AMENDMENT NO. 7

TO BE ATTACHED TO AND MADE PART OF GROUP POLICY NO.: 000010095283

ISSUED TO: Beauregard Health System

It is agreed that the above policy be replaced with the attached Policy, which is revised and dated October 1, 2022.

The effective date of this amendment is October 1, 2022; but only with respect to disabilities incurred on or after that date. Nothing contained in this amendment shall change any of the terms and conditions of this Policy; except as stated above.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY

Officer of the Company

The Lincoln National Life Insurance Company
A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066
800-423-2765 Online: www.LincolnFinancial.com

In Consideration of the Application for this Policy made by

Beauregard Health System

(herein called the Policyholder)

and the payment of all premiums when due, The Lincoln National Life Insurance Company agrees to make the payments provided in this Policy to the person or persons entitled to them.

Policy No. 000010095283 Policy Effective Date: October 1, 2007.

Monthly Premium: See Premium Rate Schedule

Policy Anniversaries will be annual beginning on: January 1, 2026

The first premium is due on this Policy's Effective Date, and subsequent premiums are due on November 1, 2007, and on the same day of each month thereafter.

This Policy is delivered in the state of Louisiana and subject to the laws of that jurisdiction.

The Lincoln National Life Insurance Company has executed this Policy at its Group Insurance Service Office in Omaha, Nebraska this 6th day of September, 2022.

SECRETARY

PRESIDENT

GROUP LONG-TERM DISABILITY INSURANCE POLICY

PREMIUM RATE SCHEDULE

Monthly Core Long Term Disability Premium: 0.094% of Total Covered Payroll per Month

Monthly Buy-Up Long Term Disability Premium:

Insured Employee's Attained Age	Monthly Rate per $100 of Covered Payroll
Less than 40	$0.040
40 - 44	$0.070
45 - 49	$0.099
50 - 54	$0.168
55 - 59	$0.232
60 and older	$0.279

Rate changes due to an increase in age will become effective on the Policy Anniversary date coinciding with or next following the Insured Person's birthday.

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ELIGIBLE CLASS

Class 1	All Full-Time and Part-Time Employees who are US Citizens/Residents

Beauregard Health System
000010095283
SCHEDULE OF BENEFITS
For
Class 1 - All Full-Time and Part-Time Employees who are US Citizens/Residents

MINIMUM HOURS: 30 hours per week

WAITING PERIOD: (For date insurance begins, refer to "Effective Date" section)
60 days of continuous Active Work

CONTRIBUTIONS: Insured employees are not required to contribute to the cost of the Long-Term Disability Core Benefit. Insured employees are required to contribute to the cost of the Long-Term Disability Buy-Up Benefit.

LONG-TERM DISABILITY BENEFITS

BENEFIT PERCENTAGE: 30% if Core Benefit only is elected; or 50% if Buy-Up Benefit is elected

MAXIMUM MONTHLY BENEFIT: $5,000 if Core Benefit only is elected; or $5,000 if Buy-Up Benefit is elected

MINIMUM MONTHLY BENEFIT: $100 or 10% of the Insured Employee's Monthly Benefit, whichever is greater

Long-Term Disability Benefits for PRE-EXISTING CONDITIONS will be subject to the Pre-Existing Condition Exclusion on the Exclusion page.

The Maximum Monthly Benefit will not exceed the Benefit Percentage times Basic Monthly Earnings.

ELIMINATION PERIOD: 180 calendar days of Disability caused by the same or a related Sickness or Injury, which must be accumulated within a 360 calendar day period.

MAXIMUM BENEFIT PERIOD: (For Sickness, Injury or Pre-Existing Conditions): The Insured Employee's Social Security Normal Retirement Age, or the Maximum Benefit Period shown below (whichever is later).

Age at Disability	Maximum Benefit Period
Less than Age 60	To Age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and Over	12 months

OWN OCCUPATION PERIOD means a period beginning at the end of the Elimination Period and ending 24 months later for Insured Employees.

Under the Policy Termination Section on form GL3001-LTD-10 04, Items (2) and (3) do not apply to the Buy-Up Benefit. Instead, the Company may terminate the Buy-Up Benefit under this Policy on the due date of any premium if less than 15% of those eligible for coverage are insured.

DEFINITIONS

As used throughout this Policy, the following terms shall have the meanings indicated below. Other parts of this Policy contain definitions specific to those provisions.

ACTIVE WORK or **ACTIVELY AT WORK** means an Employee's full-time performance of all Main Duties of his or her Own Occupation, for the regularly scheduled number of hours, at:

1. the Employer's usual place of business; or
2. any other business location where the Employer requires the Employee to travel.

Unless disabled on the prior workday or on the day of absence, an Employee will be considered Actively at Work on the following days:

1. a Saturday, Sunday or holiday that is not a scheduled workday;
2. a paid vacation day or other scheduled or unscheduled non-workday; or
3. a non-medical leave of absence of 12 weeks or less, whether taken with the Employer's prior approval or on an emergency basis.

This includes a Military Leave or an approved Family or Medical Leave that is **not** due to the Employee's own health condition.

ANNUAL SALARY means the Insured Employee's **BASIC MONTHLY EARNINGS or PREDISABILITY INCOME** multiplied by 12.

For Insured Employees receiving earnings based on Relative Value Units: BASIC MONTHLY EARNINGS or **PREDISABILITY INCOME** means $1/12^{th}$ of the Insured Employee's Relative Value Unit compensation on a monthly basis from the Employer before taxes on the Determination Date. The **"Determination Date"** is the last day worked just prior to the date the Disability begins. The Relative Value Units are averaged over the 12 month period just prior to the Determination Date or over the actual period of employment with the Employer just prior to that date, if shorter.

It does **not** include commissions, bonuses, overtime pay, or any other extra compensation. It does **not** include income from a source other than the Employer. It will not exceed the amount shown in the Employer's financial records, the amount for which premium has been paid, or the Maximum Covered Monthly Earnings permitted by this Policy; whichever is less. (Maximum Covered Monthly Earnings equals the Maximum Monthly Benefit divided by the Benefit Percentage shown in the Schedule of Benefits.) Exception: For purposes of determining the Partial Disability Monthly Benefit, Basic Monthly Earnings will not exceed the amount shown in the Employer's financial records.

For all other Insured Employees: BASIC MONTHLY EARNINGS or **PREDISABILITY INCOME** means the Insured Employee's average monthly base salary or hourly pay from the Employer before taxes on the Determination Date. The **"Determination Date"** is the last day worked just prior to the date the Disability begins.

It does **not** include commissions, bonuses, overtime pay, or any other extra compensation. It does **not** include income from a source other than the Employer. It will not exceed the amount shown in the Employer's financial records, the amount for which premium has been paid, or the Maximum Covered Monthly Earnings permitted by this Policy; whichever is less. (Maximum Covered Monthly Earnings equals the Maximum Monthly Benefit divided by the Benefit Percentage shown in the Schedule of Benefits.) Exception: For purposes of determining the Partial Disability Monthly Benefit, Basic Monthly Earnings will not exceed the amount shown in the Employer's financial records.

COMPANY means The Lincoln National Life Insurance Company, an Indiana corporation. Its Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

DAY or **DATE** means the period of time that begins at 12:01 a.m. and ends at 12:00 midnight, standard time, at the Policyholder's place of business. When used with regard to effective dates, it means 12:01 a.m. When used with regard to termination dates, it means 12:00 midnight.

DISABILITY or **DISABLED** means Total Disability or Partial Disability.

DISABILITY BENEFIT, when used with the term Retirement Plan, means a benefit that:

1. is payable under a Retirement Plan due to disability as defined in that plan; and
2. does not reduce the benefits that would have been paid as Retirement Benefits at the normal retirement age under the plan if the disability had not occurred.

If the payment of the benefit does cause such a reduction, the benefit will be deemed a Retirement Benefit as defined in this Policy.

ELIMINATION PERIOD means the number of days of Disability during which no benefit is payable. The Elimination Period is shown in the Schedule of Benefits. It applies as follows.

1. The Elimination Period:
   a. begins on the first day of Disability; and
   b. is satisfied when the required number of days is accumulated within a period which does not exceed two times the Elimination Period.

   During a period of Disability, the Insured Employee may return to full-time work, at his or her own or any other occupation, for an accumulated number of days not to exceed the Elimination Period.
2. Only days of Disability caused by the same or a related Sickness or Injury will count towards the Elimination Period. Days on which the Insured Employee returns to full-time work will not count towards the Elimination Period.

EMPLOYEE or **FULL-TIME EMPLOYEE** means a person:

1. whose employment with the Employer is the person's main occupation;
2. whose employment is for regular wage or salary, on a full-time basis;
3. who is regularly scheduled to work at such occupation at least the Minimum Hours shown in the Schedule of Benefits;
4. who is a member of an Eligible Class which is eligible for coverage under this Policy;
5. who is not a temporary or seasonal employee; and
6. who is a citizen of the United States or legally works in the United States.

EMPLOYER means the Policyholder. It includes any division, subsidiary or affiliated company named in the Application or Participation Agreement.

EVIDENCE OF INSURABILITY means a statement of proof of an Employee's medical history. The Company uses this to determine his or her acceptance for insurance or an increased amount of insurance. Such proof will be provided at the Company's expense.

FAMILY OR MEDICAL LEAVE means an approved leave of absence that:

1. is subject to the federal FMLA law (the Family and Medical Leave Act of 1993 and any amendments to it) or a similar state law;
2. is taken in accord with the Employer's leave policy and the law which applies; and
3. does not exceed the period approved by the Employer and required by that law.

Under the federal FMLA law, such leaves are permitted for up to 12 weeks in a 12-month period, as defined by the Employer. The 12 weeks:

1. may consist of consecutive or intermittent work days; or
2. may be granted on a part-time equivalency basis.

If an Employee is entitled to a leave under both the federal FMLA law and a similar state law, he or she may elect the more favorable leave (but not both). If an Employee is on an FMLA leave due to his or her own health condition on the date Policy coverage takes effect, he or she is not considered Actively at Work.

FULL-TIME, as it applies to the Partial Disability Monthly Benefit, means the average number of hours the Insured Employee was regularly scheduled to work, at his or her Own Occupation, during the month just prior to:

1. the date the Elimination Period begins; or
2. the date an approved leave of absence begins, if the Elimination Period begins while the Insured Employee is continuing coverage during a leave of absence.

INJURY means an accidental bodily Injury that:

1. requires treatment by a Physician; and
2. directly, and independently of all other causes, results in a Disability that begins while the Insured Employee is insured under this Policy.

INSURANCE MONTH or **POLICY MONTH** means that period of time:

1. beginning at 12:01 a.m. Standard Time, at the Policyholder's place of business on the first day of any calendar month; and
2. ending at 12:00 midnight on the last day of the same calendar month.

INSURED EMPLOYEE means an Employee for whom Policy coverage is in effect.

MAIN DUTIES or **MATERIAL AND SUBSTANTIAL DUTIES** means those job tasks that:

1. are normally required to perform the Insured Employee's Own Occupation; and
2. could not reasonably be modified or omitted.

To determine whether a job task could reasonably be modified or omitted, the Company will apply the Americans with Disabilities Act's standards concerning reasonable accommodation. It will apply the Act's standards, whether or not:

1. the Employer is subject to the Act; or
2. the Insured Employee has requested such a job accommodation.

An Employer's failure to modify or omit other job tasks does **not** render the Insured Employee unable to perform the Main Duties of the job.

Main Duties include those job tasks:

1. as described in the U.S. Department of Labor Dictionary of Occupational Titles; and
2. as performed in the general labor market and national economy.

Main Duties are **not** limited to those specific job tasks as performed for a certain firm or at a certain work site.

MEDICALLY APPROPRIATE TREATMENT means diagnostic services, consultation, care or services that are consistent with the symptoms or diagnosis causing the Insured Employee's Disability. Such treatment must be rendered:

1. by a Physician whose license and any specialty are consistent with the disabling condition; and
2. according to generally accepted, professionally recognized standards of medical practice.

MILITARY LEAVE means a leave of absence that:

1. is subject to the federal USERRA law (the Uniformed Services Employment and Reemployment Rights Act of 1994 and any amendments to it);
2. is taken in accord with the Employer's leave policy and the federal USERRA law; and
3. does not exceed the period required by that law.

MONTHLY BENEFIT means the amount payable monthly by the Company to the Insured Employee who is Totally Disabled or Partially Disabled.

OWN OCCUPATION or REGULAR OCCUPATION means the occupation, trade or profession:
1. in which the Insured Employee was employed with the Employer prior to Disability; and
2. which was his or her main source of earned income prior to Disability.

It means a collective description of related jobs, as defined by the U.S. Department of Labor Dictionary of Occupational Titles. It includes any work in the same occupation for pay or profit, regardless of:
1. whether such work is with the Employer, with some other firm, or on a self-employed basis; or
2. whether a suitable opening is currently available with the Employer or in the local labor market.

OWN OCCUPATION PERIOD means a period as shown in the Schedule of Benefits.

PARTIAL DISABILITY or **PARTIALLY DISABLED** will be defined as follows:
1. During the Elimination Period and Own Occupation Period, it means that due to an Injury or Sickness the Insured Employee:
   a. is unable to perform one or more of the Main Duties of his or her Own Occupation; or is unable to perform such duties full-time; and
   b. is engaged in Partial Disability Employment.
2. After the Own Occupation Period, it means that due to an Injury or Sickness the Insured Employee:
   a. is unable to perform one or more of the Main Duties of any occupation which his or her training, education or experience will reasonably allow; or is unable to perform such duties full-time; and
   b. is engaged in Partial Disability Employment.

PARTIAL DISABILITY EMPLOYMENT means the Insured Employee is working at his or her Own Occupation or any other occupation; however, because of a Partial Disability:
1. the Insured Employee's hours or production is reduced;
2. one or more Main Duties of the job are reassigned; or
3. the Insured Employee is working in a lower-paid occupation.

During Partial Disability Employment, his or her current earnings:
1. must be at least 20% of Predisability Income; and
2. may not exceed the percentage specified in the Partial Disability Benefit section.

PHYSICIAN means:
1. a legally qualified medical doctor who is licensed to practice medicine, to prescribe and administer drugs, or to perform surgery; or
2. any other duly licensed medical practitioner who is deemed by state law to be the same as a legally qualified medical doctor.

The medical doctor or other medical practitioner must be acting within the scope of his or her license. He or she must be qualified to provide Medically Appropriate Treatment for the Insured Employee's disabling condition.

Physician does **not** include the Insured Employee or a relative of the Insured Employee receiving treatment. Relatives include:
1. the Insured Employee's spouse, siblings, parents, children and grandparents; and
2. his or her spouse's relatives of like degree.

POLICY means this group insurance Policy issued by the Company to the Policyholder.

POLICYHOLDER means the person, company, or other organization as shown on the Face Page of this Policy.

PREDISABILITY INCOME—See Basic Monthly Earnings definition.

REGULAR CARE OF A PHYSICIAN or **REGULAR ATTENDANCE OF A PHYSICIAN** means the Insured Employee:

1. personally visits a Physician, as often as medically required according to standard medical practice to effectively manage and treat his or her disabling condition; and
2. receives Medically Appropriate Treatment, by a Physician whose license and any specialty are consistent with the disabling condition.

REGULAR OCCUPATION—See Own Occupation or Regular Occupation definition.

RETIREMENT BENEFIT, when used with the term Retirement Plan, means a benefit that:

1. is payable under a Retirement Plan either in a lump sum or in the form of periodic payments;
2. does not represent contributions made by an Insured Employee (Payments representing Employee contributions are deemed to be received over the Insured Employee's expected remaining life, regardless of when they are actually received.); and
3. is payable upon:
   a. early or normal retirement; or
   b. disability (if the payment does reduce the benefit which would have been paid at the normal retirement age under the plan, if disability had not occurred).

RETIREMENT PLAN means a defined benefit or defined contribution plan that:

1. provides Retirement Benefits to Employees; and
2. is not funded wholly by Employee contributions.

The term shall **not** include any 401(k), profit-sharing or thrift plan; informal salary continuance plan; individual retirement account (IRA); tax sheltered annuity (TSA); stock ownership plan; or a non-qualified plan of deferred compensation.

An Employer's Retirement Plan is deemed to include any Retirement Plan:

1. which is part of any federal, state, county, municipal or association retirement system; and
2. for which the Insured Employee is eligible as a result of employment with the Employer.

SICK LEAVE or **SALARY CONTINUANCE PLAN** means a plan that:

1. is established and maintained by the Employer for the benefit of Employees; and
2. continues payment of all or part of an Insured Employee's Predisability Income for a specified period after he or she becomes Disabled.

It does **not** include compensation the Employer pays an Insured Employee for work actually performed during a Disability.

SICKNESS means illness, pregnancy or disease.

TOTAL COVERED PAYROLL means the total amount of Basic Monthly Earnings for all Employees insured under this Policy.

TOTAL DISABILITY or **TOTALLY DISABLED** will be defined as follows:

1. During the Elimination Period and Own Occupation Period, it means that due to an Injury or Sickness the Insured Employee is unable to perform each of the Main Duties of his or her Own Occupation.
2. After the Own Occupation Period, it means that due to an Injury or Sickness the Insured Employee is unable to engage in each of the Main Duties of any occupation:
   a. for which he or she becomes qualified by reason of training, education or experience; and
   b. which provides more than 80% of his or her former earning capacity prior to the disability.

The loss of a professional license, an occupational license or certification, or a driver's license for any reason does **not**, by itself, constitute Total Disability.

WAITING PERIOD means the period of time an Employee must be employed in an eligible class with the Employer, before he or she becomes eligible to enroll for coverage under this Policy. The period of service must be continuous, except as explained in the Eligibility provision captioned Prior Service Credit Towards Waiting Period.

GENERAL PROVISIONS

ENTIRE CONTRACT. The entire contract between the parties shall consist of:

1. this Policy and any amendments to it;
2. the Policyholder's application (a copy of which is attached);
3. any Participating Employers' applications or Participation Agreements; and
4. any individual applications of the Insured Employees.

In the absence of fraud, all statements made by the Policyholder and by Insured Employees are representations and not warranties. No statement made by an Insured Employee will be used to contest the coverage provided by this Policy, unless:

1. it is contained in a written statement signed by that Insured Employee; and
2. a copy of the statement has been furnished to that Insured Employee.

AUTHORITY TO MAKE OR AMEND CONTRACT. Only a Company Officer located in the Company's Group Insurance Service Office has the authority to:

1. determine the insurability of a group or any individual within a group;
2. make a contract in the Company's name;
3. amend or waive any provision of this Policy; or
4. extend the time for payment of any premium.

No change in this Policy will be valid, unless it is made in writing and signed by such a Company Officer.

INCONTESTABILITY. Except for the non-payment of premiums or fraud, the Company may not contest the validity of this Policy after it has been in force for two years from its date of issue; and as to any Insured Employee, after his or her coverage has been in force for two years during his or her lifetime. This clause does not preclude, at any time, the assertion of defenses based upon:

1. this Policy's eligibility requirements, exclusions and limitations; and
2. other Policy provisions unrelated to the validity of coverage.

RESCISSION. The Company has the right to rescind any insurance for which Evidence of Insurability was required, if:

1. an Insured Employee incurs a claim during the first two years of coverage; and
2. the Company discovers that the Insured Employee made a Material Misrepresentation on his or her application.

A **"Material Misrepresentation"** is an incomplete or untrue statement that caused the Company to issue coverage that it would have disapproved, had it known the truth. **"To rescind"** means to cancel insurance back to its effective date. In that event, the Company will refund all premium paid for the rescinded insurance, less any benefits paid for the Insured Employee's claims. The Company reserves the right to recover any claims paid in excess of such premiums.

NON-PARTICIPATION. This is a non-participating Policy. It will not share in the divisible surplus of the Company.

INFORMATION TO BE FURNISHED. The Employer is required to furnish the Company any information needed to administer this Policy, including:

1. information about Employees:
   a. who become eligible for insurance;
   b. whose amounts of coverage change; or
   c. whose eligibility or coverage ends;
2. occupational information and other facts that may be needed to manage a claim; and
3. any other information that the Company may reasonably require.

The Company may inspect any of the Employer's records that relate to this Policy, at any reasonable time.

Clerical error by the Employer:

1. will not void or terminate insurance that otherwise would be in effect;
2. will not result in insurance coverage that otherwise would not be in effect; and
3. will not continue insurance that otherwise would be terminated.

Once an error is discovered, a fair adjustment in premium will be made. If a premium adjustment involves the return of unearned premium, the amount of the return will be limited to the 12-month period that precedes the date the Company receives proof that such an adjustment should be made.

MISSTATEMENTS OF FACTS. If relevant facts about any person were misstated:

1. a fair adjustment of the premium will be made; and
2. the true facts will decide if and in what amount insurance is valid under this Policy.

If an Insured Employee's age has been misstated, any benefits shall be in the amount the paid premium would have purchased at the correct age.

ACTS OF THE POLICYHOLDER. In administering this Policy, the Policyholder must:

1. treat Employees the same in like situations; and
2. allow the Company, without inquiry, to rely on its acts.

POLICYHOLDER'S AGENCY. For all purposes of this Policy, the Policyholder acts on its own behalf or as the Employee's agent. Under no circumstances will the Policyholder be deemed the Company's agent.

CERTIFICATES. The Employer will be furnished with individual Certificates for delivery to each Insured Employee. These Certificates summarize the benefits provided by this Policy. If there is a conflict between this Policy and the Certificate, this Policy will control.

CONFORMITY WITH STATE STATUTES. If, on its effective date, any provision of this Policy conflicts with any applicable law, the provision will be deemed to conform to the minimum requirements of the law.

CURRENCY. In administering this Policy:

1. all Predisability Income will be expressed in U.S. dollars; and
2. all premium and benefit amounts must be paid in U.S. dollars.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE. This Policy does not replace or provide benefits required by:

1. Workers' Compensation laws; or
2. any state disability insurance plan laws.

ASSIGNMENT. The rights and benefits under this Policy may not be assigned.

CLAIMS PROCEDURES

NOTICE OF CLAIM. Written notice of claim must be given during the Elimination Period. The notice must be sent to the Company's Group Insurance Service Office. It should include:

1. the Insured Employee's name and address; and
2. the number of this Policy.

If this is not possible, written notice must be given as soon as it is reasonably possible.

CLAIM FORMS. When notice of claim is received, the Company will send claim forms to the Insured Employee. If the Company does not send the forms within 15 days, the Insured Employee may send the Company written proof of Disability in a letter. It should state the date the Disability began, its cause and degree. The Company will periodically send the Insured Employee additional claim forms.

PROOF OF CLAIM. The Company must be given written proof of claim within 90 days after the end of the Elimination Period. When it is not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason, if the proof is filed:

1. as soon as reasonably possible; and
2. in no event later than one year after it was required.

These time limits will not apply while an Insured Employee lacks legal capacity.

Proof of claim must be provided at the Insured Employee's own expense. It must show the date the Disability began, its cause and degree. Documentation must include:

1. completed statements by the Insured Employee and the Employer;
2. a completed statement by the attending Physician, which must describe any restrictions on the Insured Employee's performance of the duties of his or her Regular Occupation;
3. proof of any other income received;
4. proof of any benefits available from other income sources, which may affect Policy benefits;
5. a signed authorization for the Company to obtain more information; and
6. any other items the Company may reasonably require in support of the claim.

Proof of continued Disability, Regular Care of a Physician, and any Other Income Benefits affecting the claim must be given to the Company. This must be supplied within 45 days after the Company requests it. If it is not, benefits may be denied or suspended.

EXAMINATION. The Company may have the Insured Employee examined:

1. by a Physician, specialist or vocational rehabilitation expert of the Company's choice;
2. as often as reasonably required while a claim or appeal is pending.

Any such exam will be at the Company's expense.

The Company may determine that (in its opinion) the Insured Employee has:

1. failed to cooperate with an examiner;
2. failed to take an exam scheduled by the Company; or
3. postponed such an exam more than twice.

In that event, benefits may be denied or suspended, until the required exam is completed.

TIME OF PAYMENT OF CLAIMS. Benefits payable under this Policy will be paid immediately after the Company receives complete proof of claim and confirms liability. After that:

1. Any benefits will be paid monthly, during any period for which the Company is liable. If benefits are due for less than a month, they will be paid on a pro rata basis. The daily rate will equal 1/30 of the Monthly Benefit.
2. Any balance, which remains unpaid at the end of the period of liability, will be paid immediately after the Company receives complete proof of claim and confirms liability.

TO WHOM PAYABLE. All benefits are payable to the Insured Employee, while living. After his or her death, benefits will be payable as follows.

1. Any Survivor Benefit will be payable in accord with that section.
2. Any other benefits will be payable to the Insured Employee's estate.

If a benefit becomes payable to:

1. the Insured Employee's estate; or
2. a minor or any other person who is not legally competent to give a valid receipt;

then up to $2,000 may be paid to any relative of the Insured Employee that the Company finds entitled to payment. If payment is made in good faith to such a relative, the Company will not have to pay that benefit again.

NOTICE OF CLAIM DECISION. The Company will send the Insured Employee a written notice of its claim decision. If the Company denies any part of the claim, the written notice will explain:

1. the reason for the denial, under the terms of this Policy and any internal guidelines;
2. how the Insured Employee may request a review of the Company's decision; and
3. whether more information is needed to support the claim.

This notice will be sent within 15 days after the Company resolves the claim. It will be sent within 45 days after the Company receives the first proof of claim, if reasonably possible.

Delay Notice. The Company may need more than 15 days to process the claim, due to matters beyond its control. If so, an extension will be permitted. In that event, the Company will send the Insured Employee a written delay notice:

1. by the 15th day after receiving the first proof of claim; and
2. every 30 days after that, until the claim is resolved.

The notice will explain:

1. what additional information is needed to determine liability; and
2. when a decision can be expected.

If the Insured Employee does not receive a written decision by the 105th day after the Company receives the first proof of claim, there is a right to an immediate review, as if the claim was denied.

Exception: The Company may need more information from the Insured Employee to process a claim. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for claim processing.

REVIEW PROCEDURE. Within 180 days after receiving a denial notice, the Insured Employee may request a claim review by sending the Company:

1. a written request; and
2. any written comments or other items to support the claim.

The Insured Employee may review certain non-privileged information relating to the request for review.

The Company will review the claim and send the Insured Employee a written notice of its decision. The notice will state the reasons for the Company's decision, under the terms of this Policy and any internal guidelines. If the Company upholds the denial of all or part of the claim, the notice will also describe:

1. any further appeal procedures available under this Policy;
2. the right to access relevant claim information; and
3. the right to request a state insurance department review, or to bring legal action.

This notice will be sent within 45 days after the Company receives the request for review, or within 90 days if a special case requires more time.

Delay Notice. If the Company needs more than 45 days to process an appeal, in a special case:

1. an extension of up to 45 more days will be permitted; and
2. the Company will send the Insured Employee a written delay notice, by the 30th day after receiving the request for review.

The notice will explain:

1. the special circumstances which require the delay;
2. whether more information is needed to review the claim; and
3. when a decision can be expected.

Exception: The Company may need more information from the Insured Employee to process an appeal. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974). Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under this Policy, the plan participant or beneficiary must first seek two administrative reviews of the adverse claim decision, in accord with this section. After the required reviews:

1. an ERISA plan participant or beneficiary may bring legal action under Section 502(a) of ERISA; and
2. the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

RIGHT OF RECOVERY. If benefits have been overpaid on any short-term disability or long-term disability claim, full reimbursement to the Company is required within 60 days. If reimbursement is not made, the Company has the right to:

1. reduce future benefits and suspend payment of the Minimum Monthly Benefit under this Policy, until full reimbursement is made;
2. reduce benefits payable to the Insured Employee or his or her beneficiary under any group insurance policy issued by the Company, until full reimbursement is made; or
3. recover such overpayments from the Insured Employee or his or her estate.

Such reimbursement is required whether the overpayment is due to:

1. the Company's error in processing a claim;
2. the Insured Employee's receipt of Other Income Benefits;
3. fraud, misrepresentation or omission of relevant facts; or
4. any other reason.

LEGAL ACTIONS. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than three years after the date written proof of claim is required.

COMPANY'S DISCRETIONARY AUTHORITY. Except for the functions that this Policy clearly reserves to the Policyholder or Employer, the Company has the authority to manage this Policy, interpret its provisions, administer claims and resolve questions arising under it. The Company's authority includes (but is not limited to) the right to:

1. establish administrative procedures, determine eligibility and resolve claims questions;
2. determine what information the Company reasonably requires to make such decisions; and
3. resolve all matters when an internal claim review is requested.

The Insured Employee has the right to request a state insurance department review or to bring legal action. This provision does not apply to residents of California.

ELIGIBILITY

ELIGIBLE CLASSES. The classes of Employees eligible for insurance are shown in the Schedule of Benefits. The Company has the right to review and terminate any or all classes eligible under this Policy, if any class ceases to be covered by this Policy.

ELIGIBILITY DATE. An Employee becomes eligible for coverage provided by this Policy on the later of:

1. this Policy's date of issue; or
2. the date the Waiting Period is completed.

Prior Service Credit Towards Waiting Period. The Waiting Period is shown in the Schedule of Benefits. Prior service in an Eligible Class will apply toward the Waiting Period, when:

1. a former Employee is rehired within one year after his or her employment ends; or
2. an Employee returns from an approved Family or Medical Leave within:
   a. the 12-week leave period required by federal law; or
   b. any longer period required by a similar state law; or
3. an Employee returns from a Military Leave within the period required by federal USERRA law.

EFFECTIVE DATES

EFFECTIVE DATE. An Employee's initial amount of coverage becomes effective at 12:01 a.m. on the latest of:

1. the first day of the Insurance Month coinciding with or next following the date the Employee becomes eligible for the coverage;
2. the date the Employee resumes Active Work, if not Actively at Work on the day he or she becomes eligible;
3. the date the Employee makes written application for coverage and signs;
   a. a payroll deduction order, if the Employees pay any part of the Policy premium; or
   b. an order to pay premiums from the Employee's Flexible Benefits Plan account, if premiums are paid through such an account; or
4. the date the Company approves the Employee's Evidence of Insurability, if required.

Any increased or additional coverage becomes effective at 12:01 a.m. on the latest of:

1. the first day of the Insurance Month coinciding with or next following the date on which the Insured Employee becomes eligible for the increase, if Actively at Work on that day;
2. the date the Insured Employee resumes Active Work, if not Actively at Work on the day the increase would otherwise take effect; or
3. the date any required Evidence of Insurability is approved by the Company.

Any decrease will take effect on the day of the change, whether or not the Insured Employee is Actively at Work.

EVIDENCE OF INSURABILITY. Evidence of Insurability satisfactory to the Company must be submitted (at the Company's expense) when:

1. an Employee makes written application for coverage (or an increased amount of coverage) more than 31 days after becoming eligible for the coverage;
2. an Employee makes written application to enroll for coverage after he or she has requested:
   a. to cancel insurance;
   b. to stop payroll deductions for the insurance; or
   c. to stop premium payments from the Flexible Benefits Plan account;
3. coverage is elected after the Employee has caused insurance to lapse, by failing to pay the required premium when due; or
4. optional, supplemental or voluntary coverage is elected in excess of any Guaranteed Issue Amounts shown in the Schedule of Benefits.

EFFECTIVE DATE FOR CHANGE IN ELIGIBLE CLASS. An Insured Employee may become a member of a different Eligible Class. Coverage under the different Eligible Class will be effective:

1. on the first day of the Insurance Month coinciding with or next following the date of the change;
2. except as stated in the Effective Date provision for increases or decreases.

REINSTATEMENT RIGHTS. If an Insured Employee's coverage terminates due to one of the following breaks in service, he or she will be entitled to reinstate the coverage upon resuming Active Work with the Employer within the required timeframe. "**Reinstatement**" or **"to reinstate"** means to re-enroll for Policy coverage, without satisfying a new Waiting Period or providing Evidence of Insurability. Reinstatement is available upon:

1. return from an approved Family or Medical Leave within:
   a. the 12-week period required by federal law; or
   b. any longer period required by a similar state law;
2. return from a Military Leave within the period required by federal USERRA law;
3. return from any other approved leave of absence within six months after the leave begins;
4. return within 12 months following a lay off; or
5. return within 12 months following termination of employment for any other reason.

To reinstate coverage, the Employee must apply for coverage or be re-enrolled within 31 days after resuming Active Work in an Eligible Class. The reinstated amount of insurance may not exceed the amount that terminated. Reinstatement will take effect on the date the Insured Employee returns to Active Work.

If the above conditions are met, then:

1. the months of leave will count towards any unmet Pre-Existing Condition Exclusion period; and
2. a new Pre-Existing Condition Exclusion will not apply to the reinstated amount of insurance.

A new Pre-Existing Condition Exclusion will apply to any increased amount of insurance.

INDIVIDUAL TERMINATION

INDIVIDUAL TERMINATION OF COVERAGE. An Insured Employee's coverage will terminate at 12:00 midnight on the earliest of:

1. the date this Policy or the Employer's participation terminates; (but without prejudice to any claim incurred prior to termination);
2. the date the Insured Employee's Class is no longer eligible for insurance;
3. the date such Insured Employee ceases to be a member of an Eligible Class;
4. the last day of the Insurance Month in which the Insured Employee requests termination;
5. the last day of the last Insurance Month for which premium payment is made on the Insured Employee's behalf;
6. the end of the period for which the last required premium has been paid;
7. with respect to a particular insurance benefit, the date the portion of this Policy providing that benefit terminates;
8. the date on which the Insured Employee's employment with the Employer terminates; unless coverage is continued as provided below; or
9. the date the Insured Employee enters the armed services of any state or country on active duty, except for duty of 30 days or less for training in the Reserves or National Guard. (If the Insured Employee sends proof of military service, the Company will refund any unearned premium.)

CONTINUATION RIGHTS. Ceasing Active Work results in termination of the Insured Employee's eligibility for insurance, but coverage may be continued as follows.

1. Disability. If an Insured Employee is absent due to Total Disability, or is engaged in Partial Disability Employment, coverage may be continued during:

a. the Elimination Period; provided the Company receives the required premium from the Employer; and

b. the period for which benefits are payable, without payment of premium.

Premium payments will be waived from the satisfaction of the Elimination Period until the end of the period for which benefits are payable. If coverage is to be continued following a period for which premiums were waived, premium payments must be resumed, as they become due.

2. Family or Medical Leave. If an Insured Employee goes on an approved Family or Medical Leave, and is **not** entitled to the more favorable continuation available during Disability, coverage may be continued, until the earliest of:

a. the end of the leave period approved by the Employer;

b. the end of the 12-week leave period required by federal law, or any more favorable period required by a similar state law;

c. the date the Insured Employee notifies the Employer that he or she will not return; or

d. the date the Insured Employee begins employment with another employer.

The required premium payments must be received from the Employer, throughout the period of continued coverage.

3. Military Leave. If an Insured Employee goes on a Military Leave, coverage may be continued for the same period allowed for an approved Family or Medical Leave. The required premium payments must be received from the Employer, throughout the period of continued coverage.

4. Lay-off or Other Leave. When an Insured Employee ceases work due to a temporary lay-off, or due to an approved leave of absence (other than an approved Family or Medical Leave or a Military Leave); coverage may be continued for 60 days after the lay-off or leave begins. The required premium payments must be received from the Employer, throughout the period of continued coverage.

INDIVIDUAL TERMINATION
(Continued)

Conditions. In administering the above continuation(s), the Employer must not act so as to discriminate unfairly among Employees in similar situations. Insurance may **not** be continued when an Insured Employee ceases Active Work due to a labor dispute, strike, work slowdown or lockout.

INDIVIDUAL TERMINATION DURING DISABILITY. Termination of an Insured Employee's coverage during a Disability will have no effect on benefits payable for that period of Disability.

POLICY TERMINATION

POLICY TERMINATION BY THE COMPANY. To terminate this Policy, the Company must give the Group Policyholder at least 60 days advance written notice of its intent to do so. The Company may terminate this Policy on the due date of any premium if:

1. the number of Insured Employees totals less than 10;
2. part of the premium is paid by the Insured Employee and less than 75% of those eligible for coverage are insured (this part 2 will not apply to any voluntary, optional or supplemental insurance provided under this Policy);
3. all of the premium is paid by the Policyholder and less than 100% of those eligible for coverage are insured;
4. the Policyholder, without good cause, fails to:
   a. promptly furnish any information which the Company may reasonably require;
   b. perform its duties pertaining to this Policy in good faith;
5. the Employer ceases to be covered under the state Workers' Compensation program or any other program of like intent.
6. the Company terminates all other policies where permitted by their terms, which provide long-term disability benefits in the same state in which this Policy was issued; or
7. state law otherwise requires this Policy to be terminated.

POLICY TERMINATION BY THE POLICYHOLDER. The Policyholder may terminate this Policy at any time by giving the Company advance written notice. This Policy will then terminate on:

1. the date the Company receives the notice; or
2. some later date on which the Policyholder and the Company have agreed.

However, termination will not become effective during any period for which premium has been paid to the Company. The Policyholder remains liable for the payment of premiums to the date of termination.

AUTOMATIC POLICY TERMINATION. If any premium is not paid before the end of the Grace Period; then this Policy will terminate at the end of the Grace Period, without any action on the Company's part. The Policyholder remains liable for the payment of premiums to the date of termination.

POLICY TERMINATION DURING DISABILITY. Termination of this Policy or an Employer's participation during a Disability shall have no effect on benefits payable to the Insured Employee for that period of Disability.

PREMIUMS AND PREMIUM RATES

PAYMENT OF PREMIUM. No coverage provided by this Policy will be in effect until the first premium for such coverage is paid. For coverage to remain in effect, the Employer must pay each subsequent premium on or before its due date at the Company's Group Insurance Service Office. The premium must be paid in U.S. dollars.

PREMIUM RATES. The initial premium rates for this Policy are shown on the Face Page of this Policy. Premium rates are subject to change.

PREMIUM RATE CHANGE. The Company may change any premium rate on any of the following dates:

1. the date this Policy's terms are changed;
2. the date the Company's liability is changed due to a change in federal, state or local law;
3. the date the Company's liability is changed because the Policyholder (or any covered division, subsidiary or affiliated company):
   a. relocates, dissolves or merges, or is added to or removed from this Policy; or
   b. ceases to be covered by the state Workers' Compensation program or any other program of like intent; or
   c. ceases to provide or reduces Sick Leave or Salary Continuance Plan benefits;
4. the date any coverage for one or more classes ceases to be provided under this Policy;
5. the date the number of Insured Employees changes by 25% or more from the enrollment on the date this Policy took effect, or the most recent Rate Guarantee Date expired, if later;
6. on any premium due date on or after this Policy's first anniversary, or any later rate guarantee date agreed upon by the Company.

The Company may not increase premium rates in the first 12 months of this Policy, and then not more often than once in any 6 month period thereafter. However, the Company may change any premium rate on any of the following dates when, newly covered persons are added, benefit levels are increased or when there are changes in age or geographic location:

(1) on any Policy Anniversary; or
(2) any premium due date.

Unless the Company and the Policyholder agree otherwise, the Company will give at least 45 days' advance written notice of any increase in premium rates. If the increase is 20% or more, the Company will give at least 45 days' advance written notice.

MONTHLY PREMIUM AMOUNT. The amount of monthly premium due on each due date will be the Total Covered Payroll multiplied by the premium rate. Changes will not be pro-rated daily. Instead, premium will be adjusted as follows.

1. When an Insured Employee's insurance (or increased amount of insurance) takes effect, premium will be charged from the monthly due date coinciding with or next following that change.
2. When all or part of an Insured Employee's insurance terminates, the applicable premium will cease on the monthly due date coinciding with or next following that termination.
3. When premiums are paid other than monthly, increases or decreases will result in an adjustment from the premium due date coinciding with or next following that change.

The above manner of charging premium is for accounting purposes only. It will not extend insurance coverage beyond a date it would have otherwise terminated.

Each premium payment will include any adjustments in past premiums, which are needed due to changes that have not yet been taken into account. If a premium adjustment involves a return of unearned premium, the amount of the return will be limited to the prior 12-month period.

GRACE PERIOD. A Grace Period of 31 days from the due date will be allowed for the payment of each premium after the first. This Policy will remain in effect during the Grace Period. The Policyholder will be liable to the Company for the payment of all premiums due for the period this Policy remains in effect, however.

WAIVER OF PREMIUM. Premium will be administered as follows during any period for which benefits are payable.

1. Premium payments are waived for an Insured Employee who is Disabled:
   a. from the first premium due date following the satisfaction of the Elimination Period;
   b. until the end of any period for which benefits are payable.
2. If coverage is to be continued following a period during which premiums were waived, premium payments must be resumed as they become due.

TOTAL DISABILITY MONTHLY BENEFIT

BENEFIT. The Company will pay a Total Disability Monthly Benefit to an Insured Employee, after the completion of the Elimination Period, if he or she:

1. is Totally Disabled;
2. becomes Disabled while insured for this benefit;
3. is under the Regular Care of a Physician; and
4. at his or her own expense, submits proof of continued Total Disability and Physician's care to the Company upon request.

The Total Disability Monthly Benefit will cease on the earliest of:

1. the date the Insured Employee ceases to be Totally Disabled or dies;
2. the date the Maximum Benefit Period ends; or
3. the date the Insured Employee is able, but chooses not to engage in Partial Disability Employment:
   a. in his or her Own Occupation, during the Own Occupation Period; or
   b. in any occupation, after the Own Occupation Period, which provides more than 80% of his or her former earning capacity prior to the Disability.

Proportional benefits will be paid for a partial month of Total Disability.

At the Company's option, Total Disability Monthly Benefit payments may also be denied or suspended on any of the following dates:

1. the date the Insured Employee (without good cause):
   a. fails to take a required medical exam;
   b. fails to cooperate with the examiner; or
   c. postpones a required exam more than twice;
2. the 45th day after the Company mails a request for additional proof, if not given; or
3. the 45th day after the Company mails a request for proof of the Insured Employee's application for any Other Income Benefits to which he or she may be entitled, if not given.

AMOUNT. The amount of the Total Disability Monthly Benefit equals:

1. the Insured Employee's Basic Monthly Earnings multiplied by the Benefit Percentage (limited to the Maximum Monthly Benefit); minus
2. Other Income Benefits.

The amount of the Total Disability Monthly Benefit will not be less than the Minimum Monthly Benefit, unless the Minimum Monthly Benefit plus Other Income Benefits would exceed 100% of the Insured Employee's Basic Monthly Earnings.

The Benefit Percentage, Maximum Monthly Benefit, Minimum Monthly Benefit, and Maximum Benefit Period are shown in the Schedule of Benefits.

PARTIAL DISABILITY MONTHLY BENEFIT

BENEFIT. The Company will pay a Partial Disability Monthly Benefit to an Insured Employee, after completion of the Elimination Period, if he or she:

1. is Disabled;
2. becomes Disabled while insured for this benefit;
3. is engaged in Partial Disability Employment;
4. is earning at least 20% of Predisability Income when Partial Disability Employment begins;
5. is under the Regular Care of a Physician; and
6. at his or her own expense, submits proof of continued Partial Disability, Physician's care and reduced earnings to the Company upon request.

The Insured Employee does not have to be Totally Disabled prior to receiving Partial Disability Monthly Benefits. The Elimination Period may be satisfied by days of Total Disability, Partial Disability or any combination of these.

The Partial Disability Monthly Benefit will cease on the earliest of:

1. the date the Insured Employee ceases to be Partially Disabled or dies;
2. the date the Maximum Benefit Period ends;
3. the date the Insured Employee earns more than:
   a. 99% of Predisability Income, until Partial Disability Monthly Benefits have been paid for 24 months for the same period of Disability; or
   b. 85% of Predisability Income, after Partial Disability Monthly Benefits have been paid for 24 months for the same period of Disability;
4. the date the Insured Employee is able, but chooses not to work full-time:
   a. in his or her Own Occupation, during the Own Occupation Period; or
   b. in any occupation, after the Own Occupation Period.

Proportional benefits will be paid for a partial month of Partial Disability.

At the Company's option, Partial Disability Monthly Benefit payments may also be denied or suspended on any of the following dates:

1. the date the Insured Employee (without good cause):
   a. fails to take a required medical exam;
   b. fails to cooperate with the examiner; or
   c. postpones a required exam more than twice;
2. the 45th day after the Company mails a request for additional proof, if not given; or
3. the 45th day after the Company mails a request for proof of the Insured Employee's application for any Other Income Benefits to which he or she may be entitled, if not given.

PARTIAL DISABILITY MONTHLY BENEFIT
(Continued)

BENEFIT AMOUNT. The Partial Disability Monthly Benefit will replace the Insured Employee's Lost Income; provided it does not exceed the Total Disability Monthly Benefit, which would otherwise be payable during Total Disability without the Partial Disability Employment.

Thus, the amount of the Partial Disability Monthly Benefit will equal the lesser of A or B below.

A. LOST INCOME: The Insured Employee's Predisability Income, minus all Other Income Benefits (including earnings from Partial Disability Employment).

B. TOTAL DISABILITY MONTHLY BENEFIT otherwise payable:
   1. The Insured Employee's Predisability Income multiplied by the Benefit Percentage (limited to the Maximum Monthly Benefit); minus
   2. Other Income Benefits, except for earnings from Partial Disability Employment.

The Partial Disability Monthly Benefit will never be less than the Minimum Monthly Benefit. The Benefit Percentage, Maximum Monthly Benefit, Minimum Monthly Benefit, and Maximum Benefit Period are shown in the Schedule of Benefits.

Progressive Calculation

OTHER INCOME BENEFITS

OTHER INCOME BENEFITS means benefits, awards, settlements or Earnings from the following sources. These amounts will be offset, in determining the amount of the Insured Employee's Monthly Benefit. Except for Retirement Benefits and Earnings, these amounts must result from the same Disability for which a Monthly Benefit is payable under this Policy.

Workers' Compensation. Any benefits for which the Insured Employee is eligible under a law that compensates for job related Injury or Sickness. This includes:

1. any Workers' Compensation or occupational disease law;
2. the Jones Act;
3. the Longshoreman's and Harbor Worker's Act;
4. the Maritime Doctrine of Maintenance, Wages or Cure; or
5. any plan provided in place of one of the above plans.

It includes any benefits for partial or total disability, whether temporary or permanent. It also includes any benefits for vocational rehabilitation.

Other Compulsory Benefits. Any disability income benefits the Insured Employee is eligible to receive under any other compulsory benefit act or law. This includes (but is not limited to):

1. state temporary disability income benefit laws;
2. state no fault auto insurance laws; or
3. any other compulsory benefit act or law.

Other Insurance Plans. Any disability income benefits for which the Insured Employee is eligible under:

1. any other group insurance plan (except credit or mortgage insurance); or
2. any no fault auto plan.

Employee Benefit Plans. Any disability income benefits for which the Insured Employee is eligible under the Employer's Sick Leave or Salary Continuance Plan. This does **not** include vacation pay, severance pay or pay for work actually performed during a Disability.

Employer's Retirement Plan. Any Disability Benefits or Retirement Benefits the Insured Employee receives under the Employer's Retirement Plan.

Social Security and other Government Retirement Plans. The following Social Security or other Government Retirement Plan benefits will be offset:

1. **disability benefits** for which the Insured Employee is eligible; and for which any spouse or child is eligible, because of the Insured Employee's Disability;
2. **unreduced retirement benefits** for which the Insured Employee is eligible; and for which any spouse or child is eligible, because of the Insured Employee's eligibility for unreduced retirement benefits; or
3. **reduced retirement benefits** actually received by the Insured Employee; and by any spouse or child, because of the Insured Employee's receipt of reduced retirement benefits.

As used above, **"Government Retirement Plans"** include disability and retirement benefits under:

1. the federal Social Security Act, Jones Act or Railroad Retirement Act;
2. the Canada Pension Plan or Quebec Pension Plan;
3. any similar plan or act of any country, state, province or other political unit; or
4. any plan provided in place of one of the above plans.

"Earnings", as used in this provision, means pay the Insured Employee earns or receives from any occupation or form of employment, as reported for federal income tax purposes. Earnings include (but are not limited to) a:

1. salaried or hourly Employee's gross earnings (shown on Form W-2); including:
   a. wages, tips, commissions, bonuses and overtime pay; and
   b. any pre-tax contributions to a Section 125 Plan, flexible spending account, or qualified deferred compensation plan;
2. proprietor's net profit (figured from Form 1040, Schedule C);
3. professional corporation shareholder's net profit (figured from Form 1040, Schedule C);
4. partner's net earnings from self-employment (shown on Schedule K-1) and any W-2 earnings; and
5. Subchapter S Corporation shareholder's net earnings from trade or business activities (shown on Schedule K-1).

Exceptions. The following will **not** be considered Other Income Benefits, and will not be offset in determining the Monthly Benefit:

1. a cost-of-living increase in any Other Income Benefit (except Earnings); if it takes effect after the first offset for that benefit during a period of Disability;
2. reimbursement for hospital, medical or surgical expense;
3. reimbursement for attorney fees and other reasonable costs of claiming Other Income Benefits;
4. group credit or mortgage disability insurance benefits;
5. early retirement benefits that are not elected or received under the federal Social Security Act or other Government Retirement Plan;
6. any amounts under the Employer's Retirement Plan that:
   a. represent the Insured Employee's contributions; or
   b. are received upon termination of employment without being disabled or retired;
7. benefits from a 401(k), profit-sharing or thrift plan; an individual retirement account (IRA); a tax sheltered annuity (TSA); a stock ownership plan; or a non-qualified plan of deferred compensation;
8. vacation pay, holiday pay, or severance pay; or
9. disability income benefits under any individual policy, association group plan, franchise plan, or auto liability insurance policy (except no fault auto insurance).

RULES FOR OTHER INCOME BENEFIT OFFSETS. If the Insured Employee may be entitled to Other Income Benefits that affect Policy benefits, the following rules will apply.

Claiming Other Income Benefits. An Insured Employee who may be entitled to some Other Income Benefit is required to actively pursue it. For example, if benefits may be payable under the federal Social Security Act, the Insured Employee:

1. must apply for such benefits on a timely basis;
2. must file a request for reconsideration, if benefits are denied; and
3. must request a hearing before an Administrative Law Judge, if denied again (unless the Company waives this in writing).

An Employer whose Insured Employee may be entitled to Workers' Compensation or similar benefits is also required to cooperate in filing that claim. If the Insured Employee fails to pursue Other Income Benefits on a timely basis, the Company has the option to:

1. deny or suspend Monthly Benefits; or
2. reduce Monthly Benefits by an estimated amount.

OTHER INCOME BENEFITS
(Continued)

Estimating Offsets. While a claim for Social Security or other Government Retirement Plan benefits is pending, the Insured Employee must elect one of the following options in writing. (If no written election is made, Monthly Benefits will be reduced in accord with Option 1.)

1. **Reduced Monthly Benefits.** The Insured Employee may receive Monthly Benefits reduced by estimated Social Security or other Government Retirement Plan benefits. The Company will adjust Policy benefits and will refund any underpayment, in a lump sum, upon receiving proof of:
   a. the amount actually awarded; or
   b. the claim denial and completion of any appeal the Company requires.

2. **Unreduced Monthly Benefits.** The Insured Employee may receive unreduced Monthly Benefits while the claim is pending. He or she must agree in writing to promptly refund any overpayment that results, in a lump sum, upon receiving Social Security or other Government Retirement Plan benefits. If he or she does not promptly refund an overpayment:
   a. the Company will reduce or eliminate future payments; and
   b. the Minimum Monthly Benefit will not apply, until the amount is repaid.

Lump Sum Payments. Other Income Benefits that are paid in a lump sum will be pro rated as follows.
1. The lump sum will be pro rated on a monthly basis, over the time period for which it is given.
2. If no time period is stated, the Company will continue its estimated monthly offset for that benefit, until full amount is offset.
3. If no estimated monthly offset was being made for that benefit, the lump sum will be pro rated on a monthly basis over a reasonable time period. It will not exceed 60 months or the Maximum Benefit Period (whichever occurs first).

Cost-of-Living Freeze. After the first deduction for each of the Other Income Benefits (except Earnings), its amount will be frozen. The Monthly Benefit will not be further reduced due to any cost-of-living increases payable under these Other Income Benefits.

RECURRENT DISABILITY

"Recurrent Disability" means a Disability caused by an Injury or Sickness that is the same as, or related to, the cause of a prior Disability for which Monthly Benefits were payable. A Recurrent Disability will be treated as follows.

1. **New Disability.** A Recurrent Disability will be treated as a new Disability, if the Recurrent Disability begins after the Insured Employee returns to his or her Own Occupation with the Employer:
   a. on a full-time basis working at least the Minimum Number of Hours Per Week as shown in the Schedule of Benefits; and
   b. for six consecutive months or more following the date the prior Disability benefits ended.

   A new Elimination Period must be completed before further Monthly Benefits become payable. A new Maximum Benefit Period will apply.

2. **Prior Disability.** A Recurrent Disability will be treated as part of the prior Disability, if the Recurrent Disability begins after the Insured Employee returns to his or her Own Occupation with the Employer:
   a. on a full-time basis working at least the Minimum Number of Hours Per Week as shown in the Schedule of Benefits; but
   b. for less than six consecutive months following the date the prior Disability benefits ended.

   The completion of a new Elimination Period is not required before further Monthly Benefits become payable. The same Maximum Benefit Period will apply to the Recurrent Disability as to the prior Disability. The Predisability Income used in determining the prior Disability benefit will apply as well.

   In addition, a Recurrent Disability will be treated as a prior Disability if all of the subsequent events occur in less than six consecutive months following the date the prior Disability benefits end under this Policy:
   a. a job opening is not available for the Insured Employee to return to work with the Employer;
   b. the Insured Employee's coverage under this Policy terminates;
   c. the former Employee returns to his or her Own Occupation with a new employer on a full-time basis working at least the Minimum Number of Hours Per Week as shown in the Schedule of Benefits;
   d. benefits are not payable under any other group long-term disability plan; and
   e. a Recurrent Disability begins.

   Benefits for the former Employee will be reinstated for the Recurrent Disability and the completion of a new Elimination Period will not be required before further Monthly Benefits become payable. The same Maximum Benefit Period, Exclusions, and Limitations will apply to the Recurrent Disability as to the prior Disability. The Predisability Income used in determining the prior Disability benefit will apply as well. Benefits reinstated under this provision are subject to this Policy's terms and conditions that were in effect at the time the prior Disability began.

To qualify for a Monthly Benefit, the Insured Employee or former Employee must earn less than the percentage of Predisability Income specified in the Partial Disability Monthly Benefit section. Monthly Benefit payments will be subject to all other terms of this Policy that applied to the prior Disability.

This Recurrent Disability provision will cease to apply to an Insured Employee or former Employee who becomes eligible for coverage under any other group long-term disability plan.

EXCLUSIONS

GENERAL EXCLUSIONS. This Policy will not cover any period of Total or Partial Disability:

1. due to war, declared or undeclared, or any act of war;
2. due to intentionally self-inflicted injuries;
3. due to active participation in a riot;
4. due to the Insured Employee's committing of or the attempting to commit a felony or any type of assault or battery;
5. during which the Insured Employee is incarcerated for the commission of a felony;
6. during which the Insured Employee is not under the Regular Care of a Physician; or
7. after the Insured Employee has resided outside the United States or Canada for more than 12 consecutive benefit months for purposes other than employment with the Employer.

PRE-EXISTING CONDITION EXCLUSION. This Policy will not cover any Total or Partial Disability:

1. which is caused or contributed to by, or results from a Pre-Existing Condition; and
2. which begins in the first 12 months after the Insured Employee's Effective Date.

"Pre-Existing Condition" means a Sickness or Injury for which the Insured Employee received treatment within 3 months prior to the Insured Employee's Effective Date.

"Treatment" means consultation, care or services provided by a Physician. It includes diagnostic measures and the prescription, refill of prescription, or taking of any prescribed drugs or medicines.

SPECIFIED INJURIES OR SICKNESSES LIMITATION

LIMITATION. If an Insured Employee is Disabled primarily due to one or more of the Specified Injuries or Sicknesses defined below; then Partial or Total Disability Monthly Benefits:

1. will be payable subject to the terms of this Policy; but
2. will be limited to 24 months for any one period of Disability; unless the Insured Employee is confined to a Hospital.

"Specified Injuries or Sicknesses" include any Chronic Fatigue Sickness, Environmental Sickness, Mental Sickness, Musculoskeletal/Connective Tissue Injury or Sickness, or Substance Abuse, as defined below.

CONDITIONS

1. If the Insured Employee is confined in a Hospital at the end of the 24th month for which Policy benefits are paid for the Specified Injury or Sickness; then benefits will be payable until he or she is discharged from that facility.
2. In no event will the Monthly Benefit be paid beyond the Maximum Benefit Period shown in the Schedule of Insurance, however.

DEFINITIONS

"Chronic Fatigue Sickness" means a sickness that is characterized by a debilitating fatigue, in the absence of other known medical or psychological conditions. It includes, but is not limited to:

1. chronic fatigue syndrome or chronic fatigue immunodeficiency syndrome;
2. an Epstein-Barr or herpes 6 viral infection, or post viral syndrome; and
3. limbic encephalopathy or myalgic encephalomyelitis.

It does **not** include depression or any neoplastic, neurologic, endocrine, hematologic or rheumatologic disorder.

"Environmental Sickness" means an allergy or sensitivity to chemicals or the environment. It includes, but is not limited to:

1. environmental allergies;
2. sick building syndrome;
3 multiple chemical sensitivity syndrome; and
4. chronic toxic encephalopathy.

It does **not** include asthma or allergy-induced reactive lung disease.

"Hospital," as used in this provision, means:

1. a general hospital which:
   (a) is licensed, approved or certified by the state where it is located;
   (b) is recognized by the Joint Commission on the Accreditation of Hospitals; or
   (c) is operated to treat resident inpatients; has a registered nurse always on duty; and has a lab, x-ray facility and place where major surgery is performed; and
2. a skilled nursing care facility or unit, which provides convalescent or nursing care; and which is recognized as a skilled nursing care facility under Medicare.

The term Hospital also includes:

1. a Mental Hospital when treatment is for a Mental Sickness; and
2. a Treatment Center when treatment is for Substance Abuse.

"Mental Hospital" means a health care facility (or its psychiatric unit) which:

1. is licensed, certified or approved as a mental hospital by the state where it is located;
2. is equipped to treat resident inpatients' mental diseases or disorders; and
3. has a resident psychiatrist on duty or on call at all times.

"Mental Sickness" means any emotional, behavioral, psychological, personality, adjustment, mood or stress-related abnormality, disorder, disturbance, dysfunction or syndrome; regardless of its cause. It includes, but is not limited to:

1. schizophrenia or schizoaffective disorder;
2. bipolar affective disorder, manic depression, or other psychosis; and
3. obsessive-compulsive, depressive, panic or anxiety disorders.

These conditions are usually treated by a psychiatrist, a clinical psychologist or other qualified mental health care provider. Treatment usually involves psychotherapy, psychotropic drugs or similar methods of treatment.

Mental Sickness does not include irreversible dementia resulting from:

1. stroke, trauma, viral infection, Alzheimer's disease; or
2. other conditions which are not usually treated by a mental health care provider using psychotherapy, psychotropic drugs, or similar methods of treatment.

"Musculoskeletal/Connective Tissue Injury or Sickness" includes, but is not limited to:

1. scoliosis that does not require surgery;
2. any other disease or disorder of the cervical, thoracic or lumbosacral back and surrounding soft tissue; unless documented by x-ray, electromyogram, computerized tomography or magnetic resonance imaging;
3. sprains or strains of the muscles, joints and adjacent tissues;
4. fibromyalgia, carpal tunnel syndrome, or repetitive motion syndrome; and
5. myofascial pain, or any craniomandibular or temporomandibular joint disorder (TMJ).

It does **not** include:

1. scoliosis that requires surgery, or spondylolisthesis of grade II or higher;
2. radiculopathies or herniated discs that are documented by x-ray, electromyogram, computerized tomography or magnetic resonance imaging;
3. tumors, malignancies, vascular malformations, or osteopathies;
4. myelopathies, myelitis, or demyelinating disease; or
5. lupus, or rheumatoid or psoriatic arthritis.

"Substance Abuse" means alcoholism, drug abuse, or chemical dependency of any type.

"Treatment Center" means a health care facility (or its medical or psychiatric unit) which:

1. is licensed, certified or approved by the state where it is located;
2. has a program for inpatient treatment of substance abuse; and
3. provides such treatment based upon a written plan approved and supervised by a Physician.

VOLUNTARY VOCATIONAL REHABILITATION BENEFIT PROVISION

BENEFIT. If an Insured Employee is Disabled and is receiving Policy benefits; then he or she may be eligible for a Vocational Rehabilitation Benefit. This Benefit consists of services which may include:

1. vocational evaluation, counseling, training or job placement;
2. job modification or special equipment; and
3. other services which the Company deems reasonably necessary to help the Insured Employee return to work.

The Company will determine the Insured Employee's eligibility and the amount of any Benefit payable.

ELIGIBILITY. An Insured Employee may be eligible for this Benefit, if the Company finds that he or she:

1. has a Disability that prevents the performance of his or her regular occupation; and, after the Own Occupation Period, also lacks the skills, training or experience needed to perform any other gainful occupation;
2. has the physical and mental abilities needed to complete a Program; and
3. is reasonably expected to return to work after completing the Program; in view of his or her degree of motivation and the labor force demand for workers in the proposed occupation.

The Company must also find that the cost of the proposed services is less than its expected claim liability.

AMOUNT. The amount of any Vocational Rehabilitation Benefit will not exceed the Company's expected claims liability. This benefit will not be payable for services covered under the Insured Employee's health care plan or any other vocational rehabilitation program. Payment may be made to the provider of the services, at the Company's option.

CONDITIONS. Either the Company, the Insured Employee, or his or her Physician may first propose vocational rehabilitation. When a Program is approved by the Company, this Policy's definition of "Disability" will be waived during the rehabilitation period; but it will be reapplied after the Program ends. The Company will determine the amount and duration of any Long Term Disability benefits payable after the Program ends.

LIMITATION. This Policy will not cover any period of Disability for an Insured Employee who has received a Vocational Rehabilitation Benefit and has failed to complete the Program, without Good Cause.

DEFINITIONS

"Good Cause", as used in this provision, means the Insured Employee's:

1. documented physical or mental impairments, which render the Insured Employee unable to take part in or complete a Program;
2. involvement in a medical program, which prevents or interferes with the Insured Employee's taking part in or completing a Program; or
3. participating in good faith in some other vocational rehabilitation program, which:
   (a) conflicts with taking part in or completing a Program developed by the Company; and
   (b) is reasonably expected to return the Insured Employee to work.

"Program" means a written vocational rehabilitation program:

1. which the Company develops with input from the Insured Employee; his or her Physician; and any current or prospective employer, when appropriate; and
2. which describes the Program's goals; each party's responsibilities; and the times, dates and costs of the rehabilitation services.

REASONABLE ACCOMMODATION BENEFIT

If an Insured Employee of the Employer is Disabled, and is receiving Policy benefits; then the Employer may be eligible for a Reasonable Accommodation Benefit. This Benefit reimburses the Employer for 50% of the expense incurred for reasonable accommodation services for the Insured Employee; but will not exceed:

1. a maximum benefit of $5,000 for any one Insured Employee; or
2. the Company's expected liability for the Insured Employee's Long Term Disability claim (whichever is less).

Such services may include:

1. providing the Insured Employee a more accessible parking space or entrance;
2. removing barriers or hazards to the Insured Employee from the worksite;
3. special seating, furniture or equipment for the Insured Employee's work station;
4. providing special training materials or translation services during the Insured Employee's training; and
5. other services the Company deems reasonably necessary to help the Insured Employee return to work with the Employer.

ELIGIBILITY FOR BENEFIT. The Company will determine the Employer's eligibility to receive the Benefit. To qualify for the Benefit, the Employer must have an Insured Employee:

(a) whose Disability prevents the performance of his or her regular occupation at the Employer's worksite;
(b) who has the physical and mental abilities needed to perform his or her own or another occupation at the Employer's worksite; but only with the help of the proposed accommodation; and
(c) who is reasonably expected to return to work with the help of the proposed accommodation.

The Company must also find that the requested Reasonable Accommodation Benefit is less than the expected liability for the Insured Employee's Long Term Disability claim.

WRITTEN PROPOSAL. The reasonable accommodation services must be provided in accord with a written proposal, which is developed with input from:

1. the Employer;
2. the Insured Employee; and
3. his or her Physician, when appropriate.

The proposal must state the purpose of the proposed accommodation; and the times, dates and costs of the services.

CONDITIONS. Either the Company, the Employer, the Insured Employee, or his or her Physician may first propose an accommodation.

The proposal must be approved by the Company in writing.

The Company will then reimburse the Employer, upon receipt of proof that the Employer:

1. has provided the services for the Insured Employee; and
2. has paid the provider for the services.

FAMILY INCOME BENEFIT

The Company will pay a lump sum benefit to the Eligible Survivor when proof is received that an Insured Employee died:

1. after Disability had continued for 180 or more consecutive days; and
2. while receiving a Monthly Benefit.

The benefit will be equal to three times the Insured Employee's Last Monthly Benefit.

"Last Monthly Benefit" means the gross Monthly Benefit payable to the Insured Employee immediately prior to death. Any reductions for Other Income Benefits, or for earnings the Insured Employee received for Partial Disability Employment, will not apply.

"Eligible Survivor" means the Insured Employee's:

1. surviving spouse; or, if none
2. surviving children who are under age 25 on the Insured Employee's date of death.

If payment becomes due to the Insured Employee's children; then payment will be made to:

1. the surviving children, in equal shares; or
2. a person named by the Company to receive payments on the children's behalf.

This payment will be valid and effective against all claims by others representing, or claiming to represent, the children.

If there are no Eligible Survivors, payment will be made to the Insured Employee's estate.

MINIMUM INDEMNITY FOR ACCIDENTAL DISMEMBERMENT AND LOSS OF SIGHT

BENEFIT. A Monthly Benefit will be paid to the Insured Employee for the number of months shown below if:

1. the Insured Employee sustains an Injury; and
2. such Injury directly causes one of the following losses within 100 days of such Injury.

Loss	Number of Monthly Payments
Sight of Both Eyes	46
Both Hands	46
Both Feet	46
One Hand and One Foot	46
One Hand and Sight of One Eye	46
One Foot and Sight of One Eye	46
One Hand or One Foot	23
Sight of One Eye	15
Thumb and Index Finger of Either Hand	12

The maximum number of monthly payments for all losses suffered in any one Injury shall be limited to that one loss for which the greatest number of monthly payments is provided above.

The Insured Employee does not need to complete an Elimination Period. Monthly Benefits will begin on the date the Insured Employee sustains one of the above losses.

Monthly Benefits under this provision are in lieu of any other Monthly Benefits otherwise payable under this Policy. A Total Disability Monthly Benefit or Partial Disability Monthly Benefit may be payable after the Monthly Benefits cease under this provision if such Insured Employee remains Disabled.

The amount of the Monthly Benefit equals the lesser of:

1. the Insured Employee's Basic Monthly Earnings multiplied by the Benefit Percentage; or
2. the Maximum Monthly Benefit.

If death occurs before all these payments have been made, the balance remaining at the time of death will be paid to the Insured Employee's estate.

Loss of hands and feet means loss by severance at or above the wrist or ankle joint. Loss of sight means total and irrecoverable loss of sight. Loss of thumb and index finger means actual severance at or above the knuckles joining each to the hand.

Summary of the Louisiana Life and Health Insurance Guaranty Association Act and Notice Concerning Coverage Limitations and Exclusions

Residents of Louisiana who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are required by law to be members of the Louisiana Life and Health Insurance Guaranty Association (LLHIGA). The purpose of LLHIGA is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this happens, LLHIGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state, and in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through LLHIGA is limited. As noted in the disclaimer below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The Louisiana Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. *COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.* Even if coverage is provided, there are significant limits and exclusions. Coverage is generally conditioned upon residence in this state. Other conditions may also preclude coverage.

Insurance companies and insurance agents are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer.

The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

LLHIGA
P.O. Box 3337
Baton Rouge, Louisiana 70821

Department of Insurance
P.O. Box 94214
Baton Rouge, Louisiana 70804-9214

The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Law (the law), and is set forth at R.S. 22:2081 *et seq*. The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change any person's rights or obligations under the law or the rights or obligations of LLHIGA.

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a direct non-group life, health, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons may also be protected as well even if they live in another state unless they are afforded coverage by the guaranty association of another state, or other circumstances described under the law are applicable.

(over)

EXCLUSIONS FROM COVERAGE

A person who holds a direct non-group life, health, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract is not protected by LLHIGA, if:

(1) he is eligible for protection under the laws of another state (This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.);
(2) the insurer was not authorized to do business in this state;
(3) his policy was issued by a profit or nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, an insurance exchange, an organization that issues charitable gift annuities as is defined in R.S. 22:952(A)(3), or any entity similar to any of these.

LLHIGA also does not provide coverage for:

(1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
(2) any policy of reinsurance (unless an assumption certificate was issued);
(3) interest rate or crediting rate yields, or similar factors employed in calculating changes in value, that exceed an average rate;
(4) dividends, premium refunds, or similar fees or allowances described under the Law;
(5) credits given in connection with the administration of a policy by a group contract holder;
(6) employers', associations' or similar entities' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured;
(7) unallocated annuity contracts (which give rights to group contract holders, not individuals), except unallocated annuity contracts and defined contribution government plans qualified under section 403(b) of the United States Internal Revenue Code (26 U.S.C §403(b));
(8) an obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the policy owner or contract owner, including but not limited to, claims described under the law;
(9) a policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to "Medicare Part C coverage" or "Medicare Part D coverage" and any regulations issued pursuant to those parts;
(10) interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer, whichever is earlier.

LIMITS ON AMOUNT OF COVERAGE

The Louisiana Life and Health Insurance Guaranty Association Law also limits the amount LLHIGA is obligated to pay out. The benefits for which LLHIGA may become liable shall in no event exceed the lesser of the following.

(1) LLHIGA cannot pay more than what the insurance company would owe under a policy or contract if it were not an impaired or an insolvent insurer.
(2) For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance.
(3) For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of $500,000 in health insurance benefits, and LLHIGA will pay a maximum of $250,000 in present value of annuities, including net cash surrender and net cash withdrawal values.

In no event, regardless of the number of policies and contract there were with the same company, and no matter how many different types of coverages, LLHIGA shall not be liable to expend more than $500,000 in the aggregate with respect to any one individual.