone if these services have been implemented as well as web or paper intake methods, available with or without a feed.

Both employers and employees report claims to our Interactive and Responsive Customer Contact Center.

To enhance your employees experience in filing a claim telephonically, The Standard's Contact Center system provides:

- Voice Recognition with natural language instead of complex push button menus
- Screen Pops that provide caller information to representatives to streamline the conversation
- Intelligent Routing to direct calls to the appropriate team based on the caller's intent
- Call Back Assist that allows the customer to maintain their place in the queue when they request a call back.

Our integrated approach:

- Eliminates repetitive storytelling
- Creates a better experience for you and your employees

16. Do you offer a formal rehabilitation program for claimants on STD and LTD? Please explain any contractual provisions related to this program. Will this program be offered on a fully-insured basis and with ATP services?

Exclusive to The Standard, employers of any size can access a vocational or nurse consultant directly, via phone or fax, to request services. These consultants help employers with difficult, time-consuming tasks like identifying and coordinating accommodations and assisting employees in staying at work. And we can provide personalized attention such as an embedded evaluation of an employee's work area to determine what accommodations might be possible. A disability claim does not have to be filed to take advantage of this service.

We utilize our generous Reasonable Accommodation Expense and Rehabilitation Plan provisions to provide accommodations, assistive devices, modifications, training and other assistance to help covered employees remain on the job. In complex cases, we employ local case managers to coordinate with the employee's medical providers, analyze job demands, offer accommodations, and provide new skills training as needed.

After a disability claim is filed, our Nurse Case Manager, Behavioral Health Case Manager, Vocational Case Manager and benefit analyst monitor recovery and look for opportunities to offer accommodations, case management, training and similar rehabilitation assistance to return employees to work as soon as feasible. Additionally, they can act as a conduit to other, available benefits.

Systematically, we assess transferable skills, labor market opportunities and the employee's interests and motivation. We then use a deliberative process to evaluate the complex issues that may be involved, as the assistance may mean a change of career.

With the employee's full participation, we develop a suitable plan and implement provisions that help him or her return to work. When applicable, treating physicians may review the proposed services before they are initiated.

For groups that desire a proactive, prevention-based return to work program we offer our Workplace Possibilities[SM] program. Our expert resources and provisions aim to address covered employees' needs immediately, so they can be more satisfied and productive at work. A local Consultant offers early intervention to covered employees to help them stay at work or to assist them in returning to work as soon as medically feasible, after a claim is filed.

Signature Workplace Possibilities[SM] Program Feature: The Workplace Possibilities Consultant

The Workplace Possibilities Consultant is our program's most differentiating feature. Ideally working in or near the city location of our customer's HR team, consultants act as an extension of your human resources team to assist employees whose medical conditions hinder their productivity. In addition to receiving referrals from your HR team, consultants can proactively identify covered employees who may benefit from rehabilitation services such as: referral to appropriate care, accommodation assistance, job analysis, skills training and job modifications. Their key objectives are to:

- Remove barriers to employee productivity
- Reduce disability duration
- Identify appropriate accommodations to keep employees at work and productive
- Identify return-to-work candidates at the earliest possible point
- Promote open communication between all parties
- Understand our customer's procedures, policies and philosophies regarding return to work and stay at work

The Workplace Possibilities[SM] Consultant is a medical or vocational professional with national certification, years of vocational or medical experience, ergonomic expertise, and the ability to proactively assist your employees to work healthfully, productively, and comfortably. Consultants are available to come embedded based on the level of referrals, complexity of cases and the services that are provided. This innovative service is a claims-related expense paid through our generous Reasonable Accommodation Expense benefit.

This will apply to both fully insured and ATP services as long as the member is insured for LTD.

17. Provide a brief description of the disability management process that will be included for the County's program? Will this apply for both fully-insured and ATP services?

Exclusive to The Standard, employers of any size can access a vocational or nurse consultant directly, via phone or fax, to request services. These consultants help employers with difficult, time-consuming tasks like identifying and coordinating accommodations and assisting employees in staying at work. And we can provide personalized attention such as an embedded evaluation of an employee's work area to determine what accommodations might be possible. A disability claim does not have to be filed to take advantage of this service.

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This will apply to both fully insured and ATP services as long as the member is insured for LTD.

18. Please explain your contractual provisions and claims administration procedures specific to short-term disability plan coordination of benefits with workers' compensation. For example, what are the procedures that are followed when a claim is submitted for STD that appears to be work-related? What procedures are followed while that claimant is pending approval of workers' compensation benefits – are STD benefits paid and later recovered or is the claimant's STD claim pended until the workers' compensation claim is approved or denied?

The Standard subtracts workers compensation from the total benefit if the plan does not limit coverage for work-related conditions.

We can also coordinate clinical development and rehabilitation efforts.

Our Benefits and Vocational staff work with the workers' compensation team to ensure correct payment and benefits. With approval, we will share medical information and manage return to work services. Our claims form specifically ask whether the disability is due to an occupational injury.

19. Do you provide support in administering and/or coordinating FMLA in conjunction with the County's disability benefits?

Employers are notified when claims are approved and can monitor all claim statuses on Reports Online via our online portal, AdminEASE. These reports and/or other customize built reports reflect approved through dates and other pertinent data in situations where the FMLA administrator may be utilizing the disability status as a proxy decision on the leave. The Standard offers an integrated STD and Absence/FMLA administration model but we also have experience in partnering with existing third party leave administrators in the intake and/or integration of STD and leave.

20. What assistance will be rendered to claimants to obtain a disability award from Social Security? Explain any assistance with the application process and any assistance rendered for the appeal process. Will this be different for ATP and fully-insured funding arrangements?

The Standard asks disabled employees to apply for Social Security benefits if they are likely eligible. We offer them our primary Social Security vendor's help to obtain Social Security Disability awards. We have several full-time Social Security Coordinators on site. They screen new LTD claims for Social Security viability and offer Social Security representation.

Our Social Security assistance program coaches, mentors and represents disabled employees by helping them start the application for Social Security Disability benefits. We assist with the employee's appeals and can provide representation at the Administrative Law Judge Hearings level. The vendor provides status updates to the employees and The Standard throughout the application process. This ensures early applications and reduced overpayments. Our Social Security assistance program also provides Social Security offset and overpayment recovery management.

BILLING/FINANCIAL

1. Please explain the billing process for fully-insured LTD. How long does it normally take for your billing department to make requested adjustments?

Our premium billing system is self-administered. This means that the policyholder maintains eligibility and census information. They only need to provide aggregate information each month. Premium statements will reflect the prior month's:

- Aggregate number of lives.
- Insurance volume.
- Current in-force rate for each coverage.

The policyholder adjusts the statement to reflect any changes. They will add or subtract lives and insurance volume. Premium is then remitted based on the new aggregate numbers.

Billing statements are generated and mailed about 11 to 13 days before the due date. The first statement will reflect the census information provided when coverage was first applied for. The policyholder is then responsible for updating these figures before sending payments.

We can accept payment online via:

- AdminEASE℠
- Check
- Wire or ACH

Premiums are due the first of the month. There is a 60-day grace period.

Premiums are considered delinquent if they are not received by the due date; however, no delinquency process is started until after the end of the grace period. There are no penalties or interest charged for late payments.

If the policy is terminated due to missed payments, we may require a fee that includes any past due amounts before we reinstate the policy.

2. Please explain the billing arrangement for STD ATP.

The STD ATP is billed on the same basis as the LTD on a per $100 of creditable compensation enrolled in the Hybrid retirement system.

3. Describe your renewal process for the STD and LTD plans (timing, communications support, utilization review, etc.).

The Standard's underwriting process and renewal rating is based on our best prediction of the premium needed to pay for the claims incurred in the next year (and our related expenses). We may review three components of rating to help you get the most value out of your benefits program and reduce your overall costs.

Our formulas include three different analyses of experience:

First, we look at the *demographics (also known as The Manual Rate)*. The Standard has thousands of insured groups. We use this data and actuarial tables to analyze the employees (and their occupations) along with the plan design. This information is used to prepare a calculated rate: the best estimate of a group's experience in the long term. When the group is of a smaller size and experience is not credible the underwriter will rely more heavily on this for rating.

Next, we review the *recent experience (known as The Experience Rate)*. The industry standard is known as an "Incurred Experience Analysis". This approach applies claims -- reserves and paid claims -- to the time period in which the claim was incurred. We typically look at the most recent five years, and use the resulting formulas to generate an experience rate.

If applicable, we use a formula to determine how credible your Experience Rate is in predicting your future claims costs and blend it with your Manual Rate. This produces a *Blended Rate* that we use to determine your final renewal pricing.

The Standard does not use future rating to recover losses.

After the formulas, The Standard goes "*beyond the numbers*". We make sure the formula accurately represents future expectations:

- Did the group have a bad year due to layoffs that we do not expect to repeat in the future?
- Was there an unusually large claim that we should discount?
- Have plan design changes occurred that will be reflected in the future?
- Has the makeup of the group changed, e.g. are they hiring a lot of younger employees?

At The Standard, we believe in reasonable rate stability. We will find the correct long term rate rather than jumping around to the last rate a formula suggests.

The following are the various components of experience rating a proposal or renewal:

1. Incurred Experience: Experience is analyzed on an Incurred basis. We match the total claims incurred in one year to the adjusted premium from that year. This approach prevents the experience from being impacted by claims originally incurred many years ago.

2. Earned and Adjusted Premium: Earned Premium includes premium that was actually due during the period shown. It does not include overpayments or adjustments from other periods. Therefore it reflects the group's actual insured volume and is not impacted by payment oddities. This premium is adjusted to the current rate to insure that all years risk gets equal weight, and is not skewed by radical rate changes.

3. Total Incurred Claims: Total Incurred Claims are made up of the following components: We include every claim that was incurred in a given period, including the total cash paid for that claim (all years for that claim), and its ending reserve. The most recent period will also include a fully funded IBNR (Incurred But Not Reported) Reserve. This represents the claims that have been incurred, but not reported to The

Standard. We typically give less weight to this period since the IBNR is an estimate, and often is a substantial portion of the claims in that period. Also, for LTD only, an adjustment for Interest Credit is included. This is credit for interest earned from the investment of reserves.

4. Retention: Retention includes all expenses and risk charges. These include administrative expenses, premium taxes and commissions (when appropriate), claims expenses, etc. The retention is shown based on the current percentage (not historical) applied to the past period's Adjusted Premiums. We are measuring whether the current rate will adequately fund expected claims and expenses.

5. Experience Rate: This rate would have run the experience in the period at breakeven. However, this assumes we believe the experience 100%. The rate includes retention.

6. Loss Ratio: This ratio indicates what percentage of Adjusted Premiums were used for claims. It does not include retention.

7. Life Years & Credibility: A life year is one insured member for one year. It is used to determine credibility: the larger the group, and the longer insured, the more we believe the experience.

8. Experience Formula: We have two major components in our experience formula. We combine the Experience Rate with the Calculated Rate to determine our Blended Rate. The two components are blended based on the credibility.

9. Renewal Rate: The Blended Rate is the rate the formula predicts will run the experience in the future.

As always, our goal is to help you take care of your business and your employees. Renewal time lets us work together to re-evaluate your plan design, benefits usage and discuss your future options.

4. How long will you guarantee your quoted rates/fees? Please provide these rate/fee guarantees with your price quotations.

Proposed rates are guaranteed from January 1, 2024 to December 31, 2026. If the plan is changed by amendment or by law, or if there is a significant change in the size of the group, we reserve the right to re-rate the group. At renewal, rates are developed using a combination of calculated rates and the group's experience. The group will normally be given 180 days written notice of rate change.

5. Are you willing to offer performance guarantees? If so, please outline them on Attachment I.

Our policyholders decide what aspects of service are most important to them through the Performance Guarantee Program. They do this by rating their satisfaction based on those criteria. The Standard promises to make every effort to meet those overall service expectations.

If we fail to meet expectations, we will refund five percent (5%) of the previous quarter’s plan administration expenses, excluding commission, premium tax and risk charges.

6. Please outline any minimum participation levels for the VLDP comparable program (STD or LTD). Indicate if this would be different based on the funding arrangement (ATP and fully insured).

The minimum participation is 100% of the group's employees enrolled in the Virginia Hybrid Pension plan as required by Virginia law.

Implementation Timeline

Implementation Timeline Response

As the incumbent carrier, implementation is not necessary. The County's services will continue without disruption.

Annual Report and Financial Statements

StanCorp Financial Group, Inc.
Annual Report

In an effort to better manage source reduction, a link to our Annual Report has been provided.

To view an online copy of our Annual Report on our website: http://www.stancorpfinancial.com; choose Financial Reports, then select Statutory Statements.

The Standard: Built on a Foundation of Financial Strength

These last few years have shown the importance of financial strength, organizational stability and expertise.

The Standard was founded in 1906 and our fiscally prudent management approach has helped us navigate through periods of significant volatility to ensure we can keep our financial commitments and grow profitably. This approach is built on the strength of our disciplined financial practices, sound investment strategies, unique mix of high-performing businesses, strong products and services and deep expertise.

Our company remains focused on meeting the challenges ahead and taking advantage of opportunities as they arise, all while providing the best possible experience for our customers.

Bond Portfolio

Our bond portfolio is strong. Our strategy is to maintain a diversified portfolio of high-quality, fixed-maturity securities to keep us well-protected should any industries experience difficulties. As of Dec. 31, 2022, we have:

- A $13.14 billion portfolio
- An average portfolio credit quality rating of “A” as measured by Standard & Poor’s

Commercial Mortgage Loan Portfolio

Our commercial mortgage loans have consistently provided a superior balance of risk and return. We offer small commercial mortgage loans to borrowers who want a fixed rate over time, and we rigorously underwrite every commercial mortgage loan we make. The quality of our commercial mortgage loan portfolio is excellent. As of Dec. 31, 2022, we have:

- An $8.83 billion portfolio (on approximately 5,700 loans)
- An average loan size of approximately $1.5 million

Financial Strength Ratings

In the July 2022 issue of *Best’s Review*, A.M. Best Company recognized Standard Insurance Company for maintaining a financial strength rating of “A” or higher each year since 1928, the first year of A.M. Best’s ratings. The Standard was honored to be among one of only eight life and health insurers to achieve an “A” rating or higher for each of the past 94 years. Given rapidly evolving markets, changing customer needs and challenging economic times, we are proud of this longstanding track record of financial strength.

Dan McMillan
President and CEO

Standard Insurance Company Financial Strength Ratings

A+ (Strong) by Standard & Poor’s
Fifth of 20 ratings

A1 (Good) by Moody’s
Fifth of 21 ratings

A (Excellent) by A.M. Best*
Third of 13 ratings

As of Feb. 28, 2023

* Rating includes The Standard Life Insurance Company of New York

Balance Sheet as of Dec. 31, 2022

Assets	$38.20 billion
Fixed-Maturity Securities	57.0% of cash and investments
A- or Higher	63.7%
BBB- to BBB+	31.2%
BB- to BB+	3.4%
B+ or Lower	1.7%
Commercial Mortgage Loans	38.3% of cash and investments
Real Estate and Other Invested Assets	2.0% of cash and investments
Cash and Cash Equivalents	2.7% of cash and investments
Portfolio Yields	
Fixed-Maturity Securities	3.98%
Commercial Mortgage Loans	4.57%

Capital and surplus of the insurance subsidiaries was in excess of 425% of the Company Action Level Risk-Based Capital required by regulators.

Corporate Profile

StanCorp Financial Group, Inc., through its subsidiaries marketed as The Standard — Standard Insurance Company, The Standard Life Insurance Company of New York, Standard Retirement Services, StanCorp Mortgage Investors, StanCorp Real Estate and StanCorp Equities — is a leading provider of financial products and services. StanCorp's subsidiaries offer group and individual disability insurance, group life and accidental death and dismemberment insurance, group dental and group vision insurance, group accident, critical illness and hospital indemnity insurance, absence management services, retirement plans products and services, individual annuities, and the origination and servicing of fixed-rate commercial mortgage loans. For more information about StanCorp Financial Group, Inc., visit the Investor Relations pages on **standard.com**.

StanCorp Financial Group became part of the Meiji Yasuda family of companies in 2016. The Standard serves as Meiji Yasuda's primary U.S. presence and partner, maintaining its Portland, Oregon, operations and headquarters as well as its employees, management team, brand, product mix, distribution channels and community support.

Meiji Yasuda and The Standard are both leaders in group benefit insurance in their respective markets. Meiji Yasuda, a mutual company owned by policyholders, was founded in 1881 and is headquartered in Tokyo. It is the oldest and third-largest life insurance company in Japan, with the largest share of group insurance in the Japanese market. With more than 47,000 employees and 12 million customers, Meiji Yasuda specializes in group and individual life insurance, bancassurance and group annuity products, and has assets of $360 billion and premium income of $19 billion as of March 31, 2022. In addition to Japan, Meiji Yasuda has insurance operations throughout the U.S., Poland, China, Indonesia and Thailand.

Except where indicated, data represents consolidated results for StanCorp Financial Group, Inc.

Pricing/ Cost Proposal

Presented by:

The Standard

Proposal And Cost Summary

Prepared for:

Henrico County, Virginia

- **Group STD Advice to Pay**
- **Group Long Term Disability Insurance**

How The Standard's Focused Expertise Can Benefit Your Business

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we're

Key Reasons To Choose The Standard

Partnership Focus	Standard's 40 resources and personal, responsive service. We're here to minimize your – we're easy to reach
Long-Term Perspective	We've tailored this proposal to address your needs, today and for the long combinations. We also emphasize giving you the "right rate" from the
Proactive Approach	• ™

We Keep Our Promises

STD Plan – Advice to Pay (ATP)

Covered Members

Plan

STD Weekly Benefit

Months of Continuous Service			
Less than 12			
13 - 59			
60 - 119			
120 - 179			
180 or more			

Accident/Sickness Benefits begin on day	
Major/Catastrophic Conditions Benefits begin on day	
Maximum Benefit Period	

Features

-

LTD Plan

Covered Members

[illegible]

[illegible]

[illegible]

Plan

LTD Income Benefit	[illegible]
Creditable Compensation	[illegible]
Maximum Monthly Benefit	[illegible]
Minimum Monthly Benefit	[illegible]
Benefit Waiting Period	[illegible] Employer's short term disability benefits program, [illegible]
Maximum Benefit Period	59 or younger…To age 65 SSNRA 60 through 64…5 years [illegible]through 68…To age 70 69 or older…….1 year
Own Occupation Period	[illegible]
Guarantee Issue (benefit)	[illegible]
Eligibility Waiting Period	[illegible]
Employer Contribution	[illegible]
Benefit Taxation	[illegible]

Features

- [illegible]

Cost:

-

□□□

Producer Compensation Disclosure

[illegible] **www.standard.com/compensation/eb/** [illegible]

[illegible] **Rates are net of commission**
[illegible] **N/A**

[illegible] producer's block of business. For information about our customary producer rewards program visit **www.standard.com/compensation/eb/** [illegible]

[illegible]

[illegible]

Sample Documents

CERTIFICATE

SHORT TERM DISABILITY INCOME BENEFIT PROGRAM

Program Sponsor has established a short term disability income benefit Program and agreed to provide STD Benefits according to the terms of the Program Document. Program Sponsor is solely responsible for payment of STD Benefits payable under the terms of this Program.

Program Sponsor has retained Standard Insurance Company as Claims Administrator for the Program. Standard shall receive, process, investigate and evaluate claims for benefits. Standard has authority to make initial decisions to approve, deny or close claims for benefits. Standard is also authorized to review and decide appeals of denied or closed claims, if requested by claimants as provided in the appeal provision of the Program. Thereafter, Program Sponsor may elect to hear and decide any further appeals by claimants. In each case, Program Sponsor retains the right of final review and decision on all claims and appeals.

Standard will also perform certain administrative services for the Program, including advising and assisting Program Sponsor with preparation and revision of the Program and providing actuarial services. Standard has no authority or obligation with respect to management or investment of the assets of the Program or Program Sponsor's right of subrogation under the Program.

This Program and the individual applications, if any, of the Members constitute the entire Program. Program Sponsor has the right at anytime to amend or terminate this Program or to require or change the amount of Member contributions. No change in this Program will be valid unless approved by Program Sponsor and evidenced by an amendment. No agent has authority to change this Program or to waive any of its provisions.

For purposes of effective dates and ending dates under this Program, all days begin and end at 12:00 midnight Standard Time at Program Sponsor's address.

All provisions on this and the following pages are part of this Program. "You" and "your" mean the Member. "We", "us", and "our" mean Standard Insurance Company acting in its capacity as Claims Administrator on behalf of Program Sponsor. Other defined terms appear with their initial letters capitalized. Section headings, and references to them, appear in boldface type.

Table of Contents

Index of Defined Terms

COVERAGE FEATURES

This section contains many of the features of your short term disability (STD) coverage. 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 PROGRAM INFORMATION

Program Sponsor:	Henrico County, Virginia
Employer(s):	Henrico County General Government, Henrico County Public Schools, the Henrico County Economic Development Authority
Claims Administrator:	Standard Insurance Company
ATP Number:	649721-B
Program Effective Date:	January 1, 2019

Member means:

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. Actively At Work at least the minimum hours per week required by the Employer for coverage under the Program, but in no event less than 20 hours each week (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); and
3. A citizen or resident of the United States or Canada.

Member does not include a temporary or seasonal employee, a full-time member of the armed forces of any country, a leased employee, or an independent contractor.

Class Definition: None

SCHEDULE OF COVERAGE

Eligibility Waiting Period: You are eligible on one of the following dates, but not before the Program Effective Date:

a. With respect to coverage for a Disability arising out of or in the course of employment with the Employer, your first day as a Member.

b. With respect to coverage for any other Disability, the first day after one year employment with the Employer.

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

STD Benefit:

For a Disability arising out of or in the course of employment with the Employer:

The STD Benefit provides income replacement for (i) 60 percent of a Member's Predisability Earnings for the first 60 months of continuous participation in the Virginia hybrid retirement program described in § 51.1-169 of the Code of Virginia and (ii) thereafter, a percentage of a Member's Predisability Earnings during the periods specified below, based on the number of months of continuous participation in the Virginia hybrid retirement program attained by an employee who is disabled, on maternity leave, or takes periodic absences due to a major chronic condition, as determined by the Board or its designee, as follows:

Months of Continuous Participation	Work days of 100% Replacement of Creditable Compensation	Work days of 80% Replacement of Creditable Compensation	Work days of 60% Replacement of Creditable Compensation
Fewer than 60	0	0	125
60-119	85	25	15
120 or more	85	40	0

For any other Disability:

The STD Benefit provides income replacement for (i) 60 percent of a Member's Predisability Earnings after 12 months of continuous participation through the first 60 months of continuous participation in the Virginia hybrid retirement program described in § 51.1-169 of the Code of Virginia and (ii) thereafter, a percentage of a Member's Predisability Earnings during the periods specified below, based on the number of months of continuous participation in the Virginia hybrid retirement program attained by an employee who is disabled, on maternity leave, or takes periodic absences due to a major chronic condition, as follows:

Months of Continuous Participation	Work days of 100% Replacement of Creditable Compensation	Work days of 80% Replacement of Creditable Compensation	Work days of 60% Replacement of Creditable Compensation
60-119	25	25	75
120-179	25	50	50
180 or more	25	75	25

Minimum: None

Assisted Living Benefit: An additional 20% of your Predisability Earnings, not to exceed a total STD Benefit of 80%. The Assisted Living Benefit is not reduced by Deductible Income.

Benefit Waiting Period: 7 calendar days. The Benefit Waiting Period is waived when the Assisted Living Benefit applies. See **Assisted Living Benefit** and **First Day Assisted Living Benefit**.

Maximum Benefit Period: 125 work days

If you are Disabled for less than one full week, Program Sponsor will pay one-seventh of the STD Benefit for each day of Disability.

MEMBER CONTRIBUTIONS

Coverage is: Noncontributory

STATEMENT OF COVERAGE

If you become Disabled while covered under the Program, Program Sponsor will pay STD Benefits according to the terms of Program after we receive Proof Of Loss satisfactory to us.

(ASO) ST.IC.OT.1

BECOMING COVERED

To become covered you must be a Member, complete your Eligibility Waiting Period, and meet the requirements in **Active Work Provisions** and **When Your Coverage Becomes Effective**.

You are a Member if you are:

1. A regular employee of the Employer and who is participating in the Virginia hybrid retirement program described in § 51.1-169 of the Code of Virginia;
2. Actively At Work at least the minimum hours per week required by the Employer for coverage under the Program, but in no event less than 20 hours each week (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); and
3. A citizen or resident of the United States or Canada.

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

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

(ASO_VAR MBR DEF) ST.BI.OT.1X

WHEN YOUR COVERAGE BECOMES EFFECTIVE

Subject to the **Active Work Provisions**, your coverage becomes effective on the date you become eligible.

ACTIVE WORK PROVISIONS

A. Active Work Requirement

   You must be capable of Active Work on the day before the scheduled effective date of your coverage or your coverage 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 coverage, your coverage 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 Material Duties of your Own Occupation at your Employer's usual place of business.

B. Changes In Coverage

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

(ASO) ST.AW.OT.1

WHEN YOUR COVERAGE ENDS

Your coverage ends automatically on the earliest of:

1. The date the last period ends for which a payment was made for your coverage.
2. The date the Program terminates.
3. The date your Employer's coverage under the Program terminates.

4. The date your employment terminates.

5. The date you cease to be a Member. However, your coverage 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 coverage under the Program 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 Benefit Waiting Period and while STD Benefits are payable.

(ASO) ST.EN.OT.1

REINSTATEMENT OF COVERAGE

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

1. If your coverage ends because you cease to be a Member and if you become a Member again within 90 days, the Eligibility Waiting Period will be waived.

2. If your coverage 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 coverage will be reinstated pursuant to the federal or state-mandated family or medical leave act or law.

3. In no event will coverage be retroactive.

(ASO_NONOCC) ST.RE.OT.4

DEFINITION OF DISABILITY

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

   A. Own Occupation Definition Of Disability; or

   B. Partial Disability Definition.

A. Own Occupation Definition Of Disability

   You are required to be Disabled only from your Own Occupation. You are Disabled from your Own Occupation if, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder, you are unable to perform the Material Duties of your Own Occupation with reasonable continuity.

   Note: You are not Disabled merely because your right to perform your Own Occupation is restricted, including a restriction or loss of license.

   You may work in another occupation while you meet the Own Occupation definition of Disability. However, you will no longer be Disabled when your Work Earnings from another occupation exceed 80% of your Predisability Earnings.

   Own Occupation means any employment, business, trade, profession, calling or vocation that involves Material Duties of the same general character as the occupation you are regularly performing for your Employer when Disability begins. In determining your Own Occupation, we are not limited to looking at the way you perform your job for your Employer, but we may also look at the way the occupation is generally performed in the national economy. If your Own Occupation involves the rendering of professional services and you are required to have a professional or

occupational license in order to work, your Own Occupation is as broad as the scope of your license.

Material Duties means the essential tasks, functions and operations, and the skills, abilities, knowledge, training and experience, generally required by employers from those engaged in a particular occupation, that cannot be reasonably modified or omitted. In no event will we consider working an average of more than 40 hours per week to be a Material Duty.

B. Partial Disability Definition

You are Partially Disabled when you work and, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder, you are unable to earn 80% of your Predisability Earnings or more.

Your Work Earnings may be Deductible Income. See **Return To Work Provisions** and **Deductible Income**.

ST2.DD.11

RETURN TO WORK PROVISIONS

A. Return To Work Incentive

You may serve your Benefit Waiting Period while working if you meet the Own Occupation 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 1. is greater than 2., the difference will be Deductible Income.

B. Work Earnings Definition

Work Earnings means your gross weekly earnings from work you perform while Disabled, plus the earnings you could receive if you worked as much as you are able to, considering your Disability, in work that is reasonably available in your Own Occupation. Work Earnings includes 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 week to week, we may determine your Work Earnings by averaging your earnings over the most recent four-week period. You will no

longer be Disabled when your average Work Earnings over the last four weeks exceed 80% of your Predisability Earnings.

.RW.OT.1X

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: 45 consecutive calendar 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 coverage plan under which you become covered during your period of recovery.
5. Except as stated above, the provisions of the Program will be applied as if there had been no interruption of your Disability.

(ASO) ST.TR.OT.2X

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 attain normal retirement age under the Virginia hybrid retirement program.
4. The date you die.
5. The date long term disability benefits become payable to you under a group long term disability plan, even if that occurs before the end of the Maximum Benefit Period.
6. The date benefits become payable to you under any other disability coverage plan under which you become covered through employment during a period of Temporary Recovery.
7. The date you fail to provide proof of continued Disability and entitlement to STD Benefits.

PREDISABILITY EARNINGS

Your Predisability Earnings will be based on your earnings in effect on your last full day of Active Work.

The Member's STD Benefit will be adjusted to reflect any salary increase awarded during the period covered by STD Benefits.

Predisability Earnings means your weekly rate of creditable compensation 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.

Predisability Earnings does not include:

1. Bonuses.
2. Commissions.
3. Overtime pay.
4. Stock options or stock bonuses.
5. Your Employer's contributions on your behalf to any deferred compensation arrangement or pension plan.
6. Any other extra compensation.

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

If you are paid hourly, your weekly rate of creditable compensation 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.

(REG NO COM_NO STOCK) ST.PD.OT.1

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, including donated amounts, (but not vacation pay) paid to you by your Employer, if it exceeds the amount found in a., b., and c.
   a. Determine the amount of your STD Benefit as if there were no Deductible Income, and add your sick pay or other salary continuation to that amount.
   b. Determine 100% of your Predisability Earnings.
   c. If a. is greater than b., the difference will be Deductible Income.
2. Your Work Earnings, as described in the **Return To Work Provisions**.
3. Any amount you receive or are eligible to receive because of your disability under a state disability income benefit law or similar law.
4. Any amount you receive or are eligible to receive because of your disability under another group.
5. Any amount you receive or are eligible to receive because of your disability, including amounts for partial or total disability, whether permanent, temporary, or vocational, under any of the following:
   a. A workers' compensation law;
   b. The Jones Act;

c. Maritime Doctrine of Maintenance, Wages, or Cure;

d. Longshoremen's and Harbor Worker's Act; or

e. Any similar act or law.

6. Any disability benefits you receive or are eligible to receive, or retirement benefits you receive, under your Employer'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 your Employer's contributions will be considered as distributed simultaneously throughout your lifetime, regardless of 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 monthly income for life with no survivors benefit will be Deductible Income, even if you choose a different option.

7. Any earnings or compensation included in Predisability Earnings which you receive or are eligible to receive while STD Benefits are payable.

8. Any amount you receive or are eligible to receive under any unemployment compensation law or similar act or law.

9. 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.

(ASO_PUB_ WITH RTW_100% SL_NO OTHR OFFST_NO 3RD) ST.DI.OT.1X

EXCEPTIONS TO DEDUCTIBLE INCOME

Deductible Income does not include:

1. Any cost of living increase 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, legal rehabilitation expense.

3. Military disability benefits.

4. Reasonable attorneys fees incurred in connection with a claim for Deductible Income.

5. Benefits from any individual disability insurance policy.

6. Group credit or mortgage disability insurance benefits.

7. Accelerated death benefits paid under a life coverage plan or life insurance policy.

8. Benefits from the following:

   a. Profit sharing plan.

   b. Thrift or savings plan.

   c. Deferred compensation plan.

   d. Plan under IRC Section 401(k), 408(k), 408(p), or 457.

   e. Individual Retirement Account (IRA).

   f. Tax Sheltered Annuity (TSA) under IRC Section 403(b).

   g. Stock ownership plan.

   h. Keogh (HR-10) plan.

(ASO_PUB_NO OTHR OFFST) ST.ED.OT.1

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 eligible. 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. Otherwise, we may reduce your STD Benefits by the amount we estimate you would be eligible to receive upon proper pursuit of the Deductible Income.

C. 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 your Employer for the resulting overpayment of your claim.

D. Overpayment Of Claim

We will notify you of the amount of any overpayment of your claim under the Program and any group disability insurance policy. You must immediately repay any overpayment. You will not receive any STD Benefits until the overpayment has 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.

(ASO) ST.RU.OT.2X

ASSISTED LIVING BENEFIT

A. Assisted Living Benefit

If you meet the requirements in 1 through 3 below, Program Sponsor will pay Assisted Living Benefits according to the terms of the Program after we receive Proof Of Loss satisfactory to us.

Assisted Living Benefit Requirements

1. You are Disabled and STD Benefits are payable to you.
2. Your Disability arose out of or in the course of employment with the Employer.
3. While you are Disabled:
   a. You, due to loss of functional capacity as a result of Physical Disease or Injury, become unable to safely and completely perform two or more Activities Of Daily Living without Hands-on Assistance or Standby Assistance; or
   b. You require Substantial Supervision for your health or safety due to Severe Cognitive Impairment as a result of Physical Disease or Injury.

3. The condition in 3.a or 3.b above is expected to last 90 days or more as certified by a Physician in the appropriate specialty as determined by us.

B. Definitions For Assisted Living Benefit

Activities Of Daily Living means Bathing, Continence, Dressing, Eating, Toileting, or Transferring.

Bathing means washing oneself, whether in the tub or shower or by sponge bath, with or without the help of adaptive devices.

Continence means voluntarily controlling bowel and bladder function, or, if incontinent, maintaining a reasonable level of personal hygiene.

Dressing means putting on and removing all items of clothing, footwear, and medically necessary braces and artificial limbs.

Eating means getting food and fluid into the body, whether manually, intravenously, or by feeding tube.

Toileting means getting to and from and on and off the toilet, and performing related personal hygiene.

Transferring means moving into or out of a bed, chair or wheelchair, with or without adaptive devices.

Hands-on Assistance means the physical assistance of another person without which the insured would be unable to perform the Activity Of Daily Living.

Standby Assistance means the presence of another person within arm's reach of the insured that is necessary to prevent, by physical intervention, injury to the insured while the insured is performing the Activity Of Daily Living (such as being ready to catch the insured if the insured falls while getting into or out of the bathtub or shower as part of Bathing, or being ready to remove food from the insured's throat if the insured chokes while Eating).

Severe Cognitive Impairment means a loss or deterioration in intellectual capacity that is (a) comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia, and (b) is measured by clinical evidence and standardized tests approved by us that reliably measure impairment in (i) short-term or long-term memory, (ii) orientation as to people, places, or time, and (iii) deductive or abstract reasoning.

Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect you from threats to your health or safety (such as may result from wandering).

C. Amount Of The Assisted Living Benefit

The amount of the Assisted Living Benefit is shown in the **Coverage Features**.

D. Becoming Insured For Assisted Living Benefits

You are eligible for Assisted Living Benefit coverage if you are insured for STD coverage. Subject to the **Active Work Provision**, your Assisted Living Benefit coverage becomes effective on the date your STD coverage becomes effective.

E. Payment Of Assisted Living Benefits

Program Sponsor will pay Assisted Living Benefits within 60 days after Proof Of Loss is satisfied. Living Benefits will be paid to you at the same time STD Benefits are payable.

F. Time Limits On Filing Proof Of Loss

Proof Of Loss must be provided within 90 days after the date of the loss. If that is not possible, it must be provided 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, the claim will be denied. These limits will not apply while the claimant lacks legal capacity.

G. When Assisted Living Benefits End

Assisted Living Benefits end automatically on the earliest of:

1. The date you no longer meet the requirements in item A. above.
2. The date your STD Benefits end.

H. When Assisted Living Benefits Coverage Ends

Assisted Living Benefit coverage ends automatically on the earliest of:

1. The date your STD coverage ends.
2. The date Assisted Living Benefit coverage terminates under the Program.

I. Assisted Living Benefits After Coverage Ends Or Is Changed

Your right to receive Assisted Living Benefits will not be affected by the occurrence of the events described in 1 or 2 below that become effective after you become Disabled.

1. Termination or amendment of the Program or your Employer's coverage under the Program.
2. Termination of Assisted Living Benefit coverage while the Program or your Employer's coverage under the Program remains in force.

FIRST DAY ASSISTED LIVING BENEFIT

If you meet the Assisted Living Benefit Requirements, 1 through 3 below will apply.

1. The remainder of your Benefit Waiting Period will be waived.
2. STD Benefits will become payable on the first day you meet the Assisted Living Benefit Requirements.
3. Your Maximum Benefit Period will begin on the date STD Benefits become payable.

BENEFITS AFTER COVERAGE ENDS OR IS CHANGED

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

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

.BA.OT.1

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 Program, including the **Disabilities Excluded From Coverage** and **Limitations** sections, will apply to the new cause of Disability.

(ASO) ST.ND.OT.1

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. Violent Or Criminal Conduct

You are not covered for a Disability caused or contributed to by your committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing your official duties.

D. Loss Of License Or Certification

You are not covered for a Disability caused or contributed to by the loss of your professional license, occupational license or certification.

ST.XD.OT.1

LIMITATIONS

A. Care Of A Physician

You must be under the ongoing care of a Physician in the appropriate specialty as determined by us during the Benefit Waiting Period. No STD Benefits will be paid for any period of Disability when you are not under the ongoing care of a Physician in the appropriate specialty as determined by us.

B. Imprisonment

No STD Benefits will be paid for any period of Disability when you are confined for any reason in a penal or correctional institution.

C. Rehabilitation Program

STD Benefits will be reduced to 50% of the amount determined from the Schedule Of Coverage for any period of Disability when you are not participating in good faith in a plan, program or course of medical treatment or vocational training or education approved by us unless your Disability prevents you from participating.

ST.LM.OT.1X

CLAIMS

A. Filing A Claim

Claims should be filed on our forms. If you do not receive our forms within 15 days after you ask for them, 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.

B. 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 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.

C. 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.

D. 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.

E. 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.

F. Time Of Payment

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

STD Benefits will be paid to you coinciding with the Employer's regular payroll period applicable to you. STD Benefits remaining unpaid at your death will be paid to your estate.

G. 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 Program 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.

H. 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.

After the initial determination letter responding to an initial appeal, you may appeal a second time within 90 days. However, for a second appeal, you must provide additional information supporting your claim for benefits.

As soon as practical, and in no case less than 10 days, after receiving a second appeal letter, we shall provide to you the written acknowledgment that either (i) the second appeal has been received and is under review or (ii) the second appeal is not under review since you did not provide additional information regarding your Disability.

When applicable, we shall provide to you a final written determination for any second appeal within 45 days of receiving the second written appeal. We may request up to 45 additional days to complete the review of a second appeal.

When we issue a written determination on any appeal – whether an initial appeal or a second appeal – our letter shall (i) inform you of the reasons for the decision, (ii) reference parts of the STD Program on which the decision is based, (iii) inform you of your right to receive, free of charge, a copy of all non-privileged documents and records from the claim file relevant to the decision, and (iv) inform you of your right to bring a civil action in circuit court for benefits.

Following a final written determination of any appeal, you may bring a civil action in the Circuit Court of Henrico County, Virginia, challenging the determination.

I. Assignment

The rights and benefits under the Program are not assignable.

(ASO_REV PUB WRDG) ST.CL.OT.2

LIMITED AGENCY APPOINTMENT OF STANDARD

Program Sponsor has appointed Standard to act on its behalf as Claims Administrator for the Program and grants to Standard authority to fulfill the Obligations of Claim Administrator, as provided herein. Standard is empowered to act on behalf of Program Sponsor in connection with the Program only as expressly stated in this Program. Standard has no authority or obligation with respect to (1) a Program Sponsor's right of subrogation under the Program, or (2) management or investment of the assets of the Program. In performing its obligations under this Agreement, Standard is acting solely as the agent of Program Sponsor.

Standard's authority includes, but is not limited to:

1. The right to resolve all matters when a review has been requested;
2. The right to establish and enforce rules and procedures for the administration of the Program and any claim under it;
3. The right to determine:

a. Eligibility for coverage;

b. Entitlement to benefits;

c. The amount of benefits payable;

d. The sufficiency and the amount of information we may reasonably require to determine a., b., or c., above.

Standard's decisions are subject to the review procedures of the Program Sponsor.

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 more than three years after the earlier of:

1. The date we receive Proof Of Loss; and
2. The time within which Proof Of Loss is required to be given.

.TL.OT.1

CLERICAL ERROR

Clerical error by the Program Sponsor, Claims Administrator, or their respective employees or representatives will not:

1. Cause a person to become covered.
2. Invalidate coverage under the Program otherwise validly in force.
3. Continue coverage under the Program otherwise validly terminated.

(ASO) ST.CE.OT.2

TERMINATION OR AMENDMENT OF THE PROGRAM

Program Sponsor may terminate the Program in whole, and may terminate coverage for any class or group of Members, at any time.

Benefits under the Program are limited to its terms, including any valid amendment. No change or amendment will be valid unless approved by the Program Sponsor and evidenced by an amendment.

No agent has authority to change or amend the Program or to waive any of its terms or provisions.

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

(ASO) ST.TA.OT.2

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**.

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) coverage is nonelective and the Program Sponsor or Employer pay the entire cost of coverage; or (b) the Program Sponsor or Employer require all eligible Members to have coverage and to pay all or part of the cost of coverage.

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 M.D. or D.O., acting within the scope of the license. Physician does not include you or your spouse, or the brother, sister, parent, or child of either you or your spouse.

Program means the group short term disability income benefit program established by Program Sponsor and identified by the ATP Number.

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

Prior Plan means your Employer's short term disability program in effect on the day before the effective date of your Employer's coverage under the Program and which is replaced by the Program.

STD Benefit means the benefit payable to you under the terms of the Program.

(ATP) ST.DF.OT.1

VA/STDP2000(ASO)

STANDARD INSURANCE COMPANY

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

CERTIFICATE

GROUP LONG TERM DISABILITY INSURANCE

Policyholder:	Henrico County, Virginia
Policy Number:	649720-B
Effective Date:	January 1, 2019

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.

Chairman, President and CEO

GC190-LTD/S399

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Index of Defined Terms

COVERAGE FEATURES

This section contains many of the features of your long term disability (LTD) 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:	649720-B
Policyholder:	Henrico County, Virginia
Employer(s):	Henrico County General Government, Henrico County Public Schools, the Henrico County Economic Development Authority
Group Policy Effective Date:	January 1, 2019
Policy Issued in:	Virginia

Member means:

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. Actively At Work at least the minimum hours per week required by the Employer for coverage under the Program, but in no event less than 20 hours each week (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); and
3. A citizen or resident of the United States or Canada.

Member does not include a temporary or seasonal employee, a full-time member of the armed forces of any country, a leased employee, or an independent contractor.

Class Definition:

Class 1:	Members with fewer than 12 months continuous participation in the Virginia hybrid retirement program described in § 51.1-169 of the Code of Virginia
Class 2:	Members with at least 12 months continuous participation in the Virginia hybrid retirement program described in § 51.1-169 of the Code of Virginia

SCHEDULE OF INSURANCE

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

a. The Group Policy Effective Date; and

b. The first day as a Member.

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

Own Occupation Period:	The first 24 months for which LTD Benefits are paid.
Any Occupation Period:	From the end of the Own Occupation Period to the end of the Maximum Benefit Period.

LTD Benefit (dollar values are per month as noted in the definition of LTD Benefit in the **Definitions** section);

Class 1:

For Disability arising out of or in the course of employment with the Employer:	60% of the first $41,667 of your Predisability Earnings, reduced by Deductible Income.
Maximum:	$25,000 before reduction by Deductible Income.
Minimum:	$100
For any other Disability:	None
Class 2:	60% of the first $41,667 of your Predisability Earnings, reduced by Deductible Income.
Maximum:	$25,000 before reduction by Deductible Income.
Minimum:	$100
Assisted Living Benefit:	An additional 20% of your Predisability Earnings, but not to exceed $5,000. The Assisted Living Benefit is not reduced by Deductible Income.
Lifetime Security Benefit:	Not Included
Benefit Waiting Period:	The period for which benefits are payable under the Employer's short term disability benefits program, including any benefit waiting period under that plan.
Maximum Benefit Period:	Determined by your age when Disability begins, as follows:

Age	Maximum Benefit Period
59 or younger	To SSNRA
60 through 64	5 years
65 through 68	To age 70
69 or older	1 year

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

PREMIUM CONTRIBUTIONS

Insurance is:	Noncontributory

INSURING CLAUSE

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

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BECOMING INSURED

To become insured you must be a Member, complete your Eligibility Waiting Period, and meet the requirements in **Active Work Provisions** and **When Your Insurance Becomes Effective**.

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. Actively At Work at least the minimum hours per week required by the Employer for coverage under the Program, but in no event less than 20 hours each week (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); and
3. A citizen or resident of the United States or Canada.

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

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.**

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WHEN YOUR INSURANCE BECOMES EFFECTIVE

Subject to the **Active Work Provisions**, your insurance becomes effective on the date you become eligible.

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 Material Duties 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.

2. The date the Group Policy terminates.
3. The date your Employer's coverage under the Group Policy terminates.
4. The date your employment terminates.
5. The date you cease to be a Member. 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 Benefit Waiting Period.

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WAIVER OF PREMIUM

We will waive payment of premium for your insurance while LTD 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 cease to be a Member because of a covered Disability following the Benefit Waiting Period, your insurance will end; however, if you become a Member again immediately after LTD Benefits end, the Eligibility Waiting Period will be waived.
2. If your insurance ends because you cease to be a Member for any reason other than a covered Disability, and if you become a Member again within 90 days, the Eligibility Waiting Period will be waived.
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 one of the following definitions during the period it applies:

A. Own Occupation Definition Of Disability;

B. Any Occupation Definition Of Disability; or

C. Partial Disability Definition.

A. Own Occupation Definition Of Disability

During the Benefit Waiting Period and the Own Occupation Period you are required to be Disabled only from your Own Occupation.

You are 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 Material Duties of your Own Occupation.

Note: You are not Disabled merely because your right to perform your Own Occupation is restricted, including a restriction or loss of license.

During the Own Occupation Period you may work in another occupation while you meet the Own Occupation Definition Of Disability. However, you will no longer be Disabled when your Work Earnings from another occupation meet or exceed 80% of your Indexed Predisability Earnings. Your Work Earnings may be Deductible Income. See **Return To Work Provisions** and **Deductible Income**.

Own Occupation means any employment, business, trade, profession, calling or vocation that involves Material Duties of the same general character as the occupation you are regularly performing for your Employer when Disability begins. In determining your Own Occupation, we are not limited to looking at the way you perform your job for your Employer, but we may also look at the way the occupation is generally performed in the national economy. If your Own Occupation involves the rendering of professional services and you are required to have a professional or occupational license in order to work, your Own Occupation is as broad as the scope of your license.

Material Duties means the essential tasks, functions and operations, and the skills, abilities, knowledge, training and experience, generally required by employers from those engaged in a particular occupation that cannot be reasonably modified or omitted. In no event will we consider working an average of more than 40 hours per week to be a Material Duty.

B. Any Occupation Definition Of Disability

During the Any Occupation Period you are required to be Disabled from all occupations.

You are Disabled from all occupations if, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder, you are unable to perform with reasonable continuity the Material Duties of Any Occupation.

Any Occupation means any occupation or employment which you are able to perform, whether due to education, training, or experience, which is available at one or more locations in the national economy and in which you can be expected to earn at least 80% of your Indexed Predisability Earnings within twelve months following your return to work, regardless of whether you are working in that or any other occupation.

Material Duties means the essential tasks, functions and operations, and the skills, abilities, knowledge, training and experience, generally required by employers from those engaged in a particular occupation that cannot be reasonably modified or omitted. In no event will we consider working an average of more than 40 hours per week to be a Material Duty.

C. Partial Disability Definition

During the Benefit Waiting Period and the Own Occupation Period, you are Partially Disabled when you work 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 Indexed Predisability Earnings, in that occupation.

Your Work Earnings may be Deductible Income. See **Return To Work Provisions** and **Deductible Income**.

Your Own Occupation Period and Any Occupation Period are shown in the **Coverage Features**.

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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 Own Occupation Definition Of Disability.

You are eligible for the Return To Work Incentive on the first day you work after the Benefit Waiting Period if LTD Benefits are payable on that date. The Return To Work Incentive changes 12 months after that date, as follows:

1. During the first 12 months, your Work Earnings will be Deductible Income as determined in a., b. and c:
   a. Determine the amount of your LTD Benefit as if there were no Deductible Income, and add your Work Earnings to that amount.
   b. Determine 100% of your Indexed Predisability Earnings.
   c. If a. is greater than b., the difference will be Deductible Income.
2. After those first 12 months, 50% of your Work Earnings will be Deductible Income.

B. Work Earnings Definition

Work Earnings means your gross monthly earnings from work you perform while Disabled, plus the earnings you could receive if you worked as much as you are able to, considering your Disability, in work that is reasonably available:

a. In your Own Occupation during the Own Occupation Period; and

b. In Any Occupation during the Any Occupation Period.

Work Earnings includes earnings from your Employer, any other employer, or self-employment, and 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 monthly, 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. During the Own Occupation Period you will no longer be Disabled when your average Work Earnings over the last three months exceed 80% of your Indexed Predisability Earnings. During the Any

Occupation Period you will no longer be Disabled when your average Work Earnings over the last three months exceed 80% of your Indexed Predisability Earnings.

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REASONABLE ACCOMMODATION EXPENSE BENEFIT

If you return to work in any occupation for any employer, not including self-employment, as a result of a reasonable accommodation made by such employer, we will pay that employer a Reasonable Accommodation Expense Benefit of up to $25,000, but not to exceed the expenses incurred.

The Reasonable Accommodation Expense Benefit is payable only if the reasonable accommodation is approved by us in writing prior to its implementation.

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REHABILITATION PLAN PROVISION

While you are Disabled you may qualify to participate in a Rehabilitation Plan. Rehabilitation Plan means a written plan, program or course of vocational training or education that is intended to prepare you to return to work.

To participate in a Rehabilitation Plan you must apply on our forms or in a letter to us. The terms, conditions and objectives of the plan must be accepted by you and approved by us in advance. We have the sole discretion to approve your Rehabilitation Plan.

While you are participating in an approved Rehabilitation Plan, your LTD Benefit will be increased by 10% of your Predisability Earnings. Your LTD Benefit may not exceed the Maximum LTD Benefit shown in the **Coverage Features** as a result of this increase.

An approved Rehabilitation Plan may include our payment of some or all of the expenses you incur in connection with the plan, including:

a. Training and education expenses.

b. Family care expenses.

c. Job-related expenses.

d. Job search expenses.

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TEMPORARY RECOVERY

You may temporarily recover from your Disability 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 Periods

   1. During the Benefit Waiting Period: 45 consecutive days of recovery.

   2. During the Maximum Benefit Period: 125 consecutive work days for each period of recovery.

B. Effect Of Temporary Recovery

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

   1. The Predisability Earnings used to determine your LTD Benefit will not change.

   2. The period of Temporary Recovery will not count toward your Benefit Waiting Period, your Maximum Benefit Period or your Own Occupation Period.

3. No LTD Benefits will be payable for the period of Temporary Recovery.
4. No LTD Benefits will be payable after benefits become payable to you under any other disability insurance plan under which you become insured 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 LTD BENEFITS END

Your LTD 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 benefits become payable under any other disability insurance plan under which you become insured through employment during a period of Temporary Recovery.
5. The date you fail to provide proof of continued Disability and entitlement to LTD Benefits.

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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. The Member's LTD Benefit will not be adjusted to reflect any salary increase awarded during the period covered by LTD Benefits.

Predisability Earnings means your monthly rate of creditable compensation 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.

Predisability Earnings does not include:

1. Bonuses.
2. Commissions.
3. Overtime pay.
4. Stock options or stock bonuses.
5. Your Employer's contributions on your behalf to any deferred compensation arrangement or pension plan.
6. Any other extra compensation.

If you are paid on an annual contract basis, your monthly rate of creditable compensation is one-twelfth (1/12th) of your annual contract salary.

If you are paid hourly, your monthly rate of creditable compensation is based on your hourly pay rate multiplied by the number of hours you are regularly scheduled to work per month, 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 during the preceding 12 calendar months (or during your period of employment if less than 12 months), but not more than 173 hours.

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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, including donated amounts, (but not vacation pay) paid to you by your Employer, if it exceeds the amount found in a., b., and c.

   a. Determine the amount of your LTD Benefit as if there were no Deductible Income, and add your sick pay or other salary continuation to that amount.

   b. Determine 100% of your Indexed Predisability Earnings.

   c. If a. is greater than b., the difference will be Deductible Income.

2. Your Work Earnings, as described in the **Return To Work Provisions**.

3. Any amount you receive or are eligible to receive because of your disability, including amounts for partial or total disability, whether permanent, temporary, or vocational, under any of the following:

   a. A workers' compensation law;

   b. The Jones Act;

   c. Maritime Doctrine of Maintenance, Wages, or Cure;

   d. Longshoremen's and Harbor Worker's Act; or

   e. Any similar act or law.

4. Any amount you, your Spouse, or your child under age 18 receive or are eligible to receive because of your disability or retirement under:

   a. The Federal Social Security Act;

   b. The Canada Pension Plan;

   c. The Quebec Pension Plan;

   d. The Railroad Retirement Act; or

   e. Any similar plan or act.

   Full offset: Both the primary benefit (the benefit awarded to you) and dependents benefit are Deductible Income.

   Benefits your Spouse or a child receives or are eligible to receive because of your disability are Deductible Income regardless of marital status, custody, or place of residence. The term "child" has the meaning given in the applicable plan or act.

5. Any amount you receive or are eligible to receive because of your disability under any state disability income benefit law or similar law.

6. Any amount you receive or are eligible to receive because of your disability under another group insurance coverage.
7. Any disability or retirement benefits you receive under your Employer's retirement plan.
8. Any earnings or compensation included in Predisability Earnings which you receive or are eligible to receive while LTD Benefits are payable.
9. Any amount you receive or are eligible to receive under any unemployment compensation law or similar act or law.
10. 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 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. Early retirement benefits under the Federal Social Security Act which are not actually received.
6. Group credit or mortgage disability insurance benefits.
7. Accelerated death benefits paid under a life insurance policy.
8. Benefits from the following:
   a. Profit sharing plan.
   b. Thrift or savings plan.
   c. Deferred compensation plan.
   d. Plan under IRC Section 401(k), 408(k), 408(p), or 457.
   e. Individual Retirement Account (IRA).
   f. Tax Sheltered Annuity (TSA) under IRC Section 403(b).
   g. Stock ownership plan.
   h. Keogh (HR-10) plan.
9. Any amount you receive from a military disability benefit.

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RULES FOR DEDUCTIBLE INCOME

A. Monthly Equivalents

Each month we will determine your LTD Benefit using the Deductible Income for the same monthly period, even if you actually receive the Deductible Income in another month.

If you are paid Deductible Income in a lump sum or by a method other than monthly, we will determine your LTD 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 eligible. 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. Otherwise, we may reduce your LTD Benefits by the amount we estimate you would be eligible to receive upon proper pursuit of the Deductible Income.

C. 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.

D. 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 LTD Benefits until we have been repaid in full. In the meantime, any LTD Benefits paid, including the Minimum LTD 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.

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ADDITIONAL BENEFITS FOR THE SEVERELY DISABLED

A. Assisted Living Benefit

If you meet the requirements in 1 through 3 below, we will pay Assisted Living Benefits according to the terms of the Group Policy after we receive Proof Of Loss satisfactory to us.

Requirements for Assisted Living Benefit

1. You are Disabled and LTD Benefits are payable to you.
2. While you are Disabled:
   a. You, due to loss of functional capacity as a result of Physical Disease or Injury, become unable to safely and completely perform two or more Activities Of Daily Living without Hands-on Assistance or Standby Assistance; or
   b. You require Substantial Supervision for your health or safety due to Severe Cognitive Impairment as a result of Physical Disease or Injury.
3. The condition in 2.a or 2.b above is expected to last 90 days or more as certified by a Physician in the appropriate specialty as determined by us.

B. Amount Of The Assisted Living Benefit

See the **Coverage Features** for the amount of the Assisted Living Benefit.

C. Becoming Insured For Assisted Living Benefits

You are eligible for Assisted Living Benefit coverage if you are insured for LTD insurance. Subject to the **Active Work Provision**, your Assisted Living Benefit coverage becomes effective on the date your LTD insurance becomes effective.

D. Payment Of Assisted Living Benefits

We will pay Assisted Living Benefits within 60 days after Proof Of Loss is satisfied. Your Assisted Living Benefits will be paid to you at the same time LTD Benefits are payable.

E. Time Limits On Filing Proof Of Loss

Proof Of Loss for the Assisted Living Benefit must be provided within 90 days after the date the inability to perform Activities Of Daily Living or the Severe Cognitive Impairment begins. If that is not possible, it must be provided 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, the claim will be denied. These limits will not apply while the claimant lacks legal capacity.

F. When Assisted Living Benefits End

Assisted Living Benefits end automatically on the earliest of:

1. The date you no longer meet the requirements in item A. above.
2. The date your LTD Benefits end.

G. When Assisted Living Benefits Coverage Ends

Assisted Living Benefit coverage ends automatically on the earliest of:

1. The date your LTD insurance ends.
2. The date Assisted Living Benefit coverage terminates under the Group Policy.

H. Assisted Living Benefits After Insurance Ends Or Is Changed

Your right to receive Assisted Living Benefits will not be affected by the occurrence of the events described in 1 or 2 below that become effective after you become Disabled.

1. Termination or amendment of the Group Policy or your Employer's coverage under the Group Policy.
2. Termination of Assisted Living Benefit coverage while the Group Policy or your Employer's coverage under the Group Policy remains in force.

I. Assisted Living Benefit Limitations

No Assisted Living Benefit will be paid for any period when you are confined for any reason in a penal or correctional institution.

No Assisted Living Benefit will be paid if your inability to perform Activities Of Daily Living or your Severe Cognitive Impairment is caused or contributed to by:

1. 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.
2. Any intentionally self-inflicted Injury, while sane or insane.
3. Committing or attempting to commit an assault or felony, or active participation in a violent disorder or riot. (Active participation does not include being at the scene of a violent disorder or riot while performing official duties.)

J. Definitions

1. Activities Of Daily Living means Bathing, Continence, Dressing, Eating, Toileting, or Transferring.
2. Bathing means washing oneself, whether in the tub or shower or by sponge bath, with or without the help of adaptive devices.

3. Continence means voluntarily controlling bowel and bladder function, or, if incontinent, maintaining a reasonable level of personal hygiene.
4. Dressing means putting on and removing all items of clothing, footwear, and medically necessary braces and artificial limbs.
5. Eating means getting food and fluid into the body, whether manually, intravenously, or by feeding tube.
6. Toileting means getting to and from and on and off the toilet, and performing related personal hygiene.
7. Transferring means moving into or out of a bed, chair or wheelchair, with or without adaptive devices.
8. Hands-on Assistance means the physical assistance of another person without which the insured would be unable to perform the Activity Of Daily Living.
9. Standby Assistance means the presence of another person within arm's reach of the insured that is necessary to prevent, by physical intervention, injury to the insured while the insured is performing the Activity Of Daily Living (such as being ready to catch the insured if the insured falls while getting into or out of the bathtub or shower as part of Bathing, or being ready to remove food from the insured's throat if the insured chokes while Eating).
10. Severe Cognitive Impairment means a loss or deterioration in intellectual capacity that is (a) comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia, and (b) is measured by clinical evidence and standardized tests approved by us that reliably measure impairment in (i) short-term or long-term memory, (ii) orientation as to people, places, or time, and (iii) deductive or abstract reasoning.
11. Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect you from threats to your health or safety (such as may result from wandering).

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SURVIVORS BENEFIT

If you die while LTD Benefits are payable, and on the date you die you have been continuously Disabled for at least 180 days, we will pay a Survivors Benefit according to 1 through 3 below.

1. The Survivors Benefit is a lump sum equal to 3 times your LTD Benefit without reduction by Deductible Income.
2. The Survivors Benefit will first be applied to reduce any overpayment of your claim.
3. The Survivors Benefit will be paid at our option to any one or more of the following:
   a. Your surviving Spouse;
   b. Your surviving unmarried children, including adopted children, under age 25;
   c. Your surviving Spouse's unmarried children, including adopted children, under age 25; or
   d. Any person providing the care and support of any person listed in a., b., or c. above.
   e. Your estate, if you are not survived by any person listed in a., b., or c. above.

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PENSION CONTRIBUTION BENEFIT

A. Payment Of Pension Contribution Benefit

If you are a participant in your Employer's pension plan on the date you become Disabled, we will pay a monthly Pension Contribution Benefit to your Employer, according to the terms of the Group Policy, while you are receiving LTD Benefits. The Pension Contribution Benefit will be paid to fund your future pension benefits from your Employer's pension plan, as determined by your Employer.

The Pension Contribution Benefit becomes payable on the date you meet the following requirements:

1. You are Disabled and LTD Benefits are payable to you; and
2. You are entitled to Social Security disability benefits; and
   a. are receiving such benefits; or
   b. are receiving Social Security early retirement benefits or widow's or widower's benefits; or
   c. Social Security disability benefits are not payable because they are being reduced by other income you receive.

If, in our sole discretion, you are not entitled to Social Security disability benefits solely because you have not earned the required minimum number of quarters for Social Security coverage, you will be considered to have met this requirement for the purposes of being eligible for this benefit.

The amount of the Pension Contribution Benefit is 1% of the first $41,667 of your Predisability Earnings, but not to exceed $416.67.

B. When Pension Contribution Benefits End

Pension Contribution Benefits end automatically on the earliest of:

1. The date LTD Benefits end.
2. The date your Employer's pension plan or the trust is no longer able to accept the Pension Contribution Benefit.
3. The date continued contributions may cause your Employer's pension plan to be disqualified.
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. The date you begin employment with another employer or are self employed, or return to work for your Employer.
6. The date you (a) begin withdrawing a monthly benefit or annuity, (b) withdraw contributions and/or interest, or (c) are required to withdraw or take a distribution of contributions and/or interest, from your Employer's pension plan.

C. Employer Notification

Your Employer will determine and provide us with proof satisfactory to us, which we will rely upon:

1. That your Employer's pension plan may accept the Pension Contribution Benefit on your behalf.
2. The maximum amount of the Pension Contribution Benefit that your Employer's pension plan may accept on your behalf according to the pension plan's definition of compensation for you.
3. Whether any event shown in B. When Pension Contribution Benefits End has occurred.

BENEFITS AFTER INSURANCE ENDS OR IS CHANGED

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

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

.BA.OT.1

EFFECT OF NEW DISABILITY

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

1. LTD Benefits will not continue beyond the end of the original Maximum Benefit Period.
2. The **Disabilities Excluded From Coverage, Disabilities Subject To Limited Pay Periods,** and **Limitations** sections will apply to the new cause of Disability.

.ND.OT.1

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. Preexisting Condition

This Group Policy does not include a Preexisting Condition Exclusion.

D. Loss Of License Or Certification

You are not covered for a Disability caused or contributed to by the loss of your professional license, occupational license or certification.

E. Violent Or Criminal Conduct

You are not covered for a Disability caused or contributed to by your committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing your official duties.

(NO PX) LT.XD.OT.1X

LIMITATIONS

A. Care Of A Physician

You must be under the ongoing care of a Physician in the appropriate specialty as determined by us during the Benefit Waiting Period. No LTD Benefits will be paid for any period of Disability when you are not under the ongoing care of a Physician in the appropriate specialty as determined by us.

B. Imprisonment

No LTD Benefits will be paid for any period of Disability when you are confined for any reason in a penal or correctional institution.

C. Substance Abuse

No LTD Benefits will be paid for any period of Disability caused or contributed to by your Substance Abuse, unless you are participating in good faith in a treatment plan, program or course of medical treatment for Substance Abuse.

Substance Abuse means abuse of alcohol, alcoholism, misuse of any drug, including hallucinogens, or drug addiction.

D. Rehabilitation Program

LTD Benefits will be reduced to 50% of the amount determined from the Schedule Of Insurance for any period of Disability when you are not participating in good faith in a plan, program or course of medical treatment or vocational training or education approved by us, unless your Disability prevents you from participating. If this limitation causes the LTD Benefit to be less than the Minimum LTD Benefit, the Minimum LTD Benefit will be payable.

(NO FRGN) LT.LM.OT.1X

CLAIMS

A. 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.

B. 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 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.

C. Proof Of Loss

Proof Of Loss means written proof that you are Disabled and entitled to LTD 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.

D. 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.

E. Investigation Of Claim

During the pendency of your 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 LTD Benefits if you fail to attend an examination or cooperate with the examiner.

F. Time Of Payment

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

LTD Benefits will be paid to you at the end of each month you qualify for them. LTD Benefits remaining unpaid at your death will be paid to the person(s) receiving the Survivors Benefit. If no Survivors Benefit is paid, the unpaid LTD Benefits will be paid to your estate.

G. 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. A description of any additional information needed to support your claim.

d. Information concerning your right to a review of our decision.

H. 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. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.

I. Assignment

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

(REV PUB WRDG) LT.CL.VA.2

ALLOCATION OF AUTHORITY

Except for those functions which the Group Policy specifically reserves to the Policyholder or Employer, we have full and exclusive authority to control and manage the Group Policy, to administer claims, and to interpret the Group Policy and resolve all questions arising in the administration, interpretation, and application of the Group Policy.

Our authority includes, but is not limited to:

1. The right to resolve all matters when a review has been requested;
2. The right to establish and enforce rules and procedures for the administration of the Group Policy and any claim under it;
3. The right to determine:
   a. Eligibility for insurance;
   b. Entitlement to benefits;
   c. The amount of benefits payable; and
   d. The sufficiency and the amount of information we may reasonably require to determine a., b., or c., above.

Subject to the review procedures of the Group Policy, any decision we make in the exercise of our authority is conclusive and binding.

.AL.OT.1

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 more than three years after the earlier of:

1. The date we receive Proof Of Loss; and
2. The time within which Proof Of Loss is required to be given.

LT.TL.OT.1

INCONTESTABILITY PROVISIONS

A. Incontestability Of Insurance

Any statement made to obtain insurance 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 other person claiming benefits a copy of the signed written instrument which contains the misrepresentation.

After insurance has been in effect for two years during the lifetime of the insured, we will not use a misrepresentation to reduce or deny the 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 nonpayment of premiums or fraudulent misrepresentations.

LT.IN.OT.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 premiums paid and the premiums which would have been paid if the age had been correctly stated.

LT.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.

LT.TA.OT.1

DEFINITIONS

Benefit Waiting Period means the period you must be continuously Disabled before LTD Benefits become payable. No LTD 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.

CPI-W means the Consumer Price Index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. If the CPI-W is discontinued or changed, we may use a comparable index. Where required, we will obtain prior state approval of the new index.

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 LTD insurance policy issued by us to the Policyholder and identified by the Group Policy Number.

Indexed Predisability Earnings means your Predisability Earnings adjusted by the rate of increase in the CPI-W. During your first year of Disability, your Indexed Predisability Earnings are the same as your Predisability Earnings. Thereafter, your Indexed Predisability Earnings are determined on each anniversary of your Disability by increasing the previous year's Indexed Predisability Earnings by the rate of increase in the CPI-W for the prior calendar year. The maximum adjustment in any year is 10%. Your Indexed Predisability Earnings will not decrease, even if the CPI-W decreases.

Injury means an injury to the body.

LTD Benefit means the monthly benefit payable to you under the terms of Group Policy.

Maximum Benefit Period means the longest period for which LTD 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 LTD Benefits are payable after the end of the Maximum Benefit Period, even if you are still Disabled. See **Coverage Features**.

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 the body as diagnosed by a Physician.

Physician means a licensed M.D. or D.O., acting within the scope of the license. Physician does not include you or your Spouse, or the brother, sister, parent, or child of either you or your Spouse.

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

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

Spouse means:

1. A person to whom you are legally married and from whom you are not legally separated; 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.

(DOM) LT.DF.OT.1

Act Now to Help Protect What You Care About

Explore your benefit options with ABC Company, Inc.

Having a lot of benefit choices is great — but can be confusing! You may be wondering … which ones are the best for me and my family?

Think of insurance as a financial safety net that can help protect you when life doesn't go as planned. Each benefit that ABC Company, Inc. offers can play a role in helping you achieve financial security.

Enrolling in coverage now is an easy way to help make sure you and your loved ones have the protection you need. Use this guide to explore your group insurance options from Standard Insurance Company (The Standard). The forms you need are also right here.

When you buy insurance through work, you get competitive group rates. And it's convenient, with premiums deducted right from your paycheck.

Your Employer-Paid Benefits

- Basic Life insurance
- Accidental Death and Dismemberment insurance
- Dependents Life insurance

Benefits You Can Add at Group Rates

- Additional Life insurance
- Additional Accidental Death and Dismemberment
- Short Term Disability insurance
- Long Term Disability insurance

Protect Your Family From the Unexpected

An accident, serious illness or hospital stay can be a big drain on your finances. Even with medical insurance, deductibles and copays can pile up. The insurance below pays a benefit directly to you — instead of your doctors. So, you can use the money for anything you choose — from medical costs to rent, gas and groceries.

Accident insurance can help keep your finances on track when an accident happens. It pays a benefit directly to you, not to medical providers. Another plus, your group insurance rate won't increase as you get older.

Critical Illness insurance helps you manage expenses during a serious illness, such as a heart attack, stroke or cancer. It pays a lump-sum benefit directly to you upon diagnosis with a covered illness. You can use the money to pay bills while you or a family member recover.

Hospital Indemnity insurance can help you take care of the out-of-pocket costs of a stay in the hospital. It pays you a flat benefit regardless of any medical coverage you have.

Protect Your Health

Dental insurance from The Standard helps you and your family take care of your smiles and your health. You can choose your own dentist. Visit standard.com/dental to find an in-network dentist in your area.

Vision insurance includes coverage for eye exams and helps pay for contact lenses and glasses. Visit standard.com/vision to find an in-network vision specialist.

Protect Your Loved Ones

Life insurance helps take care of your family if something happens to you. It can help your loved ones get through a difficult time and pay for important things, like a home or college plans.

Accidental Death and Dismemberment (AD&D) insurance helps protect your family's finances if an accident causes death or a severe physical loss. It pays a benefit in addition to any life insurance you have. That can help pay for a funeral or ongoing special care.

Protect Your Paycheck

Disability insurance can replace part of your paycheck if you can't work because of an illness, injury or pregnancy. The benefit payments can help with bills that continue even when you can't work — like your rent or mortgage.

Short term disability insurance can help pay the bills if you become disabled and can't work for a short period of time.

Long term disability insurance helps replace part of your paycheck if you experience a disability that lasts for months or even years.

Ready to apply? You'll find the forms right here.

Once you review your options, the next step is to apply using the forms at the end of this guide. Remember to turn them in before your enrollment period ends!

ENROLL SOON

Enrollment begins January 1, 2019 and ends January 15, 2019.

ATTEND YOUR GROUP MEETING ON:

- January 2, 2019, 3pm, Atrium
- January 10, 2019, 3pm, Atrium

Enroll online at **www.standard.com**

Contact your employee benefits representative if you have questions about submitting forms.

SI **20444**

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(3/19)

March 31, 2021
ABC Company, Inc.

Short Term Disability (STD) program. We're writing to you about your claim for STD

Next Steps

Request a Review of this Decision

within 180 days

Any Questions?

State Specific Rights Regarding Limitation, Denial or Closure of Your Claim

Standard's

If you live in California or your policy is issued in California:

If you live in Illinois or your policy is issued in Illinois:

If you live in New Hampshire or your policy is issued in New Hampshire:

If you live in South Dakota or your policy is issued in South Dakota:

Your Group Policy doesn't provide voluntary

If you live in Washington or your policy is issued in Washington:

If you live in West Virginia or your policy is issued in West Virginia:

[redacted]

[redacted]

[redacted]

[redacted]

Right to Request Review of This Decision

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

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IMPORTANT LANGUAGE INFORMATION

IMPORTANT LANGUAGE INFORMATION

You can get an interpreter to help you with any questions that you may have and to assist you with filing or appealing a claim. Please contact your claims representative for information on how to access language translation services.

INFORMACIÓN IMPORTANTE SOBRE EL IDIOMA

Puede recurrir a un intérprete para que lo ayude con cualquier pregunta que pueda tener y para que lo ayude a completar o apelar una reclamación. Póngase en contacto con su representante de reclamaciones para obtener información sobre cómo acceder a los servicios de traducción.

MAHALAGANG IMPORMASYON SA WIKA

Maaari kang kumuha ng tagapagsalin sa iyong wika upang matulungan ka sa anumang katanungan na maaaring mayroon ka at maasistihan ka sa paghain o pag-apela ng claim. Mangyaring makipag-ugnayan sa iyong kinatawan sa claims para sa impormasyon sa kung papaano ma-akses ang mga serbisyo ng pagsasalin ng wika.

重要语言信息

您可通过一名口译员来帮助您解决可能遇到的任何问题并且协助您提出理赔或对理赔结果进行申诉。请联系您的理赔代表，为您提供有关如何获得语言翻译服务方面的信息。

T'ÁÁ ÍÍYISÍÍ 'ALÁÁHÓ SAAD ÍÍSH JĄĄ IŁ NÉ

Beehás'áąh, ata' halne' níká e'el yeed ninsingo hódo łááł doo na'ídíkid naáholǫǫ binye, adoo naaltsoos hadę́ dolnił bááhó t'eí, eí doo dágo ni haa áháyá bił asíihgo nandol káh binye yinikeed. T'áá shǫǫdi naaltsoos ílínii binaanish ílínigii bił holné ata' halne' choideesh'įįł ninzǫǫ bíínįkeed.

Pregnancy Claim Guidelines
Employee Benefits

Experience supports that the majority of claimants receiving benefits due to postpartum impairment are capable of returning to work in six weeks for vaginal deliveries and eight weeks for cesarean deliveries. In general, the medical community supports up to six weeks of impairment beginning with the day of the actual vaginal delivery and up to eight weeks for cesarean delivery.

The following sheet offers guidelines for the duration of impairment both prior to and following delivery.

These guidelines should be used when evaluating pregnancy claims.

Impairment Prior to Expected Confinement or Delivery (EDC)

Job Classification	Duration of Impairment
Sedentary	Up to 2 weeks
Light; without prolonged standing; without risk of altercation	Up to 4 weeks
Medium; **or** prolonged standing; **or** risk of altercation	Up to 16 weeks
Heavy or Very Heavy	Up to 20 weeks

Impairment Beginning at Delivery

Vaginal Delivery

Job Classification	Duration of Impairment
Sedentary to Very Heavy Work	Up to 6 weeks

Cesarean Delivery

Job Classification	Duration of Impairment
Sedentary to Very Heavy Work	Up to 8 weeks

The durations indicated are reasonable for the routine pregnancy. If the physician indicates that the claimant's impairment will exceed the above guidelines, it may be necessary to obtain additional medical and/or vocational information to determine whether disability is warranted.

It is still necessary to evaluate each pregnancy claim on an individual basis.

March 31, 2021
ABC Company, Inc.

RE: Jane Smith

Short Term Disability (STD) program. We're writing to you about the claim for Ms.

Any Questions?

Employer Recipients:

March 4, 2021
ABC Company, Inc.

Next Steps

Request a Review of this Decision

within 180 days

Any Questions?

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Standard's

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If you live in Illinois or your policy is issued in Illinois:

If you live in New Hampshire or your policy is issued in New Hampshire:

If you live in South Dakota or your policy is issued in South Dakota:

Your Group Policy doesn't provide voluntary

If you live in Washington or your policy is issued in Washington:

If you live in West Virginia or your policy is issued in West Virginia:

Right to Request Review of This Decision

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Maaari kang kumuha ng tagapagsalin sa iyong wika upang matulungan ka sa anumang katanungan na maaaring mayroon ka at maasistihan ka sa paghain o pag-apela ng claim. Mangyaring makipag-ugnayan sa iyong kinatawan sa claims para sa impormasyon sa kung papaano ma-akses ang mga serbisyo ng pagsasalin ng wika.

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March 4, 2021
ABC Company, Inc.

RE: Jane Smith

We're

The Member's claim is denied because they do not meet the Definition of Disability

aren't

Any Questions?

Employer Recipients:

March 8, 2021
ABC Company, Inc.

Information Received

Missing Information

It's necessary for us to have this missing information to complete our

Next Steps

Request a Review of this Decision

within 180 days

-

Any Questions?

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If you live in West Virginia or your policy is issued in West Virginia:

Right to Request Review of This Decision

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March 8, 2021
ABC Company, Inc.

RE: Jane Smith

We're

Information Received

Missing Information

It's necessary for us to have this missing information to complete our

Any Questions?

Employer Recipients:

March 17, 2021
ABC Company, Inc.

SAMPLE

Summary of Weekly Benefits

-
-
  -
-

Your Benefits

Your Responsibilities

-

-
-
-
-

Next Steps

Request a Review of this Decision

within 180 days

-

Any Questions?

State Specific Rights Regarding Limitation, Denial or Closure of Your Claim

Standard's

If you live in California or your policy is issued in California:

If you live in Illinois or your policy is issued in Illinois:

If you live in New Hampshire or your policy is issued in New Hampshire:

If you live in South Dakota or your policy is issued in South Dakota:

Your Group Policy doesn't provide voluntary

If you live in Washington or your policy is issued in Washington:

If you live in West Virginia or your policy is issued in West Virginia:

Right to Request Review of This Decision

IMPORTANT LANGUAGE INFORMATION

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You can get an interpreter to help you with any questions that you may have and to assist you with filing or appealing a claim. Please contact your claims representative for information on how to access language translation services.

INFORMACIÓN IMPORTANTE SOBRE EL IDIOMA

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MAHALAGANG IMPORMASYON SA WIKA

Maaari kang kumuha ng tagapagsalin sa iyong wika upang matulungan ka sa anumang katanungan na maaaring mayroon ka at maasistihan ka sa paghain o pag-apela ng claim. Mangyaring makipag-ugnayan sa iyong kinatawan sa claims para sa impormasyon sa kung papaano ma-akses ang mga serbisyo ng pagsasalin ng wika.

重要语言信息

您可通过一名口译员来帮助您解决可能遇到的任何问题并且协助您提出理赔或对理赔结果进行申诉。请联系您的理赔代表，为您提供有关如何获得语言翻译服务方面的信息。

T'ÁÁ ÍÍYISÍÍ 'ALÁÁHÓ SAAD ÍÍSH JĄĄ IŁ NÉ

Beehás'áąh, ata' halne' níká e'el yeed ninsingo hódo łááł doo na'ídíkid naáholǫǫ binye, adoo naaltsoos hadę́ dolnił bááhó t'eí, eí doo dágo ni haa áháyá bił asíihgo nandol káh binye yinikeed. T'áá shǫǫdi naaltsoos ílínii binaanish ílínigii bił holné ata' halne' choideesh'įįł ninzǫǫ bíínįkeed.

Pregnancy Claim Guidelines
Employee Benefits

Experience supports that the majority of claimants receiving benefits due to postpartum impairment are capable of returning to work in six weeks for vaginal deliveries and eight weeks for cesarean deliveries. In general, the medical community supports up to six weeks of impairment beginning with the day of the actual vaginal delivery and up to eight weeks for cesarean delivery.

The following sheet offers guidelines for the duration of impairment both prior to and following delivery.

These guidelines should be used when evaluating pregnancy claims.

Impairment Prior to Expected Confinement or Delivery (EDC)

Job Classification	Duration of Impairment
Sedentary	Up to 2 weeks
Light; without prolonged standing; without risk of altercation	Up to 4 weeks
Medium; **or** prolonged standing; **or** risk of altercation	Up to 16 weeks
Heavy or Very Heavy	Up to 20 weeks

Impairment Beginning at Delivery

Vaginal Delivery

Job Classification	Duration of Impairment
Sedentary to Very Heavy Work	Up to 6 weeks

Cesarean Delivery

Job Classification	Duration of Impairment
Sedentary to Very Heavy Work	Up to 8 weeks

The durations indicated are reasonable for the routine pregnancy. If the physician indicates that the claimant's impairment will exceed the above guidelines, it may be necessary to obtain additional medical and/or vocational information to determine whether disability is warranted.

It is still necessary to evaluate each pregnancy claim on an individual basis.

March 4, 2021
ABC Company, Inc.

RE: Jane Smith

Summary of Weekly Benefits

-
-
  -
-

Any Questions?

Employer Recipients:

ARIANA PHYSICIAN
123 NORTH ST
ANYTOWN CA 12345-6789

March 26, 2020
CDF Company

Claim:	Contract:
00AA1234	987654

Dear Ms. Physician,

We've approved your claim for Long Term Disability (LTD) benefits with Standard Insurance Company (The Standard).

Summary of Monthly Benefits

- Date of Disability: November 18, 2019
- Benefit Waiting Period: 150 days
    - Benefits aren't paid during the Benefit Waiting Period
- Benefit start date: April 16, 2020
- Monthly benefit: $2,364.50
- First payment: $847.17 for the period of April 16, 2020 to May 15, 2020
- Monthly benefit due date: 16th of the month

How Your Monthly Benefits Are Calculated

Your Predisability Earnings are $3,940.84. Your maximum benefit is 60% of the first $16,667 of your Predisability Earnings which is $2,364.50, less Deductible Income (income from other sources), if any.

After subtracting the Deductible Income you're currently receiving, if any, your monthly benefit will be $2,364.50. You'll never receive less than $100.00, which is the Minimum Benefit payable. Your benefit can change at any time based on changes in your Deductible Income.

Deductible Income

Deductible Income is any other income you or your dependents receive or are eligible to receive because of your disability or retirement. This may reduce your benefits.

The information we have shows you're receiving the following sources of Deductible Income:

Standard Insurance Company
PO Box 2800
Portland, OR 97204
Tel 800.368.1135

- Short Term Disability
    - Actual Amount: $3,940.52
    - Effective Date: November 25, 2019
    - End Date: April 26, 2020

Because your benefits are paid monthly, any Deductible Income you receive will be converted to a monthly rate.

Examples:

- Weekly amounts are multiplied by 4.333
- Bi-weekly amounts are divided by 2 and then multiplied by 4.333
- Semi-monthly amounts are multiplied by 2

We use a daily rate when your benefit or your Deductible Income applies for only a partial month. We divide the monthly rate by the number of days in a particular month to get the daily rate.

Lump sum Deductible Income distributions may be prorated and deducted from your benefits.

If you receive any Deductible Income after April 15, 2020 which isn't listed in this letter, please notify us.

You May Also Be Eligible to Receive Other Deductible Income

Deductible Income you may be eligible to receive includes (but isn't limited to):

- Social Security Disability

You may not be required to apply for early retirement if it results in a reduced retirement amount. However, we will reduce your benefit if you do begin receiving early retirement benefits.

What You Need to Do

Apply for Deductible Income by May 1, 2020

Your Group Policy requires you apply for any Deductible Income that you may be eligible to receive. Please apply for the following:

- Social Security Disability

If you don't apply, we may estimate the amount you're eligible to receive and deduct that amount from your benefits.

What if You Have Already Applied?

Please send us proof of application by May 1, 2020.

Proof of application includes any of the following:

- Copy of notice stating your application was received
- Copy of award notice
- Copy of denial notice

Expect a Letter or Call from Allsup
The Standard works with Allsup, a company that helps you apply for Social Security Disability. They gather all necessary information to file the application--but only with your authorization. If Allsup contacts you, please respond immediately.

Allsup will update The Standard on the status of your Social Security Disability application. If you decide not to work with them, you still must apply for Social Security Disability and provide us with the application or decision status.

You can send the information by fax: 800.555.4321 or by prepaid envelope enclosed. We'll review the information and let you know if it changes your benefit amount or dates payable.

Let Us Know of Any Changes

You're responsible for notifying The Standard **immediately** when you receive or expect to receive other forms of Deductible Income. Be sure to keep all award or denial notice copies for your records.

If you receive Deductible Income while you're receiving benefits, your claim may be overpaid. If that happens, you must immediately repay The Standard for overpaid benefits.

How You Will Receive Your Benefits

- Unless you choose direct deposit, you'll continue to receive your benefits by check (see enclosed Electronic Funds Transfer form).
- Your first payment is due to you by May 16, 2020.

Taxability

- The taxable amount of your benefits is based on the percentage of premiums paid with pre-tax dollars.
- You'll receive a W-2 form at the end of January.
- 100% of your premiums were paid on a pre-tax basis. As a result, 100% of your benefits are taxable.

Do you want additional taxes withheld?

- Your benefits may have Federal Income Tax withheld at a minimum of $90.00 per month by completing the enclosed form.
- You may also have State Income Tax withheld at a minimum of $40.00 per month by completing the enclosed form.
- Your state may require state tax withholdings when withholding federal tax.

Next Steps

If The Standard asks for information from you or your provider, please send it promptly. If we don't get it, your claim may close.

The Standard may ask for financial information, which can include tax information, to properly calculate your benefits. Please send it promptly.

You can send the information by fax: 800.555.4321 or by prepaid envelope enclosed.

We may contact you if you become eligible to apply for other sources of Deductible Income. We'll let you know so you can apply. If you don't apply, we may estimate the amount you're eligible to receive and deduct that amount from your benefits.

What Happens if You Return to Work

If you return to work, either part-time or full-time for any employer, notify us immediately. If you're working while Disabled, you may be eligible for continued benefits under the return to work incentive. Contact us to discuss your return to work plans.

Any Questions?

If you have any questions about this letter or claim, please contact me at 800.555.1234.

Sincerely,

Annie Analyst
Sr Disability Benefits Analyst
800.555.1234 ext. 5678
fax 800.555.4321

Standard Insurance Company
PO Box 2800 Portland OR 97208-2800

Automatic Electronic Deposit (EFT) Disability Payment Option Request

Section I. Claimant Information

Full Name	Phone Number	Claim Number(s)	
Address	City	State	ZIP Code

Section II. Banking Information *Note: there may be a delay in receiving your benefits electronically if you do not provide accurate and necessary information on this form.*

As proof of account ownership, I have attached an official bank-printed document with the following:
(See reverse for acceptable types of documentation)

- **Claimant's name**
- **Account number**
- **Routing number**
- **Financial institution's logo**

Type of account	Account number	Routing number
☐ Checking ☐ Savings		

Section III. Request and Agreement with Standard Insurance Company (The Standard)

- I authorize and request The Standard to electronically deposit my disability benefit payments into my bank account indicated on this form. I authorize The Standard to contact my bank to verify the information on this request form and resolve problems related to electronic deposits or errors in deposits.
- I understand I may receive benefit checks via U.S. Mail for up to two benefit periods after submitting this form in order to allow the necessary transactions to take place between The Standard and my financial institution. I understand that not all financial institutions update their records at the same time, so my deposit may not be posted to my account until the evening of the payment due date. I understand that there may be a delay in receiving my benefits electronically if I do not provide accurate and necessary information on this form.
- I agree to notify The Standard as soon as reasonably possible of any changes to my designated bank account. This agreement will terminate if my designated bank account is closed or the account number is changed. If this agreement terminates, I understand that my disability benefit payments will be paid by check via U.S. Mail until a new EFT request is successfully submitted. Any future EFT requests submitted to The Standard will replace this request.
- I understand that deposit of my disability benefits into my account will satisfy The Standard's obligation to pay benefits to me, and that my entitlement to benefits is subject to the terms of my policy with The Standard.
- I acknowledge that electronic deposits under this request are made in payment of disability benefits because of my inability to work. With each deposit I accept into my account, I am certifying that I have made no false claims or statements or concealed any material fact.
- I may terminate this authorization at any time by contacting The Standard. I understand that discontinuation of my electronic payments may take up to two benefit periods to take effect, and once the change occurs I will receive any remaining benefits due to me by check unless I select another payment option.

By signing this document, I authorize and request The Standard to electronically deposit my disability benefit payments into my bank account indicated on this form.

Claimant Signature **Date**

Please sign and return this form with documentation proving account ownership.
See FAQ on page two for more information.

FOR INTERNAL USE ONLY

Analyst: ***Routing code:***

FAQ

What type of banking documentation do I need to provide?

As the claimant, you must provide banking documentation that shows proof of account ownership.

Examples of approved forms of documentation:

- Voided check with your name printed on it
- Direct deposit enrollment form preprinted by your financial institution
- Letter from your financial institution on official letterhead

Banking documentation must be preprinted with your account number, routing number and your full legal name, as well as your financial institution's logo. We cannot accept banking documentation with handwritten account information.

We cannot accept deposit slips due to routing number inconsistencies.

What if The Standard has a different name for me than my banking documentation?

Banking documentation needs to have the same name that is printed on claim documents or letters received from The Standard. Please contact us if your name has changed.

What if I don't have a check with my full legal name printed on it?

Contact your financial institution and ask for printed documentation on official letterhead or a form that includes your account number, routing number and full legal name. We will not accept starter checks without your name printed on them or checks that only show your initials.

My financial institution is an online bank and I don't have checks. What can I do?

Contact your bank's customer service department and ask for a letter or form with your name, full account number and routing number on letterhead.

What happens if my banking information changes (for instance, because of a bank merger, new account, etc.)?

Contact The Standard and ask for a new EFT form to fill out. You will need to provide banking documentation if your banking information changes.

I am a personal representative of the claimant, such as an attorney-in-fact under a power of attorney (POA) or legal guardian or conservator. What do I need to submit?

The Standard will need documentation supporting that you have legal authority to sign this form on behalf of the claimant, such as a copy of the POA or court order and letters of guardianship or conservatorship. In addition, the bank documentation you submit must show that the claimant is an owner of the account.

CENTURYLINK, INC.
ATTN
1234 Anywhere Dr
MARYLAND HEIGHTS MO 63043

January 11, 2021
Centurylink
Claim: 00HC12134
Contract: 123456

RE: John Doe

We sent detailed information to Mr. Doe about their Long Term Disability (LTD) benefits with Standard Insurance Company (The Standard). The following information is a summary of benefits.

- Date of Disability: March 30, 2020
- Benefit Waiting Period: the duration of Short Term Disability
  - Benefits aren't paid during the Benefit Waiting Period
- Benefit start date: January 4, 2021
- Monthly benefit: $2,916.78
- Maximum benefit: $2,916.78
- First payment: $1,528.82 for the period of January 4, 2021 to February 3, 2021
- Monthly benefit due date: 4th of the month

The minimum benefit is $291.68.

In most cases, Deductible Income can reduce benefits. Deductible Income includes other sources of income Mr. Doe receives or may be eligible to receive such as sick leave or salary continuation, Social Security, Workers' Compensation or retirement income.

Please contact us if you know Mr. Doe is receiving any Deductible Income you haven't already reported to us.

The Standard will gladly waive LTD premiums in accordance with your coverage provisions. Please contact your local account representative for more information.

If Mr. Doe has group life insurance coverage, continue with premium payments until The Standard tells you otherwise. If you have questions whether premiums should continue, or about how to terminate premiums for an employee, please contact The Standard at 888.937.4783.

Any Questions?

If you have any questions about this letter or claim, please contact me at 800.368.1135.

Sincerely,

Standard Insurance Company
PO Box 2800
Portland, OR 97204
Tel 800.368.1135

Carol Neal
Disability Claim Assistant FAX: 800-378-2397
800.368.1135 ext. 7346
fax 800.378.2397

Employer Recipients:
CENTURYLINK, INC.

CALVIN PHYSICIAN
123 NORTH ST
ANYTOWN CA 12345-6789

March 23, 2020
CDF Company
Claim: 00AA1234
Contract: 987654

Dear Mr. Physician,

I'm writing to you about your Long Term Disability (LTD) benefits with Standard Insurance Company (The Standard).

The information I have shows that you've been released to return to work on April 30, 2020.

Your claim will close on April 29, 2020 because you will no longer be Disabled.

If You Are Unable to Return to Work

If you're unable to return to work on April 30, 2020 due to a medical reason, please have your provider complete the enclosed form(s) or provide medical records from March 1, 2020 to present.

- Medical Questionnaire (form enclosed)

What Can You Do Now?

Request A Review of This Decision

You have the right to request a review of this decision. To request a review, please send a written request to me **within 180 days** after you receive this letter.

It would be helpful for you to provide:

- Any new information you may have about your claim
- Information supporting that you remain Disabled

You can send the information by fax: 800.555.4321 or by prepaid envelope enclosed.

You can also see the enclosed Right to Request Review page for full details on requesting a review.

Any Questions?

If you have any questions about this letter or claim, please contact me at 800.555.1234.

Sincerely,

Annie Analyst
Sr Disability Technical Spec
800.555.1234 ext. 5678
fax 800.555.4321

State Specific Rights Regarding Limitation, Denial or Closure of Your Claim

You may have state specific rights regarding The Standard's decision.

If you live in California or your policy is issued in California:

You have the right to contact the State of California Department of Insurance to request a review of this matter.

Department of Insurance, Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, California 90013
Toll-free: 800.927.4357
213.897.8921

If you live in Illinois or your policy is issued in Illinois:

The Rules of the Illinois Division of Insurance (Part 919) requires The Standard to advise you that you have the right to contact the Illinois Division of Insurance to request a review of this matter.

Chicago:
Illinois Division of Insurance
122 S. Michigan Avenue, 19th Floor
Chicago, Illinois 60603
312.814.2420

Springfield:
Illinois Division of Insurance
320 West Washington Street
Springfield, Illinois 62767
217.782.4515

Website: www.insurance.illinois.gov

If you live in New Hampshire or your policy is issued in New Hampshire:

You have the right to contact the New Hampshire Insurance Department to request a review of this matter.

New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, New Hampshire 03301
Toll-free: 800.852.3416

If you live in South Dakota or your policy is issued in South Dakota:

Your Group Policy doesn't provide voluntary alternative dispute resolution options. However, you may contact the U.S. Department of Labor Office and the South Dakota Division of Insurance for assistance.

If you live in West Virginia or your policy is issued in West Virginia:

The West Virginia Code of State Rules (Section 114-14-6.18) requires The Standard to advise you that you have the right to contact the West Virginia Insurance Commissioner to request a review of this matter.

West Virginia Insurance Commissioner
P.O. Box 50540
Charleston, West Virginia 25305
Toll-free: 888.879.9842

Website: www.wvinsurance.gov

Right to Request Review of This Decision

If you wish to request a review of this decision, you must send The Standard a written request within 180 days of receiving this letter.

You have the right to submit additional information about your claim. The Request a Review of this Decision section of this letter lists helpful information.

Individuals and medical professionals (if necessary) not involved in the original decision of your claim are consulted during the review.

The review is completed within 45 days after your request is received. If there are circumstances beyond our control, an additional 45 days may be required.

Please be advised no internal rules or guidelines were used by The Standard to evaluate your claim.

If the decision to limit, deny, or close your claim is upheld, you have the right to file suit under Section 502(a) of the Employee Retirement Income Security Act (ERISA) or state law, whichever is applicable. You may also have the right to bring civil action under other applicable law.

You have the right to request copies of all documents, records and other information about your claim at no charge.

The Standard reserves the right to consider and assert other reasons for limiting or denying your claim in the future if they come to our attention during the review.

Please consult your Certificate of Insurance or Summary Plan document for a complete description of your rights under the terms of your Group Policy.

IMPORTANT LANGUAGE INFORMATION

You can get an interpreter to help you with any questions that you may have and to assist you with filing or appealing a claim. Please contact your claims representative for information on how to access language translation services.

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T'ÁÁ ÍÍYISÍÍ 'ALÁÁHÓ SAAD ÍÍSH JĄĄ IL NÉ

Bechás'áąh, ata' halne' níká c'el yeed ninsingo hódo láát doo na'ídíkid naáholǫǫ binye, adoo naaltsoos hadę́ dolnił bąąhó t'eí, eí doo dágo ni haa áháyá bił asíihgo nandol káh binye yinikeed. T'áá shǫǫdi naaltsoos ílínii binaanish ílínígíí bił holné ata' halne' choideesh'įįł ninzǫǫ bíníkeed.

Standard Insurance Company

PO Box 2800 Portland OR 97208-28005031

Medical Questionnaire

Name:	Claim Number:	Date:
Date of Birth: / Employer:		

Return to:

Name:	Phone No.:	Fax No.:
	( )	( )

DEAR PROVIDER:

The purpose of this form is to help us determine whether the clinical condition of this claimant is causing functional impairment. Please complete the following report as completely as possible and provide copies of all objective data.

1. **Primary Diagnosis:** _____
   Major source of impairment

   Secondary Diagnosis: _____
   Other diagnoses that might contribute to impairment

2. Describe the symptoms and clinical f ndings, and how any diagnoses affect the claimant's functional abilities.

3. *Based upon objective findings, please indicate the amount of activity this claimant can perform in an 8-hour work day, for any employer. Indicate the functional capacities of this claimant given two breaks, positional changes, and meal break(s).*

	1 Hr.	2 Hrs.	3 Hrs.	4 Hrs.	5 Hrs.	6 Hrs.	7 Hrs.	8 Hrs.	NOT AT ALL
a. Sitting	☐	☐	☐	☐	☐	☐	☐	☐	☐
b. Standing	☐	☐	☐	☐	☐	☐	☐	☐	☐
c. Walking	☐	☐	☐	☐	☐	☐	☐	☐	☐

	Occasional	Frequent	Constant
d. Reaching	☐	☐	☐
e. Handling	☐	☐	☐
f. Fingering	☐	☐	☐

What assistive devices might improve this claimant's ability to perform work activities? _____

4. Activities claimant can perform in an 8-hour work day:

		OCCASIONALLY 1% TO 33%	FREQUENTLY 34% TO 66%	CONTINUOUSLY 67% TO 100%
Lift	1-10 lbs.			
	11-20 lbs.			
	21-50 lbs.			
	51-75 lbs.			
	76-100 lbs.			
Carry	1-10 lbs.			
	11-20 lbs.			
	21-50 lbs.			
	51-75 lbs.			
	76-100 lbs.			
Push/Pull	1-10 lbs.			
	11-20 lbs.			
	21-50 lbs.			
	51-75 lbs.			
	76-100 lbs.			

Standard Insurance Company

PO Box 2800 Portland OR 97208-2800

Medical Questionnaire

Name:

5. Current medication(s): (Include dosage and frequency)
   a. _____
   b. _____
   c. _____
   d. _____
   e. _____
6. Current treatment and/or therapy: _____
   _____
   _____
7. Referrals to other providers:
   Name:_____Specialty: _____
   Phone:_____Date: _____
   Name:_____Specialty: _____
   Phone:_____Date: _____
8. Hospitalizations within the past 12 months:
   Admit Date:_____Discharge Date:_____Reason: _____
   Admit Date:_____Discharge Date:_____Reason: _____
9. Surgery: ☐ Anticipated (Date and Procedure): _____
   ☐ Previous surgery(ies) within the past 12 months: _____
   _____
10. Date first seen for this condition:_____/_____/_____ Date last seen:_____/_____/_____Date of next visit:_____/_____/_____
    month day year month day year month day year
11. Assessment and treatment are complicated by:
    ☐ Contributing factors such as depression, anxiety, etc.
    ☐ Exaggeration, inconsistent findings or subjective complaints out of proportion to objective findings
    ☐ Malingering
    ☐ Dependence on drugs/medication/alcohol. Specify: _____
    ☐ Other (please describe): _____
12. Do you expect the individual's condition to: ☐ Improve ☐ Remain the same ☐ Regress
13. Anticipated return to work date:_____/_____/_____
    month day year
14. Comments: _____
    _____
    _____
    _____

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false, or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

Physician's Signature:		Date:		
Physician's Name: *(Please print.)*		Specialty:		
Address:		City:	State:	Zip:
Taxpayer ID #:	Phone No.: ( )	Fax No.: ( )		

CALVIN PHYSICIAN
123 NORTH ST
ANYTOWN CA 12345-6789

February 26, 2021
The Permanente Medical Group, Inc.

Claim:	Contract:
00AA1234	SAMPLE

Dear Dr. Physician,

We're writing to you about your Long Term Disability (LTD) benefits with Standard Insurance Company (The Standard).

Deductible Income

Deductible Income is any other income you receive or are eligible to receive because of your disability or retirement. This may reduce your benefits.

Your current monthly benefit is $1,508.75. This is reduced by your Deductible Income.

You May Be Eligible to Receive Deductible Income

Deductible Income you may be eligible to receive includes (but isn't limited to):

- Social Security Disability
- State Disability Insurance

Lump sum Deductible Income distributions may be prorated and deducted from your benefit.

What You Need to Do

Apply for Deductible Income by April 1, 2021
Your Group Policy requires you apply for any Deductible Income that you may be eligible to receive. Please apply for the following:

- Social Security Disability

If you don't apply, we may estimate the amount you're eligible to receive and deduct that amount from your benefits.

What if You Have Already Applied?

Please send us proof of application by April 1, 2021.

Proof of application includes any of the following:

- ☐ Copy of notice stating your application was received
- ☐ Copy of award notice
- ☐ Copy of denial notice

Expect a Letter or Call from Allsup
The Standard works with Allsup, a company that helps you apply for Social Security Disability. They gather all necessary information to file the application--but only with your authorization. If Allsup contacts you, please respond immediately.

Allsup will update The Standard on the status of your Social Security Disability application. If you decide not to work with them, you still must apply for Social Security Disability and provide us with the application or decision status.

Let Us Know of Any Changes

You're responsible for notifying The Standard **immediately** when you receive or expect to receive other forms of Deductible Income. Be sure to keep all award or denial notice copies for your records.

If you receive Deductible Income while you're receiving benefits, your claim may be overpaid. If that happens, you must immediately repay The Standard for overpaid benefits.

What to Expect Next

We may contact you
We want to make sure your benefits continue to be accurate, so you will hear from us. If you become eligible for other sources of income, you must apply and notify The Standard.

What Happens if You Return to Work

If you return to any work or self-employment, whether full-time or part-time, while you're receiving disability benefits, you must notify The Standard immediately.

Any Questions?

If you have any questions about this letter or claim, please contact me at 800.368.1135.

Sincerely,

Annie Analyst
Sr Disability Benefits Analyst
800.555.1234 ext. 5678
fax 800.555.4321

CALVIN PHYSICIAN
123 NORTH ST
ANYTOWN CA 12345-6789

March 25, 2020
CDF Company

Claim:	Contract:
00AA1234	987654

Dear Mr. Physician,

Thank you for filing for Long Term Disability (LTD) benefits with Standard Insurance Company (The Standard).

Unfortunately, your claim for benefits is denied because you did not complete the Benefit Waiting Period.

For Benefit Waiting Period wording in your Group Policy, please see the enclosed page.

Important Dates About Your Claim

- Your last day of work: October 11, 2019
- Your claimed date of disability: October 13, 2019
- End of your Benefit Waiting Period: October 11, 2020
- Released to return to work date: October 1, 2020

Reason For Denial

To be eligible for benefits, you must be Disabled as defined by your Group Policy during and beyond the Benefit Waiting Period before benefits become payable.

The information I have shows that you've been released to return to work on October 1, 2020.

As discussed today, if you are not able to return to work by October 1, 2020, please contact me so that we may discuss your current condition. I have attached some forms that you may need to complete, but I will let you know if I need them, after we talk.

Because you aren't expected to be Disabled after the end of the Benefit Waiting Period, you aren't eligible for benefits.

If You Are Unable to Return to Work

If you're unable to return to work on October 1, 2020 due to a medical reason, please have your provider complete the enclosed form(s) or provide medical records from October 1, 2020 to present.

- Medical Questionnaire (form enclosed)
- Authorization to Obtain Information (form enclosed)

What Can You Do Now?

Request A Review of This Decision

You have the right to request a review of this decision. To request a review, please send a written request to me **within 180 days** after you receive this letter.

It would be helpful for you to provide:

- Any new information you may have about your claim

You can send the information by fax: 800.555.4321 or by prepaid envelope enclosed.

You can also see the enclosed Right to Request Review page for full details on requesting a review.

Any Questions?

If you have any questions about this letter or claim, please contact me at 800.555.1234.

Sincerely,

Annie Analyst
Sr Disability Benefits Analyst
800.555.1234 ext. 5678
fax 800.555.4321

State Specific Rights Regarding Limitation, Denial or Closure of Your Claim

You may have state specific rights regarding The Standard's decision.

If you live in California or your policy is issued in California:

You have the right to contact the State of California Department of Insurance to request a review of this matter.

Department of Insurance, Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, California 90013
Toll-free: 800.927.4357
213.897.8921

If you live in Illinois or your policy is issued in Illinois:

The Rules of the Illinois Division of Insurance (Part 919) requires The Standard to advise you that you have the right to contact the Illinois Division of Insurance to request a review of this matter.

Chicago:
Illinois Division of Insurance
122 S. Michigan Avenue, 19th Floor
Chicago, Illinois 60603
312.814.2420

Springfield:
Illinois Division of Insurance
320 West Washington Street
Springfield, Illinois 62767
217.782.4515

Website: www.insurance.illinois.gov

If you live in New Hampshire or your policy is issued in New Hampshire:

You have the right to contact the New Hampshire Insurance Department to request a review of this matter.

New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, New Hampshire 03301
Toll-free: 800.852.3416

If you live in South Dakota or your policy is issued in South Dakota:

Your Group Policy doesn't provide voluntary alternative dispute resolution options. However, you may contact the U.S. Department of Labor Office and the South Dakota Division of Insurance for assistance.

If you live in West Virginia or your policy is issued in West Virginia:

The West Virginia Code of State Rules (Section 114-14-6.18) requires The Standard to advise you that you have the right to contact the West Virginia Insurance Commissioner to request a review of this matter.

West Virginia Insurance Commissioner
P.O. Box 50540
Charleston, West Virginia 25305
Toll-free: 888.879.9842

Website: www.wvinsurance.gov

Right to Request Review of This Decision

If you wish to request a review of this decision, you must send The Standard a written request within 180 days of receiving this letter.

You have the right to submit additional information about your claim. The Request a Review of this Decision section of this letter lists helpful information.

Individuals and medical professionals (if necessary) not involved in the original decision of your claim are consulted during the review.

The review is completed within 45 days after your request is received. If there are circumstances beyond our control, an additional 45 days may be required.

Please be advised no internal rules or guidelines were used by The Standard to evaluate your claim.

If the decision to limit, deny, or close your claim is upheld, you may have the right to bring civil action under applicable law.

You have the right to request copies of all documents, records and other information about your claim at no charge.

The Standard reserves the right to consider and assert other reasons for limiting or denying your claim in the future if they come to our attention during the review.

Please consult your Certificate of Insurance or Summary Plan document for a complete description of your rights under the terms of your Group Policy.

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

IMPORTANT LANGUAGE INFORMATION

You can get an interpreter to help you with any questions that you may have and to assist you with filing or appealing a claim. Please contact your claims representative for information on how to access language translation services.

INFORMACIÓN IMPORTANTE SOBRE EL IDIOMA

Puede recurrir a un intérprete para que lo ayude con cualquier pregunta que pueda tener y para que lo ayude a completar o apelar una reclamación. Póngase en contacto con su representante de reclamaciones para obtener información sobre cómo acceder a los servicios de traducción.

MAHALAGANG IMPORMASYON SA WIKA

Maaari kang kumuha ng tagapagsalin sa iyong wika upang matulungan ka sa anumang katanungan na maaaring mayroon ka at maasistihan ka sa paghain o pag-apela ng claim. Mangyaring makipag-ugnayan sa iyong kinatawan sa claims para sa impormasyon sa kung papaano ma-akses ang mga serbisyo ng pagsasalin ng wika.

重要语言信息

您可通过一名口译员来帮助您解决可能遇到的任何问题并且协助您提出理赔或对理赔结果进行申诉。请联系您的理赔代表，为您提供有关如何获得语言翻译服务方面的信息。

T'ÁÁ ÍÍYISÍÍ 'ALÁÁHÓ SAAD ÍÍSH JĄĄ IL NÉ

Bechás'áąh, ata' halne' níká c'el yeed ninsingo hódo láát doo na'ídíkid naáholǫǫ binye, adoo naaltsoos hadę́ dolnił bąąhó t'eí, eí doo dágo ni haa áháyá bił asíihgo nandol káh binye yinikeed. T'áá shǫǫdi naaltsoos ílínii binaanish ílínígíí bił holné ata' halne' choideesh'įįł ninzǫǫ bíínikeed.

Standard Insurance Company

PO Box 2800 Portland OR 97208-28005031

Medical Questionnaire

Name:	Claim Number:	Date:
Date of Birth: / Employer:		

Return to:

Name:	Phone No.:	Fax No.:
	( )	( )

DEAR PROVIDER:

The purpose of this form is to help us determine whether the clinical condition of this claimant is causing functional impairment. Please complete the following report as completely as possible and provide copies of all objective data.

1. **Primary Diagnosis:** _____
   Major source of impairment

   Secondary Diagnosis: _____
   Other diagnoses that might contribute to impairment

2. Describe the symptoms and clinical f ndings, and how any diagnoses affect the claimant's functional abilities.

3. *Based upon objective findings, please indicate the amount of activity this claimant can perform in an 8-hour work day, for any employer. Indicate the functional capacities of this claimant given two breaks, positional changes, and meal break(s).*

	1 Hr.	2 Hrs.	3 Hrs.	4 Hrs.	5 Hrs.	6 Hrs.	7 Hrs.	8 Hrs.	NOT AT ALL
a. Sitting	☐	☐	☐	☐	☐	☐	☐	☐	☐
b. Standing	☐	☐	☐	☐	☐	☐	☐	☐	☐
c. Walking	☐	☐	☐	☐	☐	☐	☐	☐	☐

	Occasional	Frequent	Constant
d. Reaching	☐	☐	☐
e. Handling	☐	☐	☐
f. Fingering	☐	☐	☐

What assistive devices might improve this claimant's ability to perform work activities? _____

4. Activities claimant can perform in an 8-hour work day:

		OCCASIONALLY 1% TO 33%	FREQUENTLY 34% TO 66%	CONTINUOUSLY 67% TO 100%
Lift	1-10 lbs.			
	11-20 lbs.			
	21-50 lbs.			
	51-75 lbs.			
	76-100 lbs.			
Carry	1-10 lbs.			
	11-20 lbs.			
	21-50 lbs.			
	51-75 lbs.			
	76-100 lbs.			
Push/Pull	1-10 lbs.			
	11-20 lbs.			
	21-50 lbs.			
	51-75 lbs.			
	76-100 lbs.			

Standard Insurance Company

PO Box 2800 Portland OR 97208-2800

Medical Questionnaire

Name:

5. Current medication(s): (Include dosage and frequency)
   a. _____
   b. _____
   c. _____
   d. _____
   e. _____
6. Current treatment and/or therapy: _____
   _____
   _____
7. Referrals to other providers:
   Name:_____Specialty: _____
   Phone:_____Date: _____
   Name:_____Specialty: _____
   Phone:_____Date: _____
8. Hospitalizations within the past 12 months:
   Admit Date:_____Discharge Date:_____Reason: _____
   Admit Date:_____Discharge Date:_____Reason: _____
9. Surgery: ☐ Anticipated (Date and Procedure): _____
   ☐ Previous surgery(ies) within the past 12 months: _____
   _____
10. Date first seen for this condition:_____/_____/_____ Date last seen:_____/_____/_____Date of next visit:_____/_____/_____
    month day year month day year month day year
11. Assessment and treatment are complicated by:
    ☐ Contributing factors such as depression, anxiety, etc.
    ☐ Exaggeration, inconsistent findings or subjective complaints out of proportion to objective findings
    ☐ Malingering
    ☐ Dependence on drugs/medication/alcohol. Specify: _____
    ☐ Other (please describe): _____
12. Do you expect the individual's condition to: ☐ Improve ☐ Remain the same ☐ Regress
13. Anticipated return to work date:_____/_____/_____
    month day year
14. Comments: _____
    _____
    _____
    _____

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false, or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

Physician's Signature:		Date:		
Physician's Name: *(Please print.)*		Specialty:		
Address:		City:	State:	Zip:
Taxpayer ID #:	Phone No.: ( )	Fax No.: ( )		

Authorization to Obtain and Release Information

I AUTHORIZE THESE PERSONS having any records or knowledge of me or my health:

- Any physician, medical practitioner or health care provider.
- Any hospital, clinic, pharmacy or other medical or medically related facility or association.
- Kaiser Permanente.
- Any insurance company or annuity company.
- Any employer, policyholder or plan sponsor.
- Any organization or entity administering a benefit or leave program (including statutory benefits) or an annuity program.
- Any educational, vocational or rehabilitation counselor, organization or program.
- Any consumer reporting agency, financial institution, accountant, or tax preparer.
- Any government agency (*for example, Social Security Administration, Public Retirement System, Railroad Retirement Board, Workers' Compensation Board, etc.).*

TO GIVE THIS INFORMATION:

- Charts, notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing and test results. Prognosis and treatment of any physical or mental condition, including:
  - Any disorder of the immune system, including HIV, Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes.
  - Any communicable disease or disorder.
  - Any psychiatric or psychological condition, including test results, but excluding psychotherapy notes. Psychotherapy notes do not include a summary of diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date.
  - Any condition, treatment, or therapy related to substance abuse, including alcohol and drugs.

and:

- Any non-medical information requested about me, including such things as education, employment history, earnings or finances, return to work accommodation discussions or evaluations, and eligibility for other benefits or leave periods including, but not limited to, claims status, benefit amount, payments, settlement terms, effective and termination dates, plan or program contributions, etc.

TO STANDARD INSURANCE COMPANY, THE STANDARD LIFE INSURANCE COMPANY OF NEW YORK, THE STANDARD BENEFIT ADMINISTRATORS AND THEIR AUTHORIZED REPRESENTATIVES (referred to as "The Companies", individually and collectively), AND MY EMPLOYER'S ABSENCE MANAGEMENT PROGRAM ADMINISTRATOR ("Absence Manager").

- I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct the persons and organizations identified above to release and disclose my entire medical record without restriction.
- I understand that each of The Companies and Absence Manager will gather my information only if they are administering or deciding my disability or leave of absence claim(s), and will use the information to determine my eligibility or entitlement for benefits or leave of absence.
- I understand that I have the right to refuse to sign this authorization and a right to revoke this authorization at any time by sending a written statement to The Companies and Absence Manager, except to the extent the authorization has been relied upon to disclose requested records. A revocation of the authorization, or the failure to sign the authorization, may impair The Companies and Absence Manager's ability to evaluate or process my claim(s), and may be a basis for denying or closing my claim(s) for benefits or leave of absence.
- I understand that in the course of conducting its business The Companies and Absence Manager may disclose to other parties information about me. They may release information to a reinsurer, a plan administrator, plan sponsor, or any person performing business or legal services for them in connection with my claim(s). I understand that The Companies and Absence Manager will release information to my employer necessary for absence management, for return to work and accommodation discussions, and when performing administration of my employer's self-funded (and not insured) disability plans.
- I understand that The Companies and Absence Manager comply with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to them pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by law. Information retained and disclosed by The Companies and Absence Manager may not be protected under the Health Insurance Portability and Accountability Act [HIPAA].
- I understand and agree that this authorization as used to gather information shall remain in force from the date signed below:
  - For Standard Insurance Company, the duration of my claim(s) or 24 months, whichever occurs first.
  - For The Standard Life Insurance Company of New York, the duration of my claim(s) or 24 months, whichever occurs first.
  - For The Standard Benefit Administrators, the duration of my claim(s) administered by The Standard Benefit Administrators or 24 months, whichever occurs first.
  - For Absence Manager, 24 months.
- I understand and agree that The Companies and Absence Manager may share information with each other regarding my disability and leave of absence claim(s). This authorization to share information shall remain valid for 12 months from the date signed below.
- I acknowledge that I have read this authorization and the New Mexico notice on page 2. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

Name (please print) _____

Signature of Claimant/Representative _____ Date _____

If signature is provided by legal representative (e.g., Attorney in Fact, guardian or conservator), please attach documentation of legal status.

Standard Insurance Company is a licensed insurance company in all states except New York. The Standard Life Insurance Company of New York is an insurance company licensed only in New York. An absence manager may be hired by your employer and may be one of The Companies.

FOR RESIDENTS OF NEW MEXICO

The state of New Mexico requires Standard Insurance Company to provide you with the following information pursuant to its Domestic Abuse Insurance Protection Act.

The Authorization form allows Standard Insurance Company to obtain personal information as it determines your eligibility for insurance benefits. The information obtained from you and from other sources may include confidential abuse information. "Confidential abuse information" means information about acts of domestic abuse or abuse status, the work or home address or telephone number of a victim of domestic abuse or the status of an applicant or insured as a family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close personal, family or abuse-related counseling relationship. With respect to confidential abuse information, you may revoke this authorization in writing, effective ten days after receipt by Standard Insurance Company, understanding that doing so may result in a claim being denied or may adversely affect a pending insurance action.

Standard Insurance Company is prohibited by law from using abuse status as a basis for denying, refusing to issue, renew or reissue or canceling or otherwise terminating a policy, restricting or excluding coverage or benefits of a policy or charging a higher premium for a policy.

Upon written request you have the right to review your confidential abuse information obtained by Standard Insurance Company. Within 30 business days of receiving the request, Standard Insurance Company will mail you a copy of the information pertaining to you. After you have reviewed the information, you may request that we correct, amend or delete any confidential abuse information which you believe is incorrect. Standard Insurance Company will carefully review your request and make changes when justified. If you would like more information about this right or our information practices, a full notice can be obtained by writing to us.

If you wish to be a protected person (a victim of domestic abuse who has notified Standard Insurance Company that you are or have been a victim of domestic abuse) and participate in Standard Insurance Company's location information confidentiality program, your request should be sent to Standard Insurance Company.

CDF COMPANY
ATTN EMILE EMPLOYER
456 SOUTH ST SUITE 300
ANYTOWN VA 09876

March 25, 2020
CDF Company
Claim: 00AA1234
Contract: 987654

RE: Calvin Claimant

We sent detailed information to Mr. Claimant about their Long Term Disability (LTD) benefits with Standard Insurance Company (The Standard). The following information is a summary of benefits.

The claim was denied because it is expected that Mr. Claimant will recover before the end of the Benefit Waiting Period, October 11, 2020.

Review your Group Policy to see if Mr. Claimant's insurance has ended. To have coverage, Mr. Claimant must meet all Group Policy requirements. If Mr. Claimant meets these requirements, you should continue premium payments.

The Standard will gladly waive Long Term Disability (LTD) premiums in accordance with your coverage provisions. Please contact your local account representative for more information.

If Mr. Claimant has group life insurance coverage, continue with premium payments until The Standard tells you otherwise. If you have questions whether premiums should continue, or how to terminate premiums for an employee, please contact The Standard at 888.937.4873.

Any Questions?

If you have any questions about this letter or claim, please contact me at 800.555.1234.

Sincerely,

Annie Analyst
Sr Disability Benefits Analyst
800.555.1234 ext. 5678
fax 800.555.4321

CALVIN PHYSICIAN
123 NORTH ST
ANYTOWN CA 12345-6789

March 20, 2020
CDF Company
Claim: 00AA1234
Contract: 987654

Dear Mr. Physician,

I've reviewed your application for Long Term Disability (LTD) benefits with Standard Insurance Company (The Standard). I'm writing to let you know that your claim is pending, why it's pending and what I need from you to continue my review.

Your claim is currently pending, as I need to confirm:

- If you meet your Group Policy's Definition of Disability

To complete my review, I need the following information.

Here's What I Need From You

- Medical or Pharmacy records from:
  - Duke Health for February 1, 2020 through present
- Authorization to Obtain Information (form enclosed)
- Job description

If you remember sending the above information, please resend. It may be that the document received was illegible and difficult to read.

You can send the information by fax: 800.555.4321 or by prepaid envelope enclosed.

I need the above information by May 3, 2020.

If I don't get the information by then, I will go ahead and review your claim with the information I have on file. Please understand that an incomplete file may mean your claim will be denied.

Why I Need This Information

I use the above information to make sure you meet your Group Policy's Definition Of Disability and all applicable policy criteria**.**

Standard Insurance Company
PO Box 2800
Portland, OR 97204
Tel 800.368.1135

Definition Of Disability
You may meet your Group Policy's Definition Of Disability if your illness, pregnancy or injury prevents you from:

- Performing the Material Duties of your Own Occupation
- Performing your occupation in the same capacity

For Definition Of Disability wording in your Group Policy, please see the enclosed page.

Next Steps

The sooner you can send me the above completed documentation, the sooner my team and I can determine your eligibility for benefits. If The Standard asked for information from someone else, please ask them to provide the information listed in this letter.

A Call or Letter from ReleasePoint

The Standard works with ReleasePoint, a company that helps obtain medical records. They help by getting your information from your medical providers directly to The Standard--but only with your authorization. If ReleasePoint contacts you to request authorization, please respond immediately.

A Call from The Standard's Team

During my review, you may receive a call from one of my team members. Please take the time to answer their questions. They assist me in gathering and reviewing information related to your claim.

You'll receive a notification every 15 days while your claim is still pending. If for any reason your claim remains pending for more than 45 days, you'll receive a detailed status update.

Any Questions?

If you have any questions about this letter or claim, please contact me at 800.555.1234.

Sincerely,

Annie Analyst
Sr Disability Benefits Analyst
800.555.1234 ext. 5678 fax
800.555.4321

Definition of Disability

You are Disabled if you meet the following definitions during the periods they apply:

A. Own Occupation Definition Of Disability.
B. Any Occupation Definition Of Disability.

A. Own Occupation Definition Of Disability

During the Benefit Waiting Period and the Own Occupation Period you are required to be Disabled only from your Own Occupation.

You are Disabled from your Own Occupation if, as a result of Physical Disease, Injury, Pregnancy, or Mental Disorder:

1. You are unable to perform with reasonable continuity the Material Duties of your Own Occupation; and
2. You suffer a loss of at least 20% in your Indexed Predisability Earnings when working in your Own Occupation.

Note: You are not Disabled merely because your right to perform your Own Occupation is restricted, including a restriction or loss of license.

During the Own Occupation Period you may work in another occupation while you meet the Own Occupation Definition Of Disability. However, you will no longer be Disabled when your Work Earnings from another occupation meet or exceed 80% of your Indexed Predisability Earnings. Your Work Earnings may be Deductible Income. See Return To Work Provisions and Deductible Income.

Own Occupation means any employment, business, trade, profession, calling or vocation that involves Material Duties of the same general character as the occupation you are regularly performing for your Employer when Disability begins. In determining your Own Occupation, we are not limited to looking at the way you perform your job for your Employer, but we may also look at the way the occupation is generally performed in the national economy. If your Own Occupation involves the rendering of professional services and you are required to have a professional or occupational license in order to work, your Own Occupation is as broad as the scope of your license.

Material Duties means the essential tasks, functions and operations, and the skills, abilities, knowledge, training and experience, generally required by employers from those engaged in a particular occupation that cannot be reasonably modified or omitted. In no event will we consider working an average of more than 40 hours per week to be a Material Duty.

B. Any Occupation Definition Of Disability

During the Any Occupation Period you are required to be Disabled from all occupations.

You are Disabled from all occupations if, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder, you are unable to perform with reasonable continuity the Material Duties of Any Occupation.

Any Occupation means any occupation or employment which you are able to perform, whether due to education, training, or experience, which is available at one or more locations in the national economy and in which you can be expected to earn at least 60% of your Indexed Predisability Earnings within twelve months following your return to work, regardless of whether you are working in that or any other occupation.

Material Duties means the essential tasks, functions and operations, and the skills, abilities, knowledge,

training and experience, generally required by employers from those engaged in a particular occupation that cannot be reasonably modified or omitted. In no event will we consider working an average of more than 40 hours per week to be a Material Duty.

Your Own Occupation Period and Any Occupation Period are shown in the Coverage Features.

Authorization to Obtain and Release Information

I AUTHORIZE THESE PERSONS having any records or knowledge of me or my health:

- Any physician, medical practitioner or health care provider.
- Any hospital, clinic, pharmacy or other medical or medically related facility or association.
- Kaiser Permanente.
- Any insurance company or annuity company.
- Any employer, policyholder or plan sponsor.
- Any organization or entity administering a benefit or leave program (including statutory benefits) or an annuity program.
- Any educational, vocational or rehabilitation counselor, organization or program.
- Any consumer reporting agency, financial institution, accountant, or tax preparer.
- Any government agency (*for example, Social Security Administration, Public Retirement System, Railroad Retirement Board, Workers' Compensation Board, etc.).*

TO GIVE THIS INFORMATION:

- Charts, notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing and test results. Prognosis and treatment of any physical or mental condition, including:
  - Any disorder of the immune system, including HIV, Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes.
  - Any communicable disease or disorder.
  - Any psychiatric or psychological condition, including test results, but excluding psychotherapy notes. Psychotherapy notes do not include a summary of diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date.
  - Any condition, treatment, or therapy related to substance abuse, including alcohol and drugs.

and:

- Any non-medical information requested about me, including such things as education, employment history, earnings or finances, return to work accommodation discussions or evaluations, and eligibility for other benefits or leave periods including, but not limited to, claims status, benefit amount, payments, settlement terms, effective and termination dates, plan or program contributions, etc.

TO STANDARD INSURANCE COMPANY, THE STANDARD LIFE INSURANCE COMPANY OF NEW YORK, THE STANDARD BENEFIT ADMINISTRATORS AND THEIR AUTHORIZED REPRESENTATIVES (referred to as "The Companies", individually and collectively), AND MY EMPLOYER'S ABSENCE MANAGEMENT PROGRAM ADMINISTRATOR ("Absence Manager").

- I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct the persons and organizations identified above to release and disclose my entire medical record without restriction.
- I understand that each of The Companies and Absence Manager will gather my information only if they are administering or deciding my disability or leave of absence claim(s), and will use the information to determine my eligibility or entitlement for benefits or leave of absence.
- I understand that I have the right to refuse to sign this authorization and a right to revoke this authorization at any time by sending a written statement to The Companies and Absence Manager, except to the extent the authorization has been relied upon to disclose requested records. A revocation of the authorization, or the failure to sign the authorization, may impair The Companies and Absence Manager's ability to evaluate or process my claim(s), and may be a basis for denying or closing my claim(s) for benefits or leave of absence.
- I understand that in the course of conducting its business The Companies and Absence Manager may disclose to other parties information about me. They may release information to a reinsurer, a plan administrator, plan sponsor, or any person performing business or legal services for them in connection with my claim(s). I understand that The Companies and Absence Manager will release information to my employer necessary for absence management, for return to work and accommodation discussions, and when performing administration of my employer's self-funded (and not insured) disability plans.
- I understand that The Companies and Absence Manager comply with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to them pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by law. Information retained and disclosed by The Companies and Absence Manager may not be protected under the Health Insurance Portability and Accountability Act [HIPAA].
- I understand and agree that this authorization as used to gather information shall remain in force from the date signed below:
  - For Standard Insurance Company, the duration of my claim(s) or 24 months, whichever occurs first.
  - For The Standard Life Insurance Company of New York, the duration of my claim(s) or 24 months, whichever occurs first.
  - For The Standard Benefit Administrators, the duration of my claim(s) administered by The Standard Benefit Administrators or 24 months, whichever occurs first.
  - For Absence Manager, 24 months.
- I understand and agree that The Companies and Absence Manager may share information with each other regarding my disability and leave of absence claim(s). This authorization to share information shall remain valid for 12 months from the date signed below.
- I acknowledge that I have read this authorization and the New Mexico notice on page 2. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

Name (please print) _____

Signature of Claimant/Representative _____ Date _____

If signature is provided by legal representative (e.g., Attorney in Fact, guardian or conservator), please attach documentation of legal status.

Standard Insurance Company is a licensed insurance company in all states except New York. The Standard Life Insurance Company of New York is an insurance company licensed only in New York. An absence manager may be hired by your employer and may be one of The Companies.

FOR RESIDENTS OF NEW MEXICO

The state of New Mexico requires Standard Insurance Company to provide you with the following information pursuant to its Domestic Abuse Insurance Protection Act.

The Authorization form allows Standard Insurance Company to obtain personal information as it determines your eligibility for insurance benefits. The information obtained from you and from other sources may include confidential abuse information. "Confidential abuse information" means information about acts of domestic abuse or abuse status, the work or home address or telephone number of a victim of domestic abuse or the status of an applicant or insured as a family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close personal, family or abuse-related counseling relationship. With respect to confidential abuse information, you may revoke this authorization in writing, effective ten days after receipt by Standard Insurance Company, understanding that doing so may result in a claim being denied or may adversely affect a pending insurance action.

Standard Insurance Company is prohibited by law from using abuse status as a basis for denying, refusing to issue, renew or reissue or canceling or otherwise terminating a policy, restricting or excluding coverage or benefits of a policy or charging a higher premium for a policy.

Upon written request you have the right to review your confidential abuse information obtained by Standard Insurance Company. Within 30 business days of receiving the request, Standard Insurance Company will mail you a copy of the information pertaining to you. After you have reviewed the information, you may request that we correct, amend or delete any confidential abuse information which you believe is incorrect. Standard Insurance Company will carefully review your request and make changes when justified. If you would like more information about this right or our information practices, a full notice can be obtained by writing to us.

If you wish to be a protected person (a victim of domestic abuse who has notified Standard Insurance Company that you are or have been a victim of domestic abuse) and participate in Standard Insurance Company's location information confidentiality program, your request should be sent to Standard Insurance Company.

March 4, 2021
ABC Company, Inc.

We're

there's

Benefits. Benefits aren't

Next Steps

Request a Review of this Decision

within 180 days

Any Questions?

March 8, 2021
ABC Company, Inc.

We're

Information Received

Missing Information

It's necessary for us to have this missing information to complete our

Next Steps

Request a Review of this Decision

within 180 days

Any Questions?

CALVIN PHYSICIAN
123 NORTH ST
ANYTOWN CA 12345-6789

March 25, 2020
CDF Company

Claim:	Contract:
00AA1234	987654

Dear Mr. Physician,

Thank you for filing for Long Term Disability (LTD) benefits with Standard Insurance Company (The Standard).

Unfortunately, your claim for benefits is denied because you did not complete the Benefit Waiting Period.

For Benefit Waiting Period wording in your Group Policy, please see the enclosed page.

Important Dates About Your Claim

- Your last day of work: October 11, 2019
- Your claimed date of disability: October 13, 2019
- End of your Benefit Waiting Period: October 11, 2020
- Released to return to work date: October 1, 2020

Reason For Denial

To be eligible for benefits, you must be Disabled as defined by your Group Policy during and beyond the Benefit Waiting Period before benefits become payable.

The information I have shows that you've been released to return to work on October 1, 2020.

As discussed today, if you are not able to return to work by October 1, 2020, please contact me so that we may discuss your current condition. I have attached some forms that you may need to complete, but I will let you know if I need them, after we talk.

Because you aren't expected to be Disabled after the end of the Benefit Waiting Period, you aren't eligible for benefits.

If You Are Unable to Return to Work

If you're unable to return to work on October 1, 2020 due to a medical reason, please have your provider complete the enclosed form(s) or provide medical records from October 1, 2020 to present.

- Medical Questionnaire (form enclosed)
- Authorization to Obtain Information (form enclosed)

What Can You Do Now?

Request A Review of This Decision

You have the right to request a review of this decision. To request a review, please send a written request to me **within 180 days** after you receive this letter.

It would be helpful for you to provide:

- Any new information you may have about your claim

You can send the information by fax: 800.555.4321 or by prepaid envelope enclosed.

You can also see the enclosed Right to Request Review page for full details on requesting a review.

Any Questions?

If you have any questions about this letter or claim, please contact me at 800.555.1234.

Sincerely,

Annie Analyst
Sr Disability Benefits Analyst
800.555.1234 ext. 5678
fax 800.555.4321

July 1, 2016

John Smith
1234 NE 50th Ave
Portland, OR 97213

Group Name: ABC Company
Policy Number: 123456
Claim Number: 00XX0000

Dear Mr. Smith:

We are writing in regard to your Long Term Disability (LTD) with Standard Insurance Company (The Standard).

We want to provide benefits to each individual who is entitled to them. Unfortunately, after completing a review of your claim, we have determined that you do not meet the Definition of Disability. Therefore, your LTD claim has been denied. An explanation of our decision, the policy provisions and a summary of the findings is follows.

The ABC Company group policy's Definition of Disability is defined as follows:

DEFINITION OF DISABILITY

You are Disabled if you meet the following definitions during the periods they apply:

A. Own Occupation Definition Of Disability
B. Any Occupation Definition Of Disability

A. Own Occupation Definition Of Disability

During the Benefit Waiting Period and the Own Occupation Period you are required to be Disabled only from your Own Occupation.

You are Disabled from your Own Occupation if, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder:

Standard Insurance Company
900 SW Fifth Avenue
Portland OR 97204
tel 971.321.7000

1. You are unable to perform with reasonable continuity the Material Duties of your Own Occupation; and

2. You suffer a loss of at least 20% in your Indexed Predisability Earnings when working in your Own Occupation.

Note: You are not Disabled merely because your right to perform your Own Occupation is restricted, including a restriction or loss of license.

During the Own Occupation Period you may work in another occupation while you meet the Own Occupation Definition Of Disability. However, you will no longer be Disabled when your Work Earnings from another occupation meet or exceed 80% of your Indexed Predisability Earnings. Your Work Earnings may be Deductible Income. See **Return To Work Provisions** and **Deductible Income**.

Own Occupation means any employment, business, trade, profession, calling or vocation that involves Material Duties of the same general character as the occupation you are regularly performing for your Employer when Disability begins. In determining your Own Occupation, we are not limited to looking at the way you perform your job for your Employer, but we may also look at the way the occupation is generally performed in the national economy. If your Own Occupation involves the rendering of professional services and you are required to have a professional or occupational license in order to work, your Own Occupation is as broad as the scope of your license.

Material Duties means the essential tasks, functions and operations, and the skills, abilities, knowledge, training and experience, generally required by employers from those engaged in a particular occupation that cannot be reasonably modified or omitted. In no event will we consider working an average of more than 40 hours per week to be a Material Duty.

B. Any Occupation Definition Of Disability

During the Any Occupation Period you are required to be Disabled from all occupations.

You are Disabled from all occupations if, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder, you are unable to perform with reasonable continuity the Material Duties of Any Occupation.

Any Occupation means any occupation or employment which you are able to perform, whether due to education, training, or experience, which is available at one or more locations in the national economy and in which you can be expected to earn at least 60% of your Indexed Predisability Earnings within 12 months following your return to work, regardless of whether you are working in that or any other occupation.

Material Duties means the essential tasks, functions and operations, and the skills, abilities, knowledge, training and experience, generally required by employers from those engaged in a particular occupation that cannot be reasonably modified or omitted. In no event will we consider working an average of more than 40 hours per week to be a Material Duty.

Your Own Occupation Period and Any Occupation Period are shown in the **Coverage Features**.

Vocational Information

Our Vocational Case Manager reviewed the information in your claim and compared the duties outlined in the job description as required in the performance of your Own Occupation as an Intake Counselor. The Vocational Case Manager reported that according to the U.S. Department of Labor Dictionary of Occupational Titles of Occupational Titles, (Fourth Edition Revised 1991 US Department of Labor Employment and Training Administration) the primary duties of from the vocational information in your claim file are consistent with the occupation of Eligibility Worker (DOT 195.267-010).The physical requirement expected from your Own Occupation as an Eligibility Worker as described by the DOT, would fall within the Sedentary level of work.

According to the Dictionary of Occupational Titles Sedentary work is defined as follows:

Sedentary Work – Exerting up to 10 pounds of force occasionally. (Occasionally: activity or condition exist up to 1/3 of the time) and/or a negligible amount force frequently (Frequently: activity or condition exists from 1/3 to 2/3 of the time) to lift, carry, push, pull, or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.

In order to reach a determination that you meet the Definition of Disability from your Own Occupation, we must have satisfactory written proof that you suffer from limitations and restrictions that would prevent you from perform the Material Duties of your Own Occupation throughout and beyond the 180 day benefit waiting period.

Medical Information

The information in your file indicates that you ceased work on January 27, 2016 due to shortness of breath. Information in your file indicates you have had a history of cardiac conditions. You indicated you had your first heart attack in 1997, congestive heart failure, sudden heart death, cardiomyopathy and TIA's since 2007. You note that your condition causes you extreme fatigue, headaches, and breathing difficulties. The original Attending Physician's Statement we received from Dr. Jones indicates a diagnosis of coronary artery disease, congestive heart failure and bronchitis.

In order to complete our review, we requested copies of your medical records from Dr. Jones, Dr. Hill, Dr. Williams and xx Hospital. The following is a summary of the information we reviewed. We have reviewed all of the medical records received. However, please understand that the following is a summary of the available medical documentation and is not intended to be

a complete account of each and every chart not or medical record currently contained in the claim file. While we may not include a description of every visit, chart note, or test result, please be assured that during our review we thoroughly took into consideration all of the medical information currently available to us.

You were hospitalized from January 27, 2016 through January 31, 2016 due to congestive heart failure. You attempted to return to work on February 15, 2016 but ceased work again as of February 23, 2016 with ongoing shortness of breath. Chest x-rays were taken on February 24, 2016 and showed cardiomegaly (an enlarged heart) and mild congestive changes. Repeat x-rays on February 26, 2016 indicated improved aeration, linear atelectasis and mild cardiomegaly. You were subsequently hospitalized and further work up was performed.

An abnormal echocardiogram was performed and showed depressed left ventricular systolic function. On March 2, 2016, an angiography and catheterization was performed. The catheterization noted you had severe pulmonary hypertension and a 10-15% ejection fraction. In your appointment on March 15, 2016, Dr. Hill (cardiologist) indicated that you were now diagnosed with dilated cardiomyopathy. He noted that he had stabilized on medication but would benefit from cardiac rehabilitation.

You began cardiac rehabilitation and returned on to Dr. Hill on April 11, 2016. Upon examination, he indicated that your cardiomyopathy had responded fairly well to medication. You were continuing to have some dyspnea (shortness of breath with increased physical activity) but that the dyspnea was improving. A repeat echocardiogram was performed and your ejection fraction was noted to have improved to 40%.

Although your ejection fraction improved, you could still qualify for a defibrillator placement, and Dr. Hill referred you to Dr. Williams. Cardiac rehabilitation was to continue, however, stopped when you underwent an ICD (implantable cardioverter defibrillator) placement on May 10, 2016. Our records indicate you were last seen by Dr. Hill on June 24, 2016. In his chart note, Dr. Hill indicated that your cardiomyopathy was stable, had an ICD in place and was to continue with current medication.

To provide us with an opinion on the medical information in your file, a Physician Consultant, Board Certified in Cardiology, reviewed your entire file. He noted that based on the notes in the file, your cardiomyopathy was stable. Based on the information in your file, the Physician Consultant indicated that you would be reasonably impaired from all occupations as of the time you ceased work through March 2016 secondary to your congestive heart failure and cardiomyopathy. The Physician Consultant noted you would be reasonably precluded from work for 2-3 days around the time of the placement of the ICD. However, as of March 2016, your conditions have been treated appropriately to the point that they had improved and you should have been able to return to a full time sedentary level occupation.

In evaluating your eligibility to long term disability benefits we must focus on whether the available medical information supports that your condition prevents you from performing the

Material Duties of your Own Occupation. The Physician Consultant who reviewed the medical records received from your care providers found that you would be capable of sedentary level work. Since the medical documentation in your file does not support an inability to perform the Material Duties of your Own Occupation beyond the benefit waiting period, your LTD claim must be denied.

The following is information regarding your right to request a review of this decision.

If you want us to review your claim and this decision, you must send us a written request within 180 days after you receive this letter. If you request a review, you will have the right to submit additional information in connection with your claim. Additional information which would be helpful in a reconsideration of your claim includes medical documentation showing that your limitations and restrictions are greater than understood. Please include any such new information along with your request for review.

If you request a review, it will be conducted by an individual who was not involved in the original decision. If necessary, the person conducting the review will consult with a medical professional with regard to this claim. The medical professional will be someone who was not previously consulted in connection with this claim. The review would be completed within 45 days after we receive your request unless circumstances beyond our control require an extension of an additional 45 days.

If you request a review and the decision to deny your claim is upheld, you will have the right to file suit under Section 502(a) of the Employee Retirement Income Security Act (ERISA) or state law, whichever is applicable.

We want to let you know that upon further investigation, other valid reasons for limiting or denying this claim, which have not been previously considered, could come to our attention. Therefore, The Standard reserves the right to consider and assert other reasons for limitation or denial of this claim should they occur in the future.

Please consult your Certificate of Insurance or Summary Plan document for a complete description of your rights under the terms of the ABC Company group policy.

We regret that we are unable to be of service to you. If you have any questions regarding your claim or this letter, please do not hesitate to contact me.

Sincerely,

Annie Analyst
Disability Benefits Analyst
(800) 368-1135 Ext. xxxx

Customer Self-Service Sample Reports

Short Term Disability Reports

STD Claim Status

Self-Service Report

- Lists all incomplete, pending, active, denied and closed STD claims within the last 90 days.

STD Claim Status
As of: mm/dd/yyyy

Contract: 123456 - Admin Unit: 01 - Status: ACTIVE			
Claimant SSN / Claim No	**Benefits Start**	**Approved Through**	**Status Reason**
ROBERT FRANK XXX-XX-0009 / 00AA002	mm/dd/yyyy	mm/dd/yyyy	ANTICIPATED RECOVERY DATE

STD Most Recent Checks

Self-Service Report

- Displays a record of all STD benefit checks issued within the last 90 days.

STD Most Recent Checks

Contract: 123456 - Admin Unit: 01 - Status: ACTIVE					
Claimant SSN / Claim No	**Payment**	**Date Paid**	**Period**	**Benefits Start**	**Disabled**
LINDA JONES XXX-XX-0001 / 00AA0002	$620.48	mm/dd/yyyy	mm/dd/yyyy mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy
HOWARD DAVIS XXX-XX-0002 / 00AA0003	$920.08	mm/dd/yyyy	mm/dd/yyyy mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy
PAT THOMPSON XXX-XX-0003 / 00AA0004	$370.44	mm/dd/yyyy	mm/dd/yyyy mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy
ROBERT FRANK XXX-XX-0007 / 00AA0005	$523.19	mm/dd/yyyy	mm/dd/yyyy mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy

STD Claims to Pay Report

Self-Service Report

- Lists all active claims and the time period for which benefits are due.

STD Claims To Pay Report

For the period: mm/dd/yyyy through mm/dd/yyyy

Contract: 123456 - Admin Unit: 01 - Status: ACTIVE					
Claimant SSN / Claim No	**Disabled**	**Benefits Start**	**Approved Through**	**Anticipated Recovery**	**Benefits Paid To Date**
LINDA JONES XXX-XX-0001 / 00AA0001	mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy	$0.00
Activity:	ANTICIPATED RECOVERY DATE				
Notes:					
PAT THOMPSON XXX-XX-0002 / 00AA0001	mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy	$0.00
Activity:	END OF USUAL RECOVERY PERIOD				
Notes:					
HOWARD DAVIS XXX-XX-0001 / 00AA0001	mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy	$0.00
Activity:	ANTICIPATED RECOVERY DATE				
Notes:					

STD Benefits Paid by Diagnosis

Self-Service Report

- Lists total benefits paid on all STD claims closed during the previous quarter, sorted by diagnostic category.

STD Benefits Paid By Diagnosis Report
For the Period: mm/dd/yyyy Through mm/dd/yyyy

Diagnosis:	Broad category of related diagnosis.
Approved Claims:	The number of claims closed during the specified time period.
Approved Claims %:	Percent of approved claims by diagnosis.
Benefits Paid:	Total benefits paid on approved claims.
Benefits Paid %:	Percent of benefits paid by diagnosis.
Average Benefits Paid:	Benefits paid divided by approved claims.
Average Duration:	Average length of duration for approved claims.
Duration:	Length of time from date of disability to date of claim closure.

Contract: 123456 - Admin Unit: 01

Diagnosis	Approved Claims	Claims %	Benefits Paid	Benefits Paid %	Average Paid	Average Duration (Days)
Bone, Joint, Muscle other than back	6	29%	$0.00	100%	$0.00	60
Digestive	3	14%	$0.00	100%	$0.00	31
Maternity	5	24%	$0.00	100%	$0.00	48
Misc/Unclassified	2	10%	$0.00	100%	$0.00	25
Suppressed	1	5%	$0.00	100%	$0.00	14
Suppressed	1	5%	$0.00	100%	$0.00	31
Suppressed	1	5%	$0.00	100%	$0.00	24
Suppressed	1	5%	$0.00	100%	$0.00	26
Suppressed	1	5%	$0.00	100%	$0.00	12
TOTAL:	21		$0.00		$0.00	40

STD Claim Duration by Diagnosis

Self-Service Report

- Provides the length of time from date of disability to date of claim closure for all STD claims closed during the previous quarter, sorted by diagnostic category.

STD Claim Duration By Diagnosis Report
For the Period: mm/dd/yyyy Through mm/dd/yyyy

Diagnosis:	Related diagnosis category.
Approved Claims:	The number of claims closed during the specified time period.
Approved Claims %:	Percent of approved claims by diagnosis.
Average Duration:	Average length of duration for approved claims.
Duration:	Length of time from date of disability to date of claim closure.

Contract: 123456 - Admin Unit: 01

Diagnosis	Closed Claims	%	Duration									Average Duration (Days)
			<1 Week	7-13 Days	14-20 Days	21-27 Days	4-6 Weeks	6-8 Weeks	8-13 Weeks	13-26 Weeks	26+ Weeks	
Bone, Joint, Muscle other than back	6	29%	0	0	1	0	0	2	2	1	0	60
Digestive	3	14%	0	0	1	0	1	1	0	0	0	31
Maternity	5	24%	0	0	0	0	3	1	1	0	0	48
Misc/Unclassified	2	10%	0	0	1	0	1	0	0	0	0	25
Suppressed	1	5%	0	0	1	0	0	0	0	0	0	14
Suppressed	1	5%	0	0	0	0	1	0	0	0	0	31
Suppressed	1	5%	0	0	0	1	0	0	0	0	0	24
Suppressed	1	5%	0	0	0	1	0	0	0	0	0	26
Suppressed	1	5%	0	1	0	0	0	0	0	0	0	12
TOTAL:	21		0	1	4	2	6	4	3	1	0	40

Long Term Disability Reports

LTD Claim Status

Self-Service Report

- Lists all incomplete, pending, active, denied and closed LTD claims within the last 90 days.

LTD Claim Status
As of: mm/dd/yyyy

Contract: 123456 - Status: ACTIVE			
Claimant SSN / Claim No	**Benefits Start**	**Approved Through**	**Status Reason**
BOB FRANKLIN XXX-XX-0000 / 00AA0001	mm/dd/yyyy		

Contract: 123456 - Status: CLOSED			
Claimant SSN / Claim No	**Benefits Start**	**Approved Through**	**Status Reason**
LINDA JONES XXX-XX-0001 / 00AA0002	mm/dd/yyyy	mm/dd/yyyy	RETURNED TO WORK

LTD Most Recent Checks

Self-Service Report

- Displays a record of all LTD benefit checks issued within the last 90 days.

Contract: 123456 - Status: ACTIVE					
Claimant SSN / Claim No	**Payment**	**Date Paid**	**Period**	**Benefits Start**	**Disabled**
HOWARD DAVIS XXX-XX-0003 / 00AA0008	$3,034.37	mm/dd/yyyy	mm/dd/yyyy mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy
JOHN SMITH XXX-XX-0004 / 00AA0009	$1,079.42	mm/dd/yyyy	mm/dd/yyyy mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy
PAT THOMPSON XXX-XX-0005 / 00AA0010	$2,209.65	mm/dd/yyyy	mm/dd/yyyy mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy

Contract: 123456 - Status: CLOSED					
Claimant SSN / Claim No	**Payment**	**Date Paid**	**Period**	**Benefits Start**	**Disabled**
LINDA JONES XXX-XX-0001 / 00AA0002	$694.70	mm/dd/yyyy	mm/dd/yyyy mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy

LTD Benefit Calculation Report

Self-Service Report

- Contains pertinent employee data and benefit calculation detail for all active claims.

Benefit Calculation Report
As of: mm/dd/yyyy

Contract: 123456 - Admin Unit: 01						
Claimant SSN / Claim No.		**Hire Date**	**Disability Date**	**Approval Date**	**Work Related**	**Monthly Salary**
LINDA JONES XXX-XX-0001 / 00AA0002		mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy	Yes	$3,819.84
	Maximum LTD Benefit:		$2,291.90			
	Net Monthly Benefit (Pre Tax):		$2,291.90			
HOWARD DAVIS XXX-XX-0003 / 00AA0008		mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy	No	$3,392.53
	Maximum LTD Benefit:		$2,035.52			
	Offsets:		$578.00	SOCIAL SECURITY DEPENDENTS		
			$1,156.00	SOCIAL SECURITY DISABILITY		
	Net Monthly Benefit (Pre Tax):		$301.52			
PAT THOMPSON XXX-XX-0005/ 00AA0010		mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy	No	$6,663.96
	Maximum LTD Benefit:		$3,998.38			
	Net Monthly Benefit (Pre Tax):		$3,998.38			
ROBERT FRANK XXX-XX-0006 / 00AA0011		mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy	No	$6,663.96
	Maximum LTD Benefit:		$3,998.38			
	Net Monthly Benefit (Pre Tax):		$3,998.38			

LTD Claim Duration By Diagnosis Report

Self-Service Report

- Provides the benefits paid and length of time from date of disability to date of closure for all LTD claims closed during the previous quarter, sorted by diagnostic category.

LTD Benefits Paid By Diagnosis Report
For the Period: mm/dd/yyyy Through mm/dd/yyyy

Diagnosis:	Broad category of related diagnosis.
Approved Claims:	The number of claims closed during the specified time period.
Approved Claims %:	Percent of closed claims by diagnosis.
Benefits Paid:	Total benefits paid on closed claims.
Benefits Paid %:	Percent of benefits paid by diagnosis.
Average Benefits Paid:	Total benefits paid divided by the number of closed claims.
Average Duration:	Average length of duration for closed claims.

Contract: 123456

Diagnosis	Approved Claims	Claims %	Benefits Paid	Benefits Paid %	Average Paid	Average Duration (Months)
Suppressed	1	100%	$118,982.51	100%	$118,982.51	160
TOTAL:	1		$118,982.51		$118,982.51	160

Contract: 123456 - Admin Unit: 01

Diagnosis	Approved Claims	Claims %	Benefits Paid	Benefits Paid %	Average Paid	Average Duration (Months)
Suppressed	1	100%	$23,323.01	100%	$23,323.01	33
TOTAL:	1		$23,323.01		$23,323.01	33

Utilization Reporting Samples

Reports for Life, Disability and Absence that can be scheduled and available on a quarterly, semi-annual or annual basis.

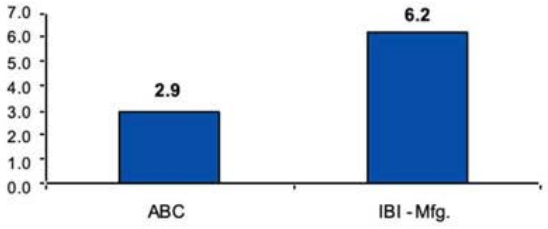
Short Term Disability Reports

STD Overview

STD Dashboard – Provides a quick overview of STD claims activity during the reporting period.

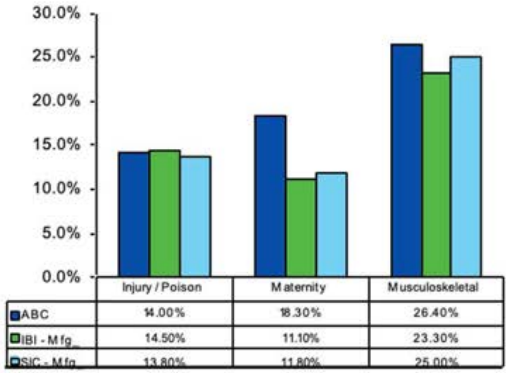
For claims with activity during the two-year reporting period

Annualized Incidence per 100 Members

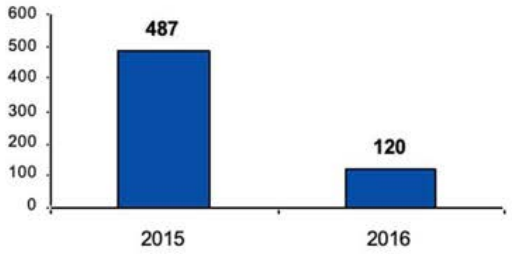


Claims by Status

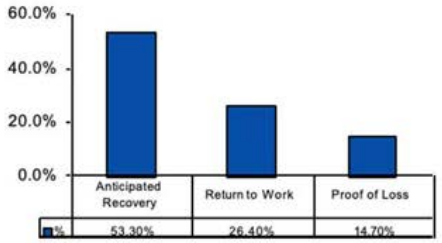
Top 3 Diagnostic Categories - Percent of Claims



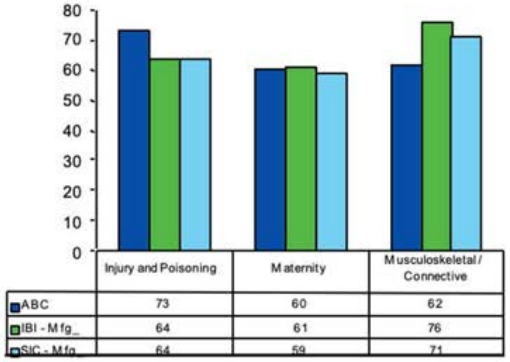
Claim Count by Year Incurred



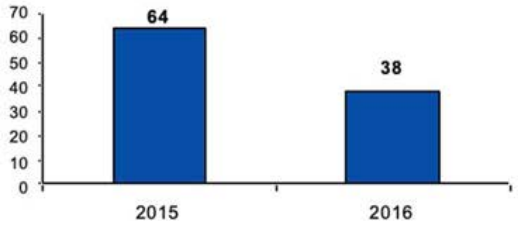
Top 3 Reasons for Claim Closure



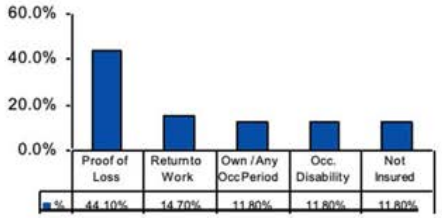
Top 3 Diagnostic Categories - Avg. Duration Days



Average Duration Days by Year Incurred



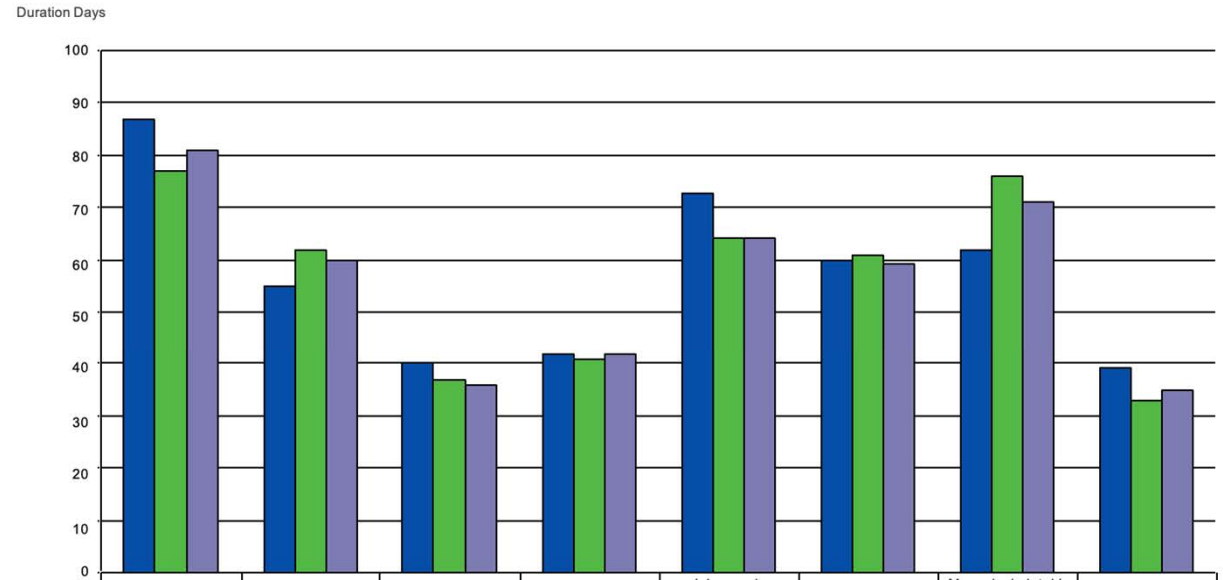
Top 3 Reasons for Claim Denial



SIC benchmarks are from The Standard and statistics use the last five complete calendar years. IBI benchmarks use the most recent Integrated Benefits Institute reports and cover one calendar year. Top three categories are determined by count, then percentage of claims and percentage of benefits paid are calculated for these categories. All charts except claims by status and reasons for claim denial exclude claims in pending or denied status.

STD Duration Days by Top Diagnostic Category Compared to Benchmarks

Displays the average duration by diagnostic category compared to similar industry benchmarks for all approved claims that were open during the period.



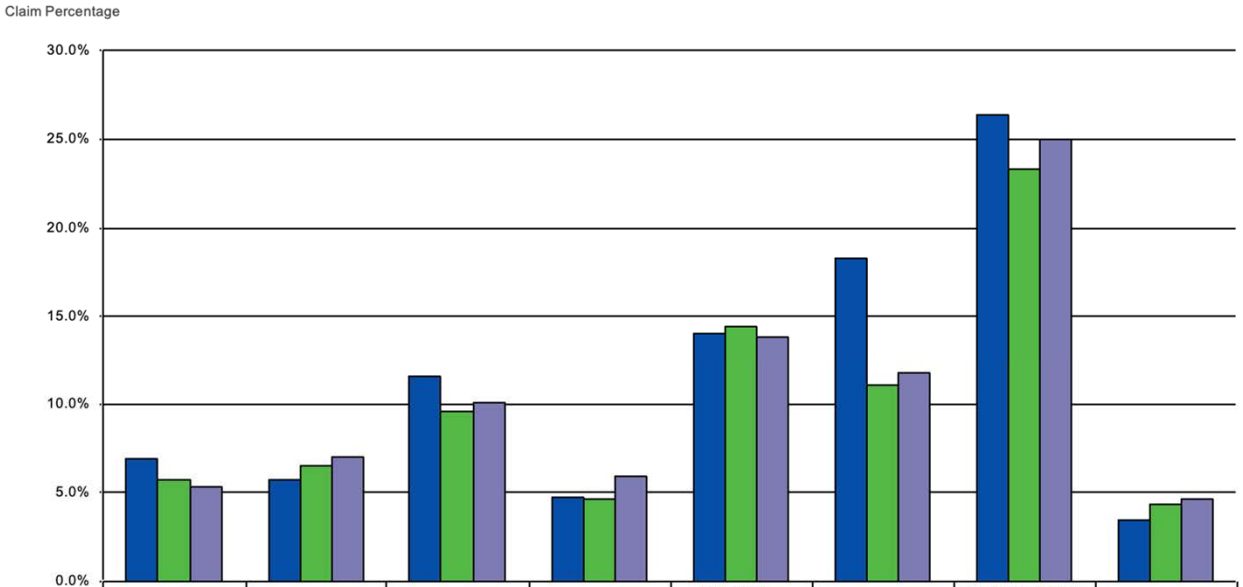
	Cancer	Circulatory	Digestive	Genitourinary	Injury and Poisoning	Maternity	Musculoskeletal / Connective	Respiratory
ABC	87	55	40	42	73	60	62	39
IBI - Mfg_	77	62	37	41	64	61	76	33
SIC - Mfg_	81	60	36	42	64	59	71	35

The data is based off of claims with activity from May 01, 2014 through April 30, 2016.

SIC benchmarks are from The Standard and statistics use the last five complete calendar years. IBI benchmarks use the most recent Integrated Benefits Institute reports and cover one calendar year. Duration is calculated as calendar days from the Date of Disability to the Closure Date.

STD Claim Percentage by Top Diagnostic Category Compared to Benchmarks

Displays the STD claim percentage by diagnostic category compared to similar industry benchmarks for all open and approved claims during the period.



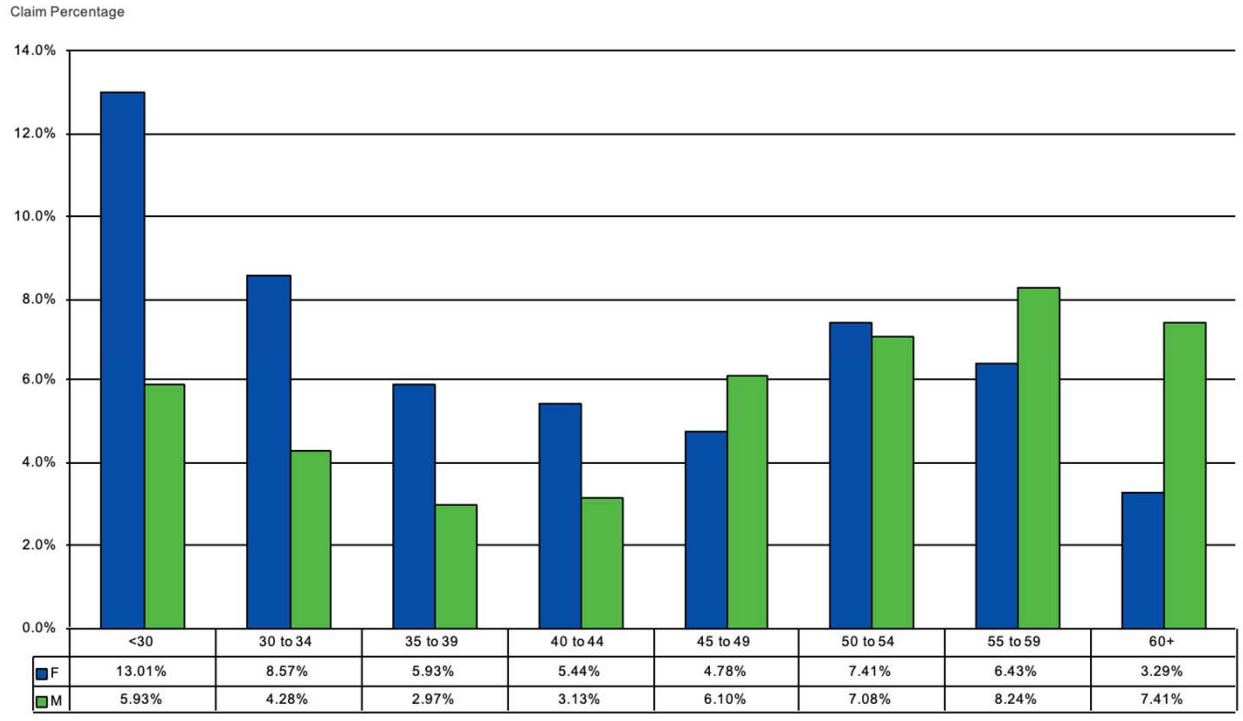
	Cancer	Circulatory	Digestive	Genitourinary	Injury and Poisoning	Maternity	Musculoskeletal / Connective	Respiratory
ABC	6.92%	5.77%	11.53%	4.78%	14.00%	18.29%	26.36%	3.46%
IBI - Mfg_	5.79%	6.49%	9.59%	4.70%	14.49%	11.09%	23.28%	4.40%
SIC - Mfg_	5.32%	7.01%	10.09%	5.90%	13.82%	11.79%	24.98%	4.66%

The data is based off of claims with activity from May 01, 2014 through April 30, 2016.

SIC benchmarks are from The Standard and statistics use the last five complete calendar years. IBI benchmarks use the most recent Integrated Benefits Institute reports and cover one calendar year.

STD Claim Count Percentage by Age and Gender

Displays the percentage of claims by age and gender for approved claims open during the time period.



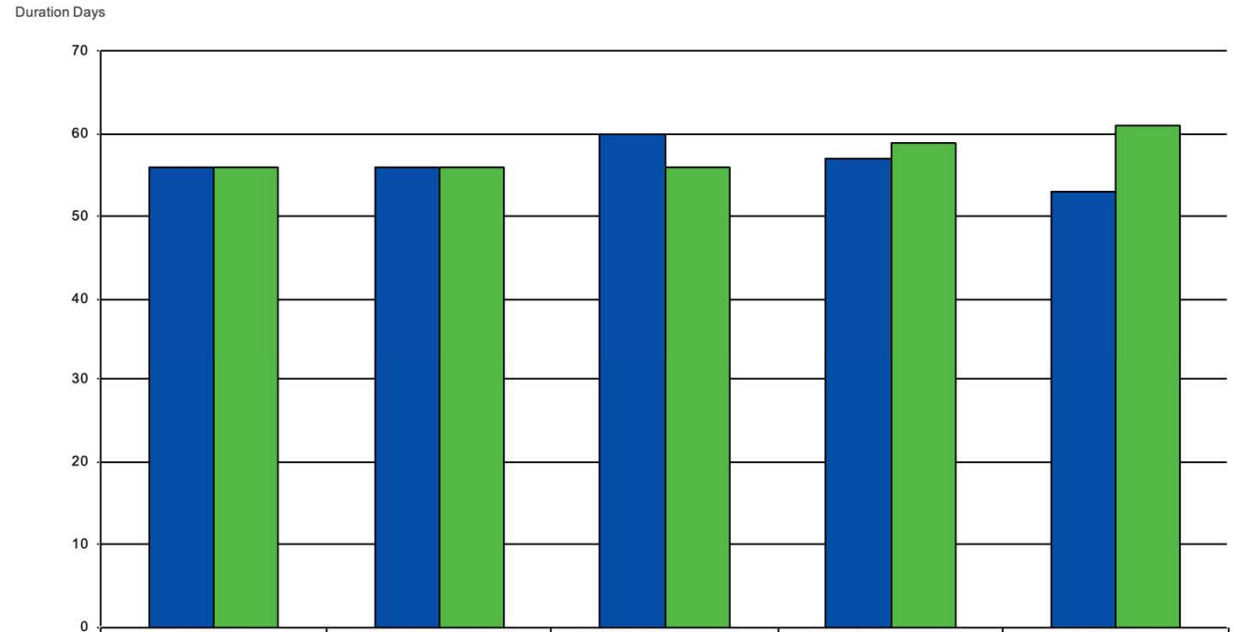
	<30	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60+
F	13.01%	8.57%	5.93%	5.44%	4.78%	7.41%	6.43%	3.29%
M	5.93%	4.28%	2.97%	3.13%	6.10%	7.08%	8.24%	7.41%

The data is based off of claims with activity from May 01, 2014 through April 30, 2016.

Age range is calculated as of the date of disability.

STD Duration Days by Tenure Compared to Benchmarks

Displays the average duration by tenure range compared to similar industry benchmarks for all approved claims open during the period.



	< 01 Year	>= 01 Year, < 03 Years	>= 03 Years, < 05 Years	>= 05 Years, < 10 Years	>= 10 Years
ABC	56	56	60	57	53
SIC - Mfg_	56	56	56	59	61

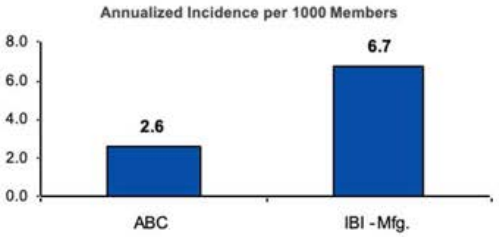
The data is based off of claims with activity from May 01, 2014 through April 30, 2016.

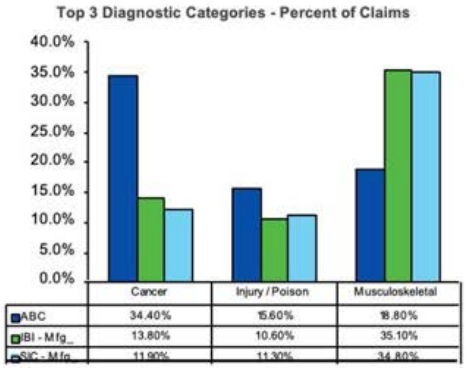
SIC benchmarks are from The Standard and statistics use the last five complete calendar years. Duration is calculated as calendar days from Date of Disability to Close Date, for closed claims only.

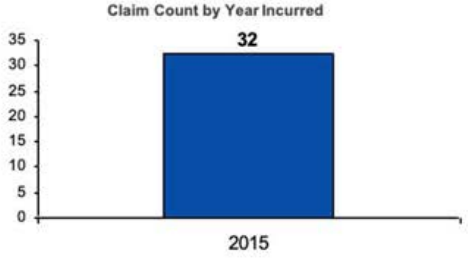
Long Term Disability Reports

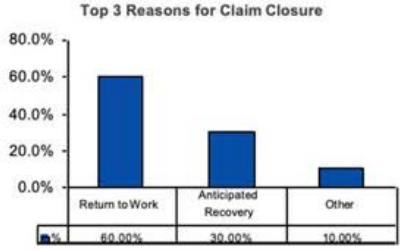
LTD Overview

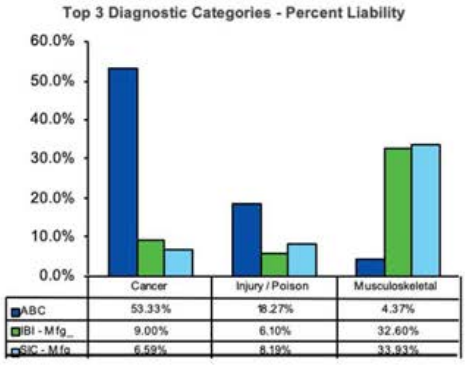
LTD Dashboard – Provides a quick overview of LTD claims activity during the reporting period.

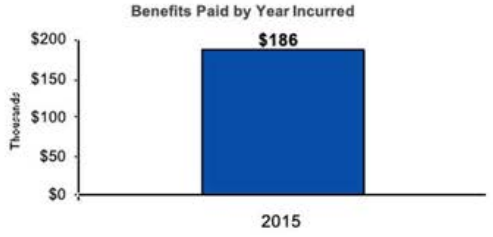












The data is based off of claims with activity from May 01, 2014 through April 30, 2016.

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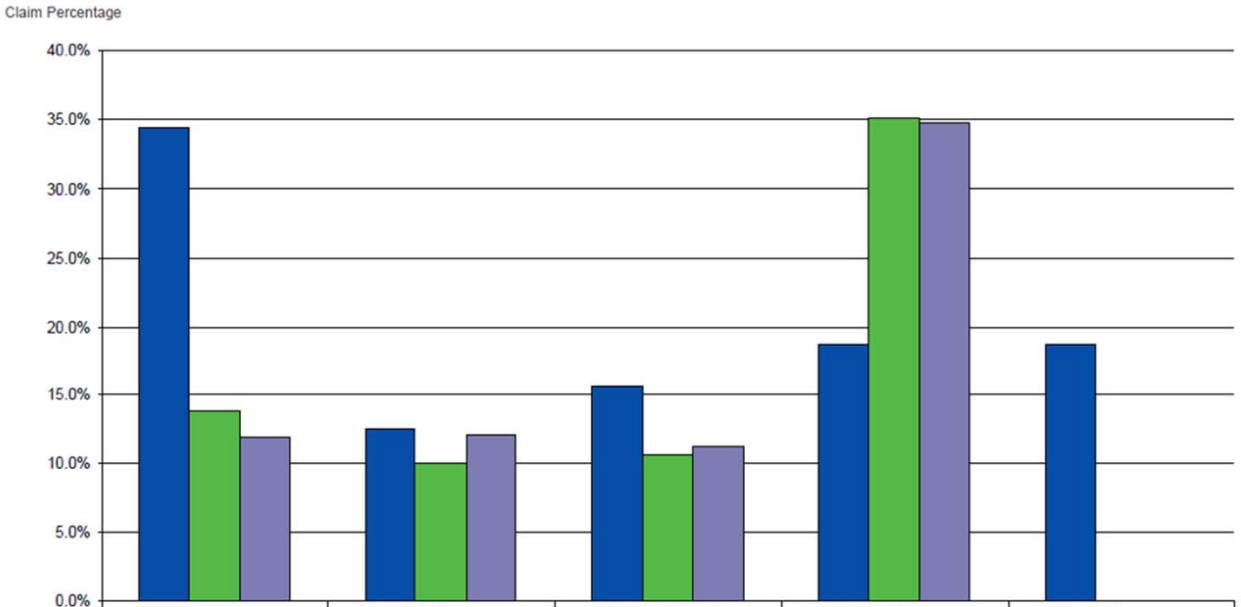
LTD Claims by Top Diagnostic Categories Compared to Benchmarks

Displays the LTD claim percentage by diagnostic category compared to similar industry benchmarks for all approved claims open during the period.



	Cancer	Circulatory	Injury and Poisoning	Musculoskeletal / Connective	Others
ABC	34.38%	12.50%	15.63%	18.75%	18.75%
IBI - Mfg_	13.80%	10.00%	10.60%	35.10%	0
SIC - Mfg_	11.91%	12.08%	11.26%	34.79%	0

The data is based off of claims with activity from May 01, 2014 through April 30, 2016.

SIC benchmarks are from The Standard and statistics use the last five complete calendar years. IBI benchmarks use the most recent Integrated Benefits Institute reports and cover one calendar year.

LTD Claims by Product and Status

Displays the claim count, benefits paid, reserve and average duration for all claims open during the time period.

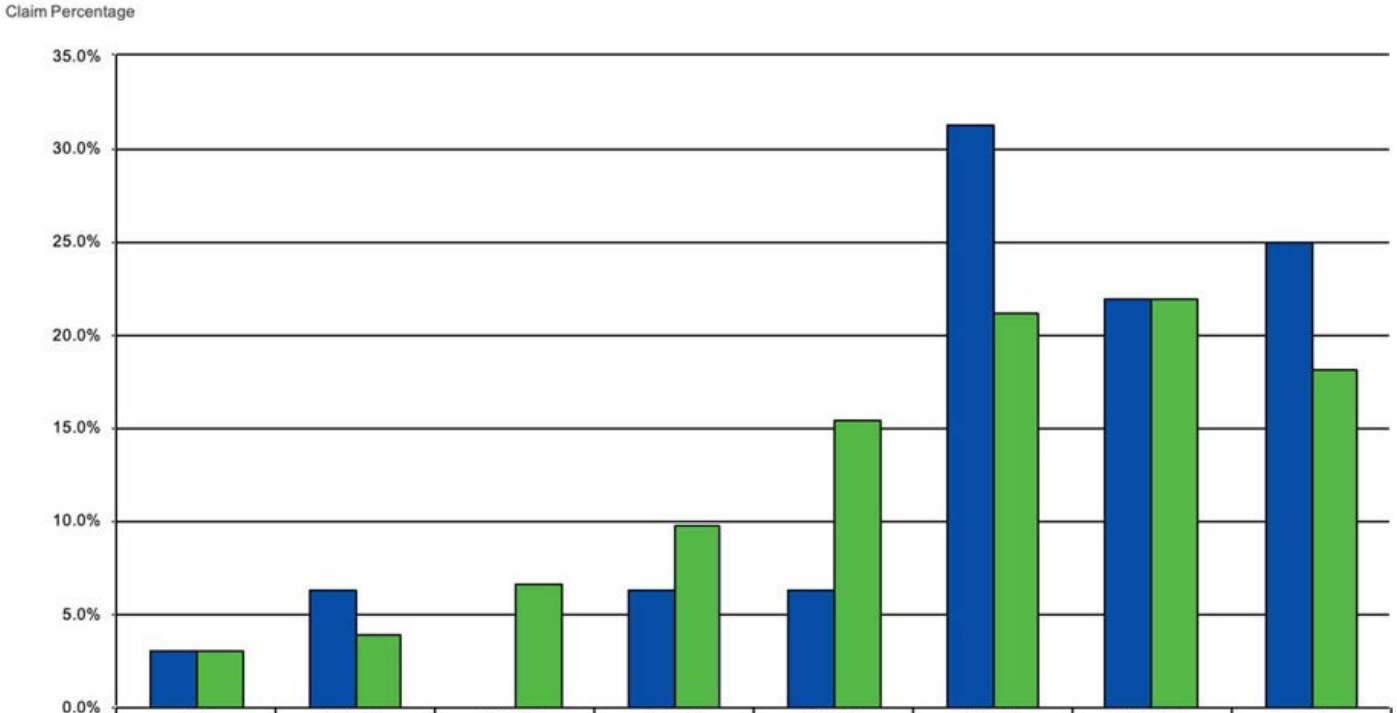
Claim Type	Current Status	Claim Count	Claim %	Paid During Period	Paid %	Reserve at End of Period	Reserve %	Duration Months (CLOSED only)
Long Term Disability	ACTIVE	22	40.7%	$144,039.28	77.3%	$1,394,463.84	90.2%	
Long Term Disability	CLOSED	10	18.5%	$42,196.80	22.7%	$0.00	0.0%	9
Long Term Disability	DENIED	17	31.5%	$0.00	0.0%	$0.00	0.0%	
Long Term Disability	PENDING	5	9.3%	$0.00	0.0%	$152,331.91	9.8%	
Long Term Disability Totals		**54**	**100%**	**$186,236.08**	**100%**	**$1,546,795.75**	**100%**	
Overall Totals		**54**	**100%**	**$186,236.08**	**100%**	**$1,546,795.75**	**100%**	

The data is based off of claims with activity from May 01, 2014 through April 30, 2016.

Data includes denied and incomplete claims.

LTD Claims by Age Compared to Benchmarks

Displays the LTD claim percentage by age compared to similar industry benchmarks for all approved claims open during the period.



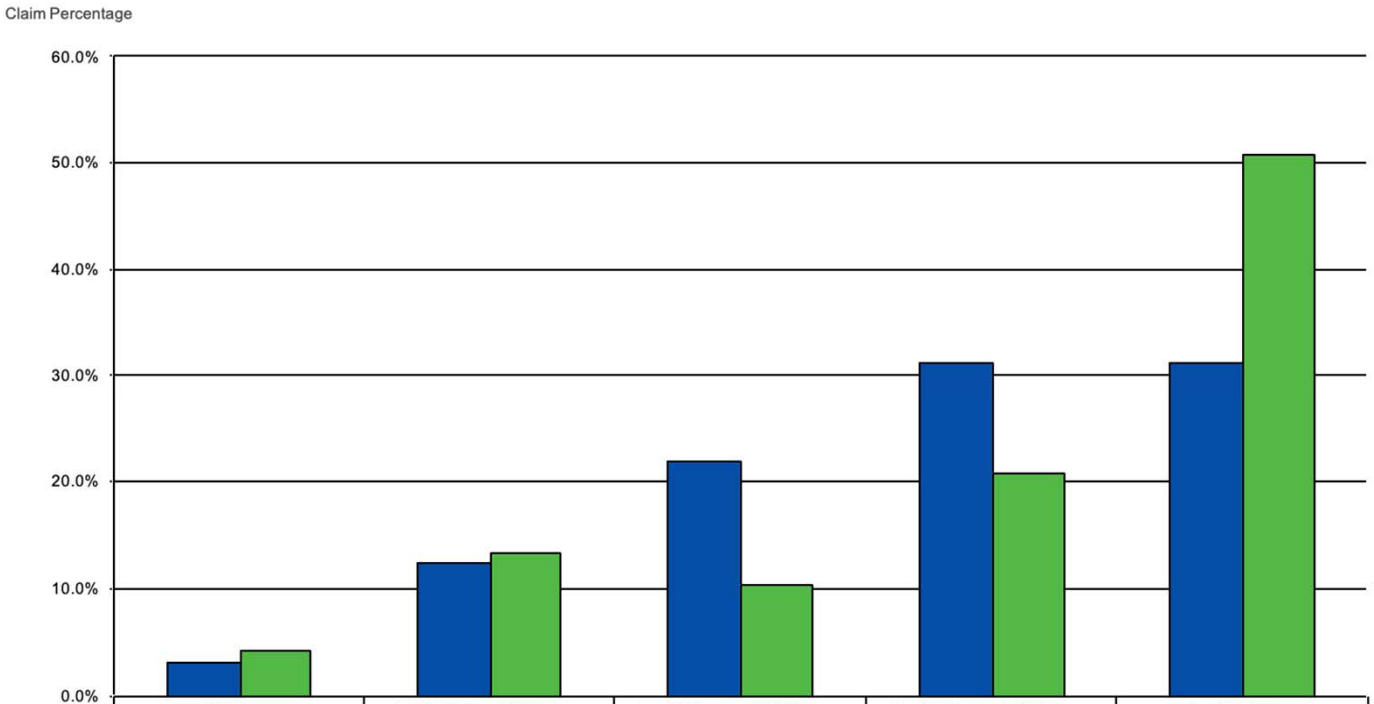
	<30	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60+
ABC	3.13%	6.25%	0	6.25%	6.25%	31.25%	21.88%	25.00%
SIC - Mfg_	3.03%	3.94%	6.62%	9.79%	15.41%	21.20%	21.85%	18.15%

The data is based off of claims with activity from May 01, 2014 through April 30, 2016.

Age range is calculated as of the date of disability. SIC benchmarks are from The Standard and statistics use the last five complete calendar years.

LTD Claims by Tenure Compared to Benchmarks

Displays the LTD claim percentage by tenure compared to similar industry benchmarks for all approved claims open during the period.



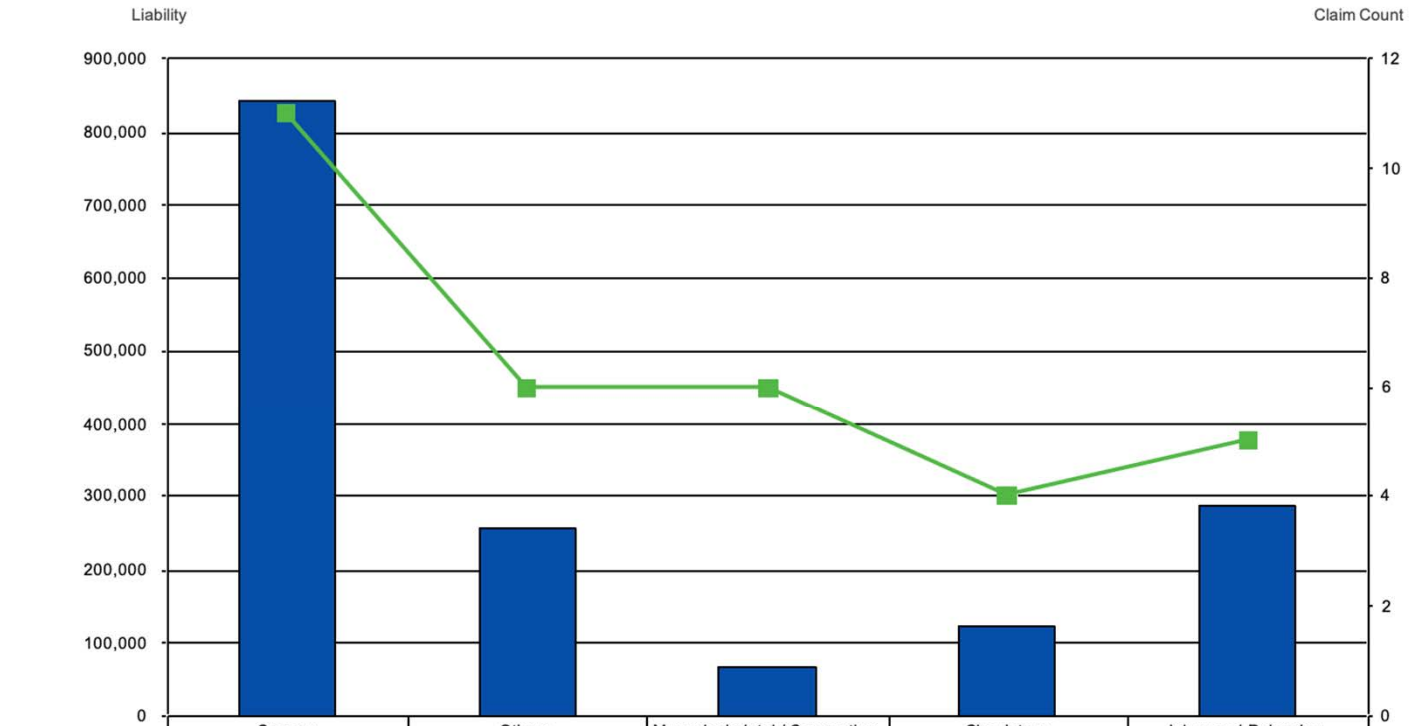
	< 01 Year	>= 01 Year, < 03 Years	>= 03 Years, < 05 Years	>= 05 Years, < 10 Years	>= 10 Years
ABC	3.13%	12.50%	21.88%	31.25%	31.25%
SIC - Mfg_	4.25%	13.46%	10.50%	20.91%	50.87%

The data is based off of claims with activity from May 01, 2014 through April 30, 2016.

SIC benchmarks are from The Standard and statistics use the last five complete calendar years.

LTD Claims and Liability by Top Diagnostic Categories

Displays the liability (benefits paid during the period and reserves at the end of the period) and the number of approved claims open during the period.

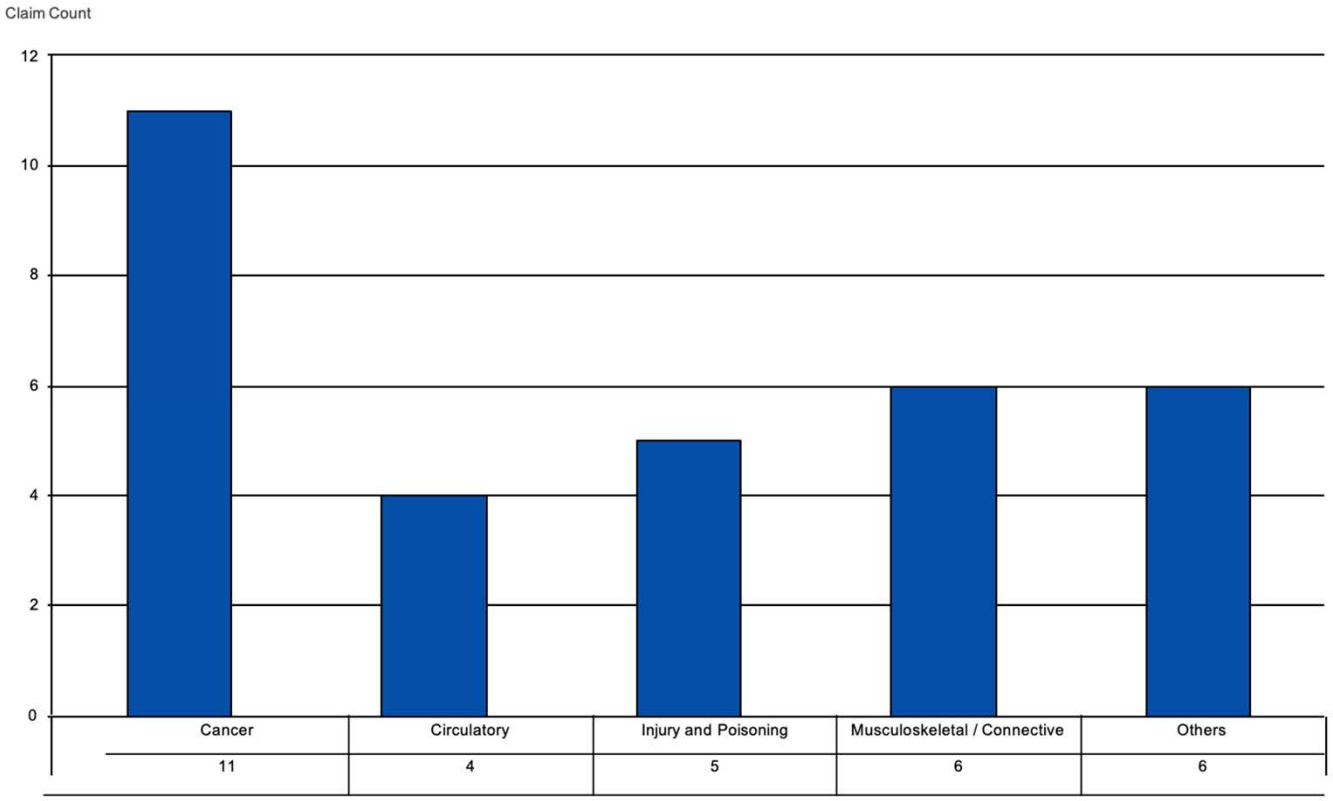


	Cancer	Others	Musculoskeletal / Connective	Circulatory	Injury and Poisoning
Total Liability	$842,984	$258,486	$69,065	$121,375	$288,790
Claim Count	11	6	6	4	5

The data is based off of claims with activity from May 01, 2014 through April 30, 2016.

LTD Claim Count by Incurred Year for Top Diagnostic Categories

Displays the number of approved claims by incurred year for the top diagnostic categories. This is limited to the most recent five years.



The data is based off of claims with activity from May 01, 2014 through April 30, 2016.

TheStandard®

Standard Insurance Company
800.368.2859 Tel 800.378.6053 Fax
PO Box 2800 Portland OR 97208

Disability Insurance Claim Packet Instructions

Your Disability Benefit Claim

This packet contains the forms necessary to apply for disability benefits. It also addresses common questions about Disability claims. **Please save this material for your future reference.** For specific information about your Disability insurance coverage, refer to your group insurance certificate. The certificates are the ultimate authority for Disability claim decisions. If you need other information, please contact your employer's benefit administrator or call our customer service line at 800.368.2859.

How To Apply For Benefits

The Disability benefits application includes claim forms and an Authorization.

1. Your employer should complete the Employer's Statement on page 2, and mail or fax it to Standard Insurance Company, before giving the claim packet to you.
2. Complete and sign your part of the claim form on page 4, and then have your treating physician complete their part of the claim form (the Attending Physician's Statement, also on page 4). If more than one physician is treating you for your disabling condition, each should complete a form. Additional forms are available from your employer's benefits administrator. Your physician may return the completed form to you for you to send to us with the other completed forms, or your physician may mail or fax the completed form to us directly, using the contact information at the top of the form.
3. Read the Claim Form Fraud Notice on page 5, then provide it to your treating physician with the Attending Physician's Statement.
4. Sign and date the Authorization and send it, along with the completed claim forms, to The Standard at the above address. This authorization allows us to request further information about your claim, if necessary.

Once we receive your completed claim application, it will take approximately one week to make a claim decision. If we have not reached a decision within one week, you will be notified with the details.

Other Benefits That May Reduce Your Disability Benefits

Other benefits you receive, or may be eligible to receive, may reduce the amount of Disability benefits due you. Your coverage or group insurance certificate lists these benefits which may include, but are not limited to, sick leave, Workers' Compensation, State Disability (including Paid Family Medical Leave for your own medical condition), Social Security and Retirement.

To avoid a possible overpayment on your claim, which would need to be repaid to The Standard, please inform The Standard if you receive other benefits.

When You Return To Work

Your disability benefits usually stop when you return to work. **Be sure that you notify The Standard immediately when you plan to return, or have returned to work** to assure no overpayment occurs.

Standard Insurance Company
800.368.2859 Tel 800.378.6053 Fax
PO Box 2800 Portland OR 97208

Disability Insurance Employer's Statement

To Be Completed By Employer

Employee's Full Name	Social Security No.	Birthdate
Employee's Home Address	State	ZIP
Employee's Phone ( )	Employee's Email	
Work Location Address	State	ZIP
Job Title *Please attach a copy of the job description.*	1. Date Employed	

2. Is employee insured for Short Term Disability? ☐ Yes ☐ No Effective Date _____
   Is employee insured for Long Term Disability? ☐ Yes ☐ No Effective Date _____
   Is employee insured for Group Life Insurance through The Standard? ☐ Yes ☐ No
   Was employee given Certificate(s) of Insurance? ☐ Yes ☐ No ☐ Don't Know

3. Is disability work related? ☐ Yes ☐ No ☐ Undetermined

4. Has the employee filed for: Workers' Compensation ☐ Yes ☐ No
   State Disability/Paid Family Medical Leave* ☐ Yes ☐ No
   Other ☐ Yes ☐ No
   Weekly Amount _____

**If employee had a prior state disability or PFML claim in the past year, or is not yet qualified for state disability or PFML, please explain below.*
IMPORTANT: Prior claims in the last year for state disability insurance (SDI) or paid family medical leave (PFML) may affect the amount of SDI/PFML for which the employee is now eligible.

_____
_____
_____

5. Employee's Earnings $ _____
   Check one ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annual ☐ Commission ☐ Other
   ☐ Shift Differential ☐ Bonuses
   Date of last increase _____ Earnings prior to increase $ _____

6. Last active date at work

7. Job status when ☐ Full-time (____ hours/week)
   disability began: ☐ Part-time (____ hours/week)

8. Date employee returned to work

9. Last date through which sick leave benefits were paid by employer

10. Last date through which any compensation was paid by employer What type(s) of compensation was paid on this date?

11. Is employee subject to:
    Social Security taxes? ☐ Yes ☐ No
    Medicare taxes? ☐ Yes ☐ No

13. Are employee premiums paid with pre-tax dollars (IRC Section 125 cafeteria plans)?
    ☐ Yes ☐ No

12. What percentage of the STD premium does the **employer** pay? _____%
    What percentage of the LTD premium does the **employer** pay? _____%
    Are employer paid premiums included in the employee's salary? ☐ Yes ☐ No ☐ N/A
    Are taxes withheld from employee paid premiums? ☐ Yes ☐ No ☐ N/A
    IMPORTANT: Remember to calculate annually the premium contribution percentage information according to the IRS 3 year averaging rule for group coverage.

Employer Name	Location Code (if applicable)	Phone No.	Policy No.
Mailing Address		City	State / ZIP
Name of employer representative completing this form		Employer representative's Email Address	

Acknowledgement – I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 3 of this form.

Signature _____ **Date** _____

Standard Insurance Company
800.368.2859 Tel 800.378.6053 Fax
PO Box 2800 Portland OR 97208

Some states require us to provide the following information to you:

ALABAMA, MARYLAND AND RHODE ISLAND RESIDENTS

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.

CALIFORNIA RESIDENTS

For your protection, California law requires the following 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 RESIDENTS

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 the 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.

DISTRICT OF COLUMBIA RESIDENTS

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 RESIDENTS

Any person who knowingly and with intent to injure, defraud or deceive an insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree

NEW JERSEY RESIDENTS

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

NEW YORK RESIDENTS

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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PENNSYLVANIA RESIDENTS

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.

ALL OTHER RESIDENTS

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

Standard Insurance Company

800.368.2859 Tel 800.378.6053 Fax
PO Box 2800 Portland OR 97208

Disability Insurance
Employee/Attending Physician's Statement

To Be Completed By Employee *For a prompt review of your claim, ALL of this form must be thoroughly completed by the appropriate persons.*

Full Name	Employer/Company Name	Group Policy No.

Social Security No.	Phone No. ( )	Birthdate	Gender	Birthdate of Youngest Child

Address	City	State	ZIP

Email Address

1. Is your disability work related? ☐ Yes ☐ No If yes, have you filed a Workers' Compensation claim? ☐ Yes ☐ No

2. Last date at work before disability _____ Date you returned or expect to return to work _____

3. Cause of Disability: ☐ Accident ☐ Illness Please explain (include date and location if applicable) _____

3a. Cause of Disabililty: ☐ Pregnancy Expected Date of Delivery _____ Actual Date of Delivery _____ Type of Delivery _____

4. Please describe all work activity, including self-employment, since the start of your disability. If none, initial here _____

5. Have you currently, or in the past year, filed for State Disability/Paid Family Medical Leave benefits? ☐ Yes* ☐ No
*If currently receiving benefits please send in a copy of award notice.

Acknowledgement – I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 5 of this form and will provide it to the physician completing the Attending Physician's Statement.

Signature _____ **Date** _____

To Be Completed By The Attending Physician

The following information is needed to document the patient's inability to work. The patient is responsible for obtaining a complete form without expense to The Standard. Please complete this form and mail or fax it to The Standard using the contact information listed above.

1. Diagnosis	A. Diagnosis	ICDA Classification

B. Symptoms	Height	Weight	B/P

2. Pregnancy (if applicable)	A. Expected date of delivery	B. Actual date of delivery	☐ Vaginal ☐ C-section

3. History and Treatment	A. Date you recommended the patient stop work	B. When did symptoms appear or accident happen?

C. Has the patient ever had the same or similar condition? ☐ Yes ☐ No If yes, when?

D. Is this condition related to the patient's employment? ☐ Yes ☐ No E. Did you complete a Workers' Compensation claim form? ☐ Yes ☐ No

F. Date of first visit for this condition	G. Frequency of subsequent visits: ☐ Weekly ☐ Monthly ☐ Other _____	H. Date of most recent visit

I. Describe planned course and duration of treatment

J. Hospitalization? ☐ Yes ☐ No	K. Date Admitted Date Discharged	L. Surgery? ☐ Yes ☐ No	M. Date Surgery Completed/Scheduled

N. Reason/Surgery Type	O. Surgery/Post-Surgery Complications? ☐ Yes ☐ No If yes, please describe

4. Level of Functional Impairment *Please attach recent chart notes/pertinent records.*

A. Describe patient's physical and/or mental limitations and restrictions (functional capacity).

B. Factors Delaying Recovery (if applicable)

C. How long do you expect these limitations and restrictions to impair your patient?
☐ Date_____ ☐ Unable to determine, follow up in_____ weeks ☐ Permanently

5. Physician Information *Please type or print.*

Name of physician completing this form	Specialty	Phone No. ( )

Address	City	State	ZIP	Fax No. ( )

Acknowledgement – I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 5 of this form.

Signature _____ **Date** _____

Standard Insurance Company
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PO Box 2800 Portland OR 97208

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COLORADO RESIDENTS

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 the 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.

DISTRICT OF COLUMBIA RESIDENTS

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 RESIDENTS

Any person who knowingly and with intent to injure, defraud or deceive an insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree

NEW JERSEY RESIDENTS

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

NEW YORK RESIDENTS

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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PENNSYLVANIA RESIDENTS

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.

ALL OTHER RESIDENTS

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

Authorization to Obtain and Release Information

Employer/Policyholder Name _____ Group Policy Number _____

I AUTHORIZE THESE PERSONS having any records or knowledge of me or my health:

- Any physician, medical practitioner or health care provider.
- Any hospital, clinic, pharmacy or other medical or medically related facility or association.
- Kaiser Permanente.
- Any insurance company or annuity company.
- Any employer, policyholder or plan sponsor.
- Any organization or entity administering a benefit or leave program (including statutory benefits) or an annuity program.
- Any educational, vocational or rehabilitation counselor, organization or program.
- Any consumer reporting agency, financial institution, accountant, or tax preparer.
- Any government agency (*for example, Social Security Administration, Public Retirement System, Railroad Retirement Board, Workers' Compensation Board, etc.).*

TO GIVE THIS INFORMATION:

- Charts, notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing and test results. Prognosis and treatment of any physical or mental condition, including:
  - Any disorder of the immune system, including HIV, Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes.
  - Any communicable disease or disorder.
  - Any psychiatric or psychological condition, including test results, but excluding psychotherapy notes. Psychotherapy notes do not include a summary of diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date.
  - Any condition, treatment, or therapy related to substance abuse, including alcohol and drugs.

and:

- Any non-medical information requested about me, including such things as education, employment history, earnings or finances, return to work accommodation discussions or evaluations and eligibility for other benefits or leave periods including but not limited to claims status, benefit amount, payments, settlement terms, effective and termination dates, plan or program contributions, etc.

TO STANDARD INSURANCE COMPANY, THE STANDARD LIFE INSURANCE COMPANY OF NEW YORK, THE STANDARD BENEFIT ADMINISTRATORS AND THEIR AUTHORIZED REPRESENTATIVES (referred to as "The Companies", individually and collectively), AND MY EMPLOYER'S ABSENCE MANAGEMENT PROGRAM ADMINISTRATOR ("Absence Manager").

- I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct the persons and organizations identified above to release and disclose my entire medical record without restriction.
- I understand that each of The Companies and Absence Manager will gather my information only if they are administering or deciding my disability or leave of absence claim(s), and will use the information to determine my eligibility or entitlement for benefits or leave of absence.
- I understand that I have the right to refuse to sign this authorization and a right to revoke this authorization at any time by sending a written statement to The Companies and Absence Manager, except to the extent the authorization has been relied upon to disclose requested records. A revocation of the authorization, or the failure to sign the authorization, may impair The Companies and Absence Manager's ability to evaluate or process my claim(s), and may be a basis for denying or closing my claim(s) for benefits or leave of absence.
- I understand that in the course of conducting its business The Companies and Absence Manager may disclose to other parties information about me. They may release information to a reinsurer, a plan administrator, plan sponsor, or any person performing business or legal services for them in connection with my claim(s). I understand that The Companies and Absence Manager will release information to my employer necessary for absence management, for return to work and accommodation discussions, and when performing administration of my employer's self-funded (and not insured) disability plans.
- I understand that The Companies and Absence Manager comply with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to them pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by law. Information retained and disclosed by The Companies and Absence Manager may not be protected under the Health Insurance Portability and Accountability Act [HIPAA].
- I understand and agree that this authorization as used to gather information shall remain in force from the date signed below:
  - For Standard Insurance Company, the duration of my claim(s) or 24 months, whichever occurs first.
  - For The Standard Life Insurance Company of New York, the duration of my claim(s) or 24 months, whichever occurs first.
  - For The Standard Benefit Administrators, the duration of my claim(s) administered by The Standard Benefit Administrators or 24 months, whichever occurs first.
  - For Absence Manager, 24 months.
- I understand and agree that The Companies and Absence Manager may share information with each other regarding my disability and leave of absence claim(s). This authorization to share information shall remain valid for 12 months from the date signed below.
- I acknowledge that I have read this authorization and the New Mexico notice on page 7. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

Name (please print) _____ Claim Number _____

Signature of Claimant/Representative _____ Date _____

If signature is provided by legal representative (e.g., Attorney in Fact, guardian or conservator), please attach documentation of legal status.

Employer/Policyholder Name _____ Group Policy Number _____

Standard Insurance Company is a licensed insurance company in all states except New York. The Standard Life Insurance Company of New York is an insurance company licensed only in New York. An absence manager may be hired by your employer and may be one of The Companies.

FOR RESIDENTS OF NEW MEXICO

The state of New Mexico requires Standard Insurance Company to provide you with the following information pursuant to its Domestic Abuse Insurance Protection Act.

The Authorization form allows Standard Insurance Company to obtain personal information as it determines your eligibility for insurance benefits. The information obtained from you and from other sources may include confidential abuse information. "Confidential abuse information" means information about acts of domestic abuse or abuse status, the work or home address or telephone number of a victim of domestic abuse or the status of an applicant or insured as a family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close personal, family or abuse-related counseling relationship. With respect to confidential abuse information, you may revoke this authorization in writing, effective ten days after receipt by Standard Insurance Company, understanding that doing so may result in a claim being denied or may adversely affect a pending insurance action.

Standard Insurance Company is prohibited by law from using abuse status as a basis for denying, refusing to issue, renew or reissue or canceling or otherwise terminating a policy, restricting or excluding coverage or benefits of a policy or charging a higher premium for a policy.

Upon written request you have the right to review your confidential abuse information obtained by Standard Insurance Company. Within 30 business days of receiving the request, Standard Insurance Company will mail you a copy of the information pertaining to you. After you have reviewed the information, you may request that we correct, amend or delete any confidential abuse information which you believe is incorrect. Standard Insurance Company will carefully review your request and make changes when justified. If you would like more information about this right or our information practices, a full notice can be obtained by writing to us.

If you wish to be a protected person (a victim of domestic abuse who has notified Standard Insurance Company that you are or have been a victim of domestic abuse) and participate in Standard Insurance Company's location information confidentiality program, your request should be sent to Standard Insurance Company.

STANDARD INSURANCE COMPANY

A Stock Life Insurance Company

900 SW Fifth Avenue
Portland, Oregon 97204-1282
(503) 321-2700

DISABILITY PROGRAM ADMINISTRATIVE SERVICES AGREEMENT

Program Sponsor:	County of Henrico, Virginia Including Henrico County Public Schools and Henrico Economic Development Authority
Claims Administrator:	Standard Insurance Company
ATP Number:	649721-B
Effective Date:	January 1, 2019

Note: The terms of this Agreement are not governed under the terms of any Master Service Agreement issued by Standard Insurance Company in conjunction with any others services provided to Program Sponsor.

Program Sponsor has adopted a self-funded short-term disability income benefit plan (Program) for certain of its employees. Program Sponsor is solely responsible for all risks, liabilities, benefits and claims under the Program.

Program Sponsor has requested Standard to provide administrative services to the Program as described in this Agreement. Standard is willing to provide such services, according to the terms of this Agreement, without assuming any financial responsibility under the Program.

Standard's willingness to provide administrative services is conditioned upon Program Sponsor's agreement that Standard is not responsible for any risk, liability, benefit or claim under the Program and upon Program Sponsor fulfilling its obligations as provided herein.

LIMITED AGENCY APPOINTMENT OF STANDARD

Program Sponsor hereby appoints Standard to act on its behalf as Claims Administrator for the Program and grants to Standard authority to fulfill the Obligations of Claims Administrator, as provided herein. Standard is empowered to act on behalf of Program Sponsor in connection with the Program only as expressly stated in this Agreement. Standard has no authority or obligation with respect to (1) Program Sponsor's right of subrogation under the Program, or (2) management or investment of the assets of the Program. In performing its obligations under this Agreement, Standard is acting solely as the agent of Program Sponsor.

OBLIGATIONS OF CLAIMS ADMINISTRATOR

Standard, acting as Claims Administrator for the Program, shall provide the following services, consistent with the terms of the Program:

A. Claims Services

1) Investigate claims for benefits under the Program, determine eligibility for coverage, make initial claim decisions to approve, deny or close claims for benefits, and notify claimants and Program Sponsor in writing of its decisions, subject to Program Sponsor's right of final review and decision on all claims.

2) If an appeal is requested by the claimant, provide an independent review and notify claimant and Program Sponsor in writing of Standard's decision, subject to Program Sponsor's right of final review and decision on all appeals.

3) Advise and assist Program Sponsor on procedures to be followed in submission of claims, including the preparation of forms necessary for submission and processing of claims.

4) Create and maintain a current and complete claim file for any claim presented to Standard for administration under the Program.

5) Submit to Program Sponsor all claims Program Sponsor may request to review.

6) If applicable, prepare benefit statements for claimants setting forth the benefit schedule applicable and explaining any adjustments.

7) Have medical and vocational examinations of claimants performed as Standard deems advisable.

8) Advise claimants concerning the need to apply for deductible income and periodically verify application for or receipt of deductible income.

9) Review claims to determine continued eligibility for benefits as frequently as claimant's condition warrants.

10) Defend, at its expense, claim litigation arising out of or relating to, in whole or in part, from the performance of Standard's Claims Administrator obligations under this Agreement. However, the Program Sponsor, not Standard, is financially responsible for the risks, liabilities and benefits of the Program. Standard shall be empowered to judge the acceptability of any compromise and to settle any such liability. Prior to entering into any settlement or compromise on behalf of Program Sponsor, Standard will make a recommendation to Program Sponsor for approval, which approval shall not be unreasonably withheld.

    In the event that Program Sponsor does not approve of Standard's recommendation, or overturns Standard's decision as set forth in item 2 above, Employer will be responsible for any obligation to defend.

B. Program Document Services

1) Advise and assist Program Sponsor with regard to the initial preparation of the Program and recommend subsequent revisions as may be appropriate.

2) Advise and assist Program Sponsor with regard to the preparation and review of Program summaries, descriptive booklets, certificates of coverage and similar material for distribution to covered employees.

C. Performance Standards

Standard and Program Sponsor each shall exercise ordinary care and reasonable diligence in the performance of its duties under this Agreement. Standard and Program Sponsor will not be liable for any mistake of judgment taken in good faith. Further, Standard shall not be considered to have failed to perform its obligations under this Agreement if any delay or nonperformance on its part is due, in whole or in part, to failure of the other party to discharge its own obligations promptly.

OBLIGATIONS OF PROGRAM SPONSOR

Program Sponsor shall:

A. Retain full financial responsibility for the Program and its operation.

B. Furnish any information reasonably required by Standard to carry out Standard's duties under this Agreement, including but not limited to relevant program documents and any other administrative guidance necessary to administer the program.

C. Review Standard's claim and appeal decisions in a timely manner. If Program Sponsor fails to notify Standard in writing of any objection it may have to any such decision within 45 days after notice thereof from Standard, Program Sponsor shall be deemed to have waived such objection and shall be conclusively presumed to have ratified and approved Standard's decision.

D. Pay benefits according to the terms of the Program.

E. Establish and maintain such accounts and records as may be required in accordance with this Agreement.

F. Provide Standard with all amendments or modifications to the Program at least 60 days prior to the proposed effective date of the change. Standard shall have no obligation to administer any such change unless and until approved by Standard, which approval shall not be unreasonably withheld. Standard retains the right to modify the **Fees** to reflect any additional services or expenses required by such change.

G. Provide Standard in writing with the names of individuals authorized to act for Program Sponsor in connection with this Agreement, together with a statement of the extent of their authority.

H. Identify Standard as Claims Administrator in relevant Program documents and related materials. Any other use of Standard's name in connection with Program administration must be authorized in advance and in writing by Standard.

BENEFIT PAYMENTS

Benefits payable under the Program will be paid by Program Sponsor.

FEES

A. Fees

Program Sponsor shall pay fees to Standard in connection with Standard's services under this Agreement as follows.

MONTHLY GENERAL FEE. The Monthly General Fee shall be the sum of the monthly fees due for all Employers covered under the Program on that due date. The monthly fee shall be as stated in the final proposal accepted by Program Sponsor.

ADDITIONAL FEES. Additional Fees may be charged to Program Sponsor upon mutual agreement between Program Sponsor and Standard.

B. Change in Fee Rates

1) Standard may change the amount, the method of determination, or both, of any fees not yet due, when a change in any law or regulation affects the manner in which Standard performs any function under this Agreement. The amount, the method of determination, or both, of any fees not yet due may also be changed upon mutual agreement between Program Sponsor and Standard.

2) Except as provided in Paragraph 1) of this section:

a. Fees will not be changed during the first four years the Agreement is in effect, provided that this limitation shall not apply to any changes in fees in connection with any change in the terms of this Agreement or the Program.

b. Thereafter Standard may change the amount, the method of determination, or both, of any fees not yet due, upon 180 days written notice to Program Sponsor. Except as provided in Paragraph 1) of this section, no such change in fees shall be made more than once in any Contract Year, provided that this limitation shall not apply to any changes in fees in connection with any change in the terms of this Agreement or the Program.

C. Payment Due Dates

All fees are due and payable within 60 days after the notice by Standard has been sent to Program Sponsor of the amount owed.

INTEREST ON LATE PAYMENTS

Program Sponsor shall pay Standard interest at a rate equal to the Wells Fargo Bank and Co. prime rate plus two percent (2%) per annum, or the highest rate permitted by applicable law, whichever is less, on any sums payable to Standard pursuant to this Agreement which are not paid by Program Sponsor on or before the date on which such sums are due.

INDEMNIFICATION AGREEMENT

A. Standard agrees to indemnify, defend, and hold Program Sponsor, including directors, officers, and employees, from any and all, liabilities, claims, lawsuits, administrative proceedings, settlements, compromises, judgments, penalties, costs and expenses, including but not limited to, attorney's fees, pretrial discovery, deposition and investigation expenses, compensatory, consequential, special, exemplary and punitive damages arising out of or relating to, in whole or in part, any negligent act or omission, criminal conduct or fraud, or intentional failure to perform any obligation under the Program or this Agreement.

B. Nothing in this **Indemnification Agreement** section is intended to or does alter the obligations of the Program Sponsor to bear full financial responsibility for any benefits payable under the

Program or to defend litigation related to such benefits as set forth in **Obligations Of Program Sponsor**.

RECORDS AND CLAIM FILES

A. All claim files, records, reports, and other information prepared and maintained by Standard pursuant to this Agreement shall be the sole property of Program Sponsor, subject to Standard's right to retain copies of any such information.

B. Upon reasonable written request, and during regular business hours Program Sponsor shall have the right to inspect any claim file and any other record or report, including but not limited to, records relating to payments of benefits which have been prepared and maintained by Standard, pursuant to this Agreement.

C. All claim files and other records and reports prepared and maintained by Standard pursuant to this Agreement shall be confidential. Standard shall take such measures as are reasonably necessary to preserve the confidentiality of such claim files, records and reports. No individually identifiable information will be released from any such claim file, except as follows:

   1) In response to a court order.

   2) For an examination conducted by regulatory authorities.

   3) At the request of the Program Sponsor.

   4) With the written consent of the identified individual or his or her legal representative.

   Pursuant to the **Obligations Of Program Sponsor** section of this Agreement, Program Sponsor shall designate employees or agents who are authorized to receive individually identifiable claim information on behalf of Program Sponsor. Standard may rely upon such authorizations until receipt of written instructions changing such authorizations.

D. Any individually identifiable claim information released to Program Sponsor pursuant to this Agreement shall be treated as confidential. Program Sponsor shall protect such information from unauthorized disclosure.

E. Claim files, records, reports and other information prepared and maintained by Standard pursuant to this Agreement may be destroyed by Standard at anytime after seven years. With respect to claim files, the seven-year period begins on the date benefits cease to be paid to the claimant. Program Sponsor may receive an inactive claim file at anytime within the first 60 days after benefits cease by sending a written request to Standard and payment of Standard's reasonable shipping and handing costs.

AMENDMENT

This Agreement constitutes the entire contract between the parties, superseding all prior or contemporaneous written or oral understandings and agreements. No modification or amendment of this Agreement shall be valid unless made in writing and signed by each party.

ASSIGNMENT AND MISCELLANEOUS PROVISIONS

A. Neither party shall assign this contract without the prior written consent of the other party.

B. Standard will not be bound by any notice, direction, requisition, or request unless and until it is received in writing at Standard's Home Office at Portland, Oregon.

C. This Agreement shall be deemed to have been entered into in the Commonwealth of Virginia and all questions concerning validity, interpretation, or performance of any of its terms or provisions or of any rights or obligations of the parties to this Agreement, shall be governed by and resolved in accordance with the laws of Commonwealth of Virginia.

D. Captions of the parts, sections, and paragraphs of this Agreement are for convenience and reference only, and the words contained in such captions shall in no way be employed to explain, modify, amplify, or aid in the interpretation, construction, or meaning of the provisions of this Agreement.

E. Standard has not and will not provide legal advice, legal opinions or other legal services to Program Sponsor in establishing or maintaining the Program or relative to this Agreement. Program Sponsor will rely solely upon the advice of its own legal counsel in evaluating the legal aspects of the Program and this Agreement.

F. Each party shall promptly give the other written notice of any claim, lawsuit, or administrative proceeding concerning a claim for benefits under the Program or any other matter embraced by the indemnity. The parties shall cooperate fully in the defense of any such claim, lawsuit, or proceeding.

G. If litigation arises out of this Agreement, the parties agree that each party shall bear its own litigation costs and attorneys fees, unless there is a court order to the contrary.

TERM AND TERMINATION

A. Contract Years are successive twelve month periods computed from the effective date of this Agreement. The date of termination of this Agreement, unless otherwise specified, shall be deemed to be the last day of a Contract Year.

B. This Agreement may be terminated by either party upon sixty (60) days written notice of termination provided to the other party.

C. This Agreement will terminate automatically on the date of termination of any group long term disability insurance policy issued to Program Sponsor by Standard.

D. Program Sponsor's failure to pay **Fees** or to reimburse Standard for payment of benefits pursuant to **Benefit Payments**, and the provisions below in **Term And Termination** or Program Sponsor's failure to fulfill its obligations under **Indemnification Agreement**, shall terminate this Agreement upon written notice by Standard to be delivered to Program Sponsor at its last known address.

E. Effect of Termination.

1) Claims Administration

Notwithstanding termination of this Agreement, the Standard will continue to provide claim services with respect to any claim for benefits under the Program with an incurred date occurring on or before the date of termination. Program Sponsor shall see to it that any such claim is immediately sent to Standard. Standard may administer any such claim until it determines the claim is inactive. The terms and provision of this Agreement shall continue to apply where applicable to the runoff of such claims, specifically including Program Sponsor's obligation to pay benefits according to the terms of the Program.

2) Claims Records

Standard may retain any open or active claim files as provided in item E.1 above of the **Term And Termination** section of this Agreement. Any such files not retained by Standard shall be sent to Program Sponsor or its successor administrator promptly upon payment of Standard's reasonable shipping and handling costs.

Standard shall retain all inactive claim files and other records and reports relating to such claims and prepared and maintained by Standard pursuant to this Agreement, and may destroy such files, etc. as provided in Records and Claim File provision. Program Sponsor may obtain possession of such extant claim files, records and reports upon written request to Standard and payment of Standard's reasonable shipping and handling costs. Program Sponsor acknowledges that locating and processing such files and records may be difficult and time consuming and will substantially increase the shipping and handling costs it is obligated to pay.

F. Outstanding Obligations

Notwithstanding any other provision of this Agreement to the contrary, the termination of this Agreement shall not release either party from any obligation already incurred, including any payment obligation already incurred under the **Fees** or **Benefit Payments** provision**.** Further, provisions of the **Indemnification Agreement** and defense obligations under **Obligation Of Program Sponsor,** and the confidentiality provisions under **Records And Claim Files** sections will not be affected by the termination of this Agreement and will remain in full force and effect.

IN WITNESS WHEREOF, the parties hereto have caused this agreement to be executed in duplicate by their respective officers duly authorized to do so.

Program Sponsor:

By _____ Date _____

STANDARD INSURANCE COMPANY

By

Chairman, President and CEO

Corporate Secretary

Account Service and Claims Management Teams

Account Management Philosophy

Standard Insurance Company understands that as a large employer, you have distinct employee benefits needs. These are best served by dedicated, experienced resources you can trust to provide innovative solutions, superior service and a firm commitment to your satisfaction.

The following list includes the designated resources that would work with County of Henrico and its employees to get the most out of your group insurance plan. While each member has distinct responsibilities and expertise, the common theme is that our business is founded on building long lasting relationships with our customers through superior customer service.

Direct phone numbers and emails for every resource listed below will be provided if we are the selected carrier.

Account Service - Home Office
Portland, OR Toll-free: 800.642.9888 Fax: 971.321.5072

Name and Title	Responsibilities
Sandy Furrer Senior Underwriter	Provides a consistent underwriting approach, analyzes claims trends and projects future plan costs. When the County of Henrico policy renews, the Underwriter will work to suggest ways to enhance the plan, control costs or offer other plan changes.
Brian Borsch Manager, National Acct. Contracts	Leads the team that prepares the policy, certificates and amendments for County of Henrico's Group policy. During renewal a Contract Analyst/ Contract Consultants will offer suggestions on policy language to help achieve a desired plan design that best meets County of Henrico's benefits needs.
Angelica Schmitt Manager – Premium Services	Leads the team responsible for premium and billing administration for County of Henrico. The Premium Services Team will ensure that all billing inquiries are handled in a timely and accurate manner.

Account Service - Sales and Service Office
Washington D.C. Tel: 804.290.7960 Toll-free: 888.309.7772 Fax: 804.290.7964

Name and Title	Responsibilities
Stephen Lovings Senior Employee Benefits Consultant	Works to find a solution for County of Henrico's employee benefits needs, and is committed to working with underwriting and claims professionals and others to make sure that we meet our goal to provide quality products at an affordable cost, as well as outstanding customer service.
Kim Haines Account Manager	Will provide assistance to County of Henrico on daily account management issues. The Account Manager works closely with the entire Home Office team.

Claim Management - Home Office*
Portland, OR Toll-free: 800.368.1135 Fax: 971.321.6400

Name and Title	Responsibilities
Courtney Cedergreen Manager Disability Benefits- STD	Supervises the disability benefit analysts and support staff that will administer claims for County of Henrico employees. The Disability Manager's role is to help assure that the large national accounts assigned to the team receive the care and level of service that they expect and deserve. The Manager checks the quality of the team's work, monitors workflow and workloads, and adjusts as appropriate.
John Maloney Manager Disability Benefits- LTD	Supervises the disability benefit analysts and support staff that will administer claims for County of Henrico employees. The Disability Manager's role is to help assure that the large national accounts assigned to the team receive the care and level of service that they expect and deserve. The Manager checks the quality of the team's work, monitors workflow and workloads, and adjusts as appropriate.

*Claims for Disability are managed in one of three fully-staffed claim processing operations located throughout the United States. We have offices in White Plains, New York; Altavista, Virginia; and Portland, Oregon. Factors that determine where claims will be managed include geography, complexity and type of coverage being administered.

Biographies

Stephen Lovings, Senior Employee Benefits Consultant, Washington D.C. Employee Benefits Sales and Service Office

With more than 27 years of experience in the insurance industry, Stephen is a Senior Employee Benefits Consultant working with employer groups of all sizes in Virginia to provide group life, disability and dental and vision insurance coverage. Stephen joined The Standard in 2010. He previously worked for a large national insurance carrier as a regional sales manager. Stephen earned his bachelor's degree in business administration and management from Virginia Commonwealth University.

Kim Haines, Account Manager

Kim is an Account Manager with our Washington DC Office, a position she has held since joining The Standard in 2022. Prior to joining our team, Kim was a sales rep with another insurance carrier. Kim has been in the industry for 24 years, she has worked with HR, broker consulting, account management and sales. Kim graduated from the University of Baltimore with a degree in Criminal Justice/Liberal Arts.

Sandy Furrer, Senior Underwriter

Sandy is a Senior Underwriter, a position she has held since 2021. She joined The Standard in 2000 as a Policy Administrator assisting customers and group offices with an array of support issues. Prior to joining The Standard, she co-owned and managed a technology service and support company for 12 years along with 8 years in Human Resources. She has attended college and completed courses in Business, Accounting and Personnel Management. In 2000, she made a career change and was hired at The Standard to pursue her goals.

Brian Borsch, Manager, National Accounts Contracts

Brian Borsch has been the Manager for the National Accounts Contracts team since 11/1/2020.

Brian has been with The Standard since 2012. He initially started as an STD Contact Center Supervisor leading 21 Contact center reps to help manage the incoming call volumes for STD claim inquiries and then decided to pursue a new career path in Contracts. He started his contracts experience in Regional Accounts in 2015 and after a few years there he moved to the National Accounts team in 2018 and functioned as a National Accounts Contract Analyst II up until he became the Manager for this team.

Brian has a BS in Business Management from PSU and, while he was born and raised in Hawaii, his father is actually from Portland, OR and his family has history here as being early horticulturists for the Portland area in the early 1900's.

Angelica Schmitt, Manager – Premium Services

Angelica is the Manager of the Premium Services team. This team manages the Premium payments for our customers making sure that moneys paid are applied and moneys not paid are collected. Angelica also works with various brokers, employers, group offices and other service areas to help with policyholders and plan sponsors' day-to-day needs and questions around their payments and bills. Prior to this role she supervised the Member and Policy support teams for 6 years starting in 2009. She joined The Standard in 2001 as the Supervisor of the Benefits Financial Services Team overseeing all of the accounting and tax needs for the claims area. Before joining The Standard, Angelica worked for 10 years at US Bank as a Branch Manager and as a Financial Services Officer.

Courtney Cedergreen, Manager Disability Benefits- STD

Courtney started her Career at US Bank in 2009, where she spent many years aiding her community with their financial needs. In 2013, she became an associates examiner at Standard Insurance, and spent the next several years working her way from an associates examiner to an examiner. Later becoming a Sr. Examiner, moving to a Management Mentor. After 4 years in this space, she took on her first Management position in mid-2019. Courtney currently manages the ST3 STD team. This team is very successful at providing customer service, focused in processing claims, and doing the right thing in all interactions both internally and externally. Courtney also enjoys spending her time facilitating trainings for both new hires and up-skilling current employees. Just another step towards her team's focus to look what they can do in any and every situation.

John Maloney, Manager Disability Benefits- LTD

John joined The Standard in 2016 as a Disability Benefits Analyst in the LTD claims department. He has also worked as a Senior Disability Analyst and currently serves as a Manager, Disability Benefits. His responsibilities include supervising a team Disability Benefits Analyst and Senior Disability Benefits Analysts to ensure timely and accurate adjudication of LTD claims and exceptional customer service and communication.

Exceptions

Exceptions

The Standard has reviewed the terms and conditions in this document and has noted exceptions to requests. Alternatives may be available to reach a mutually beneficial agreement between The Standard and the County and should be discussed with Stephen Lovings

V. GENERAL CONTRACT TERMS AND CONDITIONS

A. Annual Appropriations

The contract resulting from this procurement ("Contract") shall be subject to annual appropriations by the Henrico County Board of Supervisors. Should the Board fail to appropriate funds for this Contract, the Contract shall be terminated when existing funds are exhausted. The Successful Offeror ("Successful Offeror" or "Contractor") shall not be entitled to seek redress from the County or its elected officials, officers, agents, employees, or volunteers should the Board of Supervisors fail to make annual appropriations for the Contract.

This is acceptable provided that The Standard shall have no continuing obligation to provide insurance coverage, and the County will be responsible for all premiums due and payable up to the date of termination of the policy.

D. Compensation

The Successful Offeror must submit a complete itemized invoice for services that are performed under the Contract. The County shall pay the Successful Offeror for satisfactory compliance with the Contract within forty-five (45) days after receipt of a proper invoice.

For a group of this size, our billing is self-administered, and thus we do not itemize invoices.

E. Controlling Law and Venue

The Contract will be made, entered into, and shall be performed in the County and shall be governed by the applicable laws of the Commonwealth of Virginia without regard to its conflicts of law principles. Any dispute arising out of the Contract, its interpretations, or its performance shall be litigated only in the Henrico County General District Court or the Circuit Court of the County of Henrico, Virginia.

Provided, however, the portion of this section regarding venue shall not be interpreted to apply to disputes arising from an adverse benefit determination under The Standard's group insurance policies.

F. Termination by County

2. Termination for Cause

~~d. An equitable adjustment in the Contract price shall be made for unpaid services satisfactorily rendered and goods satisfactorily delivered before the date the Successful Offeror receives the notice of termination minus the County's cost to complete the Successful Offeror's work. The Successful Offeror shall not be entitled to payment for services rendered or goods delivered after the date the Successful Offeror receives the notice of termination or for reimbursement of any cost the Successful Offeror incurs after the date the Successful Offeror receives the notice of termination. If the County's cost to complete the Successful Offeror's work exceeds the unpaid balance due to the Successful Offeror, the County will not owe the Successful Offeror any money; instead, the Successful Offeror shall pay to the County the difference between the unpaid balance due and the County's cost to complete the work.~~

3. Termination for Convenience
    a. The County may terminate the Contract, in whole or in part, whenever the Purchasing Director determines that such termination is in the County's best interest.
    b. The County must give the Successful Offeror written notice of a termination for convenience. The notice must specify the extent to which the Contract is terminated and the effective termination date. The effective termination date shall be at least seven calendar days after the date the County issues the notice of termination for convenience.
    ~~c. An equitable adjustment in the Contract price shall be made for unpaid services satisfactorily rendered and goods satisfactorily delivered before the date the Successful Offeror receives the notice of termination. The Successful Offeror shall not be entitled to payment for services rendered or goods delivered after the date the Successful Offeror receives the notice of termination, and the Successful Offeror shall not be entitled to payment for any costs it incurs after the date it receives the notice of termination.~~
    d. Unless the County's notice specifies otherwise, the Successful Offeror must stop work on the date it receives the notice of termination.
    e. Unless the parties expressly agree otherwise, the County may transmit notices of termination for convenience by email, USPS First-Class Mail®, or courier or overnight delivery service. The Successful Offeror shall be deemed to be in receipt of any notice emailed on the day the County sends it. The Successful Offeror shall be deemed to be in receipt of any notice sent by USPS First-Class Mail® three business days after the date shown in the postmark. The Successful Offeror shall be deemed to be in receipt of any notice the County sends by courier or overnight delivery service on the date of delivery as confirmed by the courier or overnight delivery service.

    Policyholder may terminate the group policy at any time by giving The Standard written notice. The effective date of termination will be the later of:
        1. The date stated in the notice; or
        2. The date we receive the notice.

    Policyholder will be responsible for all premiums due and payable up to the date of termination of the policy.

    The Standard may terminate the group policy as follows:
        1. If premium is not paid by the end of the grace period, the group policy will terminate automatically at the end of the grace period.
        2. On any premium due date if the number of persons insured is less than the minimum participation shown in the Coverage Features of the group policy.
        3. On any premium due date if we determine that the policyholder has failed to promptly furnish any necessary information requested by us, or has failed to perform any other obligations relating to the group policy.

    For 2 & 3 above, the minimum advance notice of termination by us is 31 days.

    The Standard does not agree to be responsible to pay for replacement coverage (the difference between the contract and purchase price) or the cost to obtain replacement coverage. We also do not agree that charges can be deducted from the existing premium due.

    The County will be responsible for all premiums due and payable up to the date of termination of the policy.

G. Drug-Free Workplace to be Maintained by the Contractor (VA. Code §2.2-4312)

1. During the performance of this Contract, the Contractor agrees to (i) provide a drug-free workplace for the Contractor's employees; (ii) post in conspicuous places, available to employees and applicants for employment, a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of a controlled substance or marijuana is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition; (iii) state in all solicitations or advertisements for employees placed by or on behalf of the Contractor that the Contractor maintains a drug-free workplace; and (iv) include the provisions of the foregoing clauses in every subcontract or purchase order of over $10,000, so that the provisions will be binding upon each subcontractor or vendor.
2. For the purposes of this section, "drug-free workplace" means a site for the performance of work done in connection with a specific contract awarded to a contractor in accordance with the Virginia Public Procurement Act, the employees of whom are prohibited from engaging in the unlawful manufacture, sale, distribution, dispensation, possession or use of any controlled substance or marijuana during the performance of the contract.

The Standard maintains a drug-free workplace and complies with 1 and 2. The Standard would agree to include drug-free workplace language in contracts with subcontractors entered into in connection with the products and services to be provided under this RFP.

H. Employment Discrimination by Contractor Prohibited

1. Contractor certifies to the County of Henrico, Virginia that it will conform to the provisions of the Federal Civil Rights Act of 1964, as amended, as well as the Virginia Fair Employment Contracting Act of 1975, as amended, where applicable, the Virginians With Disabilities Act, the Americans With Disabilities Act and § 2.2-4311 of the Virginia Public Procurement Act. If the award is made to a faith-based organization, the organization shall not discriminate against any recipient of goods, services, or disbursements made pursuant to the contract on the basis of the recipient's religion, religious belief, refusal to participate in a religious practice, or on the basis of race, age, color, gender or national origin and shall be subject to the same rules as other organizations that contract with public bodies to account for the use of the funds provided; however, if the faith-based organization segregates public funds into separate accounts, only the accounts and programs funded with public funds shall be subject to audit by the public body. (Code of Virginia, § 2.2-4343.1E). During the performance of this Contract, the Contractor agrees as follows (Va. Code § 2.2-4311):
   a) The Contractor will not discriminate against any employee or applicant for employment because of race, religion, color, sex, national origin, age, disability, or other basis prohibited by state law relating to discrimination in employment, except where there is a bona fide occupational qualification reasonably necessary to the normal operation of the Contractor. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.
   b) The Contractor, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, will state that such Contractor is an equal opportunity employer.
   c) Notices, advertisements and solicitations placed in accordance with federal law, rule or regulation shall be deemed sufficient for the purpose of meeting the requirements of this section.

2. The Contractor will include the provisions of the foregoing subparagraphs (a), (b), and (c) in every subcontract or purchase order of over $10,000, so that the provisions will be binding upon each subcontractor or vendor.

   The Standard will use commercially reasonable efforts to include subparagraphs (a), (b), and (c) in any subcontract that it may enter into with a vendor to provide services solely in connection with the Contractor providing group insurance coverage to employees of the County.

L. Testing and Inspection

The County reserves the right to conduct any test/inspection it may deem advisable to assure services conform to the specifications.

The Standard will permit the County or an agreed-upon, third-party auditor (not a competitor) to perform audits or inspections of pertinent books and records. We require audits to be conducted at one of The Standard's primary business locations and be subject to applicable privacy and confidentiality laws and The Standard's internal privacy and confidentiality policies and procedures. Access to claim records requires written authorization from the insured.

Prior to the audit or inspection, we will hold a discussion between all parties (client, third-party auditor/inspector, and The Standard) to determine the desired process, as well as the amount of staff time required. If the third-party auditor/inspector anticipates a charge for time based on the audit request, we will discuss these fees and agree to terms prior to any audit.

M. Assignment of Contract

A contract shall not be assignable by the Successful Offeror in whole or in part without the written consent of the County.

To the extent The Standard proposes to enter into a subcontracting relationship solely and exclusively for the purpose of providing group insurance coverage to the County, we are willing to agree to seek prior consent.

N. Indemnification

The Successful Offeror agrees to indemnify, defend, and hold harmless the County (including Henrico County Public Schools), and the County's officers, agents, and employees ("Indemnified Parties") from any damages, liabilities, and costs, including attorneys' fees, arising from any claims, demands, actions, or proceedings made or brought against one or more of the Indemnified Parties by any person, including any employee of the Successful Offeror, related to the provision of any services, the failure to provide any services, or the use of any services or materials furnished (or made available) by the Successful Offeror, provided that such liability is not attributable to the sole negligence of the County.

Standard's group insurance policies include a provision that reads:
Individuals selected by the Policyholder or by any Employer to secure coverage under the Group Policy or to perform their administrative function under it, represent and act on behalf of the person selecting them, and do not represent or act on behalf of Standard Insurance Company. The Policyholder, Employer and such individuals 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. The Policyholder and each Employer hereby release, hold harmless and indemnify Standard Insurance Company from any liability arising from or related to any negligence, error, omission, misrepresentation or dishonesty of any of them or their representatives, agents or Employees.

Our group insurance policies do not contain a provision providing indemnification running from The Standard to the policyholder. However, The Standard will agree to indemnify the County for any negligent, reckless or willful acts of The Standard's employees or officers in the performance of this contract through a separate contract or administrative agreement.

R. Ownership of Deliverable and Related Products

1. The County shall have all rights, title, and interest in or to all specified or unspecified interim and final products, work plans, project reports and/or presentations, data, documentation, computer programs and/or applications, and documentation developed or generated during the completion of this project, including, without limitation, unlimited rights to use, duplicate, modify, or disclose any part thereof, in any manner and for any purpose, and the right to permit or prohibit any other person, including the Successful Offeror, from doing so. To the extent that the Successful Offeror may be deemed at any time to have any of the foregoing rights, the Successful Offeror agrees to irrevocably assign and does hereby irrevocably assign such rights to the County.

   The Standard does not intend to create any works for hire or transfer any copyrights as part of our group insurance coverage.

   On fully insured plans, The Standard owns all proprietary business records created in the course of administering the group insurance policy, including, but not limited to, underwriting, sales, and claim files. Subject to applicable law and The Standard's confidentiality policies and procedures, The Standard may be able to provide copies of records to the County for a reasonable charge.

S. Record Retention and Audits

1. The Successful Offeror shall retain, during the performance of the Contract and for a period of five years from the completion of the Contract, all records pertaining to the Successful Offeror's proposal and any Contract awarded pursuant to this Request for Proposal. Such records shall include but not be limited to all paid vouchers including those for out-of-pocket expenses; other reimbursement supported by invoices, including the Successful Offeror's copies of periodic estimates for partial payment; ledgers, cancelled checks; deposit slips; bank statements; journals; Contract amendments and change orders; insurance documents; payroll documents; timesheets; memoranda; and correspondence. Such records shall be available to the County on demand and without advance notice during the Successful Offeror's normal working hours.
2. County personnel may perform in-progress and post-audits of the Successful Offeror's records as a result of a Contract awarded pursuant to this Request for Proposals. Files would be available on demand and without notice during normal working hours.

The Standard shall retain records pursuant to applicable insurance laws and The Standard's Record Retention Policy. This section shall not apply to proprietary records created in the ordinary course of The Standard's business, including, but not limited to, claim, sales, and underwriting files. Subject to applicable privacy laws and regulations and The Standard's Privacy and Confidentiality policies, The Standard may provide the County copies of requested records with a reasonable charge for copying and shipping.

V. Subcontracts

No portion of the work shall be subcontracted without prior written consent of the County. In the event that the Successful Offeror desires to subcontract some part of the work specified in the contract, the Successful Offeror shall furnish the County the names, qualifications, and experience of the proposed subcontractors. The Successful Offeror

shall, however, remain fully liable and responsible for the work to be done by his/her subcontractor(s) and shall assure compliance with all the requirements of the Contract.

The Standard primarily identifies subcontractors as those solely and exclusively contracted for purposes of administering your group insurance policy. In addition, consistent with industry best practices, The Standard contracts with outside partners to perform certain subprocesses in support of our products and services. Our decisions are driven by a commitment to continuously improve the value we deliver to our customers.

CC. Payment Clauses Required by Va. Code §2.2-4354

Pursuant to Virginia Code § 2.2-4354:

1. The Successful Offeror shall take one of the two following actions within seven days after receipt of amounts paid to the Successful Offeror by the County for all or portions of the goods and/or services provided by a subcontractor: (a) pay the subcontractor for the proportionate share of the total payment received from the County attributable to the work performed by the subcontractor under that contract; or (b) notify the County and subcontractor, in writing, of the Successful Offeror's intention to withhold all or a part of the subcontractor's payment with the reason for nonpayment.

   We are willing to agree to this provision as it relates to "subcontractors" provided that term in this provision applies to those entities with whom The Standard contracts to provide services solely to the County.

2. The Successful Offeror that is a proprietor, partnership, or corporation shall provide its federal employer identification number to the County. Pursuant to Virginia Code § 2.2-4354, the Successful Offeror who is an individual contractor shall provide his/her social security numbers to the County.
3. The Successful Offeror shall pay interest to its subcontractors on all amounts owed by the Successful Offeror that remain unpaid after seven days following receipt by the Successful Offeror of payment from the County for all or portions of goods and/or services performed by the subcontractors, except for amounts withheld as allowed in Subparagraph 1. above.

   We are willing to agree to this provision as it relates to "subcontractors" provided that term in this provision applies to those entities with whom The Standard contracts to provide services solely to the County.

4. Unless otherwise provided under the terms of the Contract interest shall accrue at the rate of one percent per month.
5. The Successful Offeror shall include in each of its subcontracts a provision requiring each subcontractor to include or otherwise be subject to the same payment and interest requirements with respect to each lower-tier subcontractor.

   Offeror will use commercially reasonable efforts to include subsection 5 in any subcontract that it may enter into with a vendor to provide services solely in connection with the Offeror providing group insurance coverage to employees of the County.

6. The Successful Offeror's obligation to pay an interest charge to a subcontractor pursuant to the payment clause in Virginia Code § 2.2-4354 shall not be construed to be an obligation of the County. A Contract modification shall not be made for the purpose of providing reimbursement for the interest charge. A cost reimbursement claim shall not include any amount for reimbursement for the interest charge.

   Offeror will use commercially reasonable efforts to include subsection 6 in any subcontract that it may enter into with a vendor to provide services solely in

connection with the Offeror providing group insurance coverage to employees of the County.

JJ. Cooperative Procurement

This procurement is being conducted by the County in accordance with the provisions of Section 2.2-4304 of the Code of Virginia. Except for contracts for architectural and engineering services, if agreed to by the contractor, other public bodies may utilize this Contract. The Contractor shall deal directly with any public body it authorizes to use the Contract. The County, its officials, and its employees are not responsible for placement of orders, invoicing, payments, contractual disputes, or any other transactions between the Contractor and any other public body, and in no event shall the County, its officials, or its employees be responsible for any costs, damages or injury resulting to any party from another public body's cooperative use of a County contract. The County assumes no responsibility for any notification of the availability of the Contract for use by other public bodies, but the Contractor may conduct such notification.

We reserve the right to individually underwrite each group.

ATTACHMENT E
COUNTY OF HENRICO INSURANCE SPECIFICATIONS

☒ **Professional Liability - $2,000,000 ~~Per Occurrence~~ Per Claim (or limit in accordance with Statute for Medical Professional)**

Required if the Scope includes providing advice or consultation including but not limited to; lawyers, bankers, physicians, programming, design (including construction design), architects & engineers and others who require extensive education and/or licensing to perform their duties.

ATTACHMENT G

SAMPLE CONTRACT

The Standard reserves the right to review, negotiate and formally agree upon any Agreement terms prior to the Agreement becoming effective.

[Non-Professional *or* Professional] Services Contract
Contract No. [#]

This [Non-Professional *or* Professional Services] Contract (this "Contract") entered into this [#] day of [month] 20[##], by [Offeror's Name] (the "Contractor") and the [County of Henrico, Virginia *or* County School Board of Henrico County, Virginia] ([the "County" *or* "HCPS"]).

WHEREAS [the County *or* HCPS] has awarded the Contractor this Contract pursuant to Request for Proposals No. [#], as modified by [list addenda with dates separated by commas] (the "Request for Proposals"), for [subject matter of the RFP].

WITNESSETH that the Contractor and [the County *or* HCPS], in consideration of the mutual covenants, promises and agreements herein contained, agree as follows:

SCOPE OF CONTRACT: The Contractor shall provide the services to the [the County *or* HCPS] as set forth in the Contract Documents.

COMPENSATION: The compensation [the County *or* HCPS] will pay to the Contractor under this Contract shall be [insert information, referenced document, matrix, etc.].

{If contract is an annual contract, utilize Contract Term, if contract is a spot purchase utilize Service Schedule}
CONTRACT TERM: The Contract term shall be for a period of [number] year[s] beginning [date] and ending [date]. [The County *or* HCPS] may renew the Contract for up to [number] [number]-year terms giving 30 days' written notice before the end of the term unless Contractor has given [the County *or* HCPS] written notice that it does not wish to renew at least 180 days before the end of the term.
{or}
SERVICE SCHEDULE: Services shall be performed in accordance with the [referenced document within the proposal/BAFO].

CONTRACT DOCUMENTS: This Contract hereby incorporates by reference the documents listed below (the "Contract Documents") which shall control in the following descending order:

1. This [Non-Professional *or* Professional] Services Contract between [the County *or* HCPS] and Contractor.
2. The General Contract Terms and Conditions included in the Request for Proposals.
3. The Negotiated Modifications (Exhibit [letter]).
4. Contractor's Best and Final Offer dated [date] (Exhibit [letter]).

5. Contractor's Original Proposal dated [date] (Exhibit [letter]).
6. The Scope of Services included in the Request for Proposals.

Provided that The Standard's group insurance policy(ies) are made part of the Contract, and, in all instances, such policy(ies) shall govern eligibility for insurance and benefits and The Standard's right to re-rate and terminate the group insurance policy(ies).

IN WITNESS WHEREOF, the parties have caused this Contract to be duly executed intending to be bound hereby.

[Contractor Name]	[County of Henrico, Virginia *or* County School Board of Henrico County, Virginia]
[Address]	[P.O. Box 90775 *or* 406 Dabbs House Road]
[City, State, Zip]	[Henrico, VA 23273-0775 *or* 23223]
Signature	Signature
Printed Name and Title	[Purchasing Director *or* County Manager *or* Superintendent]
Date	Date

Assumptions

Assumptions

Coverage continues as it has since January 1, 2014 with employer paid Advice to Pay STD and LTD coverage for employees enrolled in the Hybrid Retirement system as required by Virginia Law.

Appendices

Group Short Term Disability Insurance

Protect Your Employees From Loss Of Income

Standard Insurance Company

Short Term Disability Insurance

Your Proposed Group Insurance Plan

Standard Insurance Company appreciates the opportunity to provide you with a proposal for Group Short Term Disability (STD) insurance. This booklet and the Employee Benefits Proposal together outline the basic features of your proposed STD plan. These two documents are not a contract.

Establishing group STD insurance coverage with The Standard requires your completed, signed application for group insurance and our acceptance of it. When we approve your application, we will issue you a group policy containing our customary language. It will not duplicate the language of any existing policies you may have.

Your group policy with The Standard will contain provisions and defined terms not described in this proposal. If any discrepancies exist between the group policy, the STD proposal and this booklet, your group policy will control.

Your group policy will become effective on the date determined by The Standard, which will be clearly stated on your policy. We will also supply you with certificates of insurance, describing the coverage in detail, for you to deliver to your insured employees.

The proposed premium rate and plan design for your STD coverage are based on the underwriting data received. We will determine final premium rates and plan provisions on the basis of:

- State law
- Policyholder contributions
- Confirmation of occupations
- The actual composition of the group of employees who become insured
- Our current underwriting rules and practices

The proposal will expire on the date shown in your Employee Benefits Proposal. Should you have questions or need additional information, please contact your insurance advisor or the Employee Benefits Sales and Service Office for your area.

Thank you for considering The Standard for your group STD insurance needs. Group Life and Disability are our primary business. Having this level of focused expertise means our people understand your needs better and our employee benefits work harder to support your goals. With tools designed to help you reduce your workload and a proactive approach to help you maintain a more productive and efficient workplace, we're here to partner with you for the long term.

Group Short Term Disability Insurance

An Attractive Option For Your Employee Benefits Package

Short Term Disability insurance from The Standard is designed to provide coverage for disabilities resulting from physical disease, injury, pregnancy or mental disorder. STD insurance offers an attractive option for employers who want to supplement a sick leave or statutory disability benefits program. The proposed STD benefit amount and maximum benefit period are shown in the Employee Benefits Proposal.

STD Product Information

Definition Of Disability

Insured employees are disabled if, as a result of physical disease, injury, pregnancy or mental disorder, they are unable to perform with reasonable continuity the material duties of their own occupation and suffer a loss of at least 20 percent in their predisability earnings when working in their own occupation.

Own occupation means the job the employee is regularly performing for their employer when disability begins.*

Material duties means the usual duties the employee performs in their regular job** with the employer that cannot be reasonably modified or omitted. In no event will we consider working more than 8 hours per day or an average of more than 40 hours per week to be a material duty.

Employees who are disabled from their own occupation may work in another occupation and continue to qualify for STD benefits as long as their work earnings do not exceed 80 percent of their predisability earnings. Work earnings will be used to reduce the STD benefit as noted under “Return To Work Incentive.”

*In Oregon, Own Occupation means the usual job an employee is ordinarily performing for their employer when disability begins.

** In Oregon, usual job is substituted for regular job.

Coverage For New Disabilities

If a period of disability is extended by a new cause while STD benefits are payable, benefits will continue while the employee remains disabled but not beyond the end of the original maximum benefit period. In addition, all policy limitations and exclusions apply to the new cause of disability.

Plan Options

The Standard offers STD plans that provide both non-occupational and 24-hour coverage. Non-occupational plans provide coverage for disabilities occurring off the job as a complement to workers’ compensation coverage. 24-hour STD plans provide coverage for disabilities occurring on or off the job.

Minimum STD Benefit

For STD plans that are integrated with deductible income, the minimum STD benefit is $15 per week. The Employee Benefits Proposal will indicate whether this applies to this proposed plan.

Returning To Work

Our claims management services have been carefully designed to promote and optimize the return of disabled employees to a productive life whenever possible. When a disability occurs, our focus is on returning the employee to work through our claims management process, the services we provide and the policy provisions we offer.

Reasonable Accommodation Expense Benefit

To help employers return employees with disabilities to active work whenever they are able, The Standard automatically includes a Reasonable Accommodation Expense Benefit in its STD policies. This benefit reimburses an employer for worksite modifications made on behalf of a disabled employee, which result in a return to work for the employee. The reimbursable modifications are subject to The Standard's prior approval.

Return To Work Incentive

Providing incentives for disabled employees to return to work at their full potential is critical for any successful rehabilitation plan. Automatically included in our STD policies, The Standard's Return To Work Incentive provision is designed to provide valuable financial support to disabled employees in their efforts to return to work.

The Standard's STD benefit is reduced by only the amount of work earnings which, when added to the employee's maximum STD benefit, exceeds 100 percent of predisability earnings. This typically means that employees who return to work receive more total income than those who do not. Work earnings will include amounts they could earn if they worked to their full potential in work that is reasonably available.

Return To Work Responsibility

In addition to providing positive financial incentives to return to work, The Standard's STD policy also establishes a clear expectation for those who are able to return to work. Disabled employees who are capable of part-time work have a responsibility to take advantage of available work opportunities. They are expected to accept part-time work in their own occupation if they are able to earn at least 20 percent of predisability earnings. No STD benefits are payable for any period when partially disabled employees fail to meet this responsibility.

Temporary Recovery

The Standard automatically includes a Temporary Recovery provision in every STD policy to further encourage employees to return to work. Our policy language is among the most flexible in the industry and enables us to work with employees to make permanent recoveries out of temporary ones.

Employees who recover from a disability for a period of time during the maximum benefit period but later suffer a relapse and become disabled again from the same cause or causes, may not have to serve a new benefit waiting period, depending on the length of the period of temporary recovery.

A new benefit waiting period is not required if the periods of recovery during the maximum benefit period do not exceed a total of 90 days. In addition:

- Benefits are not payable for the recovery period
- The recovery period does not count toward the maximum benefit period
- Predisability earnings used to determine the STD benefit will not change
- No STD benefits will be payable after benefits become payable to the employee under any other disability plan for which the employee became insured during the period of temporary recovery

Other than the above, the group policy is applied as if the disability were uninterrupted.

Additional Cost Options

Daily Hospital Benefit

With the Daily Hospital Benefit, the eligible insured employee will receive STD benefits for each day of hospitalization during the benefit waiting period.

First-day Hospital Benefit

If an insured employee is hospital-confined for at least four hours during the benefit waiting period, the benefit waiting period will be satisfied. Hospital-confined means the employee is admitted to a hospital as an in-patient, for which they are charged room and board. They must be under the ongoing care of a physician while they are hospital-confined. STD benefits will become payable on the date of hospitalization. The maximum benefit period will also begin on that date.

Exclusions From Coverage

The Standard's STD policies do not cover disabilities caused or contributed to by:

- War or any act of war
- An intentionally self-inflicted injury, while sane or insane*
- A disability arising out of, or in the course of, any employment for wage or profit (applies to non-occupational plans only)
- Committing or attempting to commit an assault or felony, or active participation in a violent disorder or riot
- Loss of a professional or occupational license or certification

Limitations

No STD benefit will be paid for any period when the disabled employee is:

- Not under the ongoing care of a physician in an appropriate specialty as determined by The Standard
- Eligible to receive benefits under any workers' compensation or similar law (applies to non-occupational plans only)
- Able to work part-time, but elects not to work (i.e., fails to meet the return to work responsibility)
- Confined for any reason in a penal or correctional institution
- Not participating in good faith in a plan of medical treatment or vocational training or education approved by The Standard, unless the disability prevents the employee from participating
- Receiving sick leave pay or other salary continuation from the employer, unless a sick leave integration option is chosen

Preexisting Condition Limitation

The preexisting condition limitation typically applies to STD benefit amounts of $3,500 per week or more. If on the date disability begins, the employee has not been continuously insured under the group policy for the 12- (or optional 24-) month limitation period and has not been actively at work for at least one full day after that limitation period, the weekly STD benefit will be limited to not more than $3,500 if the disability results from a preexisting condition.

*For Colorado and Missouri residents, "insane" is not applicable.

A preexisting condition is a mental or physical condition whether or not diagnosed or misdiagnosed:

- Which was discovered or suspected as a result of any routine or other medical examination at any time during the preexisting condition period
- For which the employee has (or a reasonably prudent person would have) consulted a physician or other licensed medical professional, received medical treatment, services or advice, undergone diagnostic procedures, including self administered procedures, or taken prescribed drugs or medications at any time during the preexisting condition period

The preexisting condition period is the three- or six-month period just before the employee's insurance becomes effective, as specified in the Employee Benefits Proposal.

We grant credit for time served toward satisfying the preexisting condition limitation period for eligible employees insured under the employer's prior group STD plan that was replaced by The Standard's coverage.

Deductible Income

The Standard's STD insurance helps replace a portion of income lost as a result of a disability. Often employees are eligible for other sources of income. To prevent overinsurance, the STD benefit is reduced by deductible income, which generally includes the following, although it may vary depending on whether the employer is a public or private entity:

- Work earnings, as described under "Return To Work Incentive"
- Benefits the employee receives or is eligible to receive from workers' compensation; state disability income benefit law; the Jones Act; Maritime Doctrine of Maintenance, Wages, and Cure; Longshore and Harbor Worker's Act or any similar acts or laws (applies to 24-hour coverage only)
- Benefits from other insurance (including group insurance for non-professionals) the employee receives or is eligible to receive
- Any disability or retirement benefits received from the employer's retirement plan
- Any earnings or compensation included in predisability earnings which the employee receives or is eligible to receive while STD benefits are payable
- Any amount the employee receives or is eligible to receive under any unemployment compensation law or similar act or law
- Any amount the employee receives or is eligible to receive from, or on behalf of, a third party
- Any amount received by compromise, settlement or other method, as a result of a claim for any of the above, whether disputed or undisputed

Exceptions To Deductible Income

The following are generally not considered deductible income, although exceptions vary depending on whether the employer is a private or public entity:

- Group credit, mortgage disability insurance benefits and accelerated death benefits paid under a life insurance policy
- Any cost-of-living increase in deductible income, other than work earnings
- Reimbursement for hospital, medical or surgical expenses
- Reasonable attorney fees incurred in connection with a claim for deductible income

Commonly Asked Questions

Who Is Eligible For Coverage?

Coverage is available to all of an employer's active employees who:

- Are citizens or residents of the United States or Canada
- Are actively at work at least 30 hours each week
- Meet the required eligibility waiting period as shown in the Employee Benefits Proposal

Temporary and seasonal employees, full-time members of the armed forces of any country, leased employees and independent contractors are not eligible for coverage. There is no age limit on eligibility for coverage under The Standard's group insurance plans.

When Is Coverage Effective?

Subject to the active work requirement, coverage is effective as follows:

- Coverage requiring evidence of insurability is not effective until evidence is approved
- For noncontributory plans, coverage is effective on the date the employee becomes eligible
- For contributory plans, employees must apply in writing for coverage. Coverage is effective on the later of:
  - The date the employee becomes eligible
  - The date the employee applies if the employee submits an application within 31 days of becoming eligible
  - The date that required evidence of insurability is approved, if the employee applies more than 31 days after becoming eligible

What Is The Active Work Requirement?

Employees who are performing the material duties of their own occupation at the employer's usual place of business meet the active work requirement. Employees who are not capable of active work due to physical disease, injury, pregnancy or mental disorder on the day before insurance would otherwise become effective will not become insured until the day after completing one full day of active work as an eligible employee.

What Level Of Employee Participation Is Required?

For noncontributory plans, 100 percent of the eligible employees must participate. If a plan is contributory (partially or fully funded by employees), a minimum number of eligible employees must participate, as specified in the Employee Benefits STD Proposal.

When Does The Coverage End?

STD insurance ends automatically on the earliest of the following:

- The date the last period ends for which a premium contribution is received
- The date the group policy terminates
- The date employment terminates
- The date the employee fails to meet the definition of a member (however, STD insurance may be continued under certain conditions, such as during an approved leave of absence scheduled to last no more than 30 days)

When Does The Group Policy Terminate?

An employer may terminate a group policy by providing The Standard with written notice. The group policy will automatically terminate if premium is not received by the end of the grace period shown in the Employee Benefits Proposal. The Standard may terminate the group policy if the number of employees insured is less than the minimum participation requirement shown in the Employee Benefits Proposal. The Standard may also terminate the group policy if we determine that the policyholder has failed to promptly furnish any necessary information requested by us or has failed to perform any other obligations relating to the group policy.

Founded in Portland, Oregon in 1906, The Standard is a nationally recognized provider of group Disability, Life, Dental, and Vision insurance and Individual Disability insurance. We provide insurance to more than 25,700 groups, covering approximately 6 million employees nationwide.*

Our first group policy, written in 1951 and still in force today, stands as a testament to our commitment to building long-term relationships. We always strive to do what's right – for our policyholders and their employees. This dedication has resulted in a national reputation for quality products, superior service and industry expertise.

To learn more about STD insurance from The Standard, contact your insurance advisor or the Employee Benefits Sales and Service Office for your area at 800.633.8575 or visit us at **standard.com**.

* As of December 31, 2016, based on internal data developed by Standard Insurance Company.

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

standard.com

GP399-STD, GP399-STD/TRUST, GP190-STD/S399,
GP309-STD, GP209-STD, GP399-STD/ASSOC, GP899-STD

Group Long Term Disability Insurance

Safeguarding Your Employees' Income

TheStandard®

Standard Insurance Company

Your Proposed Group Insurance Plan

Standard Insurance Company (The Standard) appreciates the opportunity to provide you with a proposal for Group Long Term Disability (LTD) insurance. This booklet and the Employee Benefits Proposal together outline the basic features of your proposed LTD insurance plan. They are not a contract.

Establishing group LTD insurance coverage with The Standard requires your completed, signed application for group insurance and our acceptance of it. When we approve your application, we will issue you a group policy containing our customary language. It will not duplicate the language of any existing policies you may have.

Your group policy with The Standard will contain provisions and defined terms not described in this booklet or your Employee Benefits Proposal. If any discrepancies exist between the group policy, the Employee Benefits Proposal and this booklet, your group policy will control.

Your group policy will become effective on the date determined by The Standard, which will be clearly stated in your policy. We will also supply you with certificates of insurance, describing the coverage in detail, for you to deliver to your insured employees.

The proposed premium rate and plan design for your LTD coverage are based on the underwriting data we received from you. We will determine final premium rates and plan provisions based on:

- State law
- Policyholder contributions
- Confirmation of occupations
- The actual composition of the group of employees who become insured
- Our current underwriting rules and practices

The proposal will expire on the date shown in your Employee Benefits Proposal.

Thank you for considering The Standard for your group LTD insurance needs. Group Life and Disability are our primary business. Having this level of focused expertise means our people understand your needs better and our employee benefits work harder to support your goals. With tools designed to help reduce your workload and a proactive approach to help you maintain a more productive and efficient workplace, we re here to partner with you for the long term.

Group Long Term Disability Insurance

A Vital Part Of Your Employee Benefits Package

Long Term Disability insurance from The Standard provides a monthly benefit to eligible employees who are partially or totally disabled due to a covered physical disease, injury, pregnancy or mental disorder. It is key to smart financial planning for both employers and employees.

Employees most likely purchase home, automobile and life insurance to safeguard themselves against the threat of loss. Yet they may not understand the importance of insuring a portion of their incomes against the threat of disability. The risk of disability is greater than most people might think. Recent statistics have shown:

- A disabling injury occurs nearly every second of each day – on and off the job. That's more than 70,000 every day, more than 25 million every year.

  National Safety Council, Injury Facts 2011

- Three in 10 workers entering the workforce today will become disabled before retiring.

  Social Security Administration Fact Sheet 2011

LTD insurance from The Standard provides benefits to replace a portion of lost income for eligible employees who meet the definition of disability under the group policy. This helps disabled employees recuperate with fewer financial worries.

Financial Support For Employees, A Recruitment Tool For Employers

Savings, sick leave, workers' compensation, Social Security, friends and family are some of the sources used to replace income lost due to disability. However, the financial impact of a long term disability often exceeds these limited resources. The Standard's LTD insurance supplements other sources of income and provides incentives and assistance to facilitate a return to work whenever possible.

LTD coverage also helps employers by enhancing their benefits package – one of the best ways to attract and retain high-caliber employees. The Standard offers LTD insurance with flexible plan designs and claims management expertise, all at competitive group rates.

Plan Design Information

LTD Benefit Schedule
LTD benefits replace a specified percentage of a disabled employee's predisability earnings, as defined in the group policy. The percentage can range from 30 to 70 percent, subject to minimum and maximum LTD benefit amounts. As part of an income-replacement program, LTD benefits will be reduced by other amounts, called deductible income, which the employee receives or is eligible to receive.

Coverage up to a certain level, the guarantee issue amount, is available without submitting evidence of insurability. Evidence may be required for higher amounts. For detailed information about this plan's design, please refer to the Employee Benefits Proposal.

Definition Of Predisability Earnings
Most definitions of predisability earnings include:

- Salary
- Shift differential pay
- Commissions averaged over the preceding 12-month period or over the period of employment if less than 12 months
- Employee contributions made through a salary reduction agreement with the employer to an Internal Revenue Code (IRC) Section 401(k), 403(b), 408(k), 408(p) or 457 deferred compensation arrangement, or an executive non-qualified deferred compensation arrangement
- Amounts contributed to fringe benefits according to salary reduction agreements under IRC Section 125 plans

The definition of predisability earnings generally excludes bonuses, overtime or any other extra compensation. However, these items may be included if approved by The Standard. If so, they will be shown in the Employee Benefits Proposal. An employer's contributions on the employee's behalf to any deferred compensation arrangement or pension plan are also generally excluded from the definition of predisability earnings.

Coverage up to a certain level, the guarantee issue amount, is available without submitting evidence of insurability. Evidence may be required for higher amounts.

When LTD Benefits Begin
When LTD benefits are payable, they begin at the end of the benefit waiting period. Benefits are not payable during the benefit waiting period.

For disabilities subject to the Preexisting Condition Limitation described on pages 8 and 9, the benefit waiting period is the longer of (a) and (b):

(a) the 12-month period beginning on the date the employee becomes insured under the group policy; and

(b) from 30 – 180 days of continuous disability (the most common selection is 90 days of continuous disability). Periods (a) and (b) run concurrently.

For disabilities not subject to the Preexisting Condition Limitation oe Exclusion, the benefit waiting period is from 30 – 180 days of continuous disability. The most common selection is 90 days of continuous disability; however, the period can range from 30 days to one year depending on the specific needs of the employer.

For more information about benefit waiting period options, please refer to the Employee Benefits Proposal.

When LTD Benefits End
LTD benefits end automatically on the date the employee:

- Ceases to be disabled or dies
- Fails to provide proof of continuing disability
- Becomes eligible for benefits under another LTD plan during a period of temporary recovery
- Reaches the end of the maximum benefit period for which LTD benefits are payable for any one period of continuous disability, whether from one or more causes

LTD benefits are not payable after the end of the maximum benefit period, even if the employee remains disabled.

For employees who become disabled after age 60, The Standard offers three age-graded reduction schedules that provide benefits beyond age 65. If the proposed pan design has a shorter maximum benefit period, such as two or five years, the maximum benefit period is adjusted accordingly for older employees.

Definitions Of Disability

The definition of disability determines whether benefits are payable and the extent to which disabilities are covered. The Standard's definitions of disability offer flexibility in designing a benefit program to meet each organization's specific needs.

Some employees will meet the applicable definition and also retain the ability to perform some of their work duties full-time or part-time, or be able to work in another occupation. The Standard's disability definitions provide coverage for individuals who work while disabled, as defined by the group policy.

Material Duties And Indexed Predisability Earnings
The Standard offers own occupation and any occupation definitions of disability. Most plans include both definitions, but they can be separated, and the time periods when they apply may vary in order to meet the needs of the organization and its employees. Our basic plan includes a 24-month own occupation period followed by an any occupation period.

Both own occupation and any occupation definitions refer to material duties and indexed predisability earnings. Material duties are the essential tasks, functions, operations, skills, abilities, knowledge, training and experience generally required by employers from those engaged in a particular occupation that cannot be reasonably modified or omitted. However, in no event would a requirement to work an average of more than 40 hours per week be considered a material duty.

Indexed predisability earnings are based upon predisability earnings and the U.S. Consumer Price Index, and are calculated strictly for purposes of determining disability. Indexed predisability earnings may apply in determining whether an employee meets the own occupation or any occupation definition of disability.

Own Occupation Disability
During the benefit waiting period and the first 24 months of the own occupation period thereafter, employees are disabled if, as a result of physical disease, injury, pregnancy or mental disorder they:

- Are unable to perform with reasonable continuity the material duties of their own occupation, and
- Suffer a loss of at least 20 percent in their indexed predisability earnings when working in their own occupation.

Own occupation means any employment, business, trade, profession, calling or vocation that involves material duties of the same general character as the occupation the employee is regularly performing for the employer when the disability begins. However, own occupation is not limited to how the employee specifically performs the job for the employer. Rather, The Standard may view how the occupation is generally performed in the national economy. If the own occupation involves the rendering of professional services and requires a professional or occupational license in order to work, the definition of own occupation is as broad as the scope of the license.

While this definition applies, employees who are disabled from their own occupation may work in another occupation and continue to qualify for LTD benefits as long as their work earnings do not meet or exceed 80 percent of their indexed predisability earnings. Work earnings will be used to reduce the LTD benefits as noted under "Return To Work Incentive" on page 6.

Any Occupation Disability
During the any occupation period, after the 24 months of the own occupation period, employees are disabled if, as a result of physical disease, injury, pregnancy or mental disorder, they are unable to perform with reasonable continuity the material duties of any occupation.

Any occupation means any occupation or employment that the employee is able to perform, whether due to education, training or experience, which is available at one or more locations in the national economy, and in which the employee could be expected to earn at least 60 percent of indexed predisability earnings within 12 months following his or her return to work, regardless of whether the employee is working in his or her own or any other occupation.

While this definition applies, disabled employees may work and continue to qualify for LTD benefits as long as they meet the any occupation definition of disability. Work earnings will reduce the LTD benefits as noted under "Return To Work Incentive."

Optional Definitions Of Disability
The Standard understands the specialized training and financial investment required for many professional careers. We offer definitions of disability specifically

designed for professionals, key management employees and certain employer groups.

Own Occupation To Age 65
The Standard offers a definition of disability that requires employees to be disabled from only their own occupations. This definition applies during the benefit waiting period and throughout the maximum benefit period. Employees who are disabled from their own occupations may work in another occupation. However, they will no longer meet the definition of disability when their work earnings meet or exceed 80 percent of indexed predisability earnings.

Own Specialty Protection
For physicians and attorneys, The Standard offers two-year, five-year, and to end of maximum benefit period own specialty protection. For physicians, own occupation is defined as the medical specialty the physician is board-certified to practice. For attorneys, own occupation is defined as the one or two legal subject-matter areas or types of legal practice in which the attorney has specialized, provided the attorney has been in practice for at least five years.[1]

Certain percentages of the gross professional fee income must have been earned in those specialty areas or types of practice during the 24 months just before disability began. These percentages are at least 60 percent for physicians and 85 percent for attorneys. During the remainder of the maximum benefit period, the employee must meet the usual own occupation definition of disability. Those who meet this definition of disability may work in another occupation. However, they will no longer be considered as disabled when their work earnings exceed 100 percent of indexed predisability earnings.

1 Trial attorney or trial practice will not be considered one of the specialty legal subject matter areas or types of legal practice unless the attorney personally appears and actively participates in legal proceedings on behalf of clients at least four hours per day on an average of at least 50 days per year during the 24 months just before disability begins. Time the attorney spends preparing to actively participate in legal proceedings can be included when calculating up to one-half of the hours-per-day and days-per-year requirement. Legal proceedings include civil or criminal trials, administrative rule-making or contested-case hearings, workers' compensation hearings, arbitration and mediation hearings, and the taking or defending of depositions.

Returning To Work

Our claims management services have been carefully designed to promote and optimize the return of disabled employees to a productive life whenever possible. Our benefits analysts work with vocational experts, nurses and physicians to provide early screening, assess disability durations and identify return-to-work opportunities. As a result, disabled employees may return to work earlier than anticipated, which may reduce the likelihood of permanent disability. This helps employers regain valuable employees and contain disability claims costs.

Return To Work Incentive
Providing incentives for disabled employees to return to work at their full potential is critical for any successful rehabilitation plan. The Standard's Return to Work Incentive is one of the most comprehensive in the employee benefits industry. It is automatically included in every LTD policy to provide valuable financial support to eligible employees in their efforts to return to work.

During the 12 (or optional 24) months immediately after a disabled employee first returns to work, the LTD benefit is reduced by only the amount of work earnings that, when added to the employee's maximum LTD benefit, exceeds 100 percent of indexed predisability earnings. Following 12 (or optional 24) months, The Standard will deduct one-half of work earnings while the employee remains disabled. This typically means that employees who return to work will receive more total income than those who do not. Work earnings will include amounts they could earn if they worked to their full potential in work that is reasonably available.

Reasonable Accommodation Expense Benefit
To help employers return employees with disabilities to active work whenever possible, The Standard automatically includes a Reasonable Accommodation Expense Benefit in its LTD policies. This reimburses an employer up to $25,000 for worksite modifications made on behalf of a disabled employee, when the modifications enable the employee to return to work. Reimbursable modifications are subject to The Standard's prior approval.

Rehabilitation Plan Provision
To help employees with disabilities prepare to return to active work, The Standard automatically includes a Rehabilitation Plan Provision in all LTD policies. Subject to The Standard's prior approval, employees may participate in a rehabilitation plan at any time, and in doing so, may receive an additional 10 percent of their predisability earnings, not to exceed the maximum LTD benefit as a result of this increase. Some or all of the expenses incurred by employees that are intended to support a return to work, include:

- Training and education
- Family (child and elder) care
- Job-search and other job-related expenses

Temporary Recovery
The Standard automatically includes a Temporary Recovery provision in every LTD policy to further encourage employees to return to work. Our flexible policy language enables us to work with employees to make permanent recoveries out of temporary ones. Employees who recover from a disability for a period of time, but later suffer a relapse and become disabled again from the same cause or causes, may not have to serve a new benefit waiting period if the period of recovery does not exceed 90 days during the benefit waiting period or 180 days during the maximum benefit period.

In either case, the recovery period does not count toward the benefit waiting period, the maximum benefit period or the own occupation period. LTD benefits are not payable during the recovery period. Predisability earnings used to determine the LTD benefits will not change. No LTD benefits will be payable after benefits become payable under any other disability plan under which the employee became insured during the recovery period. Otherwise, the group policy is applied as if the disability were uninterrupted.

Return To Work Responsibility
In addition to providing financial incentives to return to work, The Standard's LTD policy also establishes clear expectations for those who are able to return to work. Disabled employees who are capable of part-time work have a responsibility to take advantage of available work opportunities. They must accept part-time work in their own occupation during the own occupation period and in any occupation during the any occupation period, if they are able to earn at least 20 percent of indexed predisability earnings. LTD benefits will not be payable for any period when partially disabled employees fail to meet this return to work responsibility.

Workplace Possibilities℠
To help employers proactively manage absence and disability, this innovative program aims to keep employees at work by addressing and reducing the causes of absence and disability. For employers with 1,000 or more employees, we offer to place a Workplace Possibilities Consultant onsite, as part of their group disability insurance through The Standard. The Consultant – a certified case manager who may be a nurse or vocational rehabilitation specialist – works to keep employees on the job and get them back to work quicker. The goal is a more productive workplace with measurable reductions in absence and disability-related costs. And it takes a big burden off the HR team.

Cost Containment Features

Disabilities Subject To Limited Pay Periods
Payment of LTD benefits is limited to 24 (or optional 12) months during the employee's lifetime for disabilities caused or contributed to by any one or more of the following, or medical or surgical treatment of one or more of the following:

- Any mental, emotional or psychological disorder regardless of cause (such as depression, anxiety, stress, bipolar affective disorder, organic brain syndrome, schizophrenia); at the end of the limited pay period, benefits may continue if the employee is continuously confined in a hospital solely because of a mental disorder, however; hospital does not include a rest home, nursing home, convalescent home, home for the aged or a facility primarily affording custodial, educational or rehabilitative care
- The use of alcohol or any drug (including hallucinogens), alcoholism or drug addiction
- Other limited conditions include chronic fatigue conditions (such as chronic fatigue syndrome and post viral syndrome), any allergy or sensitivity to chemicals or the environment (such as sick building syndrome and multiple chemical sensitivity syndrome), chronic pain conditions (such as fibromyalgia, reflex sympathetic dystrophy and myofascial pain), carpal tunnel or repetitive motion syndrome, temporomandibular or craniomandibular joint disorder[2]

As an additional cost-containment option, employers may elect to limit payment of LTD benefits for disabilities caused or contributed to by musculoskeletal or connective tissue disorders, such as arthritis, diseases or disorders of the cervical, thoracic or lumbosacral back and its surrounding soft tissue, and strains or sprains of joints or muscles. This expanded limitation would not apply to rheumatoid or psoriatic arthritis, herniated disks with neurological abnormalities that are documented by electromyogram and computerized tomography or magnetic resonance imaging, scoliosis, traumatic spinal cord injuries, diseases or inflammations of the spinal cord, overlapping vertebrae (grade II or higher), osteoporosis, discitis or Paget's disease.

2 This limitation does not apply to neoplastic diseases, neurologic diseases, endocrine diseases, hematologic diseases, asthma, allergy-induced reactive lung disease, tumors, malignancies, vascular malformations, demyelinating diseases or lupus.

3 Employers may choose a plan design that offsets LTD benefits by part or none of the dependent's benefits.

Deductible Income
The Standard's LTD insurance helps replace part of the income lost as a result of disability. Often employees are eligible for other sources of income, such as workers' compensation or Social Security. To prevent overinsurance, LTD benefits are reduced by an employee's deductible income, which generally includes the following, although these may vary depending on if the employer is a public or private entity:

- Work earnings, as described under "Return To Work Incentive"
- Sick pay, annual or personal leave pay, severance pay or other salary continuation, including donated amounts (but not vacation pay), which, when added to the maximum LTD benefit, exceed 100 percent of indexed predisability earnings
- Benefits from the Federal Social Security Act, the Canada Pension Plan, the Quebec Pension Plan, the Railroad Retirement Act or similar plans or acts providing benefits that the employee or the employee's dependents receive or are eligible to receive[3]
- Benefits the employee receives or is eligible to receive from workers' compensation, state disability income benefits law, the Jones Act; Maritime Doctrine of Maintenance, Wages or Cure; Longshore and Harbor Workers' Act; or any similar acts or law
- Any earnings or compensation included in predisability earnings which an employee receives or is eligible to receive while LTD benefits are payable
- Any amount an employee receives or is eligible to receive under any unemployment compensation law or similar act or law
- Any amount an employee receives or is eligible to receive from or on behalf of a third party
- Any disability or retirement benefits an employee receives from a private employer's retirement plan
- Any disability or retirement benefits an employee receives or is eligible to receive from a public employer's retirement plan and any lump sum refund, withdrawal or distribution of contributions and earnings received[4]
- Any amount received by compromise, settlement or other method, as a result of a claim for any of the above, disputed or undisputed

4 If the employee receives a lump sum refund, withdrawal or distribution of contributions and earnings, LTD benefits are determined using a lifetime monthly annuity amount with no survivor income. Employee and employer contributions are considered as distributed simultaneously throughout the employee's lifetime, regardless of how funds are distributed from the retirement plan.

Exceptions To Deductible Income
The following are generally not considered deductible income, although exceptions may vary depending on if the employer is a public or private entity:

- Any amounts attributable to the employee's contributions to the employer's retirement plan or which the employee could have received upon termination of employment without being disabled or retired
- Benefits from a profit-sharing plan, thrift or savings plan, deferred-compensation plan, 401(k), 408(k) or 457 plan, IRA, tax-sheltered annuity under IRC Section 403(b), stock ownership plan or Keogh (HR-10) plan
- Any lump-sum refund, withdrawal or distribution of the employee's contributions and earnings received from the employer's retirement plan because the employee is not vested under the plan
- Social Security early-retirement benefits not received by the insured employee
- Group credit, mortgage disability insurance benefits and accelerated death benefits paid under a life insurance policy
- Any cost-of-living increases in deductible income, other than work earnings
- Reimbursement for hospital, medical or surgical expenses
- Reasonable attorney fees incurred in connection with a claim for deductible income

Limitations
No LTD benefits will be paid for any period when the disabled employee is:

- Not under the ongoing care of a physician in an appropriate specialty as determined by The Standard
- Not participating in good faith in a plan of medical treatment, vocational training or education approved by The Standard, unless the disability prevents the employee from participating
- Able to work part time, but elects not to (i.e., the employee fails to meet his return to work responsibility)
- Confined for any reason in a penal or correctional institution

In addition, payment of LTD benefits is limited to 12 months for any period when the employee resides outside the United States or Canada.

Exclusions From Coverage
Disabilities are not covered when caused or contributed to by:

- War or any act of war
- An intentionally self-inflicted injury, whether the insured employee is sane or insane[5]
- Loss of professional or occupational license or certification
- Committing or attempting to commit an assault or felony
- Active participation in a violent disorder or riot
- A preexisting condition or treatment of a preexisting condition, unless, on the date disability begins, the employee has been continuously insured under the group policy for the entire 12 months for groups with 20 or more lives and 24 months for groups with fewer than 20 lives and has been actively at work for at least one full day after the end of that exclusion period

Diagnosed or misdiagnosed, a preexisting condition is a mental or physical condition:

- That was discovered or suspected as a result of any routine or other medical examination at any time during the preexisting condition period, or
- For which the employee has (or a reasonably prudent person would have) consulted a physician or other licensed medical professional, received medical treatment, services or advice, undergone diagnostic procedures (including self-administered procedures), or taken prescribed drugs or medications at any time during the preexisting condition period.

The preexisting condition period is the three- or six-month period just before the employee's insurance becomes effective, as specified in the Employee Benefits Proposal. The Standard grants credit for time served toward satisfying the preexisting condition exclusion period for eligible employees insured under the employer's prior group LTD plan that was replaced by The Standard.

5 For Colorado and Missouri residents, "insane" is not applicable.

Additional LTD Plan Provisions And Services

Employee Assistance Program[6]
An Employee Assistance Program (EAP) can help increase productivity by assisting employees with their attempts to balance work and personal life. An EAP can address concerns such as health, marital, family, financial, alcohol, drug, legal, emotional and other personal issues that may adversely affect employee job performance. EAP and Worklife services are included with The Standard's Long Term Disability policies and are offered as optional enhancements with our group Life insurance.

A specialist will provide consultation by phone as well as arrange for up to three face-to-face assessments and short-term counseling from a network provider when necessary. The services also include Critical Incident Stress Debriefings in which a counselor will provide on-site, group counseling for employees if a traumatic event occurs in the workplace. The services also include referrals to community resources and educational materials.

Coverage For New Disabilities
If a period of disability is extended by a new cause while LTD benefits are payable, benefits will continue while the employee remains disabled, but not beyond the end of the original maximum benefit period. In addition, all policy limitations and exclusions apply to the new cause of disability.

Survivors Benefit
If an employee who has been continuously disabled for at least 180 days dies while LTD benefits are payable, The Standard will pay a Survivors Benefit. The benefit is a lump sum equal to three times the employee's monthly LTD benefit without reduction by deductible income. The Survivors Benefit is intended to meet a portion of a family's financial needs in the event of the employee's death. The benefit is paid to the surviving spouse[7] or unmarried children under age 25. As an option, it may also be paid to the deceased employee's estate. However, The Standard will first use the Survivors Benefit to reduce any overpayment on the employee's claim.

Direct Deposit
The Standard offers direct deposit (also known as Electronic Funds Transfer or EFT), a convenient and secure benefit payment option. With direct deposit, employees' LTD benefit payments will be automatically deposited into their designated checking or savings account on their payment due date, even if that date falls on a weekend or a holiday.

Social Security Assistance
The Standard offers eligible disabled employees assistance with Social Security benefits starting with the initial application. Each of our claims management teams includes a specialist who helps administer our Social Security assistance program and acts as a liaison to our nationwide network of contracted specialists.

Payment Of FICA Taxes
The Standard automatically pays the employer's portion of FICA (Social Security and Medicare) taxes for all LTD claims. Also, The Standard prepares and mails W-2 forms and reports yearly totals to the IRS and Social Security Administration for all LTD claims. This service saves the employer time and helps to expedite tax preparation for the employee.

Automatic Maximum Benefit Increase
The Automatic Maximum Benefit Increase feature provides for the maximum LTD benefit of the plan to automatically increase by 5 percent annually for five years. This is a convenient way to assure the LTD plan design keeps pace with salary increases without having to amend the group policy each year. There is no cost to add this feature to your coverage, but it must be requested – it's not automatically included in coverage plans.

6 The EAP service is provided through an arrangement with Morneau Shepell which is not affiliated with The Standard. Morneau Shepell is solely responsible for providing and administering the included service. EAP is not an insurance product and is provided to groups of 10 – 2,499 lives. This service is only available while insured under The Standard's group policy.

7 Spouse may include a civil union partner. Eligibility not available in all states. Contact your sales representative for details.

Options Available At Additional Cost

Benefits For The Severely Disabled
The Standard offers three enhancements to group LTD coverage to address the needs of severely disabled employees:

- **Assisted Living Benefit**, which may increase the income replacement level up to 80 or 100 percent of insured predisability earnings (up to a $5,000 maximum benefit)
- **Housing Assistance Benefit**, which provides an additional 25 percent of predisability earnings to pay for rent or mortgage (up to a $5,000 maximum benefit)
- **Lifetime Security Benefit**, which extends the maximum benefit period to the severely disabled employee's lifetime

Employers may choose one of the above or include the Lifetime Security Benefit in conjunction with either of the two other options. When one of these options is included, an employee to whom LTD benefits are payable may receive the additional benefits if, as a result of physical disease or injury, the employee:

- Is unable to safely and completely perform two or more activities of daily living[8] without assistance due to loss of functional capacity, or
- Requires substantial supervision for health or safety due to severe cognitive impairment.

The disabling condition must be expected to last 90 days or more and be certified by a physician in the appropriate specialty as determined by The Standard.

Other provisions and benefits may not be available and certain limitations and exclusions will apply.

Annuity Contribution Benefit
The Annuity Contribution Benefit is an optional Group Long Term Disability insurance feature designed to bridge the savings gap created when disabled employees may no longer have the financial means or opportunity to fund a retirement plan.

After a claimant has been disabled for 36 months, The Standard will set up and fund an individual annuity in the claimant's name. Each month, a designated percentage of the disabled employee's predisability earnings, not to exceed $5,000, will be deposited into the annuity.

Family Care Expenses Adjustment
As another return to work incentive, employers may add the Family Care Expenses Adjustment provision as an option to their group policy. If selected, the provision applies during the 12 (or optional 24) months immediately after a disabled employee first returns to work. While this applies, work earnings used to calculate LTD benefits may be reduced by a portion of the employee's family-care expenses, up to a monthly maximum of $250 per family member or $500 per family. Certain restrictions apply.

Dependent Education Benefit
The Dependent Education Benefit provides a monthly benefit for disabled employees who have children or a spouse[9] who are registered and in full-time attendance at an accredited educational institution beyond high school. Disabled employees can receive $150 for each eligible student, with a maximum of $600 per month for all eligible students. Spouses must be attending an institution for the purpose of obtaining employment or increasing earnings. Other restrictions may apply.

8 The six activities of daily living are bathing, continence, dressing, eating, toileting and transferring.

9 Spouse may include a civil union partner. Child may include a child of a civil union partner. Eligibility not available in all states. Contact your sales representative for details.

Conversion Provision
The Conversion of Insurance provision allows qualified employees to buy LTD conversion insurance after their insurance under the group policy ends. To qualify, an employee must meet the eligibility requirements for conversion as outlined in the group policy. Employees may maintain the same benefit level, up to a $4,000 monthly benefit, without submitting evidence of insurability. A benefit of up to $8,000 a month may be available with approved evidence of insurability. Conversion is available with most plan designs, although exclusions, limitations and reductions may apply.

Cost Of Living Adjustment (COLA) Benefit
The COLA benefit helps protect an employee's LTD benefits from inflation. The Standard offers COLA benefit options calculated according to the current Consumer Price Index. If on April 1 an employee has been disabled for the required number of calendar years (one or five), the LTD benefit will be adjusted with the COLA increase.

Age-graded Maximum Benefit Periods
The Standard offers a variety of maximum benefit period schedules for employers to provide LTD benefits to employees who work beyond age 65. Typically, the maximum benefit period is determined by the employee's age when the disability begins. The typical age-graded benefit reduction schedule includes a maximum benefit period to age 65 for employees who become disabled before age 62, with the benefit duration age-graded for employees who become disabled on or after age 62. With the Social Security normal retirement age (SSNRA) maximum benefit period option, the maximum benefit period corresponds to the employee's SSNRA under the federal Social Security Act. Additional options for maximum benefit periods beyond age 70 are also available.

Commonly Asked Questions

Who Is Eligible For Coverage?
Coverage is available to all of an employer's active employees who:

- Are citizens or residents of the United States or Canada
- Are actively at work at least 30 hours each week
- Meet the required eligibility waiting period as shown in the Employee Benefits Proposal

Temporary and seasonal employees, full-time members of the armed forces of any country, leased employees and independent contractors are not eligible for coverage. There is no age limit on eligibility for coverage under The Standard's group insurance plans.

What Is The Effective Date Of This Plan?
Subject to the active work requirement, coverage is effective as follows:

- Coverage requiring evidence of insurability is not effective until evidence is approved
- For noncontributory plans, coverage is effective on the date the employee becomes eligible

- For contributory plans, employees must apply in writing for coverage. Coverage is effective on the later of:
  - The date the employee becomes eligible
  - The date the employee applies if the employee submits an application within 31 days of becoming eligible
  - The date required evidence of insurability is approved, if the employee applies more than 31 days after becoming eligible

What Is The Active Work Requirement?
Employees who are performing the material duties of their own occupation at the employer's usual place of business meet the active work requirement. Employees who are not capable of active work due to physical disease, injury, pregnancy or mental disorder on the day before insurance would otherwise become effective will not become insured until the day after completing one full day of active work as an eligible employee.

What Level Of Employee Participation Is Required?
For noncontributory plans, 100 percent of the eligible employees must participate. If a plan is contributory (partially or fully funded by employees), a minimum number of eligible employees must participate, as specified in the Employee Benefits Proposal.

When Does Coverage End?
LTD insurance ends automatically on the earliest of the following:

- The date the last period ends for which a premium contribution is received
- The date the group policy terminates
- The date employment terminates
- The date the employee fails to meet the definition of a member (however, LTD insurance may be continued under certain conditions, such as during an approved leave of absence scheduled to last no more than 30 days)

When Does The Group Policy Terminate?
An employer may terminate a group policy by providing The Standard with written notice. The group policy will automatically terminate if premium is not received by the end of the grace period shown in the Employee Benefits Proposal. The Standard may terminate the group policy if the number of employees insured is less than the minimum participation requirement as shown in the Employee Benefits Proposal. The Standard may also terminate the group policy if we determine that the policyholder has failed to promptly furnish any necessary information requested by us or has failed to perform any other obligations relating to the group policy.

Performance Guarantee
The Standard is committed to providing world-class customer service. We guarantee we will meet the policyholder's overall service expectations or we will refund 5 percent of the quarterly expenses charged to the policyholder's account (for administration and paying claims) for any quarter in which we do not meet this guarantee.[10]

10 The minimum group size for Performance Guarantee for LTD coverage is 1,000 covered employees. No more than one refund per quarter will be paid. Claim decisions are made based on the terms of the plan. The ultimate claim decision, whether to approve or deny, is not covered by this Performance Guarantee. This guarantee is in effect for the initial rate guarantee period shown in the group policy. Thereafter, The Standard reserves the right to modify the terms or terminate this guarantee at any time at its sole discretion.

Founded in Portland, Oregon in 1906, The Standard is a nationally recognized provider of group employee benefits and Individual Disability insurance. We provide insurance to more than 25,700 groups, covering approximately 6 million employees nationwide.* Our first group policy, written in 1951 and still in force today, stands as a testament to our commitment to building long-term relationships.

We always strive to do what's right - for our policyholders and their employees. This dedication has resulted in a national reputation for quality products, superior service and industry expertise.

To learn more about Group Life insurance from The Standard, contact your insurance advisor or the Employee Benefits Sales and Service Office for your area at 800.633.8575 or visit us at **www.standard.com.**

* As of Dec. 31, 2016, based on internal data developed by Standard Insurance Company.

Standard Insurance Company
1100 SW Sixth Avenue
Portland, OR 97204

standard.com

Group LTD Insurance underwritten by Standard Insurance Company is provided
under policy form numbers: GP190-LTD/S399, GP190-LTD/TRUST/S399, GP399-LTD/TRUST, GP190-LTD/ASSOC/S399, GP491-LTD/TRUST/S399, GP899-LTD, GP209-LTD, GP608-LTD

Group Long Term Disability Insurance
SI **16544** (7/17) PR/ER

1100 SW Sixth Avenue
Portland, OR 97204

www.standard.com

Exhibit D

NOTICE OF
PROTECTION PROVIDED BY
VIRGINIA LIFE, AND 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 policyholders. 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 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:

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
804-371-9741
Toll Free Virginia only: 1-800-552-7945
http://www.scc.virginia.gov/division/boi/index.htm

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, then Virginia law will control.

COMMONWEALTH OF VIRGINIA
REQUIRED POLICY INFORMATION

In the event you need to contact someone about this policy for any reason, please contact your agent. If you have additional questions, you may contact the insurance company issuing this policy at the address and telephone number listed below.

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia Bureau of Insurance at the address and telephone number listed below.

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.

Name and address of the Insurance Company	Standard Insurance Company P.O. Box 711 Portland, OR 97207
Telephone Number	(503) 321-7000
Insurance Department Address	Virginia Bureau of Insurance Life and Health Division P.O. Box 1157 Richmond, VA 23218
Telephone Number	In state: 1-800-552-7945 Out-of-state: (804) 371-9741

STANDARD INSURANCE COMPANY

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

GROUP LONG TERM DISABILITY INSURANCE POLICY

Policyholder:	Henrico County, Virginia
Policy Number:	649720-B
Effective Date:	January 1, 2019

The consideration for this Group Policy is the application of the Policyholder and the payment by the Policyholder of premiums as provided herein.

Subject to the **Policyholder Provisions** and the **Incontestability Provisions**, this Group Policy (a) is issued for the Initial Rate Guarantee Period shown in the **Coverage Features**, and (b) may be renewed for successive renewal periods by the payment of the premium set by us on each renewal date. The length of each renewal period will be set by us, but will not be less than 12 months.

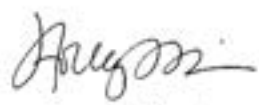
For purposes of effective dates and ending dates under this Group Policy, all days begin and end at 12:00 midnight Standard Time at the Policyholder's address.

All provisions on this and the following pages are part of this Group Policy. "You" and "your" mean the Member. "We", "us", and "our" mean Standard Insurance Company. Other defined terms appear with their initial letters capitalized. Section headings, and references to them, appear in boldface type.

STANDARD INSURANCE COMPANY

By

Chairman, President and CEO



Corporate Secretary

Table of Contents

Index of Defined Terms

COVERAGE FEATURES

This section contains many of the features of your long term disability (LTD) 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:	649720-B
Policyholder:	Henrico County, Virginia
Employer(s):	Henrico County General Government, Henrico County Public Schools, the Henrico County Economic Development Authority
Group Policy Effective Date:	January 1, 2019
Policy Issued in:	Virginia

Member means:

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. Actively At Work at least the minimum hours per week required by the Employer for coverage under the Program, but in no event less than 20 hours each week (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); and
3. A citizen or resident of the United States or Canada.

Member does not include a temporary or seasonal employee, a full-time member of the armed forces of any country, a leased employee, or an independent contractor.

Class Definition:

Class 1:	Members with fewer than 12 months continuous participation in the Virginia hybrid retirement program described in § 51.1-169 of the Code of Virginia
Class 2:	Members with at least 12 months continuous participation in the Virginia hybrid retirement program described in § 51.1-169 of the Code of Virginia

SCHEDULE OF INSURANCE

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

a. The Group Policy Effective Date; and

b. The first day as a Member.

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

Own Occupation Period:	The first 24 months for which LTD Benefits are paid.
Any Occupation Period:	From the end of the Own Occupation Period to the end of the Maximum Benefit Period.

LTD Benefit (dollar values are per month as noted in the definition of LTD Benefit in the **Definitions** section);

Class 1:	
For Disability arising out of or in the course of employment with the Employer:	60% of the first $41,667 of your Predisability Earnings, reduced by Deductible Income.
Maximum:	$25,000 before reduction by Deductible Income.
Minimum:	$100
For any other Disability:	None
Class 2:	60% of the first $41,667 of your Predisability Earnings, reduced by Deductible Income.
Maximum:	$25,000 before reduction by Deductible Income.
Minimum:	$100
Assisted Living Benefit:	An additional 20% of your Predisability Earnings, but not to exceed $5,000. The Assisted Living Benefit is not reduced by Deductible Income.
Lifetime Security Benefit:	Not Included
Benefit Waiting Period:	The period for which benefits are payable under the Employer's short term disability benefits program, including any benefit waiting period under that plan.
Maximum Benefit Period:	Determined by your age when Disability begins, as follows:

Age	Maximum Benefit Period
59 or younger	To SSNRA
60 through 64	5 years
65 through 68	To age 70
69 or older	1 year

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

PREMIUM CONTRIBUTIONS

Insurance is:	Noncontributory

PREMIUM AND RENEWALS

Premium Rates:

LTD Insurance:

Henrico County:	0.59% of the first $41,667 of each insured Member's insured Predisability Earnings.
Henrico County Economic Development Authority:	0.59% of the first $41,667 of each insured Member's insured Predisability Earnings.
Henrico County Public Schools:	
Professional employees:	0.27% of the first $41,667 of each insured Member's insured Predisability Earnings.
Non-professional employees:	0.59% of the first $41,667 of each insured Member's insured Predisability Earnings
Premium Due Dates:	January 1, 2019 and the first day of each calendar month thereafter.
Initial Rate Guarantee Period:	January 1, 2019 to January 1, 2023
Minimum Participation Number:	10 insured Members
Minimum Participation Percentage:	100% of eligible Members

INSURING CLAUSE

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

.IC.OT.1

BECOMING INSURED

To become insured you must be a Member, complete your Eligibility Waiting Period, and meet the requirements in **Active Work Provisions** and **When Your Insurance Becomes Effective**.

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. Actively At Work at least the minimum hours per week required by the Employer for coverage under the Program, but in no event less than 20 hours each week (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); and
3. A citizen or resident of the United States or Canada.

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

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.**

(VAR MBR DEF) LT.BI.OT.1X

WHEN YOUR INSURANCE BECOMES EFFECTIVE

Subject to the **Active Work Provisions**, your insurance becomes effective on the date you become eligible.

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 Material Duties 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.

LT.AW.OT.1

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.
2. The date the Group Policy terminates.
3. The date your Employer's coverage under the Group Policy terminates.
4. The date your employment terminates.
5. The date you cease to be a Member. 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 Benefit Waiting Period.

.EN.OT.1X

WAIVER OF PREMIUM

We will waive payment of premium for your insurance while LTD Benefits are payable.

.WP.OT.1

REINSTATEMENT OF INSURANCE

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

1. If you cease to be a Member because of a covered Disability following the Benefit Waiting Period, your insurance will end; however, if you become a Member again immediately after LTD Benefits end, the Eligibility Waiting Period will be waived.
2. If your insurance ends because you cease to be a Member for any reason other than a covered Disability, and if you become a Member again within 90 days, the Eligibility Waiting Period will be waived.
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.

.RE.OT.2X

DEFINITION OF DISABILITY

You are Disabled if you meet one of the following definitions during the period it applies:

A. Own Occupation Definition Of Disability;

B. Any Occupation Definition Of Disability; or

C. Partial Disability Definition.

A. Own Occupation Definition Of Disability

During the Benefit Waiting Period and the Own Occupation Period you are required to be Disabled only from your Own Occupation.

You are 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 Material Duties of your Own Occupation.

Note: You are not Disabled merely because your right to perform your Own Occupation is restricted, including a restriction or loss of license.

During the Own Occupation Period you may work in another occupation while you meet the Own Occupation Definition Of Disability. However, you will no longer be Disabled when your Work Earnings from another occupation meet or exceed 80% of your Indexed Predisability Earnings. Your Work Earnings may be Deductible Income. See **Return To Work Provisions** and **Deductible Income**.

Own Occupation means any employment, business, trade, profession, calling or vocation that involves Material Duties of the same general character as the occupation you are regularly performing for your Employer when Disability begins. In determining your Own Occupation, we are not limited to looking at the way you perform your job for your Employer, but we may also look at the way the occupation is generally performed in the national economy. If your Own Occupation involves the rendering of professional services and you are required to have a professional or occupational license in order to work, your Own Occupation is as broad as the scope of your license.

Material Duties means the essential tasks, functions and operations, and the skills, abilities, knowledge, training and experience, generally required by employers from those engaged in a particular occupation that cannot be reasonably modified or omitted. In no event will we consider working an average of more than 40 hours per week to be a Material Duty.

B. Any Occupation Definition Of Disability

During the Any Occupation Period you are required to be Disabled from all occupations.

You are Disabled from all occupations if, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder, you are unable to perform with reasonable continuity the Material Duties of Any Occupation.

Any Occupation means any occupation or employment which you are able to perform, whether due to education, training, or experience, which is available at one or more locations in the national economy and in which you can be expected to earn at least 80% of your Indexed Predisability Earnings within twelve months following your return to work, regardless of whether you are working in that or any other occupation.

Material Duties means the essential tasks, functions and operations, and the skills, abilities, knowledge, training and experience, generally required by employers from those engaged in a particular occupation that cannot be reasonably modified or omitted. In no event will we consider working an average of more than 40 hours per week to be a Material Duty.

C. Partial Disability Definition

During the Benefit Waiting Period and the Own Occupation Period, you are Partially Disabled when you work 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 Indexed Predisability Earnings, in that occupation.

Your Work Earnings may be Deductible Income. See **Return To Work Provisions** and **Deductible Income**.

Your Own Occupation Period and Any Occupation Period are shown in the **Coverage Features**.

(OR DEF_OWN_ANY_WITH 40) LT.DD.OT.1

RETURN TO WORK PROVISIONS

A. Return To Work Incentive

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

You are eligible for the Return To Work Incentive on the first day you work after the Benefit Waiting Period if LTD Benefits are payable on that date. The Return To Work Incentive changes 12 months after that date, as follows:

1. During the first 12 months, your Work Earnings will be Deductible Income as determined in a., b. and c:
   a. Determine the amount of your LTD Benefit as if there were no Deductible Income, and add your Work Earnings to that amount.
   b. Determine 100% of your Indexed Predisability Earnings.
   c. If a. is greater than b., the difference will be Deductible Income.
2. After those first 12 months, 50% of your Work Earnings will be Deductible Income.

B. Work Earnings Definition

Work Earnings means your gross monthly earnings from work you perform while Disabled, plus the earnings you could receive if you worked as much as you are able to, considering your Disability, in work that is reasonably available:

a. In your Own Occupation during the Own Occupation Period; and

b. In Any Occupation during the Any Occupation Period.

Work Earnings includes earnings from your Employer, any other employer, or self-employment, and 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 monthly, 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. During the Own Occupation Period you will no longer be Disabled when your average Work Earnings over the last three months exceed 80% of your Indexed Predisability Earnings. During the Any Occupation Period you will no longer be Disabled when your average Work Earnings over the last three months exceed 80% of your Indexed Predisability Earnings.

.RW.OT.1

REASONABLE ACCOMMODATION EXPENSE BENEFIT

If you return to work in any occupation for any employer, not including self-employment, as a result of a reasonable accommodation made by such employer, we will pay that employer a Reasonable Accommodation Expense Benefit of up to $25,000, but not to exceed the expenses incurred.

The Reasonable Accommodation Expense Benefit is payable only if the reasonable accommodation is approved by us in writing prior to its implementation.

.RA.OT.1

REHABILITATION PLAN PROVISION

While you are Disabled you may qualify to participate in a Rehabilitation Plan. Rehabilitation Plan means a written plan, program or course of vocational training or education that is intended to prepare you to return to work.

To participate in a Rehabilitation Plan you must apply on our forms or in a letter to us. The terms, conditions and objectives of the plan must be accepted by you and approved by us in advance. We have the sole discretion to approve your Rehabilitation Plan.

While you are participating in an approved Rehabilitation Plan, your LTD Benefit will be increased by 10% of your Predisability Earnings. Your LTD Benefit may not exceed the Maximum LTD Benefit shown in the **Coverage Features** as a result of this increase.

An approved Rehabilitation Plan may include our payment of some or all of the expenses you incur in connection with the plan, including:

a. Training and education expenses.

b. Family care expenses.

c. Job-related expenses.

d. Job search expenses.

(WITH REHAB INC BFT) LT.RH.OT.1

TEMPORARY RECOVERY

You may temporarily recover from your Disability 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 Periods

   1. During the Benefit Waiting Period: 45 consecutive days of recovery.

   2. During the Maximum Benefit Period: 125 consecutive work days for each period of recovery.

B. Effect Of Temporary Recovery

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

   1. The Predisability Earnings used to determine your LTD Benefit will not change.

   2. The period of Temporary Recovery will not count toward your Benefit Waiting Period, your Maximum Benefit Period or your Own Occupation Period.

   3. No LTD Benefits will be payable for the period of Temporary Recovery.

4. No LTD Benefits will be payable after benefits become payable to you under any other disability insurance plan under which you become insured 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.

(NEW TR PERIOD) LT.TR.OT.1

WHEN LTD BENEFITS END

Your LTD 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 benefits become payable under any other disability insurance plan under which you become insured through employment during a period of Temporary Recovery.
5. The date you fail to provide proof of continued Disability and entitlement to LTD Benefits.

.BE.OT.1

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. The Member's LTD Benefit will not be adjusted to reflect any salary increase awarded during the period covered by LTD Benefits.

Predisability Earnings means your monthly rate of creditable compensation 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.

Predisability Earnings does not include:

1. Bonuses.
2. Commissions.
3. Overtime pay.
4. Stock options or stock bonuses.
5. Your Employer's contributions on your behalf to any deferred compensation arrangement or pension plan.
6. Any other extra compensation.

If you are paid on an annual contract basis, your monthly rate of creditable compensation is one-twelfth (1/12th) of your annual contract salary.

If you are paid hourly, your monthly rate of creditable compensation is based on your hourly pay rate multiplied by the number of hours you are regularly scheduled to work per month, 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 during the preceding 12 calendar months (or during your period of employment if less than 12 months), but not more than 173 hours.

(REG NO COM_NO STOCK) LT.PD.OT.1X

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, including donated amounts, (but not vacation pay) paid to you by your Employer, if it exceeds the amount found in a., b., and c.

   a. Determine the amount of your LTD Benefit as if there were no Deductible Income, and add your sick pay or other salary continuation to that amount.

   b. Determine 100% of your Indexed Predisability Earnings.

   c. If a. is greater than b., the difference will be Deductible Income.

2. Your Work Earnings, as described in the **Return To Work Provisions**.

3. Any amount you receive or are eligible to receive because of your disability, including amounts for partial or total disability, whether permanent, temporary, or vocational, under any of the following:

   a. A workers' compensation law;

   b. The Jones Act;

   c. Maritime Doctrine of Maintenance, Wages, or Cure;

   d. Longshoremen's and Harbor Worker's Act; or

   e. Any similar act or law.

4. Any amount you, your Spouse, or your child under age 18 receive or are eligible to receive because of your disability or retirement under:

   a. The Federal Social Security Act;

   b. The Canada Pension Plan;

   c. The Quebec Pension Plan;

   d. The Railroad Retirement Act; or

   e. Any similar plan or act.

   Full offset: Both the primary benefit (the benefit awarded to you) and dependents benefit are Deductible Income.

   Benefits your Spouse or a child receives or are eligible to receive because of your disability are Deductible Income regardless of marital status, custody, or place of residence. The term "child" has the meaning given in the applicable plan or act.

5. Any amount you receive or are eligible to receive because of your disability under any state disability income benefit law or similar law.
6. Any amount you receive or are eligible to receive because of your disability under another group insurance coverage.
7. Any disability or retirement benefits you receive under your Employer's retirement plan.
8. Any earnings or compensation included in Predisability Earnings which you receive or are eligible to receive while LTD Benefits are payable.
9. Any amount you receive or are eligible to receive under any unemployment compensation law or similar act or law.
10. 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.

(DOM_NO OTHR OFFST_PRIV_NO 3RD) LT.DI.OT.1

EXCEPTIONS TO DEDUCTIBLE INCOME

Deductible Income does not include:

1. Any cost of living increase 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. Early retirement benefits under the Federal Social Security Act which are not actually received.
6. Group credit or mortgage disability insurance benefits.
7. Accelerated death benefits paid under a life insurance policy.
8. Benefits from the following:
   a. Profit sharing plan.
   b. Thrift or savings plan.
   c. Deferred compensation plan.
   d. Plan under IRC Section 401(k), 408(k), 408(p), or 457.
   e. Individual Retirement Account (IRA).
   f. Tax Sheltered Annuity (TSA) under IRC Section 403(b).
   g. Stock ownership plan.
   h. Keogh (HR-10) plan.
9. Any amount you receive from a military disability benefit.

(PUB_NO OTHR OFFST) LT.ED.OT.1X

RULES FOR DEDUCTIBLE INCOME

A. Monthly Equivalents

Each month we will determine your LTD Benefit using the Deductible Income for the same monthly period, even if you actually receive the Deductible Income in another month.

If you are paid Deductible Income in a lump sum or by a method other than monthly, we will determine your LTD 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 eligible. 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. Otherwise, we may reduce your LTD Benefits by the amount we estimate you would be eligible to receive upon proper pursuit of the Deductible Income.

C. 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.

D. 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 LTD Benefits until we have been repaid in full. In the meantime, any LTD Benefits paid, including the Minimum LTD 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.

.RU.OT.1

ADDITIONAL BENEFITS FOR THE SEVERELY DISABLED

A. Assisted Living Benefit

If you meet the requirements in 1 through 3 below, we will pay Assisted Living Benefits according to the terms of the Group Policy after we receive Proof Of Loss satisfactory to us.

Requirements for Assisted Living Benefit

1. You are Disabled and LTD Benefits are payable to you.
2. While you are Disabled:
   a. You, due to loss of functional capacity as a result of Physical Disease or Injury, become unable to safely and completely perform two or more Activities Of Daily Living without Hands-on Assistance or Standby Assistance; or
   b. You require Substantial Supervision for your health or safety due to Severe Cognitive Impairment as a result of Physical Disease or Injury.
3. The condition in 2.a or 2.b above is expected to last 90 days or more as certified by a Physician in the appropriate specialty as determined by us.

B. Amount Of The Assisted Living Benefit

See the **Coverage Features** for the amount of the Assisted Living Benefit.

C. Becoming Insured For Assisted Living Benefits

You are eligible for Assisted Living Benefit coverage if you are insured for LTD insurance. Subject to the **Active Work Provision**, your Assisted Living Benefit coverage becomes effective on the date your LTD insurance becomes effective.

D. Payment Of Assisted Living Benefits

We will pay Assisted Living Benefits within 60 days after Proof Of Loss is satisfied. Your Assisted Living Benefits will be paid to you at the same time LTD Benefits are payable.

E. Time Limits On Filing Proof Of Loss

Proof Of Loss for the Assisted Living Benefit must be provided within 90 days after the date the inability to perform Activities Of Daily Living or the Severe Cognitive Impairment begins. If that is not possible, it must be provided 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, the claim will be denied. These limits will not apply while the claimant lacks legal capacity.

F. When Assisted Living Benefits End

Assisted Living Benefits end automatically on the earliest of:

1. The date you no longer meet the requirements in item A. above.
2. The date your LTD Benefits end.

G. When Assisted Living Benefits Coverage Ends

Assisted Living Benefit coverage ends automatically on the earliest of:

1. The date your LTD insurance ends.
2. The date Assisted Living Benefit coverage terminates under the Group Policy.

H. Assisted Living Benefits After Insurance Ends Or Is Changed

Your right to receive Assisted Living Benefits will not be affected by the occurrence of the events described in 1 or 2 below that become effective after you become Disabled.

1. Termination or amendment of the Group Policy or your Employer's coverage under the Group Policy.
2. Termination of Assisted Living Benefit coverage while the Group Policy or your Employer's coverage under the Group Policy remains in force.

I. Assisted Living Benefit Limitations

No Assisted Living Benefit will be paid for any period when you are confined for any reason in a penal or correctional institution.

No Assisted Living Benefit will be paid if your inability to perform Activities Of Daily Living or your Severe Cognitive Impairment is caused or contributed to by:

1. 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.
2. Any intentionally self-inflicted Injury, while sane or insane.
3. Committing or attempting to commit an assault or felony, or active participation in a violent disorder or riot. (Active participation does not include being at the scene of a violent disorder or riot while performing official duties.)

J. Definitions

1. Activities Of Daily Living means Bathing, Continence, Dressing, Eating, Toileting, or Transferring.
2. Bathing means washing oneself, whether in the tub or shower or by sponge bath, with or without the help of adaptive devices.

3. Continence means voluntarily controlling bowel and bladder function, or, if incontinent, maintaining a reasonable level of personal hygiene.

4. Dressing means putting on and removing all items of clothing, footwear, and medically necessary braces and artificial limbs.

5. Eating means getting food and fluid into the body, whether manually, intravenously, or by feeding tube.

6. Toileting means getting to and from and on and off the toilet, and performing related personal hygiene.

7. Transferring means moving into or out of a bed, chair or wheelchair, with or without adaptive devices.

8. Hands-on Assistance means the physical assistance of another person without which the insured would be unable to perform the Activity Of Daily Living.

9. Standby Assistance means the presence of another person within arm's reach of the insured that is necessary to prevent, by physical intervention, injury to the insured while the insured is performing the Activity Of Daily Living (such as being ready to catch the insured if the insured falls while getting into or out of the bathtub or shower as part of Bathing, or being ready to remove food from the insured's throat if the insured chokes while Eating).

10. Severe Cognitive Impairment means a loss or deterioration in intellectual capacity that is (a) comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia, and (b) is measured by clinical evidence and standardized tests approved by us that reliably measure impairment in (i) short-term or long-term memory, (ii) orientation as to people, places, or time, and (iii) deductive or abstract reasoning.

11. Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect you from threats to your health or safety (such as may result from wandering).

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SURVIVORS BENEFIT

If you die while LTD Benefits are payable, and on the date you die you have been continuously Disabled for at least 180 days, we will pay a Survivors Benefit according to 1 through 3 below.

1. The Survivors Benefit is a lump sum equal to 3 times your LTD Benefit without reduction by Deductible Income.

2. The Survivors Benefit will first be applied to reduce any overpayment of your claim.

3. The Survivors Benefit will be paid at our option to any one or more of the following:

   a. Your surviving Spouse;

   b. Your surviving unmarried children, including adopted children, under age 25;

   c. Your surviving Spouse's unmarried children, including adopted children, under age 25; or

   d. Any person providing the care and support of any person listed in a., b., or c. above.

   e. Your estate, if you are not survived by any person listed in a., b., or c. above.

(MULTPL_EST_DOM) LT.SB.OT.1

BENEFITS AFTER INSURANCE ENDS OR IS CHANGED

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

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

.BA.OT.1

EFFECT OF NEW DISABILITY

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

1. LTD Benefits will not continue beyond the end of the original Maximum Benefit Period.
2. The **Disabilities Excluded From Coverage, Disabilities Subject To Limited Pay Periods,** and **Limitations** sections will apply to the new cause of Disability.

.ND.OT.1

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. Preexisting Condition

This Group Policy does not include a Preexisting Condition Exclusion.

D. Loss Of License Or Certification

You are not covered for a Disability caused or contributed to by the loss of your professional license, occupational license or certification.

E. Violent Or Criminal Conduct

You are not covered for a Disability caused or contributed to by your committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing your official duties.

(NO PX) LT.XD.OT.1X

LIMITATIONS

A. Care Of A Physician

You must be under the ongoing care of a Physician in the appropriate specialty as determined by us during the Benefit Waiting Period. No LTD Benefits will be paid for any period of Disability when you are not under the ongoing care of a Physician in the appropriate specialty as determined by us.

B. Imprisonment

No LTD Benefits will be paid for any period of Disability when you are confined for any reason in a penal or correctional institution.

C. Substance Abuse

No LTD Benefits will be paid for any period of Disability caused or contributed to by your Substance Abuse, unless you are participating in good faith in a treatment plan, program or course of medical treatment for Substance Abuse.

Substance Abuse means abuse of alcohol, alcoholism, misuse of any drug, including hallucinogens, or drug addiction.

D. Rehabilitation Program

LTD Benefits will be reduced to 50% of the amount determined from the Schedule Of Insurance for any period of Disability when you are not participating in good faith in a plan, program or course of medical treatment or vocational training or education approved by us, unless your Disability prevents you from participating. If this limitation causes the LTD Benefit to be less than the Minimum LTD Benefit, the Minimum LTD Benefit will be payable.

(NO FRGN) LT.LM.OT.1X

CLAIMS

A. 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.

B. 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 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.

C. Proof Of Loss

Proof Of Loss means written proof that you are Disabled and entitled to LTD 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.

D. 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.

E. Investigation Of Claim

During the pendency of your 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 LTD Benefits if you fail to attend an examination or cooperate with the examiner.

F. Time Of Payment

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

LTD Benefits will be paid to you at the end of each month you qualify for them. LTD Benefits remaining unpaid at your death will be paid to the person(s) receiving the Survivors Benefit. If no Survivors Benefit is paid, the unpaid LTD Benefits will be paid to your estate.

G. 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. A description of any additional information needed to support your claim.

d. Information concerning your right to a review of our decision.

H. 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. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.

I. Assignment

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

(REV PUB WRDG) LT.CL.VA.2

ALLOCATION OF AUTHORITY

Except for those functions which the Group Policy specifically reserves to the Policyholder or Employer, we have full and exclusive authority to control and manage the Group Policy, to administer claims, and to interpret the Group Policy and resolve all questions arising in the administration, interpretation, and application of the Group Policy.

Our authority includes, but is not limited to:

1. The right to resolve all matters when a review has been requested;
2. The right to establish and enforce rules and procedures for the administration of the Group Policy and any claim under it;
3. The right to determine:
   a. Eligibility for insurance;
   b. Entitlement to benefits;
   c. The amount of benefits payable; and
   d. The sufficiency and the amount of information we may reasonably require to determine a., b., or c., above.

Subject to the review procedures of the Group Policy, any decision we make in the exercise of our authority is conclusive and binding.

.AL.OT.1

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 more than three years after the earlier of:

1. The date we receive Proof Of Loss; and
2. The time within which Proof Of Loss is required to be given.

LT.TL.OT.1

INCONTESTABILITY PROVISIONS

A. Incontestability Of Insurance

Any statement made to obtain insurance 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 other person claiming benefits a copy of the signed written instrument which contains the misrepresentation.

After insurance has been in effect for two years during the lifetime of the insured, we will not use a misrepresentation to reduce or deny the 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 nonpayment of premiums or fraudulent misrepresentations.

LT.IN.OT.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 premiums paid and the premiums which would have been paid if the age had been correctly stated.

LT.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.

LT.TA.OT.1

DEFINITIONS

Benefit Waiting Period means the period you must be continuously Disabled before LTD Benefits become payable. No LTD 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.

CPI-W means the Consumer Price Index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. If the CPI-W is discontinued or changed, we may use a comparable index. Where required, we will obtain prior state approval of the new index.

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 LTD insurance policy issued by us to the Policyholder and identified by the Group Policy Number.

Indexed Predisability Earnings means your Predisability Earnings adjusted by the rate of increase in the CPI-W. During your first year of Disability, your Indexed Predisability Earnings are the same as your Predisability Earnings. Thereafter, your Indexed Predisability Earnings are determined on each anniversary of your Disability by increasing the previous year's Indexed Predisability Earnings by the rate of increase in the CPI-W for the prior calendar year. The maximum adjustment in any year is 10%. Your Indexed Predisability Earnings will not decrease, even if the CPI-W decreases.

Injury means an injury to the body.

LTD Benefit means the monthly benefit payable to you under the terms of Group Policy.

Maximum Benefit Period means the longest period for which LTD 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 LTD Benefits are payable after the end of the Maximum Benefit Period, even if you are still Disabled. See **Coverage Features**.

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 the body as diagnosed by a Physician.

Physician means a licensed M.D. or D.O., acting within the scope of the license. Physician does not include you or your Spouse, or the brother, sister, parent, or child of either you or your Spouse.

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

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

Spouse means:

1. A person to whom you are legally married and from whom you are not legally separated; 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.

(DOM) LT.DF.OT.1

POLICYHOLDER PROVISIONS

A. Premiums

The premium due on each Premium Due Date is the sum of the premiums for all persons then insured. Premium Rates are shown in **Coverage Features**.

B. Contributions From Members

The Policyholder determines the amount, if any, of each Member's contribution toward the cost of insurance.

C. Changes In Premium Rates

We may change Premium Rates whenever:

1. A change or clarification in law or governmental regulation affects the amount payable under the Group Policy. Any such change in Premium Rates will reflect only the change in our obligations.
2. Factors material to underwriting the risk we assumed under the Group Policy with respect to an Employer, including, but not limited to, number of persons insured, age, Predisability Earnings, gender, and occupational classification, changes by 25% or more.
3. The premium contribution arrangement for Members is changed or varies from that stated in the Group Policy when issued or last renewed.
4. We and the Policyholder or the Employer mutually agree to change Premium Rates.

Except as provided above, Premium Rates will not be changed during the Initial Rate Guarantee Period shown in **Coverage Features**. Thereafter, except as provided above, we may change Premium Rates upon 180 days advance written notice to the Policyholder. Any such change in Premium Rates may be made effective on any Premium Due Date, but no such change will be made more than once in any contract year. Contract years are successive 12 month periods computed from the end of the Initial Rate Guarantee Period.

D. Payment Of Premiums

All premiums are due on the Premium Due Dates shown in **Coverage Features**.

Each premium is payable on or before its Premium Due Date directly to us at our home office. The payment of each premium by the Policyholder as it becomes due will maintain the Group Policy in force until the next Premium Due Date.

E. Grace Period And Termination For Nonpayment

If a premium is not paid on or before its Premium Due Date, it may be paid during the following Grace Period of 31 days. The Group Policy or an Employer's coverage under the Group Policy will remain in force during the Grace Period.

If the premium is not paid during the Grace Period, the Group Policy will terminate automatically at the end of the Grace Period.

The Policyholder is liable for premium for coverage during the Grace Period. We may charge interest at the legal rate for any premium which is not paid during the Grace Period, beginning with the first day after the Grace Period.

F. Termination For Other Reasons

The Policyholder may terminate the Group Policy by giving us written notice. The effective date of termination will be the later of:

1. The date stated in the notice; and
2. The date we receive the notice.

We may terminate the Group Policy as follows:

1. On any Premium Due Date if the number of persons insured is less than the Minimum Participation shown in **Coverage Features**.
2. On any Premium Due Date if we determine that the Policyholder has failed to promptly furnish any necessary information requested by us, or has failed to perform any other obligations relating to the Group Policy.

The minimum advance notice of termination by us is 60 days.

G. Premium Adjustments

Premium adjustments involving a return of unearned premiums to the Policyholder will be limited to the 12 months just before the date we receive a request for premium adjustment.

H. Certificates

We will issue certificates to the Policyholder showing the coverage under the Group Policy. The Policyholder will distribute a certificate to each insured Member. If the terms of the certificate differ from the Group Policy, the terms stated in the Group Policy will govern.

I. Records And Reports

The Policyholder will furnish on our forms all information reasonably necessary to administer the Group Policy. We have the right at all reasonable times to inspect the payroll and other records of the Policyholder which relate to insurance under the Group Policy.

J. Agency And Release

Individuals selected by the Policyholder or by any Employer to secure coverage under the Group Policy or to perform their administrative function under it, represent and act on behalf of the person selecting them, and do not represent or act on behalf of Standard. The Policyholder, Employer and such individuals 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. The Policyholder and each Employer hereby release, hold harmless and indemnify Standard from any liability arising from or related to any negligence, error, omission, misrepresentation or dishonesty of any of them or their representatives, agents or employees.

K. Notice Of Suit

The Policyholder or Employer shall promptly give us written notice of any lawsuit or other legal proceedings arising under the Group Policy.

L. Entire Contract, Changes

The Group Policy and the applications of the Policyholder constitute the entire contract between the parties. A copy of the Policyholder's application is attached to the Group Policy when issued.

The Group Policy may be changed in whole or in part. No change in the Group Policy 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. No agent has authority to change the Group Policy, or to waive any of their provisions.

M. Effect On Workers' Compensation, State Disability Insurance

The coverage provided under the Group Policy is not a substitute for coverage under a workers' compensation or state disability income benefit law and does not relieve the Employer of any obligation to provide such coverage.

(NO DIV) LT.PH.OT.1

VA/LTDP2000X

Exhibit E

STANDARD INSURANCE COMPANY

A Stock Life Insurance Company

900 SW Fifth Avenue
Portland, Oregon 97204-1282
(503) 321-2700

DISABILITY PROGRAM ADMINISTRATIVE SERVICES AGREEMENT

Program Sponsor:	County of Henrico, Virginia Including Henrico County Public Schools and Henrico Economic Development Authority
Claims Administrator:	Standard Insurance Company
ATP Number:	649721-B
Effective Date:	January 1, 2019

Note: The terms of this Agreement are not governed under the terms of any Master Service Agreement issued by Standard Insurance Company in conjunction with any others services provided to Program Sponsor.

Program Sponsor has adopted a self-funded short-term disability income benefit plan (Program) for certain of its employees. Program Sponsor is solely responsible for all risks, liabilities, benefits and claims under the Program.

Program Sponsor has requested Standard to provide administrative services to the Program as described in this Agreement. Standard is willing to provide such services, according to the terms of this Agreement, without assuming any financial responsibility under the Program.

Standard's willingness to provide administrative services is conditioned upon Program Sponsor's agreement that Standard is not responsible for any risk, liability, benefit or claim under the Program and upon Program Sponsor fulfilling its obligations as provided herein.

LIMITED AGENCY APPOINTMENT OF STANDARD

Program Sponsor hereby appoints Standard to act on its behalf as Claims Administrator for the Program and grants to Standard authority to fulfill the Obligations of Claims Administrator, as provided herein. Standard is empowered to act on behalf of Program Sponsor in connection with the Program only as expressly stated in this Agreement. Standard has no authority or obligation with respect to (1) Program Sponsor's right of subrogation under the Program, or (2) management or investment of the assets of the Program. In performing its obligations under this Agreement, Standard is acting solely as the agent of Program Sponsor.

OBLIGATIONS OF CLAIMS ADMINISTRATOR

Standard, acting as Claims Administrator for the Program, shall provide the following services, consistent with the terms of the Program:

A. Claims Services

1) Investigate claims for benefits under the Program, determine eligibility for coverage, make initial claim decisions to approve, deny or close claims for benefits, and notify claimants and Program Sponsor in writing of its decisions, subject to Program Sponsor's right of final review and decision on all claims.

2) If an appeal is requested by the claimant, provide an independent review and notify claimant and Program Sponsor in writing of Standard's decision, subject to Program Sponsor's right of final review and decision on all appeals.

3) Advise and assist Program Sponsor on procedures to be followed in submission of claims, including the preparation of forms necessary for submission and processing of claims.

4) Create and maintain a current and complete claim file for any claim presented to Standard for administration under the Program.

5) Submit to Program Sponsor all claims Program Sponsor may request to review.

6) If applicable, prepare benefit statements for claimants setting forth the benefit schedule applicable and explaining any adjustments.

7) Have medical and vocational examinations of claimants performed as Standard deems advisable.

8) Advise claimants concerning the need to apply for deductible income and periodically verify application for or receipt of deductible income.

9) Review claims to determine continued eligibility for benefits as frequently as claimant's condition warrants.

10) Defend, at its expense, claim litigation arising out of or relating to, in whole or in part, from the performance of Standard's Claims Administrator obligations under this Agreement. However, the Program Sponsor, not Standard, is financially responsible for the risks, liabilities and benefits of the Program. Standard shall be empowered to judge the acceptability of any compromise and to settle any such liability. Prior to entering into any settlement or compromise on behalf of Program Sponsor, Standard will make a recommendation to Program Sponsor for approval, which approval shall not be unreasonably withheld.

    In the event that Program Sponsor does not approve of Standard's recommendation, or overturns Standard's decision as set forth in item 2 above, Employer will be responsible for any obligation to defend.

B. Program Document Services

1) Advise and assist Program Sponsor with regard to the initial preparation of the Program and recommend subsequent revisions as may be appropriate.

2) Advise and assist Program Sponsor with regard to the preparation and review of Program summaries, descriptive booklets, certificates of coverage and similar material for distribution to covered employees.

C. Performance Standards

Standard and Program Sponsor each shall exercise ordinary care and reasonable diligence in the performance of its duties under this Agreement. Standard and Program Sponsor will not be liable for any mistake of judgment taken in good faith. Further, Standard shall not be considered to have failed to perform its obligations under this Agreement if any delay or nonperformance on its part is due, in whole or in part, to failure of the other party to discharge its own obligations promptly.

OBLIGATIONS OF PROGRAM SPONSOR

Program Sponsor shall:

A. Retain full financial responsibility for the Program and its operation.

B. Furnish any information reasonably required by Standard to carry out Standard's duties under this Agreement, including but not limited to relevant program documents and any other administrative guidance necessary to administer the program.

C. Review Standard's claim and appeal decisions in a timely manner. If Program Sponsor fails to notify Standard in writing of any objection it may have to any such decision within 45 days after notice thereof from Standard, Program Sponsor shall be deemed to have waived such objection and shall be conclusively presumed to have ratified and approved Standard's decision.

D. Pay benefits according to the terms of the Program.

E. Establish and maintain such accounts and records as may be required in accordance with this Agreement.

F. Provide Standard with all amendments or modifications to the Program at least 60 days prior to the proposed effective date of the change. Standard shall have no obligation to administer any such change unless and until approved by Standard, which approval shall not be unreasonably withheld. Standard retains the right to modify the **Fees** to reflect any additional services or expenses required by such change.

G. Provide Standard in writing with the names of individuals authorized to act for Program Sponsor in connection with this Agreement, together with a statement of the extent of their authority.

H. Identify Standard as Claims Administrator in relevant Program documents and related materials. Any other use of Standard's name in connection with Program administration must be authorized in advance and in writing by Standard.

BENEFIT PAYMENTS

Benefits payable under the Program will be paid by Program Sponsor.

FEES

A. Fees

Program Sponsor shall pay fees to Standard in connection with Standard's services under this Agreement as follows.

MONTHLY GENERAL FEE. The Monthly General Fee shall be the sum of the monthly fees due for all Employers covered under the Program on that due date. The monthly fee shall be as stated in the final proposal accepted by Program Sponsor.

ADDITIONAL FEES. Additional Fees may be charged to Program Sponsor upon mutual agreement between Program Sponsor and Standard.

B. Change in Fee Rates

1) Standard may change the amount, the method of determination, or both, of any fees not yet due, when a change in any law or regulation affects the manner in which Standard performs any function under this Agreement. The amount, the method of determination, or both, of any fees not yet due may also be changed upon mutual agreement between Program Sponsor and Standard.

2) Except as provided in Paragraph 1) of this section:

a. Fees will not be changed during the first four years the Agreement is in effect, provided that this limitation shall not apply to any changes in fees in connection with any change in the terms of this Agreement or the Program.

b. Thereafter Standard may change the amount, the method of determination, or both, of any fees not yet due, upon 180 days written notice to Program Sponsor. Except as provided in Paragraph 1) of this section, no such change in fees shall be made more than once in any Contract Year, provided that this limitation shall not apply to any changes in fees in connection with any change in the terms of this Agreement or the Program.

C. Payment Due Dates

All fees are due and payable within 60 days after the notice by Standard has been sent to Program Sponsor of the amount owed.

INTEREST ON LATE PAYMENTS

Program Sponsor shall pay Standard interest at a rate equal to the Wells Fargo Bank and Co. prime rate plus two percent (2%) per annum, or the highest rate permitted by applicable law, whichever is less, on any sums payable to Standard pursuant to this Agreement which are not paid by Program Sponsor on or before the date on which such sums are due.

INDEMNIFICATION AGREEMENT

A. Standard agrees to indemnify, defend, and hold Program Sponsor, including directors, officers, and employees, from any and all, liabilities, claims, lawsuits, administrative proceedings, settlements, compromises, judgments, penalties, costs and expenses, including but not limited to, attorney's fees, pretrial discovery, deposition and investigation expenses, compensatory, consequential, special, exemplary and punitive damages arising out of or relating to, in whole or in part, any negligent act or omission, criminal conduct or fraud, or intentional failure to perform any obligation under the Program or this Agreement.

B. Nothing in this **Indemnification Agreement** section is intended to or does alter the obligations of the Program Sponsor to bear full financial responsibility for any benefits payable under the

Program or to defend litigation related to such benefits as set forth in **Obligations Of Program Sponsor**.

RECORDS AND CLAIM FILES

A. All claim files, records, reports, and other information prepared and maintained by Standard pursuant to this Agreement shall be the sole property of Program Sponsor, subject to Standard's right to retain copies of any such information.

B. Upon reasonable written request, and during regular business hours Program Sponsor shall have the right to inspect any claim file and any other record or report, including but not limited to, records relating to payments of benefits which have been prepared and maintained by Standard, pursuant to this Agreement.

C. All claim files and other records and reports prepared and maintained by Standard pursuant to this Agreement shall be confidential. Standard shall take such measures as are reasonably necessary to preserve the confidentiality of such claim files, records and reports. No individually identifiable information will be released from any such claim file, except as follows:

   1) In response to a court order.

   2) For an examination conducted by regulatory authorities.

   3) At the request of the Program Sponsor.

   4) With the written consent of the identified individual or his or her legal representative.

   Pursuant to the **Obligations Of Program Sponsor** section of this Agreement, Program Sponsor shall designate employees or agents who are authorized to receive individually identifiable claim information on behalf of Program Sponsor. Standard may rely upon such authorizations until receipt of written instructions changing such authorizations.

D. Any individually identifiable claim information released to Program Sponsor pursuant to this Agreement shall be treated as confidential. Program Sponsor shall protect such information from unauthorized disclosure.

E. Claim files, records, reports and other information prepared and maintained by Standard pursuant to this Agreement may be destroyed by Standard at anytime after seven years. With respect to claim files, the seven-year period begins on the date benefits cease to be paid to the claimant. Program Sponsor may receive an inactive claim file at anytime within the first 60 days after benefits cease by sending a written request to Standard and payment of Standard's reasonable shipping and handing costs.

AMENDMENT

This Agreement constitutes the entire contract between the parties, superseding all prior or contemporaneous written or oral understandings and agreements. No modification or amendment of this Agreement shall be valid unless made in writing and signed by each party.

ASSIGNMENT AND MISCELLANEOUS PROVISIONS

A. Neither party shall assign this contract without the prior written consent of the other party.

B. Standard will not be bound by any notice, direction, requisition, or request unless and until it is received in writing at Standard's Home Office at Portland, Oregon.

C. This Agreement shall be deemed to have been entered into in the Commonwealth of Virginia and all questions concerning validity, interpretation, or performance of any of its terms or provisions or of any rights or obligations of the parties to this Agreement, shall be governed by and resolved in accordance with the laws of Commonwealth of Virginia.

D. Captions of the parts, sections, and paragraphs of this Agreement are for convenience and reference only, and the words contained in such captions shall in no way be employed to explain, modify, amplify, or aid in the interpretation, construction, or meaning of the provisions of this Agreement.

E. Standard has not and will not provide legal advice, legal opinions or other legal services to Program Sponsor in establishing or maintaining the Program or relative to this Agreement. Program Sponsor will rely solely upon the advice of its own legal counsel in evaluating the legal aspects of the Program and this Agreement.

F. Each party shall promptly give the other written notice of any claim, lawsuit, or administrative proceeding concerning a claim for benefits under the Program or any other matter embraced by the indemnity. The parties shall cooperate fully in the defense of any such claim, lawsuit, or proceeding.

G. If litigation arises out of this Agreement, the parties agree that each party shall bear its own litigation costs and attorneys fees, unless there is a court order to the contrary.

TERM AND TERMINATION

A. Contract Years are successive twelve month periods computed from the effective date of this Agreement. The date of termination of this Agreement, unless otherwise specified, shall be deemed to be the last day of a Contract Year.

B. This Agreement may be terminated by either party upon sixty (60) days written notice of termination provided to the other party.

C. This Agreement will terminate automatically on the date of termination of any group long term disability insurance policy issued to Program Sponsor by Standard.

D. Program Sponsor's failure to pay **Fees** or to reimburse Standard for payment of benefits pursuant to **Benefit Payments**, and the provisions below in **Term And Termination** or Program Sponsor's failure to fulfill its obligations under **Indemnification Agreement**, shall terminate this Agreement upon written notice by Standard to be delivered to Program Sponsor at its last known address.

E. Effect of Termination.

1) Claims Administration

Notwithstanding termination of this Agreement, the Standard will continue to provide claim services with respect to any claim for benefits under the Program with an incurred date occurring on or before the date of termination. Program Sponsor shall see to it that any such claim is immediately sent to Standard. Standard may administer any such claim until it determines the claim is inactive. The terms and provision of this Agreement shall continue to apply where applicable to the runoff of such claims, specifically including Program Sponsor's obligation to pay benefits according to the terms of the Program.

2) Claims Records

Standard may retain any open or active claim files as provided in item E.1 above of the **Term And Termination** section of this Agreement. Any such files not retained by Standard shall be sent to Program Sponsor or its successor administrator promptly upon payment of Standard's reasonable shipping and handling costs.

Standard shall retain all inactive claim files and other records and reports relating to such claims and prepared and maintained by Standard pursuant to this Agreement, and may destroy such files, etc. as provided in Records and Claim File provision. Program Sponsor may obtain possession of such extant claim files, records and reports upon written request to Standard and payment of Standard's reasonable shipping and handling costs. Program Sponsor acknowledges that locating and processing such files and records may be difficult and time consuming and will substantially increase the shipping and handling costs it is obligated to pay.

F. Outstanding Obligations

Notwithstanding any other provision of this Agreement to the contrary, the termination of this Agreement shall not release either party from any obligation already incurred, including any payment obligation already incurred under the **Fees** or **Benefit Payments** provision**.** Further, provisions of the **Indemnification Agreement** and defense obligations under **Obligation Of Program Sponsor,** and the confidentiality provisions under **Records And Claim Files** sections will not be affected by the termination of this Agreement and will remain in full force and effect.

IN WITNESS WHEREOF, the parties hereto have caused this agreement to be executed in duplicate by their respective officers duly authorized to do so.

Program Sponsor:

By _____ Date _____

STANDARD INSURANCE COMPANY

By

Chairman, President and CEO

Corporate Secretary

Exhibit F

HENRICO COUNTY, VIRGINIA

PROGRAM DOCUMENT

SHORT TERM DISABILITY INCOME BENEFIT PROGRAM

Program Sponsor has established a short term disability income benefit Program and agreed to provide STD Benefits according to the terms of this Program Document. Program Sponsor is solely responsible for payment of STD Benefits payable under the terms of this Program.

Program Sponsor has retained Standard Insurance Company as Claims Administrator for the Program. Standard shall receive, process, investigate and evaluate claims for benefits. Standard has authority to make initial decisions to approve, deny or close claims for benefits. Standard is also authorized to review and decide appeals of denied or closed claims, if requested by claimants as provided in the appeal provision of the Program. Thereafter, Program Sponsor may elect to hear and decide any further appeals by claimants. In each case, Program Sponsor retains the right of final review and decision on all claims and appeals.

Standard will also perform certain administrative services for the Program, including advising and assisting Program Sponsor with preparation and revision of the Program and providing actuarial services. Standard has no authority or obligation with respect to management or investment of the assets of the Program or Program Sponsor's right of subrogation under the Program.

This Program and the individual applications, if any, of the Members constitute the entire Program. Program Sponsor has the right at anytime to amend or terminate this Program or to require or change the amount of Member contributions. No change in this Program will be valid unless approved by Program Sponsor and evidenced by an amendment. No agent has authority to change this Program or to waive any of its provisions.

For purposes of effective dates and ending dates under this Program, all days begin and end at 12:00 midnight Standard Time at Program Sponsor's address.

All provisions on this and the following pages are part of this Program. "You" and "your" mean the Member. "We", "us", and "our" mean Standard Insurance Company acting in its capacity as Claims Administrator on behalf of Program Sponsor. Other defined terms appear with their initial letters capitalized. Section headings, and references to them, appear in boldface type.

PROGRAM SPONSOR

By

_____

_____

Signature(s) and Title(s) of Authorized Representative(s)

Table of Contents

Index of Defined Terms

COVERAGE FEATURES

This section contains many of the features of your short term disability (STD) coverage. 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 PROGRAM INFORMATION

Program Sponsor:	Henrico County, Virginia
Employer(s):	Henrico County General Government, Henrico County Public Schools, the Henrico County Economic Development Authority
Claims Administrator:	Standard Insurance Company
ATP Number:	649721-B
Program Effective Date:	January 1, 2019

Member means:

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. Actively At Work at least the minimum hours per week required by the Employer for coverage under the Program, but in no event less than 20 hours each week (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); and
3. A citizen or resident of the United States or Canada.

Member does not include a temporary or seasonal employee, a full-time member of the armed forces of any country, a leased employee, or an independent contractor.

Class Definition: None

SCHEDULE OF COVERAGE

Eligibility Waiting Period: You are eligible on one of the following dates, but not before the Program Effective Date:

a. With respect to coverage for a Disability arising out of or in the course of employment with the Employer, your first day as a Member.

b. With respect to coverage for any other Disability, the first day after one year employment with the Employer.

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

STD Benefit:

For a Disability arising out of or in the course of employment with the Employer:

The STD Benefit provides income replacement for (i) 60 percent of a Member's Predisability Earnings for the first 60 months of continuous participation in the Virginia hybrid retirement program described in § 51.1-169 of the Code of Virginia and (ii) thereafter, a percentage of a Member's Predisability Earnings during the periods specified below, based on the number of months of continuous participation in the Virginia hybrid retirement program attained by an employee who is disabled, on maternity leave, or takes periodic absences due to a major chronic condition, as determined by the Board or its designee, as follows:

Months of Continuous Participation	Work days of 100% Replacement of Creditable Compensation	Work days of 80% Replacement of Creditable Compensation	Work days of 60% Replacement of Creditable Compensation
Fewer than 60	0	0	125
60-119	85	25	15
120 or more	85	40	0

For any other Disability:

The STD Benefit provides income replacement for (i) 60 percent of a Member's Predisability Earnings after 12 months of continuous participation through the first 60 months of continuous participation in the Virginia hybrid retirement program described in § 51.1-169 of the Code of Virginia and (ii) thereafter, a percentage of a Member's Predisability Earnings during the periods specified below, based on the number of months of continuous participation in the Virginia hybrid retirement program attained by an employee who is disabled, on maternity leave, or takes periodic absences due to a major chronic condition, as follows:

Months of Continuous Participation	Work days of 100% Replacement of Creditable Compensation	Work days of 80% Replacement of Creditable Compensation	Work days of 60% Replacement of Creditable Compensation
60-119	25	25	75
120-179	25	50	50
180 or more	25	75	25

Minimum: None

Assisted Living Benefit: An additional 20% of your Predisability Earnings, not to exceed a total STD Benefit of 80%. The Assisted Living Benefit is not reduced by Deductible Income.

Benefit Waiting Period: 7 calendar days. The Benefit Waiting Period is waived when the Assisted Living Benefit applies. See **Assisted Living Benefit** and **First Day Assisted Living Benefit**.

Maximum Benefit Period: 125 work days

If you are Disabled for less than one full week, Program Sponsor will pay one-seventh of the STD Benefit for each day of Disability.

MEMBER CONTRIBUTIONS

Coverage is: Noncontributory

STATEMENT OF COVERAGE

If you become Disabled while covered under the Program, Program Sponsor will pay STD Benefits according to the terms of Program after we receive Proof Of Loss satisfactory to us.

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BECOMING COVERED

To become covered you must be a Member, complete your Eligibility Waiting Period, and meet the requirements in **Active Work Provisions** and **When Your Coverage Becomes Effective**.

You are a Member if you are:

1. A regular employee of the Employer and who is participating in the Virginia hybrid retirement program described in § 51.1-169 of the Code of Virginia;
2. Actively At Work at least the minimum hours per week required by the Employer for coverage under the Program, but in no event less than 20 hours each week (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); and
3. A citizen or resident of the United States or Canada.

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

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

(ASO_VAR MBR DEF) ST.BI.OT.1X

WHEN YOUR COVERAGE BECOMES EFFECTIVE

Subject to the **Active Work Provisions**, your coverage becomes effective on the date you become eligible.

ACTIVE WORK PROVISIONS

A. Active Work Requirement

   You must be capable of Active Work on the day before the scheduled effective date of your coverage or your coverage 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 coverage, your coverage 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 Material Duties of your Own Occupation at your Employer's usual place of business.

B. Changes In Coverage

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

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WHEN YOUR COVERAGE ENDS

Your coverage ends automatically on the earliest of:

1. The date the last period ends for which a payment was made for your coverage.
2. The date the Program terminates.
3. The date your Employer's coverage under the Program terminates.

4. The date your employment terminates.
5. The date you cease to be a Member. However, your coverage 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 coverage under the Program 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 Benefit Waiting Period and while STD Benefits are payable.

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REINSTATEMENT OF COVERAGE

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

1. If your coverage ends because you cease to be a Member and if you become a Member again within 90 days, the Eligibility Waiting Period will be waived.
2. If your coverage 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 coverage will be reinstated pursuant to the federal or state-mandated family or medical leave act or law.
3. In no event will coverage be retroactive.

(ASO_NONOCC) ST.RE.OT.4

DEFINITION OF DISABILITY

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

   A. Own Occupation Definition Of Disability; or

   B. Partial Disability Definition.

A. Own Occupation Definition Of Disability

   You are required to be Disabled only from your Own Occupation. You are Disabled from your Own Occupation if, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder, you are unable to perform the Material Duties of your Own Occupation with reasonable continuity.

   Note: You are not Disabled merely because your right to perform your Own Occupation is restricted, including a restriction or loss of license.

   You may work in another occupation while you meet the Own Occupation definition of Disability. However, you will no longer be Disabled when your Work Earnings from another occupation exceed 80% of your Predisability Earnings.

   Own Occupation means any employment, business, trade, profession, calling or vocation that involves Material Duties of the same general character as the occupation you are regularly performing for your Employer when Disability begins. In determining your Own Occupation, we are not limited to looking at the way you perform your job for your Employer, but we may also look at the way the occupation is generally performed in the national economy. If your Own Occupation involves the rendering of professional services and you are required to have a professional or

occupational license in order to work, your Own Occupation is as broad as the scope of your license.

Material Duties means the essential tasks, functions and operations, and the skills, abilities, knowledge, training and experience, generally required by employers from those engaged in a particular occupation, that cannot be reasonably modified or omitted. In no event will we consider working an average of more than 40 hours per week to be a Material Duty.

B. Partial Disability Definition

You are Partially Disabled when you work and, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder, you are unable to earn 80% of your Predisability Earnings or more.

Your Work Earnings may be Deductible Income. See **Return To Work Provisions** and **Deductible Income**.

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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 Own Occupation 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 1. is greater than 2., the difference will be Deductible Income.

B. Work Earnings Definition

Work Earnings means your gross weekly earnings from work you perform while Disabled, plus the earnings you could receive if you worked as much as you are able to, considering your Disability, in work that is reasonably available in your Own Occupation. Work Earnings includes 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 week to week, we may determine your Work Earnings by averaging your earnings over the most recent four-week period. You will no

longer be Disabled when your average Work Earnings over the last four weeks 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: 45 consecutive calendar 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 coverage plan under which you become covered during your period of recovery.
5. Except as stated above, the provisions of the Program 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 attain normal retirement age under the Virginia hybrid retirement program.
4. The date you die.
5. The date long term disability benefits become payable to you under a group long term disability plan, even if that occurs before the end of the Maximum Benefit Period.
6. The date benefits become payable to you under any other disability coverage plan under which you become covered through employment during a period of Temporary Recovery.
7. The date you fail to provide proof of continued Disability and entitlement to STD Benefits.

PREDISABILITY EARNINGS

Your Predisability Earnings will be based on your earnings in effect on your last full day of Active Work.

The Member's STD Benefit will be adjusted to reflect any salary increase awarded during the period covered by STD Benefits.

Predisability Earnings means your weekly rate of creditable compensation 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.

Predisability Earnings does not include:

1. Bonuses.
2. Commissions.
3. Overtime pay.
4. Stock options or stock bonuses.
5. Your Employer's contributions on your behalf to any deferred compensation arrangement or pension plan.
6. Any other extra compensation.

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

If you are paid hourly, your weekly rate of creditable compensation 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.

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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, including donated amounts, (but not vacation pay) paid to you by your Employer, if it exceeds the amount found in a., b., and c.
   a. Determine the amount of your STD Benefit as if there were no Deductible Income, and add your sick pay or other salary continuation to that amount.
   b. Determine 100% of your Predisability Earnings.
   c. If a. is greater than b., the difference will be Deductible Income.
2. Your Work Earnings, as described in the **Return To Work Provisions**.
3. Any amount you receive or are eligible to receive because of your disability under a state disability income benefit law or similar law.
4. Any amount you receive or are eligible to receive because of your disability under another group.
5. Any amount you receive or are eligible to receive because of your disability, including amounts for partial or total disability, whether permanent, temporary, or vocational, under any of the following:
   a. A workers' compensation law;
   b. The Jones Act;

c. Maritime Doctrine of Maintenance, Wages, or Cure;

d. Longshoremen's and Harbor Worker's Act; or

e. Any similar act or law.

6. Any disability benefits you receive or are eligible to receive, or retirement benefits you receive, under your Employer'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 your Employer's contributions will be considered as distributed simultaneously throughout your lifetime, regardless of 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 monthly income for life with no survivors benefit will be Deductible Income, even if you choose a different option.

7. Any earnings or compensation included in Predisability Earnings which you receive or are eligible to receive while STD Benefits are payable.

8. Any amount you receive or are eligible to receive under any unemployment compensation law or similar act or law.

9. 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 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, legal rehabilitation expense.

3. Military disability benefits.

4. Reasonable attorneys fees incurred in connection with a claim for Deductible Income.

5. Benefits from any individual disability insurance policy.

6. Group credit or mortgage disability insurance benefits.

7. Accelerated death benefits paid under a life coverage plan or life insurance policy.

8. Benefits from the following:

   a. Profit sharing plan.

   b. Thrift or savings plan.

   c. Deferred compensation plan.

   d. Plan under IRC Section 401(k), 408(k), 408(p), or 457.

   e. Individual Retirement Account (IRA).

   f. Tax Sheltered Annuity (TSA) under IRC Section 403(b).

   g. Stock ownership plan.

   h. Keogh (HR-10) plan.

(ASO_PUB_NO OTHR OFFST) ST.ED.OT.1

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 eligible. 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. Otherwise, we may reduce your STD Benefits by the amount we estimate you would be eligible to receive upon proper pursuit of the Deductible Income.

C. 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 your Employer for the resulting overpayment of your claim.

D. Overpayment Of Claim

We will notify you of the amount of any overpayment of your claim under the Program and any group disability insurance policy. You must immediately repay any overpayment. You will not receive any STD Benefits until the overpayment has 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.

(ASO) ST.RU.OT.2X

ASSISTED LIVING BENEFIT

A. Assisted Living Benefit

If you meet the requirements in 1 through 3 below, Program Sponsor will pay Assisted Living Benefits according to the terms of the Program after we receive Proof Of Loss satisfactory to us.

Assisted Living Benefit Requirements

1. You are Disabled and STD Benefits are payable to you.
2. Your Disability arose out of or in the course of employment with the Employer.
3. While you are Disabled:
   a. You, due to loss of functional capacity as a result of Physical Disease or Injury, become unable to safely and completely perform two or more Activities Of Daily Living without Hands-on Assistance or Standby Assistance; or
   b. You require Substantial Supervision for your health or safety due to Severe Cognitive Impairment as a result of Physical Disease or Injury.

3. The condition in 3.a or 3.b above is expected to last 90 days or more as certified by a Physician in the appropriate specialty as determined by us.

B. Definitions For Assisted Living Benefit

Activities Of Daily Living means Bathing, Continence, Dressing, Eating, Toileting, or Transferring.

Bathing means washing oneself, whether in the tub or shower or by sponge bath, with or without the help of adaptive devices.

Continence means voluntarily controlling bowel and bladder function, or, if incontinent, maintaining a reasonable level of personal hygiene.

Dressing means putting on and removing all items of clothing, footwear, and medically necessary braces and artificial limbs.

Eating means getting food and fluid into the body, whether manually, intravenously, or by feeding tube.

Toileting means getting to and from and on and off the toilet, and performing related personal hygiene.

Transferring means moving into or out of a bed, chair or wheelchair, with or without adaptive devices.

Hands-on Assistance means the physical assistance of another person without which the insured would be unable to perform the Activity Of Daily Living.

Standby Assistance means the presence of another person within arm's reach of the insured that is necessary to prevent, by physical intervention, injury to the insured while the insured is performing the Activity Of Daily Living (such as being ready to catch the insured if the insured falls while getting into or out of the bathtub or shower as part of Bathing, or being ready to remove food from the insured's throat if the insured chokes while Eating).

Severe Cognitive Impairment means a loss or deterioration in intellectual capacity that is (a) comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia, and (b) is measured by clinical evidence and standardized tests approved by us that reliably measure impairment in (i) short-term or long-term memory, (ii) orientation as to people, places, or time, and (iii) deductive or abstract reasoning.

Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect you from threats to your health or safety (such as may result from wandering).

C. Amount Of The Assisted Living Benefit

The amount of the Assisted Living Benefit is shown in the **Coverage Features**.

D. Becoming Insured For Assisted Living Benefits

You are eligible for Assisted Living Benefit coverage if you are insured for STD coverage. Subject to the **Active Work Provision**, your Assisted Living Benefit coverage becomes effective on the date your STD coverage becomes effective.

E. Payment Of Assisted Living Benefits

Program Sponsor will pay Assisted Living Benefits within 60 days after Proof Of Loss is satisfied. Living Benefits will be paid to you at the same time STD Benefits are payable.

F. Time Limits On Filing Proof Of Loss

Proof Of Loss must be provided within 90 days after the date of the loss. If that is not possible, it must be provided 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, the claim will be denied. These limits will not apply while the claimant lacks legal capacity.

G. When Assisted Living Benefits End

Assisted Living Benefits end automatically on the earliest of:

1. The date you no longer meet the requirements in item A. above.
2. The date your STD Benefits end.

H. When Assisted Living Benefits Coverage Ends

Assisted Living Benefit coverage ends automatically on the earliest of:

1. The date your STD coverage ends.
2. The date Assisted Living Benefit coverage terminates under the Program.

I. Assisted Living Benefits After Coverage Ends Or Is Changed

Your right to receive Assisted Living Benefits will not be affected by the occurrence of the events described in 1 or 2 below that become effective after you become Disabled.

1. Termination or amendment of the Program or your Employer's coverage under the Program.
2. Termination of Assisted Living Benefit coverage while the Program or your Employer's coverage under the Program remains in force.

FIRST DAY ASSISTED LIVING BENEFIT

If you meet the Assisted Living Benefit Requirements, 1 through 3 below will apply.

1. The remainder of your Benefit Waiting Period will be waived.
2. STD Benefits will become payable on the first day you meet the Assisted Living Benefit Requirements.
3. Your Maximum Benefit Period will begin on the date STD Benefits become payable.

BENEFITS AFTER COVERAGE ENDS OR IS CHANGED

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

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

.BA.OT.1

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 Program, including the **Disabilities Excluded From Coverage** and **Limitations** sections, will apply to the new cause of Disability.

(ASO) ST.ND.OT.1

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. Violent Or Criminal Conduct

You are not covered for a Disability caused or contributed to by your committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing your official duties.

D. Loss Of License Or Certification

You are not covered for a Disability caused or contributed to by the loss of your professional license, occupational license or certification.

ST.XD.OT.1

LIMITATIONS

A. Care Of A Physician

You must be under the ongoing care of a Physician in the appropriate specialty as determined by us during the Benefit Waiting Period. No STD Benefits will be paid for any period of Disability when you are not under the ongoing care of a Physician in the appropriate specialty as determined by us.

B. Imprisonment

No STD Benefits will be paid for any period of Disability when you are confined for any reason in a penal or correctional institution.

C. Rehabilitation Program

STD Benefits will be reduced to 50% of the amount determined from the Schedule Of Coverage for any period of Disability when you are not participating in good faith in a plan, program or course of medical treatment or vocational training or education approved by us unless your Disability prevents you from participating.

ST.LM.OT.1X

CLAIMS

A. Filing A Claim

Claims should be filed on our forms. If you do not receive our forms within 15 days after you ask for them, 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.

B. 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 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.

C. 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.

D. 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.

E. 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.

F. Time Of Payment

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

STD Benefits will be paid to you coinciding with the Employer's regular payroll period applicable to you. STD Benefits remaining unpaid at your death will be paid to your estate.

G. 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 Program 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.

H. 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.

After the initial determination letter responding to an initial appeal, you may appeal a second time within 90 days. However, for a second appeal, you must provide additional information supporting your claim for benefits.

As soon as practical, and in no case less than 10 days, after receiving a second appeal letter, we shall provide to you the written acknowledgment that either (i) the second appeal has been received and is under review or (ii) the second appeal is not under review since you did not provide additional information regarding your Disability.

When applicable, we shall provide to you a final written determination for any second appeal within 45 days of receiving the second written appeal. We may request up to 45 additional days to complete the review of a second appeal.

When we issue a written determination on any appeal – whether an initial appeal or a second appeal – our letter shall (i) inform you of the reasons for the decision, (ii) reference parts of the STD Program on which the decision is based, (iii) inform you of your right to receive, free of charge, a copy of all non-privileged documents and records from the claim file relevant to the decision, and (iv) inform you of your right to bring a civil action in circuit court for benefits.

Following a final written determination of any appeal, you may bring a civil action in the Circuit Court of Henrico County, Virginia, challenging the determination.

I. Assignment

The rights and benefits under the Program are not assignable.

(ASO_REV PUB WRDG) ST.CL.OT.2

LIMITED AGENCY APPOINTMENT OF STANDARD

Program Sponsor has appointed Standard to act on its behalf as Claims Administrator for the Program and grants to Standard authority to fulfill the Obligations of Claim Administrator, as provided herein. Standard is empowered to act on behalf of Program Sponsor in connection with the Program only as expressly stated in this Program. Standard has no authority or obligation with respect to (1) a Program Sponsor's right of subrogation under the Program, or (2) management or investment of the assets of the Program. In performing its obligations under this Agreement, Standard is acting solely as the agent of Program Sponsor.

Standard's authority includes, but is not limited to:

1. The right to resolve all matters when a review has been requested;
2. The right to establish and enforce rules and procedures for the administration of the Program and any claim under it;
3. The right to determine:

a. Eligibility for coverage;

b. Entitlement to benefits;

c. The amount of benefits payable;

d. The sufficiency and the amount of information we may reasonably require to determine a., b., or c., above.

Standard's decisions are subject to the review procedures of the Program Sponsor.

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 more than three years after the earlier of:

1. The date we receive Proof Of Loss; and
2. The time within which Proof Of Loss is required to be given.

.TL.OT.1

CLERICAL ERROR

Clerical error by the Program Sponsor, Claims Administrator, or their respective employees or representatives will not:

1. Cause a person to become covered.
2. Invalidate coverage under the Program otherwise validly in force.
3. Continue coverage under the Program otherwise validly terminated.

(ASO) ST.CE.OT.2

TERMINATION OR AMENDMENT OF THE PROGRAM

Program Sponsor may terminate the Program in whole, and may terminate coverage for any class or group of Members, at any time.

Benefits under the Program are limited to its terms, including any valid amendment. No change or amendment will be valid unless approved by the Program Sponsor and evidenced by an amendment.

No agent has authority to change or amend the Program or to waive any of its terms or provisions.

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

(ASO) ST.TA.OT.2

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**.

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) coverage is nonelective and the Program Sponsor or Employer pay the entire cost of coverage; or (b) the Program Sponsor or Employer require all eligible Members to have coverage and to pay all or part of the cost of coverage.

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 M.D. or D.O., acting within the scope of the license. Physician does not include you or your spouse, or the brother, sister, parent, or child of either you or your spouse.

Program means the group short term disability income benefit program established by Program Sponsor and identified by the ATP Number.

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

Prior Plan means your Employer's short term disability program in effect on the day before the effective date of your Employer's coverage under the Program and which is replaced by the Program.

STD Benefit means the benefit payable to you under the terms of the Program.

(ATP) ST.DF.OT.1

VA/STDP2000(ASO)

Statement of Scope

Response to Section II. Scope of Services

II. SCOPE OF SERVICES

The Scope of Services is intended to establish Minimum Services and Additional Specific Conditions the Successful Offeror shall meet to fulfill the County's intent as stated in Section I of this RFP.

A. Minimum Services

The Successful Offeror shall:

1. Provide STD and LTD plans which meet or exceed the VRS-mandated "comparable" benefit requirement. The comparable plan must include STD and LTD coverage only, not long-term care.

   Confirmed. As the incumbent, the plans will continue to run as they have been.

2. Provide and/or make available necessary, appropriate and high-quality income protection benefits and services to each employee.

   Our Group Disability insurance isn't an add-on, it's our primary business. Our knowledge and experience covers the full spectrum of disability. From underwriting, plan design and claims handling to worksite and job analysis and rehabilitation. For you, that means having distinct advantages that work harder to support you, your employees and your goals.

   Innovative Workplace Possibilities℠ Program
   Our customers get much more than a product with our Group Disability insurance. They get a proactive, whole-person approach focused on helping employees stay at work or return sooner. The Workplace Possibilities approach:

   - Treat the whole person – We do more than pay claims. Our approach looks at the range of factors that can delay an employee's recovery from a physical or behavioral condition. Then we customize a plan to help the individual return to work quickly and safely.
   - Focus on stay at work – Our on-site consultants work proactively with employees.* We coach managers on hot to spot employees who need support and refer them to our program. Early intervention helps keep employees from missing work, so they can stay productive and keep receiving a full paycheck.
   - Bring expertise right to you – It starts with integrating into an organization's culture and making a personal connection with employees. Employers can have local or on-site support. This includes working directly with employees, coordinating the programs and services available, and providing help with ADAAA accommodations.** All these efforts may help reduce the burden on HR.

     ** This type of local, on-site support will vary depending on employer size and plan design. In all cases, a consultant is available to you for calls and visits. Contact us to talk about the options available to you.*
     *** Consultants provide this assistance for employers using ADAAA Accommodation Services.*

   Reasonable Accommodation Expense Benefit
   The Standard may cover up to $25,000 of approved expenses toward: worksite modifications; assistive devices; training; other assistance that results in the covered employee staying at work or returning to work after a disability

   Mental Health & Musculoskeletal Outreach

At The Standard, all mental health and musculoskeletal cases receive clinical case management. Our team of eight mental health case managers averages more than 20 years of experience. They review claims each week to identify claimants who may benefit from assistance. They help employees follow through with medical providers' treatment recommendations. They can make referrals to available services, such as the employer's EAP.

1:6–7 Ratio of Nurses/Vocational Case Managers to Analysts
Our best practices model reflects a 1:7 (or less) ratio of clinical and vocational resources to claim-paying staff. This means that our nurse case managers – averaging 27 years of experience – and vocational case managers – averaging 26 years of experience – are readily accessible to our benefit examiners and analysts. Employees benefit from our integrated support and continuous case management.

Flexible Plan Designs – Our policies are flexible enough to meet the demands of employers with special requirements or those looking to match the benefits of their existing plans, including: Family Care Expense Adjustment; Dependent Education Benefit; Lifetime Security Benefit; Annuity Contribution Benefit.

Public employers have unique needs. These include: special administrative requirements; reporting needs; integration with other benefits and programs; union representation; employee classification; funding requirements; budget concerns.

Public Experience
The Standard is a leading provider of employee benefit products serving the public sector for more than 70 years. Our very first policyholder was a public entity. We are proud to say that we still have them insured today.

Long-term relationships are a primary goal of our organization. Most of our public employers maintain relationships with us that average nearly 9 years per policyholder. We provide Life or Disability coverage to more than 4,900* public entities.

*Standard Insurance Company internal data as of March 31, 2023.

3. Ensure disability claims are managed effectively, efficiently, and consistent with the Code of Virginia requirements.

   Confirmed. The County's designated claims team will continue to manage claims.

4. Provide high quality, efficient program administration and services, including but not limited to:
   a. Maintaining accurate payment records.

      Our premium billing system is self-administered. This means that the policyholder maintains eligibility and census information. They only need to provide aggregate information each month. Premium statements will reflect the prior month's:
      - Aggregate number of lives.
      - Insurance volume.
      - Current in-force rate for each coverage.

      The policyholder adjusts the statement to reflect any changes. They will add or subtract lives and insurance volume. Premium is then remitted based on the new aggregate numbers.

Billing statements are generated and mailed about 11 to 13 days before the due date. The first statement will reflect the census information provided when coverage was first applied for. The policyholder is then responsible for updating these figures before sending payments.

b. Providing state-of-the-art data tracking and claims payment services.

The Standard's STD, state disability claims and LTD claims are stored, assessed, and tracked in a paperless online system.

We use a claims adjudication and payment system that provides online transaction processing to support immediate customer inquiries.

Our claims processing system:

- automates all benefit calculations
- claims payment
- tax
- benefit contribution deductions
- offset withholding and reporting
- overpayment calculation
- claims reserving
- creates standard correspondence and reports

Additionally, the County can pull a variety of claims data through our Reports OnlineSM system. Reports OnlineSM provides benefit managers with ready access to disability claims status, payment, and experience data. You'll be able to quickly confirm when The Standard has issued benefits.

c. Providing plan utilization, claims, enrollment, and premium data to the County General Government and Public Schools on at minimum at quarterly basis.

The Standard will provide a customized financial and claim utilization reports based on the County's needs. We not only provide the reports, but we will be consultative in walking through the data and providing recommendations for changes and improvements.

We have provided samples of our reporting package in Tab 9.

As demonstrated in our sample reporting package in Tab VII, The Standard provides a full suite of financial and claim utilization reports that includes benchmarking to our public block of business and the leading research organization in health and productivity, Integrated Benefits Institute. If additional reporting is needed, The Standard is able to create ad hoc reporting based on data points collected in our claim system and/or provided in an eligibility file from Henrico County.

In addition, to make pertinent disability claims information readily available to employers, The Standard offers Reports Online[SM], our web-based claims management reporting system. Reports include:

Daily Reports

- Disability claim status
- Disability claims payment detail
- Benefit Calculation Report (LTD only)
- Waiver claims detail

Quarterly Reports

- Disability benefits paid by diagnosis and occupation
- Disability claim duration by diagnosis and closure reason

The Standard provides online access to:

- **Daily FICA Tax Activity Report:** This tells employers when we make a FICA Tax deduction from a claims payment. It also shows the Social Security and Medicare tax withheld. We can report this information by employer location or affiliate with different taxpayer identification numbers (if requested).

In addition to the information available through Reports Online[SM], we print and mail the following Disability reports to a designated contact at the County for fully-insured plans:

- **Group Benefits Activity Report:** This details disability payments and claim determinations made during the previous month. We generate the report monthly and can report in aggregate or by employer location or affiliate.
- **Disability Income Report:** This shows yearly total benefit payments per claim and tax withholding for each employee who received disability benefits from The Standard during the calendar year. This also shows when The Standard has prepared a W-2 for the employee. We generate this report for all disability plans.

We can also provide the following reports, as needed, for fully-insured plans:

- **Experience Report:** We produce this at renewal. It shows the current policy year and all years' experience, including ASO fees and paid claims, if applicable.
- **Claim Experience Report:** This printout lists the individual claims that were active during the time period requested. The information includes benefits paid as well as beginning and ending reserves. We can produce this by group office for any time period from the policy effective date through the last full month.

d. Maintaining separate accounts or subgroups as required by the County.

We can separate billing, claims, and experience by various accounts or subgroups within the County. For example, we can provide claim utilization reports by separate policies and by sub-groups such as government entities versus school entities.

5. Provide administrative support services that simplify the work input and administrative time of General Government and Public Schools' benefits staff.

We are a leader in the industry for disability claims management. We have tenured claims staff and robust medical and vocations resources to manage claims effectively and fairly while providing best in class customer service. In addition, our telephonic intake service streamlines the process for employers and employees.

6. Maintain a local or toll-free customer service number for covered employees and General Government and Schools' benefits staff.

   We can confirm that there is a toll-free customer service number available to covered employees and benefits staff.

   Moreover, The Standard implemented a Telephone intake service for Short Term Disability claims with Henrico for the Hybrid Disability plan. For both employers and employees, claims are reported to The Standard's Customer Contact Center.

7. Designate a single point of contact (account manager) responsible for resolving issues, answering claims, administrative, and billing inquiries, and expediting services related to the overall performance of the Contract.

   Our approach to account management is to provide our customers with a single, dedicated point of contact for whom they can trust.

   Kim Haines, Account Manager, will continue to serve as the County's point of contact. Account managers pride themselves on being your advocate, representing your interests and providing you with timely responses.

8. Provide an account team chart which lists contacts in relevant, functional areas (with phone numbers, email addresses, departments, and titles) that will be updated as changes occur.

   We have included a team chart in Tab 9. We confirm that we will provide updates as they occur.

9. Provide specific performance guarantees that include financial penalties for non-performance. (See **Attachment I)**

   Our policyholders decide what aspects of service are most important to them through the Performance Guarantee Program. They do this by rating their satisfaction based on those criteria. The Standard promises to make every effort to meet those overall service expectations.

   If we fail to meet expectations, we will refund five percent (5%) of the previous quarter's plan administration expenses, excluding commission, premium tax, and risk charges.

10. Meet with the County 15 days after the Contract award date to review the disability program, to present the proposed employee communication material, and to jointly establish a preliminary implementation plan and schedule.

    As the incumbent carrier, implementation is not necessary. Service will continue without disruption.

11. Work with the benefits staff of the General Government and County Schools to develop employee communications materials.

    Communication materials already exist. If changes are needed, we will be happy to work with the County.

12. Work with the benefits staff of the General Government and County Schools to develop a benefits booklet (or booklets) for employees to include a summary of benefits, plan limitations, exclusions, and claims appeal procedures. This booklet proof must be provided to the County on a timely basis, but not later than November 1, 2023. The General Government and Schools shall review and approve the booklet(s) prior to distribution. Booklets must be reprinted if changes are required at no additional cost to the County.

    Benefit summaries have been provided. If more communications are needed, we will be happy to work with the County on a timely basis.

13. Provide the County with contractual documents necessary to this coverage, no later than December 1, 2023.

    The Policy will continue to be in place unless we receive notice of termination from the County pursuant to the terms and conditions of the policy in place. We will work with the County contract team to finalize any agreements needed by the purchasing department. The Standard does not require any additional documents to continue the coverage on January 1, 2024.

14. Provide a detailed renewal underwriting analysis each July 1 (or earlier if requested by the County) for the upcoming January 1 renewal. Detailed utilization data comparing current and prior years (if applicable) must be provided.

    Confirmed.

B. Additional Specific Conditions

The Successful Offeror shall transfer all data and records necessary to administer the disability program upon the termination or expiration of the Contract within 30 days of the County's request. Such transfer may be accomplished either electronically or by paper based upon the mutual agreement between the Successful Offeror and the County.

The Standard will share and/or transfer data and records consistent with applicable law.

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 6/30/2023

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Crystal IBC, LLC
560 Mission St., 6th Floor
San Francisco CA 94105

License#: 0C36861

CONTACT NAME: Heather Shoemaker Williams
PHONE (A/C, No, Ext): 628 502 2836 **FAX (A/C, No):**
E-MAIL ADDRESS: Heather.shoemaker@alliant.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Atlantic Specialty Insurance C	27154
INSURER B : Sentry Insurance Company	24988
INSURER C : National Union Fire Insurance	19445
INSURER D : Underwriters at Lloyds Brit Sy	0
INSURER E :	
INSURER F :	

INSURED
STANFIN-01
StanCorp Financial Group, Inc.
(See Additional Named Insureds Below)
1100 SW Sixth Avenue
Portland OR 97204

COVERAGES **CERTIFICATE NUMBER:** 1741245123 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X **COMMERCIAL GENERAL LIABILITY** CLAIMS-MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY [ ] PRO-JECT [X] LOC OTHER:	Y		712-00-77-55-0016	7/1/2023	7/1/2024	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG 	$ 1,000,000 $ 1,000,000 $ 15,000 $ 1,000,000 $ 2,000,000 $ 2,000,000 $
A	**AUTOMOBILE LIABILITY** X ANY AUTO OWNED AUTOS ONLY [ ] SCHEDULED AUTOS X HIRED AUTOS ONLY X NON-OWNED AUTOS ONLY	Y		712-00-77-55-0016	7/1/2023	7/1/2024	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) 	$ 1,000,000 $ $ $ $
A	X **UMBRELLA LIAB** X OCCUR **EXCESS LIAB** CLAIMS-MADE DED RETENTION $			712-00-77-55-0016	7/1/2023	7/1/2024	EACH OCCURRENCE AGGREGATE 	$ 10,000,000 $ 10,000,000 $
B B	**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY** Y / N ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [ ] **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		9016876001 9016876002	7/1/2023 7/1/2023	7/1/2024 7/1/2024	X PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ 1,000,000 $ 1,000,000 $ 1,000,000
C D	Professional Liability Privacy/Cyber Liability			01-309-57-86 B0146CYUSA2301398	7/1/2023 7/1/2023	7/1/2024 7/1/2024	Limit Limit	$5,000,000 $5,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Named Insureds: StanCorp Financial Group, Inc.; Standard Insurance Company; The Standard Life Insurance Company of New York; StanCorp Equities, Inc.; StanCorp Investment Advisers, Inc.; StanCorp Mortgage Investors, LLC; Standard Management, Inc.; Standard Retirement Services, Inc.; StanCorp Real Estate, LLC; StanCorp Insurance Company Inc.; Standard Insurance Company Continuing Health & Wealth Benefits Trust; StanCorp Mortgage Investors Pass-through, LLC

As Required by Written Contract -
County of Henrico and Henrico County Public Schools are included as Additional Insured with regards to the General Liability and Auto Liability policies as required by written contract subject to the policy terms and conditions. Coverage is Primary and Non-Contributory as required by written contract subject to the policy terms and conditions. 30 days' notice of cancellation applies in accordance with the terms and conditions of the policy.

CERTIFICATE HOLDER

County of Henrico
Risk Management
P.O. Box 90775
Henrico VA 23273

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

712-00-77-55-0016

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

BROAD FORM GENERAL LIABILITY ENDORSEMENT

A. Section I – Coverages

1. Expected or Intended Injury (Property Damage)

2.a. Expected Or Intended Injury **Section I – Coverages – Coverage A – Bodily Injury and Property Damage Liability**

"

2. Non-Owned Aircraft and Watercraft Under 55 Feet

a. **2.g. Aircraft, Auto or Watercraft** **Section I – Coverages – Coverage A – Bodily Injury and Property Damage Liability**

(a)

(b)

b. **2.g.(2)(a)** **Section I – Coverages – Coverage A – Bodily Injury and Property Damage Liability**

(a)

c. [illegible] b.(1) [illegible] 4. Other Insurance [illegible] Section IV – Commercial General Liability Conditions [illegible]

[illegible]

3. Alienated Premises

[illegible] 2.j.(2) [illegible] Section I – Coverages – Coverage A – Bodily Injury and Property Damage Liability [illegible]

(2) Premises you sell, give away or abandon, if the "property damage" arises out of any part of those [illegible]

4. Broadened Property Damage – Rented Premises, Borrowed Equipment and Use of Elevators

a. [illegible] 2.j. Damage To Property [illegible] Section I – Coverages – Coverage A – Bodily Injury and Property Damage Liability [illegible]

[illegible] (1) [illegible] "property damage" to real property you rent or [illegible]

[illegible] (4) [illegible] "[illegible]" [illegible]

[illegible] (3) (4) [illegible] (6) [illegible] "[illegible]"

b. [illegible] 6. [illegible] Section III – Limits Of Insurance [illegible]

6. [illegible] 5. [illegible] A for damages because of "property [illegible]e" to any one premises while rented to you or occupied by you with permission of the [illegible]

c. [illegible] b.(1) [illegible] 4. Other Insurance [illegible] Section IV – Commercial General Liability Conditions [illegible]

[illegible]

5. Personal and Advertising Injury [illegible]

a. Non-Employment Related Discrimination

[illegible] 14. "personal and advertising injury" of Section V – Definitions [illegible] B [illegible]

"Personal and advertising injury" includes injury, including consequential "bodily injury", arising out [illegible]

(1 [illegible]

(a) [illegible]

(b) Any "executive officer", director, stockholder, partner, member, manager or "employee"; and [illegible]

(2) [illegible]

[illegible]

b. Limited Contractual Liability Coverage

2.e. Contractual Liability Section I – Coverages – Coverage B – Personal and Advertising Injury Liability

ded the "personal and advertising injury":

(1)

(2)

6. Medical Payments – Increased Limits and Time Period

C

a. **a.(3)(b) 1. Insuring Agreement Section I – Coverage C – Medical Payments**

(b)

b. **7. Section III – Limits Of Insurance**

C

7. Product Recall Expense Coverage

a. **Section I – Coverages**

Product Recall Expense Schedule	

PRODUCT RECALL EXPENSE COVERAGE

Section III – Limits Of Insurance

b. **Section III – Limits Of Insurance**

c. **Section IV – Commercial General Liability Conditions**

Duties In The Event Of "Covered Recall"

1.

2. No insured will, except at that insured's own cost, voluntarily make a payment, assume any

3.

(a)

(b)

(c)

(1)

(2)

(d)

(e) insurance or your claim, including an insured's books and records. An insured's answers to

d. **Section V – Definitions**

a.

(1)

(2)

(3)

(4)

(5)

(6)

(7)

b.

(1)

(2)

(3)

(4)

(a)

(b)

(c)

(d)

(e) The insured's caprice or whim;

(f) [illegible]

(g) [illegible]

8. Supplementary Payments – Cost of Bail Bonds and Loss of Earnings

[illegible] **1.b.** [illegible] **1.d.** [illegible] **Supplementary Payments – Coverages A and B** [illegible] **Section I – Coverages** [illegible]

b. [illegible]

d. [illegible]

B. Section II – Who is an Insured

1. Broadened Named Insured

Section II – Who Is An Insured [illegible]

2. Additional Insured – Broad Form Vendor

a. Section II – Who Is An Insured [illegible] "[illegible]" [illegible] [illegible] "[illegible]" [illegible] "[illegible]" [illegible] ibuted or sold in the regular course of the vendor's business. [illegible]

(1) [illegible]

(2) [illegible]

(3) For "b[illegible]" [illegible]

(4) For "b[illegible]" [illegible]

(a) [illegible]

(b) [illegible]

(c) [illegible]

(d) [illegible]

(e) [illegible] the vendor's premises in co[illegible]

(f) [illegible]

(g) [illegible]

(i) In the course of repackaging "your products" [illegible]

(ii) [illegible] of "your products" [illegible] at the vendor's premises in connection with the sale of the product; or

(iii) [illegible] of "your products" [illegible]

b. [illegible] **a.** [illegible]

(1) [illegible]

(2) [illegible]

c. [illegible] **Section III – Limits Of Insurance** [illegible]

[illegible]

a. [illegible]

b. [illegible]

[illegible]

3. Additional Insured – Written Contract, Agreement, Permit or Authorization

a. Section II – Who Is An Insured [illegible]

(1) "B[illegible]" "[illegible]" "[illegible]" i[illegible]

(2) "B[illegible]" "[illegible]" "[illegible]" i[illegible]

(3) "B[illegible]" "[illegible]" "[illegible]" i[illegible]

b. [illegible] **a.** [illegible]

(1) [illegible]

(a) [illegible] "[illegible]" "[illegible]" "[illegible]"

(b) [illegible]

(2) [illegible]

(a) [illegible]

(b) [illegible]

(c) [illegible]

(d) [illegible]

(i) [illegible] "[illegible]"

(ii) [illegible] "[illegible]" "[illegible]" "[illegible]"

(e) Person or organization if the "bodily injury", "property damage" or "personal and advertising injury" arising out of the rendering of, or the f[illegible]

(i) [illegible]

(ii)

(f) "odily injury" or "property damage" occurring after:

(i)

(ii) That portion of "your work" out of which the injury or damage arises has been put to its

c. **a.**

(1)

(2)

d. **a.** **Section III – Limits Of Insurance**

a.

b.

4. Incidental Malpractice by Employed Physicians, Nurses, EMTs and Paramedics

a. **2.a.(1)(d)** **Section II – Who Is An Insured**

b. **b.(1)** **4. Other Insurance** **Section IV – Commercial General Liability Conditions**

"employee" or volunteer worker who is a

5. User of Covered Watercraft

a. **Section II – Who Is An Insured**

a. to that person's or organization's "

b.

(1)

(2)

b. [illegible] **b.(1)** [illegible] **4. Other Insurance** [illegible] **Section IV – Commercial General Liability Conditions** [illegible]

[illegible]

6. Newly Acquired or Formed Organizations

[illegible] **3.a.** [illegible] **Section II – Who Is An Insured** [illegible]

a. [illegible]

C. Section III – Limits of Insurance – Aggregate Limit Per Location

[illegible] **2.** [illegible] **Section III – Limits Of Insurance** [illegible]

[illegible] "location" [illegible] "[illegible]" [illegible] [illegible]

D. Section IV – Commercial General Liability Conditions

1. Duties in the Event of Occurrence, Offense, Claim or Suit

[illegible] **2. Duties In The Event Of Occurrence, Offense, Claim Or Suit** [illegible] **Section IV – Commercial General Liability Conditions** [illegible]

[illegible] "[illegible]" [illegible] "[illegible]" [illegible] "[illegible]" [illegible] "[illegible]"

(1) [illegible]

(2) [illegible]

(3) [illegible] "[illegible]" [illegible]

(4) [illegible]

[illegible] "[illegible]" [illegible] to your workers' [illegible] "[illegible]" [illegible] a liability claim rather than a workers' compensation claim, you must comply with all parts of Paragraph [illegible] **2. Duties In The Event Of Occurrence, Offense, Claim Or Suit** [illegible] **Section IV – Commercial General Liability Conditions** [illegible]

2. Waiver of Subrogation When Required by Written Contract or Agreement

[illegible] **8. Transfer of Rights of Recovery Against Others to Us** [illegible] **Section IV – Commercial General Liability Conditions** [illegible]

[illegible] "[illegible]" [illegible] "[illegible]" [illegible] "[illegible]" [illegible]

E. Section V – Definitions

1. Bodily Injury – Includes Mental Anguish

[illegible] **3.** [illegible] **Section V – Definitions** [illegible]

"[illegible]" [illegible]

2. Coverage Territory – Worldwide

[illegible] **4.** [illegible] **Section V – Definitions** [illegible]

4. "[illegible]" [illegible] the insured's [illegible] "[illegible]" [illegible]

3. **Mobile Equipment – Self-Propelled Snow Removal, Road Maintenance and Street Cleaning Equipment Less than 1,000 Pounds Gross Vehicle Weight**

12.f.(1) Section V – Definitions

considered “mobile equipment” and not an “auto”

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

BROAD FORM AUTOMOBILE ENDORSEMENT

A. Drive Other Car Coverage – Executive Officers and Certain Individuals

1. **Section I – Covered Autos**

Drive Other Car Coverage

a. For Covered Autos Liability Coverage and Physical Damage Coverage, "autos" in the care, custody or control of an "insured" described in Paragraph **2.** re covered "autos". But this does not include any "auto":

(1) Owned by any "insured" described in Paragraph **2.** including any "auto" that is owned but not insured;

(2) Used by an "insured" described in Paragraph **2.**

(3)

b. "insured" described in Paragraph **2.** household, are "insureds" while:

(1)

(2)

any "auto" you do not own, hire, lease or borrow, except an "auto" owned by an "insured" described **2.** below or members of their household, or an "auto" insured or covered under any

2. **A.1. Who is an Insured** **Section II – Liability Coverage** is amended to include as an "insured" the following:

   a.

   b.

   c. An organization other than an individual or a partnership, your "executive officers" and their

3. **Limit of Insurance and Deductible**

   applicable coverage for an "auto" you own. The Deductible for Drive Other Car Coverage is the largest Deductible for the applicable coverage for an "auto" you own.

4. **Other Insurance**

   B.5. Other Insurance **Section IV – Business Auto Conditions**

B. Section II – Covered Autos Liability Coverage

1. **Additional Insured – Written Contract, Agreement, Permit or Authorization**

   A.1. Who is an Insured **Section II – Covered Autos Liability Coverage** include as an additional "insured" any person or organization with whom you have agreed in a written Coverage Form but only with respect to liability for "bodily injury" or "property damage" caused in whole or in part by your maintenance, operation or use of a covered "auto".

   a. issued prior to the "accident" that caused the "bodily injury" or "property damage";

   b. To any person or organization included as an "insured" under any other provisions of this pol

   c.

   d. To any lessor of "autos" when their contract or agreement with you for such leased "auto" ends or possession of the "auto".

2. **Broadened Named Insured**

   A.1. Who is an Insured **Section II – Covered Autos Liability Coverage**

3. **Employees as Insureds (Including Employee Hired Autos and Fellow Employee Coverage)**

   a. **A.1. Who is an Insured** **Section II – Covered Autos Liability Coverage** to include as an "insured" your "employee" while:

      (1) Using a covered "auto"

      (2) Operating an "auto" hired or rented under a contract or agreement in that "employee's" name,

   b. **B.5. Fellow Employee** **Section II – Covered Autos Liability**

   c. **B.5.b** **Section IV – Business Auto Conditions**

      Any covered "auto" h by your "employee" under a contract or agreement in that "employee's" name, with your permission, while performing duties related deemed to be a covered "auto" you own.

4. **Newly Acquired or Formed Organizations**

   A.1. Who is an Insured **Section II – Covered Autos Liability Coverage** include as an "insured" any organization you newly acquire or

(1)

(2) Coverage does not apply to "bodily injury" or "property damage" caused by an "accident" that

5. Supplementary Payments – Bail Bonds and Loss of Earnings

A.2.a. Supplementary Payments **Section II – Covered Autos Liability** **(2)** **(4)**

(2)

(4)

C. Section III – Physical Damage Coverage

1. Hired Auto Physical Damage Coverage

a. If hired "autos" are covered "autos" under **Section II – Covered Autos Liability Coverage**, any "auto" you lease, hire, rent or borrow will be deemed a covered "auto" for **b.** Coverage to borrowed "autos" when:

(1) You have agreed to provide physical damage coverage to such "autos" by written contract or

(2) Such contract or agreement was entered into prior to "loss" to such "auto".

b. **a.**

(1) The most we will pay for "loss" to any hired "auto" is the lesser of:

(a) $75,000 for "autos" of the private passenger type and $50,000 for all other "autos";

(b) The actual cash value of the damaged or stolen property as of the time of the "loss"; or

(c)

(2) The Deductible is the largest Deductible for the applicable coverage for an "auto" you own.

(3)

2. Towing – Any Covered Autos

A.2. Towing **Section III – Physical Damage Coverage**

time a covered "auto" is disabled

3. Transportation Expenses Increased

A.4.a. Transportation Expenses **Section III – Physical Damage Coverage**
a covered "auto" of the private passenger type are increased

4. Loss of Use Expenses Increased

A.4.b. Loss Of Use Expenses **Section III – Physical Damage Coverage**

5. Other Coverage Extensions

A.4. Coverage Extensions **Section III – Physical Damage Coverage**

a. Airbag Discharge

"auto's" airbag that accidentally discharges without the "auto" being involved in an "accident" if the airbag is not covered under a manufacturer's warranty

b. Auto Theft Reward

$2,000 for information leading to the arrest and conviction of anyone stealing a covered "auto". But "employees" or

c. Loan/Lease Gap Coverage

covered "auto" is subject to a loan or we will pay the difference between the actual cash value of the "auto" at the time of "loss" and the

(1) Any amount paid under the policy's Physical Damage Coverage; or

(2)

d. Rental Reimbursement

We will pay for expenses to rent an "auto" of the private passenger type because of "loss" to a covered "auto" of the private passenger type.

(1) the "loss" and ending, regardless of the policy period, six days after the "loss".

(2)

(a)

(b)

(3) This coverage does not apply if a spare or reserve "auto" is available to you.

(4) If "loss" is because of the total theft of a covered "auto", we will pay only those amounts that are

6. Diminution in Value

B.6. Section III – Physical Damage Coverage

This exclusion does not apply to "diminution in value" of a covered "auto" of the private passenger type used in the conduct of the "insured's" business that is leased, rented, hired or borrowed without a driver t we will pay for such "diminution in value" is the lesser of:

a. 20 percent of the actual cash value of the "auto" as of the time of the "loss"

b.

7. Communications Equipment

B. Exclusions Section III – Physical Damage Coverage

4.c. **4.d.** accessories, that is permanently installed in, and not removable from, a covered "auto" and designed for

a. Citizen's band ra

b.

c.

d.

No Deductible applies to “loss” to such communications equipment. But the most we will pay for all such communications equipment is $5,000 for any one “loss”.

8. Deductible Waived For Glass Repair

The following is added to Paragraph **D. Deductible** of **Section III – Physical Damage Coverage**:

No Deductible applies if glass that is damaged is repaired rather than replaced.

D. Section IV – Business Auto Conditions

1. Duties in the Event of Accident, Claim, Suit or Loss

The following is added to Paragraph **A.2. Duties in the Event of Accident, Claim, Suit or Loss** of **Section IV – Business Auto Conditions**:

The requirements that you must notify us of an “accident”, claim, “suit” or “loss”, or send us documents concerning a claim or “suit”, apply only if the “accident”, claim, “suit” or “loss” is known to:

(1) You, if you are an individual;

(2) A partner, if you are a partnership;

(3) An “executive officer” or insurance or risk manager, if you are a corporation; or

(4) A manager, if you are a limited liability company.

The requirement that you must notify us as soon as practicable of an “accident”, claim, “suit” or “loss” does not apply if you report the “accident”, claim, “suit” or “loss” to your workers’ compensation insurer and the “accident”, claim, “suit” or “loss” later develops into a liability claim for which coverage is provided by this policy. But as soon as you become aware that an “accident”, claim, “suit” or “loss” is a liability claim rather than a workers’ compensation claim, you must comply with all parts of Paragraph **A.2. Duties in the Event of Accident, Claim, Suit or Loss** of **Section IV – Business Auto Conditions**.

2. Waiver of Transfer or Rights of Recovery Against Others to Us (Waiver of Subrogation) Automatic When Required by Written Contract or Agreement

The following is added to Paragraph **A.5. Transfer of Rights of Recovery Against Others to Us** of **Section IV – Business Auto Conditions**:

This condition does not apply to any person(s) or organization(s) for whom you are required to waive subrogation with respect to the coverage provided under this Coverage Form, but only to the extent that subrogation is waived:

a. Under a written contact or agreement with such person(s) or organization(s); and

b. Prior to the "accident" or the "loss."

E. Section V – Definitions

1. Bodily Injury – Includes Mental Anguish

The following is added to Paragraph **C**. of **Section V – Definitions**:

“Bodily injury” includes mental anguish resulting from bodily injury, sickness, or disease sustained by a person at any time.

2. Executive Officer

The following is added to **Section V – Definitions**:

“Executive officer” means a person holding any of the officer positions created by your charter, constitution, bylaws or any other similar governing document.

COMMERCIAL AUTO
CA 04 49 11 16

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

PRIMARY AND NONCONTRIBUTORY – OTHER INSURANCE CONDITION

A. **Other Insurance**
Other Insurance – Primary And Excess Insurance Provisions

1.

2.

B. **Other Insurance**

1.

2.

COMMERCIAL GENERAL LIABILITY
CG 20 01 12 19

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

PRIMARY AND NONCONTRIBUTORY – OTHER INSURANCE CONDITION

Other Insurance

Primary And Noncontributory Insurance

(1)

(2)

Exhibit D

Request for Group Insurance Amendment

Standard Insurance Company
900 SW Fifth Avenue
Portland, OR 97204-1282

Employee Benefits Consultant: Stephen Lovings
Employee Benefits Service Representative: Brooke Spurlock
Employee Benefits Sales and Service Office: Washington DC

Policyholder: Henrico County, Virginia
Employer Name: Henrico County, Virginia
Group Number: See Below

As an authorized representative of the Employer, I request that Standard Insurance Company ("The Standard") amend the above Employer's coverage under the Group Policy to make the following change(s):

LTD 649720-A

- Include the following as an Exception to Deductible Income: "Any amount you receive from a military disability benefit"
- Change the cross-reference in subsection F.1 in the section Additional Benefits for the Severely Disabled. The cross-reference should be to "item A"
- Change the Member Definition in the Coverage Features in the LTD policy to read as follows: "Member means:

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. Actively At Work at least the minimum hours per week required by the Employer for coverage under the Program, but in no event less than 20 hours each week (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); and
3. A citizen or resident of the United States or Canada.

Member does not include a temporary or seasonal employee, a full-time member of the armed forces of any country, a leased employee, or an independent contractor."

STD 649721-A

Update what a Member means where applicable in the STD policy as follows:

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. Actively At Work at least the minimum hours per week required by the Employer for coverage under the Program, but in no event less than 20 hours each week (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); and

3. A citizen or resident of the United States or Canada.

I request that the amendment become effective on 01/01/2019. I understand that the amendment will not become effective unless approved and issued by The Standard.

I request that the amendment be approved by The Standard subject to The Standard's usual underwriting requirements, including, if applicable, Evidence of Insurability or a Pre-existing Condition provision.

I understand that the amendment, if approved by The Standard, will be issued in the policy language customarily used by The Standard.

I understand that any increase in Insurance for a Member who is not Actively At Work all day on the Member's last regular work day before the scheduled effective date of the amendment will be deferred until the first day after the Member completes one full day of Active Work.

I request that the amendment, if approved and issued by The Standard, become effective by its terms without any further acceptance by the Employer, and that a copy of this Request for Group Insurance Amendment form be attached to and made a part of the amendment.

Sign Name: _____ Title: County Mayor
Authorized Representative

Print Name: John A. Wheeler Date: 11/19/2019

APPROVED AS TO FORM

Asst. **COUNTY ATTORNEY**

STANDARD INSURANCE COMPANY
Employee Benefits - Underwriting
900 SW Fifth Ave. Portland, OR 97204-1282

Application for Group Insurance

Please type or print

REQUESTED EFFECTIVE DATE 1/1/14

APPLICANT

Full Legal Name of Group (Exactly as it is to be shown in the policy.)
County of Henrico, Va, Henrico County Public Schools and Henrico Economic Development Authority

Street Address **4301 E. Parham Road**

City **Henrico** State **VA** Zip Code **23273**

Phone Number (**804**) **501-4389** FAX Number (____) _____

Group Contact **Julia Sleemen** Contact's Title **Benefits Manager**

Contact's Phone No. if different (____) _____ Contact's FAX No. if different (____) _____

Nature of Business **Local Gov't**

INSURANCE COVERAGE REQUESTED

- ☐ Life Only
- ☐ Life & AD&D
- ☐ Dependent Life
- ☐ Supplemental Life
- ☐ Additional/Optional Life
- ☐ Stand Alone AD&D
- ☐ Dental/Employees
- ☐ Dental/Employees and Dep(s)
- ☐ Dental/Orthodontia
- ☑ LTD
- ☐ STD
- ☐ LTD with Transitional Duty Agreement
- ☐ Eye Care
- ☐ _____

OTHER INSURANCE

A. Does this insurance supplement other insurance? ☐ Yes ☑ No
If yes, specify for each line of coverage and Insurance Carrier: _____

B. Does this insurance replace existing insurance? ☐ Yes ☑ No
If yes, specify for each existing line of coverage: _____

- Please submit a copy of each in force policy, certificate or plan document.

Effective date of Prior Plan: _____ Termination date of Prior Plan: _____

ACTIVE WORK REQUIREMENT: A person must meet an Active Work requirement to become insured. Members who have not met an Active Work requirement are not insured until returning to work for one full day and meeting all other contractual requirements.

Initial: _____

Note: Some members who do not meet an Active Work requirement may be eligible for Waiver of Premium with a prior carrier.

APPLICANT AGREES THAT: **I hereby apply for Group Insurance as provided in the attached proposal.**

The above information is true and correct to the best of the Applicant's knowledge and belief. It forms the basis for this request for group insurance.

If the requested insurance is acceptable to Standard Insurance Company under its current rules and practices and is legally permissible, a Group Policy will be issued in the language customarily used by Standard. It will be effective on the date determined by Standard. No producer has the authority to guarantee the acceptability of the requested insurance.

Standard may issue separate Group Policies if more than one coverage is requested in this Application. The insurance, if approved, will be subject to Standard Insurance Company's usual underwriting requirements, including the exclusions and limitations in the Group Policy and, if applicable, Evidence Of Insurability. The effective date of insurance for which a person is required to submit satisfactory Evidence Of Insurability will be determined in accordance with the terms of the Group Policy, subject to the Active Work requirement. No premiums will be collected or paid by the Applicant for such insurance until notification of approval.

No material describing coverage under the Group Policy will be distributed by the Applicant to any person to be insured without the prior written consent of Standard Insurance Company.

Premium rate quotations were based on data submitted to Standard. Final premium rates will be determined by the actual composition of the group.

The consideration for any Group Policy which may be issued is this Application and the payment of premiums. Payment of premium after receipt of the Group Policy is acceptance of the terms of the Group Policy.

This Application is made a part of the Group Policy.

Applicant authorizes the producer, broker of record, or consultant to receive information regarding the applicant's claims status and experience that the applicant has a right to receive and which is reasonably necessary to assist the applicant in conducting a review of the information.

Carla H. Hayes Purchasing Director
Signature and Title of Applicant's Authorized Representative

12-23-13
Date
(Must be signed or submitted prior to the requested effective date.)

APPROVED AS TO FORM
COUNTY ATTORNEY
12/23/13

Initial Deposit $ N/A

STANDARD INSURANCE COMPANY
Employee Benefits - Underwriting
900 SW Fifth Ave. Portland, OR 97204-1282

Receipt for Initial Deposit

Received from _____, an initial deposit of
$ N/A * in connection with the Application for Group Insurance bearing the same date as this conditional receipt.

Date _____
This receipt is subject to the terms and conditions below.
Received By

_____ _____
Name Title

*All premium checks must be made payable to Standard Insurance Company.
Do not make check payable to the producer or leave payee blank.

Terms of Receipt (Please read carefully.)

If the requested insurance is acceptable to Standard Insurance Company under its current rules and practices and is legally permissible, a Group Policy will be issued in the language customarily used by Standard. It will be effective on the date determined by Standard. No producer has the authority to guarantee the acceptability of the requested insurance.

Standard may issue separate Group Policies if more than one coverage is requested in this Application. The insurance, if approved, will be subject to Standard Insurance Company's usual underwriting requirements, including the exclusions and limitations in the Group Policy and, if applicable, Evidence Of Insurability. The effective date of insurance for which a person is required to submit satisfactory Evidence Of Insurability will be determined in accordance with the terms of the Group Policy, subject to the Active Work requirement. No premiums will be collected or paid by the Applicant for such insurance until notification of approval.

No material describing coverage under the Group Policy will be distributed by the Applicant to any person to be insured without the prior written consent of Standard insurance Company

Premium rate quotations were based on data submitted to Standard. Final premium rates will be determined by the actual composition of the group.

The consideration for any Group Policy which may be issued is this Application and the payment of premiums. Payment of premium after receipt of the Group Policy is acceptance of the terms of the Group Policy.

This Application is made a part of The Group Policy.

Standard Insurance Company

Underwriting
900 SW Fifth Avenue Portland OR 97204

STD Self-Funded Plan Application

Requested Effective Date: 01/01/14

APPLICANT

Full legal name of group *(exactly as it is to be shown below)*:			
County of Henrico, VA, Henrico County Public Schools and Henrico Economic Development Authority			
Street Address: 4301 E. Parham Road	City: Henrico	State: VA	Zip Code: 23273
Phone No.: (804) 501-4389	Fax No.: ( )	Tax ID No.:	
Group Contact: Julia Sleeman	Contact's Title: Benefits Manager		
Contact's Phone No. *(if different)*: ( )	Contact's Fax No. *(if different)*: ( )		

COVERAGE REQUESTED

☐ STD ASO
☑ STD ATP ..... Benefit Calculation? ☐ Yes ☑ No
☐ STD Select Claim

OTHER INSURANCE

A. What is your Group LTD Insured Policy No. with The Standard?

B. Does this plan replace existing insurance? ☐ Yes ☑ No
If yes, please submit a copy of the inforce policy, certificate or plan document.

OTHER OPTIONS

A. Plan documents ☑ The Standard to create ☐ Use existing *(subject to The Standard's approval)*

B. Who will produce certificates/SPDs? ☑ The Standard *(N/A if not using The Standard's Plan Document)*
☐ Employer

APPLICANT AGREES THAT: I hereby apply for administrative services for my STD Plan for my employees as provided in the attached proposal.

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false, or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

For use in Maryland and Rhode Island: 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.

Signature and Title of Applicant's Authorized Representative:		
Caroline H Stone Purchasing Director		
Signature of Witness:	Signature of Licensed Agent *(where required by law)*:	
Date *(must be signed prior to requested effective date)*: 12-23-13	License No.:	Initial Deposit if ATP: $ N/A

APPROVED AS TO FORM

COUNTY ATTORNEY 12/23/13

For Contract No. 1670, the group contact is as shown below:

Lauren Taylor
Benefits Division Manager
Department of Human Resources
Ph: 804.501.4302
Email: tay151@henrico.us

Exhibit E

NOTICE OF
PROTECTION PROVIDED BY
VIRGINIA LIFE, AND 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 policyholders. 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 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:

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
804-371-9741
Toll Free Virginia only: 1-800-552-7945
http://www.scc.virginia.gov/division/boi/index.htm

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, then Virginia law will control.

COMMONWEALTH OF VIRGINIA
REQUIRED POLICY INFORMATION

In the event you need to contact someone about this policy for any reason, please contact your agent. If you have additional questions, you may contact the insurance company issuing this policy at the address and telephone number listed below.

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia Bureau of Insurance at the address and telephone number listed below.

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.

Name and address of the Insurance Company	Standard Insurance Company P.O. Box 711 Portland, OR 97207
Telephone Number	(503) 321-7000
Insurance Department Address	Virginia Bureau of Insurance Life and Health Division P.O. Box 1157 Richmond, VA 23218
Telephone Number	In state: 1-800-552-7945 Out-of-state: (804) 371-9741

STANDARD INSURANCE COMPANY

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

GROUP LONG TERM DISABILITY INSURANCE POLICY

Policyholder:	Henrico County, Virginia
Policy Number:	649720-B
Effective Date:	January 1, 2019

The consideration for this Group Policy is the application of the Policyholder and the payment by the Policyholder of premiums as provided herein.

Subject to the **Policyholder Provisions** and the **Incontestability Provisions**, this Group Policy (a) is issued for the Initial Rate Guarantee Period shown in the **Coverage Features**, and (b) may be renewed for successive renewal periods by the payment of the premium set by us on each renewal date. The length of each renewal period will be set by us, but will not be less than 12 months.

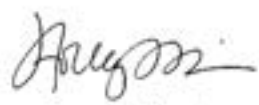
For purposes of effective dates and ending dates under this Group Policy, all days begin and end at 12:00 midnight Standard Time at the Policyholder's address.

All provisions on this and the following pages are part of this Group Policy. "You" and "your" mean the Member. "We", "us", and "our" mean Standard Insurance Company. Other defined terms appear with their initial letters capitalized. Section headings, and references to them, appear in boldface type.

STANDARD INSURANCE COMPANY

By

Chairman, President and CEO



Corporate Secretary

Table of Contents

Index of Defined Terms

COVERAGE FEATURES

This section contains many of the features of your long term disability (LTD) 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:	649720-B
Policyholder:	Henrico County, Virginia
Employer(s):	Henrico County General Government, Henrico County Public Schools, the Henrico County Economic Development Authority
Group Policy Effective Date:	January 1, 2019
Policy Issued in:	Virginia

Member means:

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. Actively At Work at least the minimum hours per week required by the Employer for coverage under the Program, but in no event less than 20 hours each week (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); and
3. A citizen or resident of the United States or Canada.

Member does not include a temporary or seasonal employee, a full-time member of the armed forces of any country, a leased employee, or an independent contractor.

Class Definition:

Class 1:	Members with fewer than 12 months continuous participation in the Virginia hybrid retirement program described in § 51.1-169 of the Code of Virginia
Class 2:	Members with at least 12 months continuous participation in the Virginia hybrid retirement program described in § 51.1-169 of the Code of Virginia

SCHEDULE OF INSURANCE

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

a. The Group Policy Effective Date; and

b. The first day as a Member.

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

Own Occupation Period:	The first 24 months for which LTD Benefits are paid.
Any Occupation Period:	From the end of the Own Occupation Period to the end of the Maximum Benefit Period.

LTD Benefit (dollar values are per month as noted in the definition of LTD Benefit in the **Definitions** section);

Class 1:	
For Disability arising out of or in the course of employment with the Employer:	60% of the first $41,667 of your Predisability Earnings, reduced by Deductible Income.
Maximum:	$25,000 before reduction by Deductible Income.
Minimum:	$100
For any other Disability:	None
Class 2:	60% of the first $41,667 of your Predisability Earnings, reduced by Deductible Income.
Maximum:	$25,000 before reduction by Deductible Income.
Minimum:	$100
Assisted Living Benefit:	An additional 20% of your Predisability Earnings, but not to exceed $5,000. The Assisted Living Benefit is not reduced by Deductible Income.
Lifetime Security Benefit:	Not Included
Benefit Waiting Period:	The period for which benefits are payable under the Employer's short term disability benefits program, including any benefit waiting period under that plan.
Maximum Benefit Period:	Determined by your age when Disability begins, as follows:

Age	Maximum Benefit Period
59 or younger	To SSNRA
60 through 64	5 years
65 through 68	To age 70
69 or older	1 year

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

PREMIUM CONTRIBUTIONS

Insurance is:	Noncontributory

PREMIUM AND RENEWALS

Premium Rates:

LTD Insurance:

Henrico County:	0.59% of the first $41,667 of each insured Member's insured Predisability Earnings.
Henrico County Economic Development Authority:	0.59% of the first $41,667 of each insured Member's insured Predisability Earnings.
Henrico County Public Schools:	
Professional employees:	0.27% of the first $41,667 of each insured Member's insured Predisability Earnings.
Non-professional employees:	0.59% of the first $41,667 of each insured Member's insured Predisability Earnings
Premium Due Dates:	January 1, 2019 and the first day of each calendar month thereafter.
Initial Rate Guarantee Period:	January 1, 2019 to January 1, 2023
Minimum Participation Number:	10 insured Members
Minimum Participation Percentage:	100% of eligible Members

INSURING CLAUSE

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

.IC.OT.1

BECOMING INSURED

To become insured you must be a Member, complete your Eligibility Waiting Period, and meet the requirements in **Active Work Provisions** and **When Your Insurance Becomes Effective**.

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. Actively At Work at least the minimum hours per week required by the Employer for coverage under the Program, but in no event less than 20 hours each week (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); and
3. A citizen or resident of the United States or Canada.

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

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.**

(VAR MBR DEF) LT.BI.OT.1X

WHEN YOUR INSURANCE BECOMES EFFECTIVE

Subject to the **Active Work Provisions**, your insurance becomes effective on the date you become eligible.

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 Material Duties 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.

LT.AW.OT.1

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.
2. The date the Group Policy terminates.
3. The date your Employer's coverage under the Group Policy terminates.
4. The date your employment terminates.
5. The date you cease to be a Member. 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 Benefit Waiting Period.

.EN.OT.1X

WAIVER OF PREMIUM

We will waive payment of premium for your insurance while LTD Benefits are payable.

.WP.OT.1

REINSTATEMENT OF INSURANCE

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

1. If you cease to be a Member because of a covered Disability following the Benefit Waiting Period, your insurance will end; however, if you become a Member again immediately after LTD Benefits end, the Eligibility Waiting Period will be waived.
2. If your insurance ends because you cease to be a Member for any reason other than a covered Disability, and if you become a Member again within 90 days, the Eligibility Waiting Period will be waived.
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.

.RE.OT.2X

DEFINITION OF DISABILITY

You are Disabled if you meet one of the following definitions during the period it applies:

A. Own Occupation Definition Of Disability;

B. Any Occupation Definition Of Disability; or

C. Partial Disability Definition.

A. Own Occupation Definition Of Disability

During the Benefit Waiting Period and the Own Occupation Period you are required to be Disabled only from your Own Occupation.

You are 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 Material Duties of your Own Occupation.

Note: You are not Disabled merely because your right to perform your Own Occupation is restricted, including a restriction or loss of license.

During the Own Occupation Period you may work in another occupation while you meet the Own Occupation Definition Of Disability. However, you will no longer be Disabled when your Work Earnings from another occupation meet or exceed 80% of your Indexed Predisability Earnings. Your Work Earnings may be Deductible Income. See **Return To Work Provisions** and **Deductible Income**.

Own Occupation means any employment, business, trade, profession, calling or vocation that involves Material Duties of the same general character as the occupation you are regularly performing for your Employer when Disability begins. In determining your Own Occupation, we are not limited to looking at the way you perform your job for your Employer, but we may also look at the way the occupation is generally performed in the national economy. If your Own Occupation involves the rendering of professional services and you are required to have a professional or occupational license in order to work, your Own Occupation is as broad as the scope of your license.

Material Duties means the essential tasks, functions and operations, and the skills, abilities, knowledge, training and experience, generally required by employers from those engaged in a particular occupation that cannot be reasonably modified or omitted. In no event will we consider working an average of more than 40 hours per week to be a Material Duty.

B. Any Occupation Definition Of Disability

During the Any Occupation Period you are required to be Disabled from all occupations.

You are Disabled from all occupations if, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder, you are unable to perform with reasonable continuity the Material Duties of Any Occupation.

Any Occupation means any occupation or employment which you are able to perform, whether due to education, training, or experience, which is available at one or more locations in the national economy and in which you can be expected to earn at least 80% of your Indexed Predisability Earnings within twelve months following your return to work, regardless of whether you are working in that or any other occupation.

Material Duties means the essential tasks, functions and operations, and the skills, abilities, knowledge, training and experience, generally required by employers from those engaged in a particular occupation that cannot be reasonably modified or omitted. In no event will we consider working an average of more than 40 hours per week to be a Material Duty.

C. Partial Disability Definition

During the Benefit Waiting Period and the Own Occupation Period, you are Partially Disabled when you work 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 Indexed Predisability Earnings, in that occupation.

Your Work Earnings may be Deductible Income. See **Return To Work Provisions** and **Deductible Income**.

Your Own Occupation Period and Any Occupation Period are shown in the **Coverage Features**.

(OR DEF_OWN_ANY_WITH 40) LT.DD.OT.1

RETURN TO WORK PROVISIONS

A. Return To Work Incentive

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

You are eligible for the Return To Work Incentive on the first day you work after the Benefit Waiting Period if LTD Benefits are payable on that date. The Return To Work Incentive changes 12 months after that date, as follows:

1. During the first 12 months, your Work Earnings will be Deductible Income as determined in a., b. and c:
   a. Determine the amount of your LTD Benefit as if there were no Deductible Income, and add your Work Earnings to that amount.
   b. Determine 100% of your Indexed Predisability Earnings.
   c. If a. is greater than b., the difference will be Deductible Income.
2. After those first 12 months, 50% of your Work Earnings will be Deductible Income.

B. Work Earnings Definition

Work Earnings means your gross monthly earnings from work you perform while Disabled, plus the earnings you could receive if you worked as much as you are able to, considering your Disability, in work that is reasonably available:

a. In your Own Occupation during the Own Occupation Period; and

b. In Any Occupation during the Any Occupation Period.

Work Earnings includes earnings from your Employer, any other employer, or self-employment, and 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 monthly, 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. During the Own Occupation Period you will no longer be Disabled when your average Work Earnings over the last three months exceed 80% of your Indexed Predisability Earnings. During the Any Occupation Period you will no longer be Disabled when your average Work Earnings over the last three months exceed 80% of your Indexed Predisability Earnings.

.RW.OT.1

REASONABLE ACCOMMODATION EXPENSE BENEFIT

If you return to work in any occupation for any employer, not including self-employment, as a result of a reasonable accommodation made by such employer, we will pay that employer a Reasonable Accommodation Expense Benefit of up to $25,000, but not to exceed the expenses incurred.

The Reasonable Accommodation Expense Benefit is payable only if the reasonable accommodation is approved by us in writing prior to its implementation.

.RA.OT.1

REHABILITATION PLAN PROVISION

While you are Disabled you may qualify to participate in a Rehabilitation Plan. Rehabilitation Plan means a written plan, program or course of vocational training or education that is intended to prepare you to return to work.

To participate in a Rehabilitation Plan you must apply on our forms or in a letter to us. The terms, conditions and objectives of the plan must be accepted by you and approved by us in advance. We have the sole discretion to approve your Rehabilitation Plan.

While you are participating in an approved Rehabilitation Plan, your LTD Benefit will be increased by 10% of your Predisability Earnings. Your LTD Benefit may not exceed the Maximum LTD Benefit shown in the **Coverage Features** as a result of this increase.

An approved Rehabilitation Plan may include our payment of some or all of the expenses you incur in connection with the plan, including:

a. Training and education expenses.

b. Family care expenses.

c. Job-related expenses.

d. Job search expenses.

(WITH REHAB INC BFT) LT.RH.OT.1

TEMPORARY RECOVERY

You may temporarily recover from your Disability 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 Periods

   1. During the Benefit Waiting Period: 45 consecutive days of recovery.

   2. During the Maximum Benefit Period: 125 consecutive work days for each period of recovery.

B. Effect Of Temporary Recovery

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

   1. The Predisability Earnings used to determine your LTD Benefit will not change.

   2. The period of Temporary Recovery will not count toward your Benefit Waiting Period, your Maximum Benefit Period or your Own Occupation Period.

   3. No LTD Benefits will be payable for the period of Temporary Recovery.

4. No LTD Benefits will be payable after benefits become payable to you under any other disability insurance plan under which you become insured 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.

(NEW TR PERIOD) LT.TR.OT.1

WHEN LTD BENEFITS END

Your LTD 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 benefits become payable under any other disability insurance plan under which you become insured through employment during a period of Temporary Recovery.
5. The date you fail to provide proof of continued Disability and entitlement to LTD Benefits.

.BE.OT.1

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. The Member's LTD Benefit will not be adjusted to reflect any salary increase awarded during the period covered by LTD Benefits.

Predisability Earnings means your monthly rate of creditable compensation 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.

Predisability Earnings does not include:

1. Bonuses.
2. Commissions.
3. Overtime pay.
4. Stock options or stock bonuses.
5. Your Employer's contributions on your behalf to any deferred compensation arrangement or pension plan.
6. Any other extra compensation.

If you are paid on an annual contract basis, your monthly rate of creditable compensation is one-twelfth (1/12th) of your annual contract salary.

If you are paid hourly, your monthly rate of creditable compensation is based on your hourly pay rate multiplied by the number of hours you are regularly scheduled to work per month, 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 during the preceding 12 calendar months (or during your period of employment if less than 12 months), but not more than 173 hours.

(REG NO COM_NO STOCK) LT.PD.OT.1X

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, including donated amounts, (but not vacation pay) paid to you by your Employer, if it exceeds the amount found in a., b., and c.

   a. Determine the amount of your LTD Benefit as if there were no Deductible Income, and add your sick pay or other salary continuation to that amount.

   b. Determine 100% of your Indexed Predisability Earnings.

   c. If a. is greater than b., the difference will be Deductible Income.

2. Your Work Earnings, as described in the **Return To Work Provisions**.

3. Any amount you receive or are eligible to receive because of your disability, including amounts for partial or total disability, whether permanent, temporary, or vocational, under any of the following:

   a. A workers' compensation law;

   b. The Jones Act;

   c. Maritime Doctrine of Maintenance, Wages, or Cure;

   d. Longshoremen's and Harbor Worker's Act; or

   e. Any similar act or law.

4. Any amount you, your Spouse, or your child under age 18 receive or are eligible to receive because of your disability or retirement under:

   a. The Federal Social Security Act;

   b. The Canada Pension Plan;

   c. The Quebec Pension Plan;

   d. The Railroad Retirement Act; or

   e. Any similar plan or act.

   Full offset: Both the primary benefit (the benefit awarded to you) and dependents benefit are Deductible Income.

   Benefits your Spouse or a child receives or are eligible to receive because of your disability are Deductible Income regardless of marital status, custody, or place of residence. The term "child" has the meaning given in the applicable plan or act.

5. Any amount you receive or are eligible to receive because of your disability under any state disability income benefit law or similar law.
6. Any amount you receive or are eligible to receive because of your disability under another group insurance coverage.
7. Any disability or retirement benefits you receive under your Employer's retirement plan.
8. Any earnings or compensation included in Predisability Earnings which you receive or are eligible to receive while LTD Benefits are payable.
9. Any amount you receive or are eligible to receive under any unemployment compensation law or similar act or law.
10. 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.

(DOM_NO OTHR OFFST_PRIV_NO 3RD) LT.DI.OT.1

EXCEPTIONS TO DEDUCTIBLE INCOME

Deductible Income does not include:

1. Any cost of living increase 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. Early retirement benefits under the Federal Social Security Act which are not actually received.
6. Group credit or mortgage disability insurance benefits.
7. Accelerated death benefits paid under a life insurance policy.
8. Benefits from the following:
   a. Profit sharing plan.
   b. Thrift or savings plan.
   c. Deferred compensation plan.
   d. Plan under IRC Section 401(k), 408(k), 408(p), or 457.
   e. Individual Retirement Account (IRA).
   f. Tax Sheltered Annuity (TSA) under IRC Section 403(b).
   g. Stock ownership plan.
   h. Keogh (HR-10) plan.
9. Any amount you receive from a military disability benefit.

(PUB_NO OTHR OFFST) LT.ED.OT.1X

RULES FOR DEDUCTIBLE INCOME

A. Monthly Equivalents

Each month we will determine your LTD Benefit using the Deductible Income for the same monthly period, even if you actually receive the Deductible Income in another month.

If you are paid Deductible Income in a lump sum or by a method other than monthly, we will determine your LTD 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 eligible. 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. Otherwise, we may reduce your LTD Benefits by the amount we estimate you would be eligible to receive upon proper pursuit of the Deductible Income.

C. 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.

D. 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 LTD Benefits until we have been repaid in full. In the meantime, any LTD Benefits paid, including the Minimum LTD 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.

.RU.OT.1

ADDITIONAL BENEFITS FOR THE SEVERELY DISABLED

A. Assisted Living Benefit

If you meet the requirements in 1 through 3 below, we will pay Assisted Living Benefits according to the terms of the Group Policy after we receive Proof Of Loss satisfactory to us.

Requirements for Assisted Living Benefit

1. You are Disabled and LTD Benefits are payable to you.
2. While you are Disabled:
   a. You, due to loss of functional capacity as a result of Physical Disease or Injury, become unable to safely and completely perform two or more Activities Of Daily Living without Hands-on Assistance or Standby Assistance; or
   b. You require Substantial Supervision for your health or safety due to Severe Cognitive Impairment as a result of Physical Disease or Injury.
3. The condition in 2.a or 2.b above is expected to last 90 days or more as certified by a Physician in the appropriate specialty as determined by us.

B. Amount Of The Assisted Living Benefit

See the **Coverage Features** for the amount of the Assisted Living Benefit.

C. Becoming Insured For Assisted Living Benefits

You are eligible for Assisted Living Benefit coverage if you are insured for LTD insurance. Subject to the **Active Work Provision**, your Assisted Living Benefit coverage becomes effective on the date your LTD insurance becomes effective.

D. Payment Of Assisted Living Benefits

We will pay Assisted Living Benefits within 60 days after Proof Of Loss is satisfied. Your Assisted Living Benefits will be paid to you at the same time LTD Benefits are payable.

E. Time Limits On Filing Proof Of Loss

Proof Of Loss for the Assisted Living Benefit must be provided within 90 days after the date the inability to perform Activities Of Daily Living or the Severe Cognitive Impairment begins. If that is not possible, it must be provided 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, the claim will be denied. These limits will not apply while the claimant lacks legal capacity.

F. When Assisted Living Benefits End

Assisted Living Benefits end automatically on the earliest of:

1. The date you no longer meet the requirements in item A. above.
2. The date your LTD Benefits end.

G. When Assisted Living Benefits Coverage Ends

Assisted Living Benefit coverage ends automatically on the earliest of:

1. The date your LTD insurance ends.
2. The date Assisted Living Benefit coverage terminates under the Group Policy.

H. Assisted Living Benefits After Insurance Ends Or Is Changed

Your right to receive Assisted Living Benefits will not be affected by the occurrence of the events described in 1 or 2 below that become effective after you become Disabled.

1. Termination or amendment of the Group Policy or your Employer's coverage under the Group Policy.
2. Termination of Assisted Living Benefit coverage while the Group Policy or your Employer's coverage under the Group Policy remains in force.

I. Assisted Living Benefit Limitations

No Assisted Living Benefit will be paid for any period when you are confined for any reason in a penal or correctional institution.

No Assisted Living Benefit will be paid if your inability to perform Activities Of Daily Living or your Severe Cognitive Impairment is caused or contributed to by:

1. 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.
2. Any intentionally self-inflicted Injury, while sane or insane.
3. Committing or attempting to commit an assault or felony, or active participation in a violent disorder or riot. (Active participation does not include being at the scene of a violent disorder or riot while performing official duties.)

J. Definitions

1. Activities Of Daily Living means Bathing, Continence, Dressing, Eating, Toileting, or Transferring.
2. Bathing means washing oneself, whether in the tub or shower or by sponge bath, with or without the help of adaptive devices.

3. Continence means voluntarily controlling bowel and bladder function, or, if incontinent, maintaining a reasonable level of personal hygiene.

4. Dressing means putting on and removing all items of clothing, footwear, and medically necessary braces and artificial limbs.

5. Eating means getting food and fluid into the body, whether manually, intravenously, or by feeding tube.

6. Toileting means getting to and from and on and off the toilet, and performing related personal hygiene.

7. Transferring means moving into or out of a bed, chair or wheelchair, with or without adaptive devices.

8. Hands-on Assistance means the physical assistance of another person without which the insured would be unable to perform the Activity Of Daily Living.

9. Standby Assistance means the presence of another person within arm's reach of the insured that is necessary to prevent, by physical intervention, injury to the insured while the insured is performing the Activity Of Daily Living (such as being ready to catch the insured if the insured falls while getting into or out of the bathtub or shower as part of Bathing, or being ready to remove food from the insured's throat if the insured chokes while Eating).

10. Severe Cognitive Impairment means a loss or deterioration in intellectual capacity that is (a) comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia, and (b) is measured by clinical evidence and standardized tests approved by us that reliably measure impairment in (i) short-term or long-term memory, (ii) orientation as to people, places, or time, and (iii) deductive or abstract reasoning.

11. Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect you from threats to your health or safety (such as may result from wandering).

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SURVIVORS BENEFIT

If you die while LTD Benefits are payable, and on the date you die you have been continuously Disabled for at least 180 days, we will pay a Survivors Benefit according to 1 through 3 below.

1. The Survivors Benefit is a lump sum equal to 3 times your LTD Benefit without reduction by Deductible Income.

2. The Survivors Benefit will first be applied to reduce any overpayment of your claim.

3. The Survivors Benefit will be paid at our option to any one or more of the following:

   a. Your surviving Spouse;

   b. Your surviving unmarried children, including adopted children, under age 25;

   c. Your surviving Spouse's unmarried children, including adopted children, under age 25; or

   d. Any person providing the care and support of any person listed in a., b., or c. above.

   e. Your estate, if you are not survived by any person listed in a., b., or c. above.

(MULTPL_EST_DOM) LT.SB.OT.1

BENEFITS AFTER INSURANCE ENDS OR IS CHANGED

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

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

.BA.OT.1

EFFECT OF NEW DISABILITY

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

1. LTD Benefits will not continue beyond the end of the original Maximum Benefit Period.
2. The **Disabilities Excluded From Coverage, Disabilities Subject To Limited Pay Periods,** and **Limitations** sections will apply to the new cause of Disability.

.ND.OT.1

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. Preexisting Condition

This Group Policy does not include a Preexisting Condition Exclusion.

D. Loss Of License Or Certification

You are not covered for a Disability caused or contributed to by the loss of your professional license, occupational license or certification.

E. Violent Or Criminal Conduct

You are not covered for a Disability caused or contributed to by your committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing your official duties.

(NO PX) LT.XD.OT.1X

LIMITATIONS

A. Care Of A Physician

You must be under the ongoing care of a Physician in the appropriate specialty as determined by us during the Benefit Waiting Period. No LTD Benefits will be paid for any period of Disability when you are not under the ongoing care of a Physician in the appropriate specialty as determined by us.

B. Imprisonment

No LTD Benefits will be paid for any period of Disability when you are confined for any reason in a penal or correctional institution.

C. Substance Abuse

No LTD Benefits will be paid for any period of Disability caused or contributed to by your Substance Abuse, unless you are participating in good faith in a treatment plan, program or course of medical treatment for Substance Abuse.

Substance Abuse means abuse of alcohol, alcoholism, misuse of any drug, including hallucinogens, or drug addiction.

D. Rehabilitation Program

LTD Benefits will be reduced to 50% of the amount determined from the Schedule Of Insurance for any period of Disability when you are not participating in good faith in a plan, program or course of medical treatment or vocational training or education approved by us, unless your Disability prevents you from participating. If this limitation causes the LTD Benefit to be less than the Minimum LTD Benefit, the Minimum LTD Benefit will be payable.

(NO FRGN) LT.LM.OT.1X

CLAIMS

A. 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.

B. 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 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.

C. Proof Of Loss

Proof Of Loss means written proof that you are Disabled and entitled to LTD 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.

D. 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.

E. Investigation Of Claim

During the pendency of your 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 LTD Benefits if you fail to attend an examination or cooperate with the examiner.

F. Time Of Payment

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

LTD Benefits will be paid to you at the end of each month you qualify for them. LTD Benefits remaining unpaid at your death will be paid to the person(s) receiving the Survivors Benefit. If no Survivors Benefit is paid, the unpaid LTD Benefits will be paid to your estate.

G. 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. A description of any additional information needed to support your claim.

d. Information concerning your right to a review of our decision.

H. 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. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.

I. Assignment

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

(REV PUB WRDG) LT.CL.VA.2

ALLOCATION OF AUTHORITY

Except for those functions which the Group Policy specifically reserves to the Policyholder or Employer, we have full and exclusive authority to control and manage the Group Policy, to administer claims, and to interpret the Group Policy and resolve all questions arising in the administration, interpretation, and application of the Group Policy.

Our authority includes, but is not limited to:

1. The right to resolve all matters when a review has been requested;
2. The right to establish and enforce rules and procedures for the administration of the Group Policy and any claim under it;
3. The right to determine:
   a. Eligibility for insurance;
   b. Entitlement to benefits;
   c. The amount of benefits payable; and
   d. The sufficiency and the amount of information we may reasonably require to determine a., b., or c., above.

Subject to the review procedures of the Group Policy, any decision we make in the exercise of our authority is conclusive and binding.

.AL.OT.1

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 more than three years after the earlier of:

1. The date we receive Proof Of Loss; and
2. The time within which Proof Of Loss is required to be given.

LT.TL.OT.1

INCONTESTABILITY PROVISIONS

A. Incontestability Of Insurance

Any statement made to obtain insurance 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 other person claiming benefits a copy of the signed written instrument which contains the misrepresentation.

After insurance has been in effect for two years during the lifetime of the insured, we will not use a misrepresentation to reduce or deny the 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 nonpayment of premiums or fraudulent misrepresentations.

LT.IN.OT.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 premiums paid and the premiums which would have been paid if the age had been correctly stated.

LT.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.

LT.TA.OT.1

DEFINITIONS

Benefit Waiting Period means the period you must be continuously Disabled before LTD Benefits become payable. No LTD 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.

CPI-W means the Consumer Price Index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. If the CPI-W is discontinued or changed, we may use a comparable index. Where required, we will obtain prior state approval of the new index.

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 LTD insurance policy issued by us to the Policyholder and identified by the Group Policy Number.

Indexed Predisability Earnings means your Predisability Earnings adjusted by the rate of increase in the CPI-W. During your first year of Disability, your Indexed Predisability Earnings are the same as your Predisability Earnings. Thereafter, your Indexed Predisability Earnings are determined on each anniversary of your Disability by increasing the previous year's Indexed Predisability Earnings by the rate of increase in the CPI-W for the prior calendar year. The maximum adjustment in any year is 10%. Your Indexed Predisability Earnings will not decrease, even if the CPI-W decreases.

Injury means an injury to the body.

LTD Benefit means the monthly benefit payable to you under the terms of Group Policy.

Maximum Benefit Period means the longest period for which LTD 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 LTD Benefits are payable after the end of the Maximum Benefit Period, even if you are still Disabled. See **Coverage Features**.

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 the body as diagnosed by a Physician.

Physician means a licensed M.D. or D.O., acting within the scope of the license. Physician does not include you or your Spouse, or the brother, sister, parent, or child of either you or your Spouse.

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

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

Spouse means:

1. A person to whom you are legally married and from whom you are not legally separated; 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.

(DOM) LT.DF.OT.1

POLICYHOLDER PROVISIONS

A. Premiums

The premium due on each Premium Due Date is the sum of the premiums for all persons then insured. Premium Rates are shown in **Coverage Features**.

B. Contributions From Members

The Policyholder determines the amount, if any, of each Member's contribution toward the cost of insurance.

C. Changes In Premium Rates

We may change Premium Rates whenever:

1. A change or clarification in law or governmental regulation affects the amount payable under the Group Policy. Any such change in Premium Rates will reflect only the change in our obligations.
2. Factors material to underwriting the risk we assumed under the Group Policy with respect to an Employer, including, but not limited to, number of persons insured, age, Predisability Earnings, gender, and occupational classification, changes by 25% or more.
3. The premium contribution arrangement for Members is changed or varies from that stated in the Group Policy when issued or last renewed.
4. We and the Policyholder or the Employer mutually agree to change Premium Rates.

Except as provided above, Premium Rates will not be changed during the Initial Rate Guarantee Period shown in **Coverage Features**. Thereafter, except as provided above, we may change Premium Rates upon 180 days advance written notice to the Policyholder. Any such change in Premium Rates may be made effective on any Premium Due Date, but no such change will be made more than once in any contract year. Contract years are successive 12 month periods computed from the end of the Initial Rate Guarantee Period.

D. Payment Of Premiums

All premiums are due on the Premium Due Dates shown in **Coverage Features**.

Each premium is payable on or before its Premium Due Date directly to us at our home office. The payment of each premium by the Policyholder as it becomes due will maintain the Group Policy in force until the next Premium Due Date.

E. Grace Period And Termination For Nonpayment

If a premium is not paid on or before its Premium Due Date, it may be paid during the following Grace Period of 31 days. The Group Policy or an Employer's coverage under the Group Policy will remain in force during the Grace Period.

If the premium is not paid during the Grace Period, the Group Policy will terminate automatically at the end of the Grace Period.

The Policyholder is liable for premium for coverage during the Grace Period. We may charge interest at the legal rate for any premium which is not paid during the Grace Period, beginning with the first day after the Grace Period.

F. Termination For Other Reasons

The Policyholder may terminate the Group Policy by giving us written notice. The effective date of termination will be the later of:

1. The date stated in the notice; and
2. The date we receive the notice.

We may terminate the Group Policy as follows:

1. On any Premium Due Date if the number of persons insured is less than the Minimum Participation shown in **Coverage Features**.
2. On any Premium Due Date if we determine that the Policyholder has failed to promptly furnish any necessary information requested by us, or has failed to perform any other obligations relating to the Group Policy.

The minimum advance notice of termination by us is 60 days.

G. Premium Adjustments

Premium adjustments involving a return of unearned premiums to the Policyholder will be limited to the 12 months just before the date we receive a request for premium adjustment.

H. Certificates

We will issue certificates to the Policyholder showing the coverage under the Group Policy. The Policyholder will distribute a certificate to each insured Member. If the terms of the certificate differ from the Group Policy, the terms stated in the Group Policy will govern.

I. Records And Reports

The Policyholder will furnish on our forms all information reasonably necessary to administer the Group Policy. We have the right at all reasonable times to inspect the payroll and other records of the Policyholder which relate to insurance under the Group Policy.

J. Agency And Release

Individuals selected by the Policyholder or by any Employer to secure coverage under the Group Policy or to perform their administrative function under it, represent and act on behalf of the person selecting them, and do not represent or act on behalf of Standard. The Policyholder, Employer and such individuals 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. The Policyholder and each Employer hereby release, hold harmless and indemnify Standard from any liability arising from or related to any negligence, error, omission, misrepresentation or dishonesty of any of them or their representatives, agents or employees.

K. Notice Of Suit

The Policyholder or Employer shall promptly give us written notice of any lawsuit or other legal proceedings arising under the Group Policy.

L. Entire Contract, Changes

The Group Policy and the applications of the Policyholder constitute the entire contract between the parties. A copy of the Policyholder's application is attached to the Group Policy when issued.

The Group Policy may be changed in whole or in part. No change in the Group Policy 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. No agent has authority to change the Group Policy, or to waive any of their provisions.

M. Effect On Workers' Compensation, State Disability Insurance

The coverage provided under the Group Policy is not a substitute for coverage under a workers' compensation or state disability income benefit law and does not relieve the Employer of any obligation to provide such coverage.

(NO DIV) LT.PH.OT.1

VA/LTDP2000X

Exhibit F

STANDARD INSURANCE COMPANY

A Stock Life Insurance Company

900 SW Fifth Avenue
Portland, Oregon 97204-1282
(503) 321-2700

DISABILITY PROGRAM ADMINISTRATIVE SERVICES AGREEMENT

Program Sponsor:	County of Henrico, Virginia Including Henrico County Public Schools and Henrico Economic Development Authority
Claims Administrator:	Standard Insurance Company
ATP Number:	649721-B
Effective Date:	January 1, 2019

Note: The terms of this Agreement are not governed under the terms of any Master Service Agreement issued by Standard Insurance Company in conjunction with any others services provided to Program Sponsor.

Program Sponsor has adopted a self-funded short-term disability income benefit plan (Program) for certain of its employees. Program Sponsor is solely responsible for all risks, liabilities, benefits and claims under the Program.

Program Sponsor has requested Standard to provide administrative services to the Program as described in this Agreement. Standard is willing to provide such services, according to the terms of this Agreement, without assuming any financial responsibility under the Program.

Standard's willingness to provide administrative services is conditioned upon Program Sponsor's agreement that Standard is not responsible for any risk, liability, benefit or claim under the Program and upon Program Sponsor fulfilling its obligations as provided herein.

LIMITED AGENCY APPOINTMENT OF STANDARD

Program Sponsor hereby appoints Standard to act on its behalf as Claims Administrator for the Program and grants to Standard authority to fulfill the Obligations of Claims Administrator, as provided herein. Standard is empowered to act on behalf of Program Sponsor in connection with the Program only as expressly stated in this Agreement. Standard has no authority or obligation with respect to (1) Program Sponsor's right of subrogation under the Program, or (2) management or investment of the assets of the Program. In performing its obligations under this Agreement, Standard is acting solely as the agent of Program Sponsor.

OBLIGATIONS OF CLAIMS ADMINISTRATOR

Standard, acting as Claims Administrator for the Program, shall provide the following services, consistent with the terms of the Program:

A. Claims Services

1) Investigate claims for benefits under the Program, determine eligibility for coverage, make initial claim decisions to approve, deny or close claims for benefits, and notify claimants and Program Sponsor in writing of its decisions, subject to Program Sponsor's right of final review and decision on all claims.

2) If an appeal is requested by the claimant, provide an independent review and notify claimant and Program Sponsor in writing of Standard's decision, subject to Program Sponsor's right of final review and decision on all appeals.

3) Advise and assist Program Sponsor on procedures to be followed in submission of claims, including the preparation of forms necessary for submission and processing of claims.

4) Create and maintain a current and complete claim file for any claim presented to Standard for administration under the Program.

5) Submit to Program Sponsor all claims Program Sponsor may request to review.

6) If applicable, prepare benefit statements for claimants setting forth the benefit schedule applicable and explaining any adjustments.

7) Have medical and vocational examinations of claimants performed as Standard deems advisable.

8) Advise claimants concerning the need to apply for deductible income and periodically verify application for or receipt of deductible income.

9) Review claims to determine continued eligibility for benefits as frequently as claimant's condition warrants.

10) Defend, at its expense, claim litigation arising out of or relating to, in whole or in part, from the performance of Standard's Claims Administrator obligations under this Agreement. However, the Program Sponsor, not Standard, is financially responsible for the risks, liabilities and benefits of the Program. Standard shall be empowered to judge the acceptability of any compromise and to settle any such liability. Prior to entering into any settlement or compromise on behalf of Program Sponsor, Standard will make a recommendation to Program Sponsor for approval, which approval shall not be unreasonably withheld.

    In the event that Program Sponsor does not approve of Standard's recommendation, or overturns Standard's decision as set forth in item 2 above, Employer will be responsible for any obligation to defend.

B. Program Document Services

1) Advise and assist Program Sponsor with regard to the initial preparation of the Program and recommend subsequent revisions as may be appropriate.

2) Advise and assist Program Sponsor with regard to the preparation and review of Program summaries, descriptive booklets, certificates of coverage and similar material for distribution to covered employees.

C. Performance Standards

Standard and Program Sponsor each shall exercise ordinary care and reasonable diligence in the performance of its duties under this Agreement. Standard and Program Sponsor will not be liable for any mistake of judgment taken in good faith. Further, Standard shall not be considered to have failed to perform its obligations under this Agreement if any delay or nonperformance on its part is due, in whole or in part, to failure of the other party to discharge its own obligations promptly.

OBLIGATIONS OF PROGRAM SPONSOR

Program Sponsor shall:

A. Retain full financial responsibility for the Program and its operation.

B. Furnish any information reasonably required by Standard to carry out Standard's duties under this Agreement, including but not limited to relevant program documents and any other administrative guidance necessary to administer the program.

C. Review Standard's claim and appeal decisions in a timely manner. If Program Sponsor fails to notify Standard in writing of any objection it may have to any such decision within 45 days after notice thereof from Standard, Program Sponsor shall be deemed to have waived such objection and shall be conclusively presumed to have ratified and approved Standard's decision.

D. Pay benefits according to the terms of the Program.

E. Establish and maintain such accounts and records as may be required in accordance with this Agreement.

F. Provide Standard with all amendments or modifications to the Program at least 60 days prior to the proposed effective date of the change. Standard shall have no obligation to administer any such change unless and until approved by Standard, which approval shall not be unreasonably withheld. Standard retains the right to modify the **Fees** to reflect any additional services or expenses required by such change.

G. Provide Standard in writing with the names of individuals authorized to act for Program Sponsor in connection with this Agreement, together with a statement of the extent of their authority.

H. Identify Standard as Claims Administrator in relevant Program documents and related materials. Any other use of Standard's name in connection with Program administration must be authorized in advance and in writing by Standard.

BENEFIT PAYMENTS

Benefits payable under the Program will be paid by Program Sponsor.

FEES

A. Fees

Program Sponsor shall pay fees to Standard in connection with Standard's services under this Agreement as follows.

MONTHLY GENERAL FEE. The Monthly General Fee shall be the sum of the monthly fees due for all Employers covered under the Program on that due date. The monthly fee shall be as stated in the final proposal accepted by Program Sponsor.

ADDITIONAL FEES. Additional Fees may be charged to Program Sponsor upon mutual agreement between Program Sponsor and Standard.

B. Change in Fee Rates

1) Standard may change the amount, the method of determination, or both, of any fees not yet due, when a change in any law or regulation affects the manner in which Standard performs any function under this Agreement. The amount, the method of determination, or both, of any fees not yet due may also be changed upon mutual agreement between Program Sponsor and Standard.

2) Except as provided in Paragraph 1) of this section:

a. Fees will not be changed during the first four years the Agreement is in effect, provided that this limitation shall not apply to any changes in fees in connection with any change in the terms of this Agreement or the Program.

b. Thereafter Standard may change the amount, the method of determination, or both, of any fees not yet due, upon 180 days written notice to Program Sponsor. Except as provided in Paragraph 1) of this section, no such change in fees shall be made more than once in any Contract Year, provided that this limitation shall not apply to any changes in fees in connection with any change in the terms of this Agreement or the Program.

C. Payment Due Dates

All fees are due and payable within 60 days after the notice by Standard has been sent to Program Sponsor of the amount owed.

INTEREST ON LATE PAYMENTS

Program Sponsor shall pay Standard interest at a rate equal to the Wells Fargo Bank and Co. prime rate plus two percent (2%) per annum, or the highest rate permitted by applicable law, whichever is less, on any sums payable to Standard pursuant to this Agreement which are not paid by Program Sponsor on or before the date on which such sums are due.

INDEMNIFICATION AGREEMENT

A. Standard agrees to indemnify, defend, and hold Program Sponsor, including directors, officers, and employees, from any and all, liabilities, claims, lawsuits, administrative proceedings, settlements, compromises, judgments, penalties, costs and expenses, including but not limited to, attorney's fees, pretrial discovery, deposition and investigation expenses, compensatory, consequential, special, exemplary and punitive damages arising out of or relating to, in whole or in part, any negligent act or omission, criminal conduct or fraud, or intentional failure to perform any obligation under the Program or this Agreement.

B. Nothing in this **Indemnification Agreement** section is intended to or does alter the obligations of the Program Sponsor to bear full financial responsibility for any benefits payable under the

Program or to defend litigation related to such benefits as set forth in **Obligations Of Program Sponsor**.

RECORDS AND CLAIM FILES

A. All claim files, records, reports, and other information prepared and maintained by Standard pursuant to this Agreement shall be the sole property of Program Sponsor, subject to Standard's right to retain copies of any such information.

B. Upon reasonable written request, and during regular business hours Program Sponsor shall have the right to inspect any claim file and any other record or report, including but not limited to, records relating to payments of benefits which have been prepared and maintained by Standard, pursuant to this Agreement.

C. All claim files and other records and reports prepared and maintained by Standard pursuant to this Agreement shall be confidential. Standard shall take such measures as are reasonably necessary to preserve the confidentiality of such claim files, records and reports. No individually identifiable information will be released from any such claim file, except as follows:

   1) In response to a court order.

   2) For an examination conducted by regulatory authorities.

   3) At the request of the Program Sponsor.

   4) With the written consent of the identified individual or his or her legal representative.

   Pursuant to the **Obligations Of Program Sponsor** section of this Agreement, Program Sponsor shall designate employees or agents who are authorized to receive individually identifiable claim information on behalf of Program Sponsor. Standard may rely upon such authorizations until receipt of written instructions changing such authorizations.

D. Any individually identifiable claim information released to Program Sponsor pursuant to this Agreement shall be treated as confidential. Program Sponsor shall protect such information from unauthorized disclosure.

E. Claim files, records, reports and other information prepared and maintained by Standard pursuant to this Agreement may be destroyed by Standard at anytime after seven years. With respect to claim files, the seven-year period begins on the date benefits cease to be paid to the claimant. Program Sponsor may receive an inactive claim file at anytime within the first 60 days after benefits cease by sending a written request to Standard and payment of Standard's reasonable shipping and handing costs.

AMENDMENT

This Agreement constitutes the entire contract between the parties, superseding all prior or contemporaneous written or oral understandings and agreements. No modification or amendment of this Agreement shall be valid unless made in writing and signed by each party.

ASSIGNMENT AND MISCELLANEOUS PROVISIONS

A. Neither party shall assign this contract without the prior written consent of the other party.

B. Standard will not be bound by any notice, direction, requisition, or request unless and until it is received in writing at Standard's Home Office at Portland, Oregon.

C. This Agreement shall be deemed to have been entered into in the Commonwealth of Virginia and all questions concerning validity, interpretation, or performance of any of its terms or provisions or of any rights or obligations of the parties to this Agreement, shall be governed by and resolved in accordance with the laws of Commonwealth of Virginia.

D. Captions of the parts, sections, and paragraphs of this Agreement are for convenience and reference only, and the words contained in such captions shall in no way be employed to explain, modify, amplify, or aid in the interpretation, construction, or meaning of the provisions of this Agreement.

E. Standard has not and will not provide legal advice, legal opinions or other legal services to Program Sponsor in establishing or maintaining the Program or relative to this Agreement. Program Sponsor will rely solely upon the advice of its own legal counsel in evaluating the legal aspects of the Program and this Agreement.

F. Each party shall promptly give the other written notice of any claim, lawsuit, or administrative proceeding concerning a claim for benefits under the Program or any other matter embraced by the indemnity. The parties shall cooperate fully in the defense of any such claim, lawsuit, or proceeding.

G. If litigation arises out of this Agreement, the parties agree that each party shall bear its own litigation costs and attorneys fees, unless there is a court order to the contrary.

TERM AND TERMINATION

A. Contract Years are successive twelve month periods computed from the effective date of this Agreement. The date of termination of this Agreement, unless otherwise specified, shall be deemed to be the last day of a Contract Year.

B. This Agreement may be terminated by either party upon sixty (60) days written notice of termination provided to the other party.

C. This Agreement will terminate automatically on the date of termination of any group long term disability insurance policy issued to Program Sponsor by Standard.

D. Program Sponsor's failure to pay **Fees** or to reimburse Standard for payment of benefits pursuant to **Benefit Payments**, and the provisions below in **Term And Termination** or Program Sponsor's failure to fulfill its obligations under **Indemnification Agreement**, shall terminate this Agreement upon written notice by Standard to be delivered to Program Sponsor at its last known address.

E. Effect of Termination.

1) Claims Administration

Notwithstanding termination of this Agreement, the Standard will continue to provide claim services with respect to any claim for benefits under the Program with an incurred date occurring on or before the date of termination. Program Sponsor shall see to it that any such claim is immediately sent to Standard. Standard may administer any such claim until it determines the claim is inactive. The terms and provision of this Agreement shall continue to apply where applicable to the runoff of such claims, specifically including Program Sponsor's obligation to pay benefits according to the terms of the Program.

2) Claims Records

Standard may retain any open or active claim files as provided in item E.1 above of the **Term And Termination** section of this Agreement. Any such files not retained by Standard shall be sent to Program Sponsor or its successor administrator promptly upon payment of Standard's reasonable shipping and handling costs.

Standard shall retain all inactive claim files and other records and reports relating to such claims and prepared and maintained by Standard pursuant to this Agreement, and may destroy such files, etc. as provided in Records and Claim File provision. Program Sponsor may obtain possession of such extant claim files, records and reports upon written request to Standard and payment of Standard's reasonable shipping and handling costs. Program Sponsor acknowledges that locating and processing such files and records may be difficult and time consuming and will substantially increase the shipping and handling costs it is obligated to pay.

F. Outstanding Obligations

Notwithstanding any other provision of this Agreement to the contrary, the termination of this Agreement shall not release either party from any obligation already incurred, including any payment obligation already incurred under the **Fees** or **Benefit Payments** provision**.** Further, provisions of the **Indemnification Agreement** and defense obligations under **Obligation Of Program Sponsor,** and the confidentiality provisions under **Records And Claim Files** sections will not be affected by the termination of this Agreement and will remain in full force and effect.

IN WITNESS WHEREOF, the parties hereto have caused this agreement to be executed in duplicate by their respective officers duly authorized to do so.

Program Sponsor:

By _____ Date _____

STANDARD INSURANCE COMPANY

By

Chairman, President and CEO

Corporate Secretary

Exhibit G

HENRICO COUNTY, VIRGINIA

PROGRAM DOCUMENT

SHORT TERM DISABILITY INCOME BENEFIT PROGRAM

Program Sponsor has established a short term disability income benefit Program and agreed to provide STD Benefits according to the terms of this Program Document. Program Sponsor is solely responsible for payment of STD Benefits payable under the terms of this Program.

Program Sponsor has retained Standard Insurance Company as Claims Administrator for the Program. Standard shall receive, process, investigate and evaluate claims for benefits. Standard has authority to make initial decisions to approve, deny or close claims for benefits. Standard is also authorized to review and decide appeals of denied or closed claims, if requested by claimants as provided in the appeal provision of the Program. Thereafter, Program Sponsor may elect to hear and decide any further appeals by claimants. In each case, Program Sponsor retains the right of final review and decision on all claims and appeals.

Standard will also perform certain administrative services for the Program, including advising and assisting Program Sponsor with preparation and revision of the Program and providing actuarial services. Standard has no authority or obligation with respect to management or investment of the assets of the Program or Program Sponsor's right of subrogation under the Program.

This Program and the individual applications, if any, of the Members constitute the entire Program. Program Sponsor has the right at anytime to amend or terminate this Program or to require or change the amount of Member contributions. No change in this Program will be valid unless approved by Program Sponsor and evidenced by an amendment. No agent has authority to change this Program or to waive any of its provisions.

For purposes of effective dates and ending dates under this Program, all days begin and end at 12:00 midnight Standard Time at Program Sponsor's address.

All provisions on this and the following pages are part of this Program. "You" and "your" mean the Member. "We", "us", and "our" mean Standard Insurance Company acting in its capacity as Claims Administrator on behalf of Program Sponsor. Other defined terms appear with their initial letters capitalized. Section headings, and references to them, appear in boldface type.

PROGRAM SPONSOR

By

_____

_____

Signature(s) and Title(s) of Authorized Representative(s)

Table of Contents

Index of Defined Terms

COVERAGE FEATURES

This section contains many of the features of your short term disability (STD) coverage. 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 PROGRAM INFORMATION

Program Sponsor:	Henrico County, Virginia
Employer(s):	Henrico County General Government, Henrico County Public Schools, the Henrico County Economic Development Authority
Claims Administrator:	Standard Insurance Company
ATP Number:	649721-B
Program Effective Date:	January 1, 2019

Member means:

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. Actively At Work at least the minimum hours per week required by the Employer for coverage under the Program, but in no event less than 20 hours each week (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); and
3. A citizen or resident of the United States or Canada.

Member does not include a temporary or seasonal employee, a full-time member of the armed forces of any country, a leased employee, or an independent contractor.

Class Definition: None

SCHEDULE OF COVERAGE

Eligibility Waiting Period: You are eligible on one of the following dates, but not before the Program Effective Date:

a. With respect to coverage for a Disability arising out of or in the course of employment with the Employer, your first day as a Member.

b. With respect to coverage for any other Disability, the first day after one year employment with the Employer.

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

STD Benefit:

For a Disability arising out of or in the course of employment with the Employer:

The STD Benefit provides income replacement for (i) 60 percent of a Member's Predisability Earnings for the first 60 months of continuous participation in the Virginia hybrid retirement program described in § 51.1-169 of the Code of Virginia and (ii) thereafter, a percentage of a Member's Predisability Earnings during the periods specified below, based on the number of months of continuous participation in the Virginia hybrid retirement program attained by an employee who is disabled, on maternity leave, or takes periodic absences due to a major chronic condition, as determined by the Board or its designee, as follows:

Months of Continuous Participation	Work days of 100% Replacement of Creditable Compensation	Work days of 80% Replacement of Creditable Compensation	Work days of 60% Replacement of Creditable Compensation
Fewer than 60	0	0	125
60-119	85	25	15
120 or more	85	40	0

For any other Disability:

The STD Benefit provides income replacement for (i) 60 percent of a Member's Predisability Earnings after 12 months of continuous participation through the first 60 months of continuous participation in the Virginia hybrid retirement program described in § 51.1-169 of the Code of Virginia and (ii) thereafter, a percentage of a Member's Predisability Earnings during the periods specified below, based on the number of months of continuous participation in the Virginia hybrid retirement program attained by an employee who is disabled, on maternity leave, or takes periodic absences due to a major chronic condition, as follows:

Months of Continuous Participation	Work days of 100% Replacement of Creditable Compensation	Work days of 80% Replacement of Creditable Compensation	Work days of 60% Replacement of Creditable Compensation
60-119	25	25	75
120-179	25	50	50
180 or more	25	75	25

Minimum: None

Assisted Living Benefit: An additional 20% of your Predisability Earnings, not to exceed a total STD Benefit of 80%. The Assisted Living Benefit is not reduced by Deductible Income.

Benefit Waiting Period: 7 calendar days. The Benefit Waiting Period is waived when the Assisted Living Benefit applies. See **Assisted Living Benefit** and **First Day Assisted Living Benefit**.

Maximum Benefit Period: 125 work days

If you are Disabled for less than one full week, Program Sponsor will pay one-seventh of the STD Benefit for each day of Disability.

MEMBER CONTRIBUTIONS

Coverage is: Noncontributory

STATEMENT OF COVERAGE

If you become Disabled while covered under the Program, Program Sponsor will pay STD Benefits according to the terms of Program after we receive Proof Of Loss satisfactory to us.

(ASO) ST.IC.OT.1

BECOMING COVERED

To become covered you must be a Member, complete your Eligibility Waiting Period, and meet the requirements in **Active Work Provisions** and **When Your Coverage Becomes Effective**.

You are a Member if you are:

1. A regular employee of the Employer and who is participating in the Virginia hybrid retirement program described in § 51.1-169 of the Code of Virginia;
2. Actively At Work at least the minimum hours per week required by the Employer for coverage under the Program, but in no event less than 20 hours each week (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); and
3. A citizen or resident of the United States or Canada.

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

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

(ASO_VAR MBR DEF) ST.BI.OT.1X

WHEN YOUR COVERAGE BECOMES EFFECTIVE

Subject to the **Active Work Provisions**, your coverage becomes effective on the date you become eligible.

ACTIVE WORK PROVISIONS

A. Active Work Requirement

   You must be capable of Active Work on the day before the scheduled effective date of your coverage or your coverage 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 coverage, your coverage 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 Material Duties of your Own Occupation at your Employer's usual place of business.

B. Changes In Coverage

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

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WHEN YOUR COVERAGE ENDS

Your coverage ends automatically on the earliest of:

1. The date the last period ends for which a payment was made for your coverage.
2. The date the Program terminates.
3. The date your Employer's coverage under the Program terminates.

4. The date your employment terminates.
5. The date you cease to be a Member. However, your coverage 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 coverage under the Program 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 Benefit Waiting Period and while STD Benefits are payable.

(ASO) ST.EN.OT.1

REINSTATEMENT OF COVERAGE

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

1. If your coverage ends because you cease to be a Member and if you become a Member again within 90 days, the Eligibility Waiting Period will be waived.
2. If your coverage 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 coverage will be reinstated pursuant to the federal or state-mandated family or medical leave act or law.
3. In no event will coverage be retroactive.

(ASO_NONOCC) ST.RE.OT.4

DEFINITION OF DISABILITY

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

   A. Own Occupation Definition Of Disability; or

   B. Partial Disability Definition.

A. Own Occupation Definition Of Disability

   You are required to be Disabled only from your Own Occupation. You are Disabled from your Own Occupation if, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder, you are unable to perform the Material Duties of your Own Occupation with reasonable continuity.

   Note: You are not Disabled merely because your right to perform your Own Occupation is restricted, including a restriction or loss of license.

   You may work in another occupation while you meet the Own Occupation definition of Disability. However, you will no longer be Disabled when your Work Earnings from another occupation exceed 80% of your Predisability Earnings.

   Own Occupation means any employment, business, trade, profession, calling or vocation that involves Material Duties of the same general character as the occupation you are regularly performing for your Employer when Disability begins. In determining your Own Occupation, we are not limited to looking at the way you perform your job for your Employer, but we may also look at the way the occupation is generally performed in the national economy. If your Own Occupation involves the rendering of professional services and you are required to have a professional or

occupational license in order to work, your Own Occupation is as broad as the scope of your license.

Material Duties means the essential tasks, functions and operations, and the skills, abilities, knowledge, training and experience, generally required by employers from those engaged in a particular occupation, that cannot be reasonably modified or omitted. In no event will we consider working an average of more than 40 hours per week to be a Material Duty.

B. Partial Disability Definition

You are Partially Disabled when you work and, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder, you are unable to earn 80% of your Predisability Earnings or more.

Your Work Earnings may be Deductible Income. See **Return To Work Provisions** and **Deductible Income**.

ST2.DD.11

RETURN TO WORK PROVISIONS

A. Return To Work Incentive

You may serve your Benefit Waiting Period while working if you meet the Own Occupation 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 1. is greater than 2., the difference will be Deductible Income.

B. Work Earnings Definition

Work Earnings means your gross weekly earnings from work you perform while Disabled, plus the earnings you could receive if you worked as much as you are able to, considering your Disability, in work that is reasonably available in your Own Occupation. Work Earnings includes 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 week to week, we may determine your Work Earnings by averaging your earnings over the most recent four-week period. You will no

longer be Disabled when your average Work Earnings over the last four weeks 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: 45 consecutive calendar 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 coverage plan under which you become covered during your period of recovery.
5. Except as stated above, the provisions of the Program will be applied as if there had been no interruption of your Disability.

(ASO) ST.TR.OT.2X

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 attain normal retirement age under the Virginia hybrid retirement program.
4. The date you die.
5. The date long term disability benefits become payable to you under a group long term disability plan, even if that occurs before the end of the Maximum Benefit Period.
6. The date benefits become payable to you under any other disability coverage plan under which you become covered through employment during a period of Temporary Recovery.
7. The date you fail to provide proof of continued Disability and entitlement to STD Benefits.

PREDISABILITY EARNINGS

Your Predisability Earnings will be based on your earnings in effect on your last full day of Active Work.

The Member's STD Benefit will be adjusted to reflect any salary increase awarded during the period covered by STD Benefits.

Predisability Earnings means your weekly rate of creditable compensation 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.

Predisability Earnings does not include:

1. Bonuses.
2. Commissions.
3. Overtime pay.
4. Stock options or stock bonuses.
5. Your Employer's contributions on your behalf to any deferred compensation arrangement or pension plan.
6. Any other extra compensation.

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

If you are paid hourly, your weekly rate of creditable compensation 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.

(REG NO COM_NO STOCK) ST.PD.OT.1

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, including donated amounts, (but not vacation pay) paid to you by your Employer, if it exceeds the amount found in a., b., and c.
   a. Determine the amount of your STD Benefit as if there were no Deductible Income, and add your sick pay or other salary continuation to that amount.
   b. Determine 100% of your Predisability Earnings.
   c. If a. is greater than b., the difference will be Deductible Income.
2. Your Work Earnings, as described in the **Return To Work Provisions**.
3. Any amount you receive or are eligible to receive because of your disability under a state disability income benefit law or similar law.
4. Any amount you receive or are eligible to receive because of your disability under another group.
5. Any amount you receive or are eligible to receive because of your disability, including amounts for partial or total disability, whether permanent, temporary, or vocational, under any of the following:
   a. A workers' compensation law;
   b. The Jones Act;

c. Maritime Doctrine of Maintenance, Wages, or Cure;

d. Longshoremen's and Harbor Worker's Act; or

e. Any similar act or law.

6. Any disability benefits you receive or are eligible to receive, or retirement benefits you receive, under your Employer'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 your Employer's contributions will be considered as distributed simultaneously throughout your lifetime, regardless of 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 monthly income for life with no survivors benefit will be Deductible Income, even if you choose a different option.

7. Any earnings or compensation included in Predisability Earnings which you receive or are eligible to receive while STD Benefits are payable.

8. Any amount you receive or are eligible to receive under any unemployment compensation law or similar act or law.

9. 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.

(ASO_PUB_ WITH RTW_100% SL_NO OTHR OFFST_NO 3RD) ST.DI.OT.1X

EXCEPTIONS TO DEDUCTIBLE INCOME

Deductible Income does not include:

1. Any cost of living increase 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, legal rehabilitation expense.

3. Military disability benefits.

4. Reasonable attorneys fees incurred in connection with a claim for Deductible Income.

5. Benefits from any individual disability insurance policy.

6. Group credit or mortgage disability insurance benefits.

7. Accelerated death benefits paid under a life coverage plan or life insurance policy.

8. Benefits from the following:

   a. Profit sharing plan.

   b. Thrift or savings plan.

   c. Deferred compensation plan.

   d. Plan under IRC Section 401(k), 408(k), 408(p), or 457.

   e. Individual Retirement Account (IRA).

   f. Tax Sheltered Annuity (TSA) under IRC Section 403(b).

   g. Stock ownership plan.

   h. Keogh (HR-10) plan.

(ASO_PUB_NO OTHR OFFST) ST.ED.OT.1

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 eligible. 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. Otherwise, we may reduce your STD Benefits by the amount we estimate you would be eligible to receive upon proper pursuit of the Deductible Income.

C. 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 your Employer for the resulting overpayment of your claim.

D. Overpayment Of Claim

We will notify you of the amount of any overpayment of your claim under the Program and any group disability insurance policy. You must immediately repay any overpayment. You will not receive any STD Benefits until the overpayment has 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.

(ASO) ST.RU.OT.2X

ASSISTED LIVING BENEFIT

A. Assisted Living Benefit

If you meet the requirements in 1 through 3 below, Program Sponsor will pay Assisted Living Benefits according to the terms of the Program after we receive Proof Of Loss satisfactory to us.

Assisted Living Benefit Requirements

1. You are Disabled and STD Benefits are payable to you.
2. Your Disability arose out of or in the course of employment with the Employer.
3. While you are Disabled:
   a. You, due to loss of functional capacity as a result of Physical Disease or Injury, become unable to safely and completely perform two or more Activities Of Daily Living without Hands-on Assistance or Standby Assistance; or
   b. You require Substantial Supervision for your health or safety due to Severe Cognitive Impairment as a result of Physical Disease or Injury.

3. The condition in 3.a or 3.b above is expected to last 90 days or more as certified by a Physician in the appropriate specialty as determined by us.

B. Definitions For Assisted Living Benefit

Activities Of Daily Living means Bathing, Continence, Dressing, Eating, Toileting, or Transferring.

Bathing means washing oneself, whether in the tub or shower or by sponge bath, with or without the help of adaptive devices.

Continence means voluntarily controlling bowel and bladder function, or, if incontinent, maintaining a reasonable level of personal hygiene.

Dressing means putting on and removing all items of clothing, footwear, and medically necessary braces and artificial limbs.

Eating means getting food and fluid into the body, whether manually, intravenously, or by feeding tube.

Toileting means getting to and from and on and off the toilet, and performing related personal hygiene.

Transferring means moving into or out of a bed, chair or wheelchair, with or without adaptive devices.

Hands-on Assistance means the physical assistance of another person without which the insured would be unable to perform the Activity Of Daily Living.

Standby Assistance means the presence of another person within arm's reach of the insured that is necessary to prevent, by physical intervention, injury to the insured while the insured is performing the Activity Of Daily Living (such as being ready to catch the insured if the insured falls while getting into or out of the bathtub or shower as part of Bathing, or being ready to remove food from the insured's throat if the insured chokes while Eating).

Severe Cognitive Impairment means a loss or deterioration in intellectual capacity that is (a) comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia, and (b) is measured by clinical evidence and standardized tests approved by us that reliably measure impairment in (i) short-term or long-term memory, (ii) orientation as to people, places, or time, and (iii) deductive or abstract reasoning.

Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect you from threats to your health or safety (such as may result from wandering).

C. Amount Of The Assisted Living Benefit

The amount of the Assisted Living Benefit is shown in the **Coverage Features**.

D. Becoming Insured For Assisted Living Benefits

You are eligible for Assisted Living Benefit coverage if you are insured for STD coverage. Subject to the **Active Work Provision**, your Assisted Living Benefit coverage becomes effective on the date your STD coverage becomes effective.

E. Payment Of Assisted Living Benefits

Program Sponsor will pay Assisted Living Benefits within 60 days after Proof Of Loss is satisfied. Living Benefits will be paid to you at the same time STD Benefits are payable.

F. Time Limits On Filing Proof Of Loss

Proof Of Loss must be provided within 90 days after the date of the loss. If that is not possible, it must be provided 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, the claim will be denied. These limits will not apply while the claimant lacks legal capacity.

G. When Assisted Living Benefits End

Assisted Living Benefits end automatically on the earliest of:

1. The date you no longer meet the requirements in item A. above.
2. The date your STD Benefits end.

H. When Assisted Living Benefits Coverage Ends

Assisted Living Benefit coverage ends automatically on the earliest of:

1. The date your STD coverage ends.
2. The date Assisted Living Benefit coverage terminates under the Program.

I. Assisted Living Benefits After Coverage Ends Or Is Changed

Your right to receive Assisted Living Benefits will not be affected by the occurrence of the events described in 1 or 2 below that become effective after you become Disabled.

1. Termination or amendment of the Program or your Employer's coverage under the Program.
2. Termination of Assisted Living Benefit coverage while the Program or your Employer's coverage under the Program remains in force.

FIRST DAY ASSISTED LIVING BENEFIT

If you meet the Assisted Living Benefit Requirements, 1 through 3 below will apply.

1. The remainder of your Benefit Waiting Period will be waived.
2. STD Benefits will become payable on the first day you meet the Assisted Living Benefit Requirements.
3. Your Maximum Benefit Period will begin on the date STD Benefits become payable.

BENEFITS AFTER COVERAGE ENDS OR IS CHANGED

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

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

.BA.OT.1

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 Program, including the **Disabilities Excluded From Coverage** and **Limitations** sections, will apply to the new cause of Disability.

(ASO) ST.ND.OT.1

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. Violent Or Criminal Conduct

You are not covered for a Disability caused or contributed to by your committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing your official duties.

D. Loss Of License Or Certification

You are not covered for a Disability caused or contributed to by the loss of your professional license, occupational license or certification.

ST.XD.OT.1

LIMITATIONS

A. Care Of A Physician

You must be under the ongoing care of a Physician in the appropriate specialty as determined by us during the Benefit Waiting Period. No STD Benefits will be paid for any period of Disability when you are not under the ongoing care of a Physician in the appropriate specialty as determined by us.

B. Imprisonment

No STD Benefits will be paid for any period of Disability when you are confined for any reason in a penal or correctional institution.

C. Rehabilitation Program

STD Benefits will be reduced to 50% of the amount determined from the Schedule Of Coverage for any period of Disability when you are not participating in good faith in a plan, program or course of medical treatment or vocational training or education approved by us unless your Disability prevents you from participating.

ST.LM.OT.1X

CLAIMS

A. Filing A Claim

Claims should be filed on our forms. If you do not receive our forms within 15 days after you ask for them, 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.

B. 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 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.

C. 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.

D. 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.

E. 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.

F. Time Of Payment

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

STD Benefits will be paid to you coinciding with the Employer's regular payroll period applicable to you. STD Benefits remaining unpaid at your death will be paid to your estate.

G. 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 Program 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.

H. 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.

After the initial determination letter responding to an initial appeal, you may appeal a second time within 90 days. However, for a second appeal, you must provide additional information supporting your claim for benefits.

As soon as practical, and in no case less than 10 days, after receiving a second appeal letter, we shall provide to you the written acknowledgment that either (i) the second appeal has been received and is under review or (ii) the second appeal is not under review since you did not provide additional information regarding your Disability.

When applicable, we shall provide to you a final written determination for any second appeal within 45 days of receiving the second written appeal. We may request up to 45 additional days to complete the review of a second appeal.

When we issue a written determination on any appeal – whether an initial appeal or a second appeal – our letter shall (i) inform you of the reasons for the decision, (ii) reference parts of the STD Program on which the decision is based, (iii) inform you of your right to receive, free of charge, a copy of all non-privileged documents and records from the claim file relevant to the decision, and (iv) inform you of your right to bring a civil action in circuit court for benefits.

Following a final written determination of any appeal, you may bring a civil action in the Circuit Court of Henrico County, Virginia, challenging the determination.

I. Assignment

The rights and benefits under the Program are not assignable.

(ASO_REV PUB WRDG) ST.CL.OT.2

LIMITED AGENCY APPOINTMENT OF STANDARD

Program Sponsor has appointed Standard to act on its behalf as Claims Administrator for the Program and grants to Standard authority to fulfill the Obligations of Claim Administrator, as provided herein. Standard is empowered to act on behalf of Program Sponsor in connection with the Program only as expressly stated in this Program. Standard has no authority or obligation with respect to (1) a Program Sponsor's right of subrogation under the Program, or (2) management or investment of the assets of the Program. In performing its obligations under this Agreement, Standard is acting solely as the agent of Program Sponsor.

Standard's authority includes, but is not limited to:

1. The right to resolve all matters when a review has been requested;
2. The right to establish and enforce rules and procedures for the administration of the Program and any claim under it;
3. The right to determine:

a. Eligibility for coverage;

b. Entitlement to benefits;

c. The amount of benefits payable;

d. The sufficiency and the amount of information we may reasonably require to determine a., b., or c., above.

Standard's decisions are subject to the review procedures of the Program Sponsor.

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 more than three years after the earlier of:

1. The date we receive Proof Of Loss; and
2. The time within which Proof Of Loss is required to be given.

.TL.OT.1

CLERICAL ERROR

Clerical error by the Program Sponsor, Claims Administrator, or their respective employees or representatives will not:

1. Cause a person to become covered.
2. Invalidate coverage under the Program otherwise validly in force.
3. Continue coverage under the Program otherwise validly terminated.

(ASO) ST.CE.OT.2

TERMINATION OR AMENDMENT OF THE PROGRAM

Program Sponsor may terminate the Program in whole, and may terminate coverage for any class or group of Members, at any time.

Benefits under the Program are limited to its terms, including any valid amendment. No change or amendment will be valid unless approved by the Program Sponsor and evidenced by an amendment.

No agent has authority to change or amend the Program or to waive any of its terms or provisions.

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

(ASO) ST.TA.OT.2

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**.

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) coverage is nonelective and the Program Sponsor or Employer pay the entire cost of coverage; or (b) the Program Sponsor or Employer require all eligible Members to have coverage and to pay all or part of the cost of coverage.

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 M.D. or D.O., acting within the scope of the license. Physician does not include you or your spouse, or the brother, sister, parent, or child of either you or your spouse.

Program means the group short term disability income benefit program established by Program Sponsor and identified by the ATP Number.

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

Prior Plan means your Employer's short term disability program in effect on the day before the effective date of your Employer's coverage under the Program and which is replaced by the Program.

STD Benefit means the benefit payable to you under the terms of the Program.

(ATP) ST.DF.OT.1

VA/STDP2000(ASO)

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 6/30/2023

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Crystal IBC, LLC
560 Mission St., 6th Floor
San Francisco CA 94105

License#: 0C36861

CONTACT NAME: Heather Shoemaker Williams
PHONE (A/C, No, Ext): 628 502 2836 **FAX (A/C, No):**
E-MAIL ADDRESS: Heather.shoemaker@alliant.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Atlantic Specialty Insurance C	27154
INSURER B : Sentry Insurance Company	24988
INSURER C : National Union Fire Insurance	19445
INSURER D : Underwriters at Lloyds Brit Sy	0
INSURER E :	
INSURER F :	

INSURED
STANFIN-01
StanCorp Financial Group, Inc.
(See Additional Named Insureds Below)
1100 SW Sixth Avenue
Portland OR 97204

COVERAGES **CERTIFICATE NUMBER:** 1741245123 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X **COMMERCIAL GENERAL LIABILITY** CLAIMS-MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY [ ] PRO-JECT [X] LOC OTHER:	Y		712-00-77-55-0016	7/1/2023	7/1/2024	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG 	$ 1,000,000 $ 1,000,000 $ 15,000 $ 1,000,000 $ 2,000,000 $ 2,000,000 $
A	**AUTOMOBILE LIABILITY** X ANY AUTO OWNED AUTOS ONLY [ ] SCHEDULED AUTOS X HIRED AUTOS ONLY X NON-OWNED AUTOS ONLY	Y		712-00-77-55-0016	7/1/2023	7/1/2024	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) 	$ 1,000,000 $ $ $ $
A	X **UMBRELLA LIAB** X OCCUR **EXCESS LIAB** CLAIMS-MADE DED RETENTION $			712-00-77-55-0016	7/1/2023	7/1/2024	EACH OCCURRENCE AGGREGATE 	$ 10,000,000 $ 10,000,000 $
B B	**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY** Y / N ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [ ] **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		9016876001 9016876002	7/1/2023 7/1/2023	7/1/2024 7/1/2024	X PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ 1,000,000 $ 1,000,000 $ 1,000,000
C D	Professional Liability Privacy/Cyber Liability			01-309-57-86 B0146CYUSA2301398	7/1/2023 7/1/2023	7/1/2024 7/1/2024	Limit Limit	$5,000,000 $5,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Named Insureds: StanCorp Financial Group, Inc.; Standard Insurance Company; The Standard Life Insurance Company of New York; StanCorp Equities, Inc.; StanCorp Investment Advisers, Inc.; StanCorp Mortgage Investors, LLC; Standard Management, Inc.; Standard Retirement Services, Inc.; StanCorp Real Estate, LLC; StanCorp Insurance Company Inc.; Standard Insurance Company Continuing Health & Wealth Benefits Trust; StanCorp Mortgage Investors Pass-through, LLC

As Required by Written Contract -
County of Henrico and Henrico County Public Schools are included as Additional Insured with regards to the General Liability and Auto Liability policies as required by written contract subject to the policy terms and conditions. Coverage is Primary and Non-Contributory as required by written contract subject to the policy terms and conditions. 30 days' notice of cancellation applies in accordance with the terms and conditions of the policy.

CERTIFICATE HOLDER

County of Henrico
Risk Management
P.O. Box 90775
Henrico VA 23273

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

BROAD FORM GENERAL LIABILITY ENDORSEMENT

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

This endorsement extends certain coverages. The following listing and the headers in this endorsement are only for convenience. Provisions in this endorsement might be modified by other endorsements. Read the entire policy carefully to determine rights, duties and what is and is not covered.

A. Section I – Coverages

1. Expected or Intended Injury (Property Damage)

The following is added to Exclusion **2.a. Expected Or Intended Injury** of **Section I – Coverages – Coverage A – Bodily Injury and Property Damage Liability**:

This exclusion does not apply to "property damage" resulting from the use of reasonable force to protect persons or property.

2. Non-Owned Aircraft and Watercraft Under 55 Feet

a. The following is added to Exclusion **2.g. Aircraft, Auto or Watercraft** of **Section I – Coverages – Coverage A – Bodily Injury and Property Damage Liability**:

This exclusion does not apply to an aircraft that is:

(a) Hired, chartered or loaned with a paid crew; and

(b) Not owned by any insured.

b. The following replaces Exclusion **2.g.(2)(a)** of **Section I – Coverages – Coverage A – Bodily Injury and Property Damage Liability**:

(a) Less than 55 feet long; and

c. The following is added to Paragraph **b.(1)** in Paragraph **4. Other Insurance** of **Section IV – Commercial General Liability Conditions**:

This insurance is excess over any of the other valid and collectible insurance available to the insured that provides coverage for aircraft or watercraft not owned by any insured, whether such insurance is primary, excess, contingent or on any other basis.

3. Alienated Premises

The following replaces Exclusion **2.j.(2)** of **Section I – Coverages – Coverage A – Bodily Injury and Property Damage Liability**:

(2) Premises you sell, give away or abandon, if the "property damage" arises out of any part of those premises and occurs from hazards that were known to you, or should have been known to you, at the time the property was transferred or abandoned;

4. Broadened Property Damage – Rented Premises, Borrowed Equipment and Use of Elevators

a. The following is added to Exclusion **2.j. Damage To Property** of **Section I – Coverages – Coverage A – Bodily Injury and Property Damage Liability**:

Paragraph **(1)** of this exclusion does not apply to "property damage" to real property you rent or temporarily occupy with permission of the owner.

Paragraph **(4)** of this exclusion does not apply to "property damage" to equipment you borrow while at a job site if the equipment is not being used by anyone to perform work or operations at the time of loss.

Paragraphs **(3)**, **(4)** and **(6)** of this exclusion do not apply to "property damage" arising out of the use of elevators at premises you own, rent, lease or occupy.

b. The following replaces Paragraph **6.** of **Section III – Limits Of Insurance**:

6. Subject to Paragraph **5.** above, the Damage to Premises Rented to You Limit shown in the Declarations is the most we will pay under Coverage **A** for damages because of "property damage" to any one premises while rented to you or occupied by you with permission of the owner. If a Damage to Premises Rented to You Limit is not shown in the Declarations, that Limit will be $500,000.

c. The following is added to Paragraph **b.(1)** of Paragraph **4. Other Insurance** of **Section IV – Commercial General Liability Conditions**:

This insurance is excess over any of the other valid and collectible insurance available to the insured that provides coverage for real property you rent or temporarily occupy with the permission of the owner, borrowed equipment or use of elevators, whether such insurance is primary, excess, contingent or on any other basis.

5. Personal and Advertising Injury

a. Non-Employment Related Discrimination

The following is added to the Paragraph **14.** "personal and advertising injury" of **Section V – Definitions**, but only if Coverage **B** is not otherwise excluded by the provisions of this Coverage Part or any endorsement:

"Personal and advertising injury" includes injury, including consequential "bodily injury", arising out of discrimination because of race, color, creed, national origin, age, sex or physical disability, where such insurance is not prohibited by law, but only if the discrimination is:

(1) Not done intentionally by or at the direction of:

(a) The insured; or

(b) Any "executive officer", director, stockholder, partner, member, manager or "employee"; and

(2) Not directly or indirectly related to the employment, prospective employment or termination of employment of any person by any insured.

This insurance afforded for discrimination does not apply to fines or penalties, or that portion of any award or judgment resulting from the multiplied portion of any damages under state or federal law.

b. Limited Contractual Liability Coverage

The following is added to Exclusion **2.e. Contractual Liability** of **Section I – Coverages – Coverage B – Personal and Advertising Injury Liability**:

This exclusion does not apply to liability for damages assumed in a written contract or agreement if the liability assumed pertains to your business and is the tort liability (meaning liability that would be imposed by law in the absence of contract or agreement) of another party to pay for "personal and advertising injury" to a third person or organization, provided the "personal and advertising injury":

(1) Occurs after the execution of the contract or agreement; and

(2) Arises out of the offense of false arrest, detention or imprisonment.

6. Medical Payments – Increased Limits and Time Period

The following provisions are modified only if Coverage **C** is not otherwise excluded by the provisions of this Coverage Part or any endorsement.

a. The following replaces Paragraph **a.(3)(b)** in Paragraph **1. Insuring Agreement** of **Section I – Coverage C – Medical Payments**:

(b) The expenses are incurred and reported to us within three years of the date of the accident; and

b. The following is added to Paragraph **7.** of **Section III – Limits Of Insurance**:

The Medical Expenses Limit for Coverage **C** is the greater of $15,000 per person or the amount shown in the Declarations.

7. Product Recall Expense Coverage

a. The following is added to **Section I – Coverages**:

Product Recall Expense Schedule	
Product Recall Aggregate Limit	$ 50,000
Each Product Recall Limit	$ 25,000
Each Product Recall Deductible	$1,000
The limits and deductible in this Schedule apply to Product Recall Expense Coverage unless other amounts are shown in the Declarations.	

PRODUCT RECALL EXPENSE COVERAGE

We will pay "product recall expense" incurred by you or on your behalf for a "covered recall" to which this insurance applies. This insurance applies to "product recall expense" for a "covered recall" that takes place in the "coverage territory" and during the policy period. The amount we will pay for "product recall expense" is limited as described in **Section III – Limits Of Insurance**.

We will only pay the amount of "product recall expense" in excess of the Each Product Recall Deductible shown in the Schedule above. You must pay the Each Product Recall Deductible for each "covered recall" that is initiated.

b. The following is added to **Section III – Limits Of Insurance**:

The Product Recall Aggregate Limit shown in the Schedule above is the most we will pay for the sum of all "product recall expense" incurred for all "covered recalls" initiated during the policy period.

Subject to the Product Recall Aggregate Limit, the Each Product Recall Limit shown in the Schedule above is the most we will pay for all "product recall expenses" arising out of any one "covered recall" for the same defect or deficiency.

c. The following is added **Section IV – Commercial General Liability Conditions**:

Duties In The Event Of "Covered Recall"

1. You must report a "covered recall" to us as soon as practicable and no later than 30 days after you discover or are made aware of such recall.

2. No insured will, except at that insured's own cost, voluntarily make a payment, assume any obligation, or incur any expense, other than for first aid, without our consent.

3. You must see to it that the following are done as soon as practicable after an actual or anticipated "covered recall" that may result in "product recall expense":

(a) Give us notice of any discovery or notification that "your product" must be withdrawn or recalled, including a description of "your product" and the reason for the withdrawal or recall;

(b) Cease any further release, shipment, consignment or any other method of distribution of such product, as well as any similar products, until it has been determined that all such products are free from defects that could result in "product recall expense";

(c) As often as may be reasonably required, permit us to:

(1) Inspect "your product" and take damaged and undamaged samples of "your products" for inspection, testing and analysis; and

(2) Examine and make copies from your books and records;

(d) Within 60 days of our request and providing you the necessary forms, send us a signed, sworn proof of loss containing the information we request to settle the claim; and

(e) Permit us to examine any insured under oath, while not in the presence of any other insured, at such times as may reasonably be required, about any matter relating to this insurance or your claim, including an insured's books and records. An insured's answers to the examination must be signed.

d. The following are added to **Section V – Definitions**:

"Covered recall" means a recall of "your product" made necessary because the insured or a government entity has determined that a known or suspected defect, deficiency, inadequacy or dangerous condition in "your product" has resulted in, or will result in, "bodily injury" or "property damage".

"Product recall expense":

a. Means the following necessary and reasonable extra expenses incurred by you or on your behalf exclusively for the purpose of recalling "your product":

(1) Expenses for communications, including broadcast announcements or printed "advertisements" and associated stationery, envelopes and postage;

(2) Expenses for shipping the recalled products from any purchaser, distributor or user to the place or places designated by you;

(3) Expenses for overtime paid to your regular non-salaried "employees";

(4) Expenses for hiring "temporary workers";

(5) Expenses incurred by "employees", including transportation and accommodations;

(6) Expenses to rent additional warehouse or storage space; or

(7) Expenses for proper disposal of "your product" if the disposal is necessary to avoid "bodily injury" or "property damage" and is other than regularly used to discard, trash or dispose of "your product".

b. Does not include the following:

(1) Damages, fines or penalties;

(2) Defense expenses;

(3) The cost of regaining your market share, goodwill, revenue or profit; or

(4) Any expenses resulting from:

(a) Failure of any product to accomplish its intended purpose;

(b) Breach of warranties of fitness, quality, durability or performance;

(c) Loss of customer approval, or any cost incurred to regain customer approval;

(d) Redistribution or replacement of "your product" that was recalled with like products or substitutes;

(e) The insured's caprice or whim;

(f) A condition any insured knew, or had reason to know, of at the inception of this insurance that was likely to cause loss; or

(g) Recall of "your products" that have no known or suspected defect solely because a known or suspected defect in another of "your products" has been found.

8. Supplementary Payments – Cost of Bail Bonds and Loss of Earnings

The following replaces Paragraphs **1.b.** and **1.d.** of **Supplementary Payments – Coverages A and B** in **Section I – Coverages**:

b. Up to $2,500 for cost of bail bonds required because of accidents or traffic law violations arising out of the use of any vehicle to which the Bodily Injury Liability Coverage applies. We do not have to furnish these bonds.

d. All reasonable expenses incurred by the insured at our request to assist us in the investigation or defense of the claim or "suit", including actual loss of earnings up to $250 a day because of time off from work.

B. Section II – Who is an Insured

1. Broadened Named Insured

Section II – Who Is An Insured is amended to include as a Named Insured any legally incorporated entity in which you maintain ownership of more than 50 percent of the voting stock on the effective date of this endorsement, but only if there is no other similar insurance available to that organization. This insurance does not apply to any organization that is an insured under another policy or would be an insured under such policy but for its termination or the exhaustion of its limits of insurance.

2. Additional Insured – Broad Form Vendor

a. Section II – Who Is An Insured is amended to include as an additional insured any person or organization (referred to below as "vendor") with whom you have agreed in a written contract or agreement to provide insurance, but only with respect to "bodily injury" or "property damage" arising out of "your products" that are distributed or sold in the regular course of the vendor's business. But none of these vendors are an additional insured:

(1) If the "products-completed operations hazard" is excluded under the Coverage Part or by endorsement;

(2) If the vendor is a person or organization from whom you have acquired the products, or any ingredient, part or container entering into, accompanying or containing those products;

(3) For "bodily injury" or "property damage" for which the vendor is obligated to pay damages by reason of the assumption of liability in a contract or agreement unless that the vendor would have otherwise been liable for such "bodily injury" or "property damage" in the absence of that contract or agreement; or

(4) For "bodily injury" or "property damage" caused by or arising out of:

(a) Any express warranty not authorized by you;

(b) Any physical or chemical change in the product made intentionally by the vendor;

(c) Repackaging, except when unpacked solely for the purpose of inspection, demonstration, testing or the substitution of parts under instructions from the manufacturer, and then repackaged in the original container;

(d) Any failure to make such inspections, adjustments, tests or servicing as the vendor has agreed to make or normally undertakes to make in the usual course of business, in connection with the distribution or sale of the products;

(e) Operations to demonstrate, install, service or repair, except those operations performed at the vendor's premises in connection with the sale of the product;

(f) Products which, after distribution or sale by you, have been labeled or relabeled or used as a container, part or ingredient of any other thing or substance by or for the vendor; or

(g) The sole negligence of the vendor for its own acts or omissions or those of its employees or anyone else acting on its behalf, unless such act or omission is:

(i) In the course of repackaging "your products" in the original container after unpacking solely for the purpose of inspection, demonstration, testing or the substitution of parts under instructions from the manufacturer;

(ii) A demonstration, installation, servicing or repair operation of "your products" performed at the vendor's premises in connection with the sale of the product; or

(iii) An inspection, adjustment, test or servicing of "your products" the vendor has agreed to make or normally undertakes to make in the usual course of business, in connection with the distribution or sale of the products.

b. The insurance afforded to such vendor under Paragraph **a.** above:

(1) Applies only to the extent permitted by law; and

(2) Will not be broader than that which you are required by the contract or agreement to provide to such vendor.

c. The following is added to **Section III – Limits Of Insurance**:

The most we will pay on behalf of a vendor that qualifies as an additional insured is the amount of insurance:

a. Required by the contract or agreement; or

b. Available under the applicable Limits of Insurance shown in the Declarations;

whichever is less. This provision does not increase the applicable Limits of Insurance shown in the Declarations.

3. Additional Insured – Written Contract, Agreement, Permit or Authorization

a. Section II – Who Is An Insured is amended to include as an additional insured any person or organization with whom you have agreed in a written contract, agreement, permit or authorization to provide insurance but only with respect to liability for injury or damage caused, in whole or in part, by your acts or omissions or the acts or omissions of those acting on your behalf for:

(1) "Bodily injury", "property damage" or "personal and advertising injury" in the performance of your ongoing operations, and only until your operations are completed, for such person or organization at the location designated in the contract, agreement, permit or authorization;

(2) "Bodily injury", "property damage" or "personal and advertising injury" in the maintenance, operation or use of equipment leased to you by such person or organization; or

(3) "Bodily injury", "property damage" or "personal and advertising injury" in connection with premises you own, rent, lease or occupy.

b. The insurance afforded to an additional insured under Paragraph **a.** above does not apply:

(1) Unless:

(a) The contract or agreement is executed, or the permit or authorization is issued, before the "bodily injury", "property damage" or "personal and advertising injury" occurs; and

(b) The contract, agreement, permit or authorization is in effect or becomes effective during the policy period.

(2) To any:

(a) Person or organization included as an insured under any other provision of this policy, including this or any other endorsement;

(b) Lessor of equipment after the equipment lease terminates or expires;

(c) Owner or other interests from whom land has been leased;

(d) Manager or lessor of premises if:

(i) The "occurrence" takes place after you cease to be a tenant in that premises; or

(ii) The "bodily injury", "property damage" or "personal and advertising injury" arises out of structural alterations, new construction or demolition operations performed by or on behalf of the manager or lessor;

(e) Person or organization if the "bodily injury", "property damage" or "personal and advertising injury" arising out of the rendering of, or the failure to render, any professional architectural, engineering or surveying services, including:

(i) The preparing, approving, or failing to prepare or approve, maps, shop drawings, opinions, reports, surveys, field orders, change orders or drawings and specifications; or

(ii) Supervisory, inspection, architectural or engineering activities.

This exclusion applies even if the claims against any insured allege negligence or other wrongdoing in the supervision, hiring, employment, training or monitoring of others by that insured, if the "occurrence" which caused the "bodily injury" or "property damage", or the offense which caused the "personal and advertising injury", involved the rendering of or the failure to render any professional architectural, engineering or surveying services; or

(f) "Bodily injury" or "property damage" occurring after:

(i) All work, including materials, parts or equipment furnished in connection with such work, on the project (other than service, maintenance or repairs) to be performed by or on behalf of the additional insured at the location of the covered operations has been completed; or

(ii) That portion of "your work" out of which the injury or damage arises has been put to its intended use by any person or organization other than another contractor or subcontractor engaged in performing operations for a principal as a part of the same project.

c. The insurance afforded to an additional insured under Paragraph **a.** above:

(1) Applies only to the extent permitted by law; and

(2) Will not be broader than that which you are required by the contract, agreement, permit or authorization to provide to such additional insured.

d. With respect to the insurance afforded to an additional insured under Paragraph **a.** above, the following is added to **Section III – Limits Of Insurance**:

The most we will pay on behalf of the additional insured is the amount of insurance:

a. Required by the contract, agreement, permit or authorization; or

b. Available under the applicable Limits of Insurance shown in the Declarations;

whichever is less. This provision does not increase the applicable Limits of Insurance shown in the Declarations.

4. Incidental Malpractice by Employed Physicians, Nurses, EMTs and Paramedics

a. The following is added to Paragraph **2.a.(1)(d)** of **Section II – Who Is An Insured**:

But an "employee" or "volunteer worker" employed or volunteering as a physician, dentist, nurse, emergency medical technician or paramedic is an insured if you are not engaged in the business or occupation of providing professional health care services.

b. The following is added to Paragraph **b.(1)** in Paragraph **4. Other Insurance** of **Section IV – Commercial General Liability Conditions**:

This insurance is excess over any of the other valid and collectible insurance available to the insured for coverage for insured "employee" or volunteer worker who is a physician, dentist, nurse, emergency medical technician or paramedic, whether such insurance is primary, excess, contingent or on any other basis.

5. User of Covered Watercraft

a. **Section II – Who Is An Insured** is amended to include as an additional insured any person or organization who uses, or is responsible for the use of, a watercraft covered by this policy if the use is with your express or implied consent. But no such person or organization is an insured with respect to:

a. "Bodily injury" to that person's or organization's "employee"; or

b. "Property damage" to property:

(1) Owned, occupied or used by; or

(2) In the care, custody or control of, rented to or over which physical control is being exercised for any purpose by;

that person or organization.

b. The following is added to Paragraph **b.(1)** in Paragraph **4. Other Insurance** of **Section IV – Commercial General Liability Conditions**:

This insurance is excess over any of the other valid and collectible insurance available to the insured for use of, or responsibility for use of, a watercraft covered by this policy, whether such insurance is primary, excess, contingent or on any other basis.

6. Newly Acquired or Formed Organizations

The following replaces Paragraph **3.a.** of **Section II – Who Is An Insured**:

a. Coverage under this provision is afforded only until the end of the policy period;

C. Section III – Limits of Insurance – Aggregate Limit Per Location

The following is added to Paragraph **2.** of **Section III – Limits Of Insurance**:

The General Aggregate Limit applies separately to each "location" of yours. As used in this provision, "location" means premises you own, rent or lease involving the same or connecting lots, or whose connection is interrupted only by a street, roadway, waterway or right-of-way of a railroad.

D. Section IV – Commercial General Liability Conditions

1. Duties in the Event of Occurrence, Offense, Claim or Suit

The following is added to Paragraph **2. Duties In The Event Of Occurrence, Offense, Claim Or Suit** of **Section IV – Commercial General Liability Conditions**:

The requirements that you must notify us of an "occurrence", offense, claim or "suit", or send us documents concerning a claim or "suit", apply only if the "occurrence", offense, claim or "suit" is known to:

(1) You, if you are an individual;

(2) A partner, if you are a partnership;

(3) An "executive officer" or insurance or risk manager, if you are a corporation; or

(4) A manager, if you are a limited liability company.

The requirement that you must notify us as soon as practicable of an "occurrence" or an offense that may result in a claim does not apply if you report the "occurrence" or offense to your workers' compensation insurer and that "occurrence" or offense later develops into a liability claim for which coverage is provided by this policy. But as soon as you become aware that an "occurrence" or offense is a liability claim rather than a workers' compensation claim, you must comply with all parts of Paragraph **2. Duties In The Event Of Occurrence, Offense, Claim Or Suit** of **Section IV – Commercial General Liability Conditions**.

2. Waiver of Subrogation When Required by Written Contract or Agreement

The following is added to Paragraph **8. Transfer of Rights of Recovery Against Others to Us** of **Section IV – Commercial General Liability Conditions**:

We will waive any right of recovery we may have against any person or organization because of payments we make for injury or damage arising out of your ongoing operations or "your work" included within the "products-completed operations hazard" if the operations or work is done under a written contract or agreement with that person or organization, but only if the contract or agreement is executed before the "bodily injury" or "property damage" occurs and requires you to waive your rights of recovery.

E. Section V – Definitions

1. Bodily Injury – Includes Mental Anguish

The following is added to Paragraph **3.** of **Section V – Definitions**:

"Bodily injury" includes mental anguish resulting from bodily injury, sickness, or disease sustained by a person at any time.

2. Coverage Territory – Worldwide

The following replaces Paragraph **4.** of **Section V – Definitions**:

4. "Coverage territory" means anywhere other than a country or jurisdiction that is subject to trade or other economic sanction or embargo by the United States of America. But the insured's responsibility to pay damages must be determined in a settlement we agree to or in a "suit" on the merits brought within the United States of America (including its territories and possessions), Puerto Rico or Canada.

3. Mobile Equipment – Self-Propelled Snow Removal, Road Maintenance and Street Cleaning Equipment Less than 1,000 Pounds Gross Vehicle Weight

The following is added after Paragraph **12.f.(1)** of **Section V – Definitions**:

But a self-propelled vehicle of less than 1,000 pounds gross vehicle weight that is maintained primarily for purposes other than transportation of persons or cargo with permanently attached equipment for snow removal, road maintenance (other than construction or resurfacing) or street cleaning will be considered “mobile equipment” and not an “auto”.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

BROAD FORM AUTOMOBILE ENDORSEMENT

This endorsement modifies insurance provided under the following:

BUSINESS AUTO COVERAGE FORM

This endorsement extends certain coverages. The following listing and the headers in this endorsement are only for convenience. Provisions in this endorsement might be modified by other endorsements. Read the entire policy carefully to determine rights, duties and what is and is not covered.

A. Drive Other Car Coverage – Executive Officers and Certain Individuals

1. The following is added to **Section I – Covered Autos**:

Drive Other Car Coverage

a. For Covered Autos Liability Coverage and Physical Damage Coverage, "autos" in the care, custody or control of an "insured" described in Paragraph **2.** below, which you do not own, hire, lease or borrow, are covered "autos". But this does not include any "auto":

(1) Owned by any "insured" described in Paragraph **2.** below, or any member of their household, including any "auto" that is owned but not insured;

(2) Used by an "insured" described in Paragraph **2.** below while working in the business of selling, servicing, repairing or parking autos; or

(3) Insured or covered under another policy.

b. If Medical Payments, Uninsured/Underinsured Motorist, Personal Injury Protection or other compulsory coverages required by the governing jurisdiction are provided by this policy, then an "insured" described in Paragraph **2.** below, and their family members residing in the same household, are "insureds" while:

(1) Occupying as a passenger; or

(2) A pedestrian when struck by;

any "auto" you do not own, hire, lease or borrow, except an "auto" owned by an "insured" described in Paragraph **2.** below or members of their household, or an "auto" insured or covered under any other policy.

2. With respect to Drive Other Car Coverage only, Paragraph **A.1. Who is an Insured** of **Section II – Liability Coverage** is amended to include as an "insured" the following:

   If you are designated in the Declarations as:

   a. An individual, you and your spouse.

   b. A partnership, your partners and their spouses.

   c. An organization other than an individual or a partnership, your "executive officers" and their spouses.

3. **Limit of Insurance and Deductible**

   The most we will pay for Drive Other Car Coverage is the single highest Limit of Insurance for the applicable coverage for an "auto" you own. The Deductible for Drive Other Car Coverage is the largest Deductible for the applicable coverage for an "auto" you own.

4. **Other Insurance**

   Regardless of the existence of other insurance or Paragraph **B.5. Other Insurance** of **Section IV – Business Auto Conditions**, Drive Other Car Coverage is primary.

B. Section II – Covered Autos Liability Coverage

1. **Additional Insured – Written Contract, Agreement, Permit or Authorization**

   Paragraph **A.1. Who is an Insured** of **Section II – Covered Autos Liability Coverage** is amended to include as an additional "insured" any person or organization with whom you have agreed in a written contract, agreement, permit or authorization to provide insurance such as is afforded under this Coverage Form but only with respect to liability for "bodily injury" or "property damage" caused in whole or in part by your maintenance, operation or use of a covered "auto". But this insurance does not apply:

   a. Unless the written contract or agreement has been executed or the permit or authorization has been issued prior to the "accident" that caused the "bodily injury" or "property damage";

   b. To any person or organization included as an "insured" under any other provisions of this policy, including this or any other endorsement;

   c. To the independent acts or omissions of such person or organization; or

   d. To any lessor of "autos" when their contract or agreement with you for such leased "auto" ends or the lessor or its agent takes possession of the "auto".

2. **Broadened Named Insured**

   Paragraph **A.1. Who is an Insured** of **Section II – Covered Autos Liability Coverage** is amended to include as a Named Insured any legally incorporated entity in which you maintain ownership of more than 50 percent of the voting stock on or after the effective date of this endorsement, but only if there is no other similar insurance available to that organization. This insurance does not apply to any organization that is an insured under another policy or would be an insured under such policy but for its termination or the exhaustion of its limits of insurance.

3. **Employees as Insureds (Including Employee Hired Autos and Fellow Employee Coverage)**

   a. Paragraph **A.1. Who is an Insured** of **Section II – Covered Autos Liability Coverage** is amended to include as an "insured" your "employee" while:

   (1) Using a covered "auto" you do not own, hire or borrow in your business or your personal affairs.

   (2) Operating an "auto" hired or rented under a contract or agreement in that "employee's" name, with your permission, while performing duties related to the conduct of your business.

   b. Exclusion **B.5. Fellow Employee** of **Section II – Covered Autos Liability** is deleted.

   c. The following is added to **B.5.b** of **Section IV – Business Auto Conditions**:

   Any covered "auto" hired or rented without a driver by your "employee" under a contract or agreement in that "employee's" name, with your permission, while performing duties related to the conduct of your business is also deemed to be a covered "auto" you own.

4. **Newly Acquired or Formed Organizations**

   Paragraph **A.1. Who is an Insured** of **Section II – Covered Autos Liability Coverage** is amended to include as an "insured" any organization you newly acquire or form, other than a partnership or joint

venture, and over which you maintain ownership or majority interest, if there is no other similar insurance available to that organization. But:

(1) Coverage under this provision is afforded only until the end of the policy period; and

(2) Coverage does not apply to “bodily injury” or “property damage” caused by an “accident” that occurred before you acquired or formed the organization.

5. Supplementary Payments – Bail Bonds and Loss of Earnings

In Paragraph **A.2.a. Supplementary Payments** of **Section II – Covered Autos Liability**, the following replaces Paragraphs **(2)** and **(4)**:

(2) Up to $3,500 for cost of bail bonds (including bonds for related traffic law violations) required because of an "accident" we cover. We do not have to furnish these bonds.

(4) All reasonable expenses incurred by the "insured" at our request, including actual loss of earnings up to $500 a day because of time off from work.

C. Section III – Physical Damage Coverage

1. Hired Auto Physical Damage Coverage

a. If hired “autos” are covered “autos” under **Section II – Covered Autos Liability Coverage** and this policy provides Comprehensive, Specified Causes of Loss or Collision Coverage, any “auto” you lease, hire, rent or borrow will be deemed a covered “auto” for Physical Damage Coverage, subject to the provisions in Paragraph **b.** below. However, we will only provide such Physical Damage Coverage to borrowed “autos” when:

(1) You have agreed to provide physical damage coverage to such “autos” by written contract or agreement; and

(2) Such contract or agreement was entered into prior to “loss” to such “auto”.

b. For Hired Physical Damage Coverage provided by paragraph **a.** above:

(1) The most we will pay for “loss” to any hired “auto” is the lesser of:

(a) $75,000 for “autos” of the private passenger type and $50,000 for all other “autos”;

(b) The actual cash value of the damaged or stolen property as of the time of the “loss”; or

(c) The cost of repairing or replacing the damaged or stolen property with other property of like kind and quality.

(2) The Deductible is the largest Deductible for the applicable coverage for an “auto” you own.

(3) This insurance is excess over any other valid and collectible insurance, whether such insurance is primary, excess, contingent or on any other basis.

2. Towing – Any Covered Autos

The following replaces Paragraph **A.2. Towing** of **Section III – Physical Damage Coverage**:

Provided that a premium charge for Towing and Labor is shown in the Declarations, we will pay up to the Limit shown in the Declarations, plus an additional $50, for towing and labor costs incurred each time a covered “auto” is disabled. However, the labor must be performed at the place of disablement.

3. Transportation Expenses Increased

In Paragraph **A.4.a. Transportation Expenses** of **Section III – Physical Damage Coverage**, the amounts we will pay for temporary transportation expenses incurred by you because of the total theft of a covered “auto” of the private passenger type are increased to $75 per day, to a maximum of $2,250.

4. Loss of Use Expenses Increased

The following replaces the last paragraph in Paragraph **A.4.b. Loss Of Use Expenses** of **Section III – Physical Damage Coverage**:

However, the most we will pay for any expenses for loss of use is $1,000.

5. Other Coverage Extensions

If you have Physical Damage Coverage, the following are added to Paragraph **A.4. Coverage Extensions** of **Section III – Physical Damage Coverage**:

a. Airbag Discharge

We will pay to reset or replace a covered "auto's" airbag that accidentally discharges without the "auto" being involved in an "accident" if the airbag is not covered under a manufacturer's warranty and you did not intentionally cause the discharge. No Deductible applies to this Coverage Extension.

b. Auto Theft Reward

If you have Comprehensive or Specified Cause of Loss Coverage, we will pay a reward up to $2,000 for information leading to the arrest and conviction of anyone stealing a covered "auto". But we will not pay a reward to you, any family members or "employees" or any public officials while performing their duties.

c. Loan/Lease Gap Coverage

If a covered "auto" is subject to a loan or long-term lease that requires, in writing, that the lender or lessor be a loss payee, and you are legally obligated for the remaining balance on the loan or lease, we will pay the difference between the actual cash value of the "auto" at the time of "loss" and the remaining balance on your loan or lease. But we will not pay for:

(1) Any amount paid under the policy's Physical Damage Coverage; or

(2) Any amounts for abnormal or excess wear and tear, additional or high mileage charges, carry-over balances from previous loans or leases, extended warranties or insurance purchased with the loan or lease, lease termination fees, taxes, overdue payments, unreturned security deposits or any penalties, interest or charges resulting from overdue payments.

For purposes of this provision, a long-term lease is a lease for a period of six months or longer.

d. Rental Reimbursement

We will pay for expenses to rent an "auto" of the private passenger type because of "loss" to a covered "auto" of the private passenger type. But:

(1) We will only pay expenses incurred during the policy period at the time of the "loss" and ending, regardless of the policy period, six days after the "loss".

(2) The most we will pay is the lesser of:

(a) Reasonable and necessary expenses actually incurred; or

(b) $50 per day.

(3) This coverage does not apply if a spare or reserve "auto" is available to you.

(4) If "loss" is because of the total theft of a covered "auto", we will pay only those amounts that are not already covered under Transportation Expenses.

No Deductible applies to this Coverage Extension.

6. Diminution in Value

The following is added to Exclusion **B.6.** of **Section III – Physical Damage Coverage**:

This exclusion does not apply to "diminution in value" of a covered "auto" of the private passenger type used in the conduct of the "insured's" business that is leased, rented, hired or borrowed without a driver for a period of 30 days or less. But the most we will pay for such "diminution in value" is the lesser of:

a. 20 percent of the actual cash value of the "auto" as of the time of the "loss"; or

b. $7,500.

7. Communications Equipment

The following is added to Paragraph **B. Exclusions** of **Section III – Physical Damage Coverage**:

Exclusions **4.c.** and **4.d.** do not apply to communications equipment, including its antenna and other accessories, that is permanently installed in, and not removable from, a covered "auto" and designed for use as a:

a. Citizen's band radio;

b. Two-way mobile radio or telephone;

c. Scanning monitor receiver; or

d. GPS navigation system.

No Deductible applies to “loss” to such communications equipment. But the most we will pay for all such communications equipment is $5,000 for any one “loss”.

8. Deductible Waived For Glass Repair

The following is added to Paragraph **D. Deductible** of **Section III – Physical Damage Coverage**:

No Deductible applies if glass that is damaged is repaired rather than replaced.

D. Section IV – Business Auto Conditions

1. Duties in the Event of Accident, Claim, Suit or Loss

The following is added to Paragraph **A.2. Duties in the Event of Accident, Claim, Suit or Loss** of **Section IV – Business Auto Conditions**:

The requirements that you must notify us of an “accident”, claim, “suit” or “loss”, or send us documents concerning a claim or “suit”, apply only if the “accident”, claim, “suit” or “loss” is known to:

(1) You, if you are an individual;

(2) A partner, if you are a partnership;

(3) An “executive officer” or insurance or risk manager, if you are a corporation; or

(4) A manager, if you are a limited liability company.

The requirement that you must notify us as soon as practicable of an “accident”, claim, “suit” or “loss” does not apply if you report the “accident”, claim, “suit” or “loss” to your workers’ compensation insurer and the “accident”, claim, “suit” or “loss” later develops into a liability claim for which coverage is provided by this policy. But as soon as you become aware that an “accident”, claim, “suit” or “loss” is a liability claim rather than a workers’ compensation claim, you must comply with all parts of Paragraph **A.2. Duties in the Event of Accident, Claim, Suit or Loss** of **Section IV – Business Auto Conditions**.

2. Waiver of Transfer or Rights of Recovery Against Others to Us (Waiver of Subrogation) Automatic When Required by Written Contract or Agreement

The following is added to Paragraph **A.5. Transfer of Rights of Recovery Against Others to Us** of **Section IV – Business Auto Conditions**:

This condition does not apply to any person(s) or organization(s) for whom you are required to waive subrogation with respect to the coverage provided under this Coverage Form, but only to the extent that subrogation is waived:

a. Under a written contact or agreement with such person(s) or organization(s); and

b. Prior to the "accident" or the "loss."

E. Section V – Definitions

1. Bodily Injury – Includes Mental Anguish

The following is added to Paragraph **C**. of **Section V – Definitions**:

“Bodily injury” includes mental anguish resulting from bodily injury, sickness, or disease sustained by a person at any time.

2. Executive Officer

The following is added to **Section V – Definitions**:

“Executive officer” means a person holding any of the officer positions created by your charter, constitution, bylaws or any other similar governing document.

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THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

PRIMARY AND NONCONTRIBUTORY – OTHER INSURANCE CONDITION

This endorsement modifies insurance provided under the following:

AUTO DEALERS COVERAGE FORM
BUSINESS AUTO COVERAGE FORM
MOTOR CARRIER COVERAGE FORM

With respect to coverage provided by this endorsement, the provisions of the Coverage Form apply unless modified by the endorsement.

A. The following is added to the **Other Insurance** Condition in the Business Auto Coverage Form and the **Other Insurance – Primary And Excess Insurance Provisions** in the Motor Carrier Coverage Form and supersedes any provision to the contrary:

This Coverage Form's Covered Autos Liability Coverage is primary to and will not seek contribution from any other insurance available to an "insured" under your policy provided that:

1. Such "insured" is a Named Insured under such other insurance; and

2. You have agreed in writing in a contract or agreement that this insurance would be primary and would not seek contribution from any other insurance available to such "insured".

B. The following is added to the **Other Insurance** Condition in the Auto Dealers Coverage Form and supersedes any provision to the contrary:

This Coverage Form's Covered Autos Liability Coverage and General Liability Coverages are primary to and will not seek contribution from any other insurance available to an "insured" under your policy provided that:

1. Such "insured" is a Named Insured under such other insurance; and

2. You have agreed in writing in a contract or agreement that this insurance would be primary and would not seek contribution from any other insurance available to such "insured".

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

PRIMARY AND NONCONTRIBUTORY – OTHER INSURANCE CONDITION

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART
LIQUOR LIABILITY COVERAGE PART
PRODUCTS/COMPLETED OPERATIONS LIABILITY COVERAGE PART

The following is added to the **Other Insurance** Condition and supersedes any provision to the contrary:

Primary And Noncontributory Insurance

This insurance is primary to and will not seek contribution from any other insurance available to an additional insured under your policy provided that:

(1) The additional insured is a Named Insured under such other insurance; and

(2) You have agreed in writing in a contract or agreement that this insurance would be primary and would not seek contribution from any other insurance available to the additional insured.

