

**LONG TERM DISABILITY CERTIFICATE  
SCHEDULE OF BENEFITS**

EPIC certifies that you are insured for covered expenses as described in this certificate as of the effective date shown in our records, subject to the terms, conditions, exclusions, limitations and all other provisions of the policy. Final interpretation of all provisions and coverages will be governed by the policy on file with EPIC at its home office.

If the term NONE or N/A (Not Applicable) appears in this schedule, that coverage or provision doesn't apply to you, and no benefits are payable under that coverage or that provision doesn't apply to the policy.

The policy provides you with loss of income protection if you become disabled from a covered accidental bodily injury, sickness or pregnancy.

1. The elimination period is the period of time you must be disabled before benefits become payable. It is the last to be satisfied of the following:
  - a. the first 90 consecutive day(s) of any one period of disability; or
  - b. with the exception of benefits required by state law, the expiration of any employer sponsored short term disability benefits or salary continuation program.
  
2. Benefit Percentage: 60.00 % of monthly income loss
  
3. Maximum Monthly Benefit: \$3,000
  
4. Minimum Monthly Benefit: The greater of: \$100/10% of the benefit based on monthly income loss, before the deduction of other income benefits
  
5. Waiting Period for Pre-existing Conditions:
  - a. 3 months look back period
  - b. 12 months being continuously insured
  
6. Temporary Lay-off: 3 months

**7. MAXIMUM DURATION OF BENEFITS TABLE**

**Age When Disabled**

**Benefits Payable**

Prior to age 63	To normal retirement age or 48 months, if greater
Age 63	42 months
Age 64	36 months
Age 65	30 months
Age 66	27 months
Age 67	24 months
Age 68	21 months
Age 69 and over	18 months

Normal retirement age means the Social Security normal retirement age as stated in the 1983 revision of the United States Social Security Act. It is determined by your date of birth as follows:

**Age When Disabled****Benefits Payable**

1937 or before	65
1938	65 + 2 months
1939	65 + 4 months
1940	65 + 6 months
1941	65 + 8 months
1942	65 + 10 months
1943 thru 1954	66
1955	66 + 2 months
1956	66 + 4 months
1957	66 + 6 months
1958	66 + 8 months
1959	66 + 10 months
1960 and after	67

The above table shows the maximum duration for which benefits may be paid. All other limitations of the plan will apply.

# LONG TERM DISABILITY CERTIFICATE

Please read this certificate, including the Schedule of Benefits and all endorsements, if any, carefully, so you know and understand your coverage.

This certificate is not the contract of insurance. It is merely evidence of insurance provided under the group long term disability insurance policy (hereinafter called "group policy" or "policy") issued by The EPIC Life Insurance Company ("EPIC") to the group policyholder (hereinafter called "group policyholder" or "policyholder"). This certificate describes the essential features of such insurance. This certificate replaces and supersedes all certificates and endorsements thereto which we may have previously issued to you prior to the effective date of this certificate.

EPIC, in performing its obligations under the policy, is acting only as a long term disability insurer with respect to the policy and is not in any way acting as a plan administrator, a plan sponsor or a plan trustee for the purposes of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, or any other federal or state law.

The policy is issued by EPIC and delivered to the policyholder. All terms, conditions and all other provisions of the policy are governed by the laws of the state in which the policyholder is located. All benefits are provided in accordance with the terms, conditions, exclusions, limitations and provisions of the policy, including all endorsements, if any, attached to this certificate, and applicable laws and regulations of the state in which the policyholder is located.

**The EPIC Life Insurance Company**

A handwritten signature in black ink that reads "Michael F. Hamerlik". The signature is written in a cursive style with a large, prominent initial "M".

Michael F. Hamerlik, President

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# GENERAL INFORMATION

## General Description of Coverage

EPIC certifies that a group policy has been issued to a group insuring certain employees of the group. We call the group the policyholder. Those persons to whom we've issued certificates are called covered employees. The group policy forms a contract between us and the policyholder. We'll provide the insurance described here under the terms, conditions and provisions of that contract. Subject to that contract, each covered employee is insured for the coverage described in this certificate. Please see subsection "Entire Contract".

## Coverage

Coverage is subject to terms, conditions, exclusions, limitations, and all other provisions of the policy. As a certificate, this document describes the essential features of the insurance provided by the policy, but does not constitute the actual policy. You may examine the policy at the office of the policyholder during regular business hours.

This certificate replaces and supersedes all certificates and endorsements thereto which we may have previously issued to you prior to the effective date of this certificate.

## How to Use This Certificate

This certificate, including its Schedule of Benefits and all endorsements, should be read carefully and completely by you. You should also review this certificate periodically. The provisions of this certificate are interrelated. This means that each provision is subject to all of the other provisions. Therefore, reading just one or two provisions may not give you a clear or full understanding of your coverage under the policy.

Each term used in this certificate has a special meaning. These terms are defined for you in section "Definitions". By understanding these definitions, you will have a clearer and better understanding of your coverage under the policy as described in this certificate by us.

From time to time, the policy may be amended by us. When that happens, a new endorsement for this certificate will be sent by us to the policyholder for its delivery to each covered employee. That means your coverage under the policy will change to the extent described in the endorsement, as of the effective date of that endorsement. This certificate should be kept in a safe place for your future reference.

## Payment of Benefits

EPIC has the sole and exclusive right to interpret and apply the policy's terms, conditions, limitations, exclusions, and all other provisions of the policy, including, but not limited to, making factual determinations under the policy's provisions, including, but not limited to, whether benefits are payable. At any time, we may, at our sole discretion, give certain discretionary authority to other persons or entities providing administrative services to us in regard to the policy. We reserve the right to change, interpret, modify, remove or add benefits, or terminate the policy, at our sole discretion, without giving prior notice to you, or getting your approval. Other than EPIC, no person or entity has any authority to make any oral changes or amendments to the policy. Please also see subsection "Waiver and Change".

We may, at our sole discretion, arrange for various persons or entities to provide administrative services in regard to the policy, including claims processing and utilization review management services. Their identity and the nature of the services being provided by them may be changed by us at any time at our sole discretion, and without giving prior notice to you, or getting your approval. By accepting this certificate, you agree to and must cooperate fully with those persons or entities in the performance of their responsibilities.

## DEFINITIONS

In this certificate, the following terms shall mean:

**Actively at Work:** when an employee is performing all of the full-time duties of his/her principal occupation in his/her job with the policyholder for the required number of hours per week as shown in the policyholder's current EPIC application for coverage, and paid a reasonable wage, as determined by us. These duties must be performed at the policyholder's place of business, except to the extent that the employee must travel to perform his/her duties, or an alternate location if approved by the policyholder. The covered employee shall be deemed to be actively at work on: (1) each day of a paid vacation; or (2) a regularly-scheduled non-working day, provided that, in either case, he/she has performed all of the full-time duties of his/her principal occupation in his/her job on a full-time basis on his/her entire last regularly-scheduled work day prior to such date.

**Active Full-time Employee:** an employee who is actively at work with the policyholder.

**Any Occupation:** any occupation for which you are qualified by education, training or experience, and that has an earnings potential greater than an amount equal to the lesser of the product of your indexed pre-disability earnings and the benefit percentage and the maximum monthly benefit shown in the Schedule of Benefits. Any occupation does not mean the specific job you are performing for a specific employer or at a specific location.

**Certificate:** the document issued by us to a covered employee under the policy issued by us to the policyholder. It is not a contract of insurance, but only evidence of coverage, and describes the essential features of the insurance provided by the policy.

**Covered Employee:** an employee who meets all of the following requirements: (1) he/she is employed by the policyholder; (2) he/she is eligible for coverage under the policy; (3) he/she has properly enrolled; and (4) he/she is approved by us for coverage under the policy; and for whom we've accepted the appropriate premium paid by the policyholder.

**Current Monthly Earnings:** the monthly earnings you receive from: (1) the employer while disabled; and (2) other employment. However, if the other employment is a job you held in addition to active full-time employment with the employer, then, during the elimination period and while eligible to receive benefits for being disabled from your occupation, any earnings from this other employment will be current monthly earnings only to the extent that such earnings exceed the average monthly earnings you were receiving from this other job during the six-month period immediately prior to becoming disabled.

**Dependent Child:** your child residing in your home (including your stepchild, adopted child and legal ward).

**Disability or Disabled:** means

1. during the elimination period, you are prevented from performing one or more of the essential duties of your occupation;
2. for 24 months following the elimination period, you are prevented from performing one or more of the essential duties of your occupation, and as a result, your current monthly earnings are less than 80% of your indexed pre-disability earnings;
3. after that, you are prevented from performing one or more of the essential duties of any occupation.

If at the end of the elimination period, you are prevented from performing one or more of the essential duties of your occupation, but your current monthly earnings are greater than 80% of your pre-disability earnings, your elimination period will be extended for a total period of 12 months from the original date of disability, or until such time as your current monthly earnings are less than 80% of your pre-disability earnings, whichever occurs first.

Your disability must be the result of: (1) accidental bodily injury; (2) sickness; (3) mental illness; (4) substance abuse; or (5) pregnancy.

Your failure to pass a physical examination required to maintain a license in order for you to perform the duties of your occupation does not alone mean that you are disabled.

**Elimination Period:** the period of time stated in Section 1. of the Schedule of Benefits.

**Employee:** see subsection "Eligible Employee" of section "Eligibility and Effective Date" for employee eligibility.

**Employer:** the policyholder.

**Enrollment Date:** the effective date of coverage under the policy or the first day of the probationary period, if any, as shown in the policyholder's current application for coverage whichever is the earlier. A late enrollee's enrollment date will always be his/her effective date of coverage under the policy.

**Enrollment Period:** the period beginning immediately following an eligible employee's enrollment date through the 31st day immediately following the end of his/her probationary period, if any.

**EPIC:** The EPIC Life Insurance Company with its principal office located in Madison, Wisconsin.

**Essential Duty:** a duty that you're required to perform as part of your job with your employer for compensation and that: (1) is substantial, not incidental; (2) is fundamental or inherent to the occupation; and (3) can not be reasonably omitted or changed. To be at work for the number of hours in your regularly scheduled workweek for your employer is also an essential duty.

**Group Master Policy/Policy:** the insurance policy issued by us to the employer, trustee, union, association, organization or other entity known as the group policyholder. In it, we agree to insure covered employees of the group policyholder for future losses covered by the policy through benefit payments, subject to the terms, conditions, and provisions of the policy.

**Illness:** a disturbance in a function, structure or system of the human body which causes one or more physical signs and/or symptoms and which, if left untreated, will result in deterioration of the health state of the function, structure or system of the human body. Physical illness includes pregnancy and complications of pregnancy. Illness shall include alcoholism, drug abuse, or a nervous or mental disorder.

**Indexed Pre-disability Earnings:** your pre-disability earnings adjusted annually by adding the lesser of: (a) 10%; or (b) the percentage change in the Consumer Price Index (CPI-W).

The adjustment is made January 1st each year after you have been disabled for 12 consecutive months, and if you are receiving benefits at the time the adjustment is made.

The term Consumer Price Index (CPI-W) means the index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. It measures on a periodic (usually monthly) basis the change in the cost of typical urban wage earners' and clerical workers' purchase of certain goods and services. If the index is discontinued or changed, we may use another nationally published index that is comparable to the CPI-W.

For the purposes of this benefit, the percentage change in the CPI-W means the difference between the current year's CPI-W as of July 31st, and the prior year's CPI-W as of July 31st, divided by the prior year's CPI-W.

**Injury:** bodily damage caused by an accident. The bodily damage must result from the accident directly and independently of all other causes. An accident caused by chewing resulting in damage to your teeth is not considered an injury.

**Mental Illness:** a nervous or mental disorder.

**Nervous or Mental Disorders:** a health condition listed in the latest edition of the International Classification of Disease (ICD-9-CM) within one of the following classification categories or codes: 295 - Schizophrenic Disorders; 296 - Episodic Mood Disorders; 297 - Delusional Disorders; 298 - Other Nonorganic Psychoses; 300 - Anxiety, Dissociative and Somatoform Disorders; 301 - Personality Disorders; 302 - Sexual and Gender Identity Disorders; 306 - Physiological Malfunction Arising From Mental Factors; 307 - Special Symptoms or Syndromes, Not Elsewhere Classified; 308 - Acute Reaction to Stress; 309 - Adjustment Reaction; 311 - Depressive Disorder, Not Elsewhere Classified; 312 - Disturbance of Conduct, Not Elsewhere Classified; 313 - Overanxious Disorder; and 314 - Hyperkinetic Syndrome of Childhood.

**Monthly Benefit:** a monthly sum payable to you while you are disabled, subject to the terms of the group insurance policy.

**Monthly Income Loss:** the difference of your pre-disability earnings less your current monthly earnings.

**Monthly Rate of Basic Earnings:** your regular monthly rate of pay from the employer just prior to the date you become disabled:

1. including contributions you make through a salary reduction agreement with the employer to: (a) an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement; (b) an executive non qualified deferred compensation arrangement; or (c) a salary reduction arrangement under an IRC Section 125 plan; and
2. not including commissions, bonuses, overtime pay or expense reimbursements for the same period as above.

**Other Income Benefits:** the amount of any benefit for loss of income, provided to you or to your family, as a result of the period of disability for which you or your family are claiming benefits under this plan. This includes any such benefits for which you are eligible or that are paid to you, to your family or to a third party on your behalf, pursuant to any:

1. temporary disability benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;
2. governmental law or program that provides disability or unemployment benefit as a result of your job with the employer;
3. plan or arrangement of coverage, whether insured or not, or as a result of employment by or association with the employer or as a result of membership in or association with any group, association, union or other organization;
4. individual insurance policy where the premium is wholly or partially paid by the employer;
5. mandatory "no-fault" automobile insurance plan;
6. disability benefits under: (a) the United States Social Security Act or alternative plan offered by a state or municipal government; (b) the Railroad Retirement Act; (c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan; or (d) similar plan or act that you, your spouse and children are eligible to receive because of your disability; or
7. disability benefit from the Veteran's Administration, or any other foreign or domestic governmental agency: (a) that begins after you become disabled; or (b) if you were receiving the benefit before becoming disabled, the amount of any increase in the benefit that is attributed to your disability.

Other income benefits also mean any payments that are made to you, your family or to a third party on your behalf, pursuant to any:

1. disability benefit under the employer's retirement plan;
2. permanent disability or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges of such benefits;
3. portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates for your loss of earnings; or
4. retirement benefit from a retirement plan that wholly or partially funded by employer contributions, unless:
  - a. you were receiving it prior to becoming disabled; or
  - b. you immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement.

Other income benefits will not include the portion, if any, of such retirement benefit that was funded by your after-tax contributions; or

5. retirement benefits under: (a) the United States Social Security Act or alternative plan offered by a state or municipal government; (b) the Railroad Retirement Act; (c) the Canada Pension Plan, the Canada Old Age Security Act; the



Quebec Pension Plan or any provincial pension or disability plan; or (d) similar plan or act that you, your spouse and children receive because of your retirement, unless you were receiving them prior to becoming disabled.

If you are paid other income benefits in a lump sum or settlement, you must provide proof satisfactory to us of: (a) the amount attributed to loss of income; and (b) the period of time covered by the lump sum or settlement.

We will pro-rate the lump sum or settlement over this period of time. If you cannot or do not provide this information, we will assume the entire sum to be for loss of income, and the time period to be 24 months. We may make a retroactive allocation of any retroactive other income benefit. A retroactive allocation may result in an overpayment of your claim. Please see section "Overpayment of Benefits"

The amount of any increase in other income benefits will not be included as other income benefits if such increase: (a) takes effect after the date benefits become payable under this plan; and (b) is a general increase which applies to all persons who are entitled to such benefits.]

**Physician:** a person who is: (1) a doctor of medicine, osteopathy, psychology or other healing art recognized by us; (2) licensed to practice in the state or jurisdiction where care is being given; and (3) practicing within the scope of that license.

**Pre-disability Earnings:** your monthly rate of basic earnings in effect on the day before you became disabled.

**Prior Plan:** the long term disability insurance carried by the employer on the day before the plan effective date.

**Regular Care of a Physician:** when you are attended by a physician, who is not related to you:

1. with medical training and clinical experience suitable to treat your disabling condition; and
2. whose treatment is:
  - a. consistent with the diagnosis of the disabling condition;
  - b. according to guidelines established by medical, research and rehabilitative organizations; and
  - c. administered as often as needed,to achieve the maximum medical improvement.

**Retirement Plan:** a defined benefit or defined contribution plan that provides benefits for your retirement and which is not funded wholly by your contributions. It does not include: (1) a profit sharing plan; (2) thrift, savings or stock ownership plans; (3) a non-qualified deferred compensation plan; or (4) an individual retirement account (IRA), a tax sheltered annuity (TSA), Keogh Plan, 401(k) plan or 403(b) plan.

**Substance Abuse:** the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by: (1) impairments in social and/or occupational functioning; (2) debilitating physical condition; (3) inability to abstain from or reduce consumption of the substance; or (4) the need for daily substance use to maintain adequate functioning. Substance includes alcohol and drugs but excludes tobacco and caffeine.

**We, us or our:** The EPIC Life Insurance Company.

**You, your:** the covered employee to whom this booklet-certificate is issued.

**Your Occupation:** your job as it is recognized in the national economy that involves material duties for the same general character as the occupation you are regularly performing for your employer when the disability begins. For an employee whose occupation requires a license, a restriction or loss of license does not, in itself, constitute a disability.

# ELIGIBILITY AND EFFECTIVE DATE

## Eligible Employee

All persons in the class or classes shown in the policyholder's current application for coverage will be considered eligible employees.

An eligible employee is a person who:

1. appears on the policyholder's regular payroll records (excluding employees working on a temporary or substitute basis); and
2. performs all of the duties of his/her principal occupation in his/her job with the policyholder for at least the minimum number of hours as shown in the policyholder's current EPIC application for coverage.

An employee is eligible for coverage under the policy if he/she:

1. is actively at work performing all of the duties of his/her principal occupation in his/her job with the policyholder and paid at least the minimum wage required by law for at least the minimum number of hours as shown in the policyholder's current EPIC application for coverage;
2. has completed his/her probationary period, if any, as shown in the policyholder's current EPIC application for coverage.

## Effective Date

If application for coverage is properly made on our application form or other documentation approved by us by an eligible employee and the required premium for his/her coverage is submitted to EPIC, the effective date of coverage to be issued under the policy for that eligible employee shall be determined by EPIC as follows:

### 1. Initial Enrollees.

An initial enrollee is an eligible employee who enrolls during the commencement of the policyholder's initial enrollment period with EPIC. An initial enrollee's effective date shall be the policy's effective date. The eligible employee must be actively at work with the policyholder on his/her effective date of coverage under the policy, unless stated otherwise below.

If you were insured under the policyholder's prior plan and were actively at work and not eligible to receive benefits under the policyholder's prior plan, on the day before the policy effective date, coverage will become effective on the policy effective date.

For purposes of this continuity of coverage provision only, you shall be considered actively at work while on any scheduled leave of absence for reasons other than your own disability or any regularly scheduled vacation day, holiday, or weekend day, or any approved unscheduled absence for reasons other than your own disability otherwise permitted by the employer's normal leave or absence policies.

If you become insured under the policy on the policy effective date and were covered under the policyholder's prior plan on the day before the policy effective date, the pre-existing conditions limitation will cease to apply on the first to occur of the following dates:

- a. the policy effective date, if your coverage for the disability was not limited by a pre-existing condition restriction under the policyholder's prior plan; or
- b. if your coverage was limited by a pre-existing condition restriction under the policyholder's prior plan, the date the restriction would have ceased to apply had the policyholder's prior plan remained in force.

The amount of the monthly benefit payable for a pre-existing condition in accordance with the previous paragraph will be the lesser of: (a) the monthly benefit payable by the prior plan; or (b) the monthly benefit provided by the policy.

No payment shall be made after the earlier to occur of: (a) the date payments would have ceased under the prior plan; or (b) the date payments cease under the policy.

If you received monthly benefits for disability under the prior plan, and:

- a. you returned to work as an active full-time employee before the effective date of the policy;
- b. within 6 months of the return to work, you have a recurrence of the same disability under the policy; and
- c. there are no benefits available for the recurrence under the prior plan,

the elimination period of the policy, which would otherwise apply to the recurrence, will be waived if the recurrence would have been covered without any further elimination period under the prior plan had it remained in force.

## **2. New Entrants.**

A new entrant's effective date of coverage under the policy will be determined by us as follows:

An eligible employee shall become insured as indicated in the policyholder's current application for coverage, if he/she applies for coverage under the policy within 31 days after the completion of his/her probationary period, if any, as shown in the policyholder's current application for coverage. The application must be received by EPIC within 31 days following the end of the enrollment period. However, if the application is received by us more than 31 days after his/her enrollment period ends, that employee is a late enrollee. Please see paragraph 3. below.

The eligible employee must be actively at work with the policyholder on his/her effective date of coverage under the policy, unless stated otherwise in section "Continuity from a Prior Plan".

However, if an otherwise eligible employee is not actively at work on the date his/her coverage would otherwise become effective under the policy, his/her coverage shall not become effective until the earliest later date he/she is eligible and is actively at work with the policyholder.

## **3. Late Enrollees.**

A late enrollee may make written application to us at any time, subject to our approval of evidence of insurability. You must: (a) complete and sign a health and medical history form provided by us; (b) submit to a medical examination, if requested; (c) provide any additional information and attending physician's statement that we may require; and (d) furnish all such evidence at your own expense. We will then determine if you are approved as insurable under the plan. If you are approved, coverage shall be the first day of the calendar month following the date of our approval.

A late enrollee must apply using our application form and pay the required premium for coverage.

However, if an otherwise eligible employee is not actively at work on the date his/her coverage would otherwise become effective under the policy, his/her coverage shall not become effective until the earliest later date he/she is eligible and is actively at work with the policyholder.

## **CHANGES IN COVERAGE**

Your coverage may increase or decrease on the date there is a change in your class or monthly rate of basic earnings or when there is a change in the policy. However, no increase or decrease in coverage will be effective unless on that date you:

1. are an active full-time employee; and

2. are not absent from work due to being disabled.

If you were so absent from work, the effective date of such increase will be deferred until the day after completion of one full day of being actively at work.

No change in your rate of basic earnings will become effective until the date we receive notice of the change.

## **BENEFITS**

### **Payment of Benefits**

You will be paid a monthly benefit if:

1. you become disabled while insured under the policy;
2. you are disabled throughout the elimination period;
3. you remain disabled beyond the elimination period;
4. you are, and have been during the elimination period, under the regular care of a physician; and
5. you submit proof of loss satisfactory to us.

Benefits accrue as of the first day after the elimination period and are paid monthly.

### **Benefit Calculation**

Benefit calculations as stated in 1. and 2. below shall be based on the salary information provided to us prior to your disability and for which premium has been paid.

1. If you remain disabled after the elimination period, but work while you are disabled, we will determine your monthly benefit for a period of up to 24 consecutive months as follows:
  - a. multiply your pre-disability earnings by the benefit percentage shown in Section 2. of the Schedule of Benefits;
  - b. compare the result with the maximum benefit shown in Section 3. of the Schedule of Benefits; and
  - c. from the lesser amount, deduct other income benefits.

Current monthly earnings will not be used to reduce your monthly benefit. However, if the sum of your monthly benefit and your current monthly earnings exceeds 100% of your pre-disability earnings, we will reduce your monthly benefit by the amount of excess.

The 24 consecutive month period will start on the last to occur of:

- a. the day you first start work; or
  - b. the last day of the elimination period.
2. If you are disabled and not receiving benefits under paragraph 1. above, we will calculate your monthly benefit as follows:
    - a. multiply your pre-disability earnings by the benefit percentage shown in Section 2. of the Schedule of Benefits;

- b. compare the result with the maximum benefit shown in Section 3. of the Schedule of Benefits; and
- c. from the lesser amount, deduct other income benefits.

The result is your monthly benefit. However, if the sum of your monthly benefit and your current monthly earnings exceeds 100% of your pre-disability earnings, we will reduce your monthly benefit by the amount of excess.

Your monthly benefit will not be less than the minimum monthly benefit shown in Section 4. of the Schedule of Benefits. If a monthly benefit is payable for less than a month, we will pay 1/30 of the monthly benefit for each day you were disabled.

## **Termination of Benefits**

We will terminate benefit payment on the first to occur:

1. the date you are no longer disabled as defined in the policy;
2. the date you fail to furnish proof of loss when requested by us;
3. the date you are no longer under the regular care of a physician, or refuse our request that you submit to an examination by a physician;
4. the date you fail to provide satisfactory, objective medical proof of continued disability;
5. the date you die;
6. the date your current monthly earnings exceed:
  - a. 80% of your indexed pre-disability earnings if you are receiving benefits for being disabled from your occupation;
  - b. an amount that is equal to the product of your indexed pre-disability earnings and the benefit percentage if you are receiving benefits for being disabled from any occupation;
7. the date determined from the maximum duration of benefits table shown in Section 5. of the Schedule of Benefits.
8. the date no further benefits are payable under any provision in this plan that limits benefit duration; or
9. the date you refuse to participate in a rehabilitation program as described in section "Rehabilitation" or, refuse to cooperate with or try:
  - a. modifications made to the work site or job process to accommodate your identified medical limitations to enable you to perform the essential duties of your occupation;
  - b. adaptive equipment or devices designed to accommodate your identified medical limitations to enable you to perform the essential duties of your occupation;
  - c. modifications made to the work site or job process to accommodate your identified medical limitations to enable you to perform the essential duties of any occupation, if you were receiving benefits for being disabled from any occupation; or
  - d. adaptive equipment or devices designed to accommodate your identified medical limitations to enable you to perform the essential duties of any occupation, if you were receiving benefits for being disabled from any occupation,

provided a qualified physician agrees that such modifications, rehabilitation program or adaptive equipment accommodate your medical limitation; or

10. the date you receive retirement benefits from any employer's retirement plan, unless:

- a. you were receiving them prior to becoming disabled;
  - b. you immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement; or
11. the date you refuse to receive recommended treatment that is generally acknowledged by physicians to cure, correct or limit the disabling condition.

## **MENTAL ILLNESS AND SUBSTANCE ABUSE BENEFITS**

If you are disabled because of:

1. mental illness that results from any cause;
2. any condition that may result from mental illness;
3. alcoholism; or
4. the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance,

then, subject to all other policy provisions, benefits will be payable:

1. only for so long as you are confined in a hospital or other place licensed to provide medical care for the disabling condition; or
2. when you are not so confined, a total of 24 months for all such disabilities during your lifetime.

## **RECURRENT DISABILITY**

Periods of recovery during the elimination period will not interrupt the elimination period, provided the number of days you return to work as an active full-time employee are less than  $\frac{1}{2}$  the number of days of your elimination period.

Any day of a period of recovery will not count towards the elimination period.

“Recover” or “recovery” means that you are no longer disabled and have returned to work with the employer and premiums are being paid for you.

After the elimination period, when a return to work as an active full-time employee is followed by a recurrent disability, and such disability is:

1. due to the same cause; or
2. due to a related cause; and
3. within 6 month(s) of the return to work,

the period of disability prior to your return to work and the recurrent disability will be considered one period of disability, provided the policy remains in force.

If you return to work as an active full-time employee for six month(s) or more, any recurrence of a disability will be treated as a new disability. A new disability is subject to a new elimination period and a new maximum duration of benefits. The elimination period and maximum duration of benefits table are in Section 5. of the Schedule of Benefits.

The term "Period of Disability" as used in this provision means a continuous length of time during which you are disabled under the policy.

## REHABILITATION

### Rehabilitation Plan

While disabled, you may qualify to participate in a rehabilitation plan. Rehabilitation plan means a written plan, program or course of medical treatment or education that is intended to prepare you to return to work on a full-time basis. A rehabilitation plan may include:

1. vocational testing;
2. vocational training;
3. alternative treatment plans such as:
  - a. support groups;
  - b. physical therapy;
  - c. occupational therapy; and
  - d. speech therapy;
4. work-place modification to the extent not otherwise provided; and
5. job placement,

and similar services.

To participate in a rehabilitation plan, you must apply in writing 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 and/or terminate your rehabilitation plan.

Benefits paid for such rehabilitation plan shall not exceed the amount shown in Section 3. of the Schedule of Benefits.

### Family Care Credit

If you are working as part of a rehabilitation program, we will, for the purpose of calculating your benefit, deduct the cost of family care from earnings received from such employment, subject to the following limitations:

1. Family care means the care or supervision of: (a) your dependent child under age 13; or (b) a member of your household who is mentally or physically handicapped and dependent upon you for support and maintenance;
2. The maximum monthly deduction allowed for each qualifying child or family member is: (a) \$350 during the first six months of the rehabilitation program; and (b) \$175 thereafter; but in no event may the deduction exceed the amount of your monthly earnings;
3. Family care credits may not exceed a total of \$2,500 during a calendar year;
4. The deduction will be reduced proportionally for periods of less than a month;
5. The charges for family care must be documented by a receipt from the caregiver;

6. The credit will cease on the first to occur of the following: (a) you are no longer in a rehabilitation program; or (b) family care credits for 24 months have been deducted during your disability; and
7. No family care provided by an immediate relative of the family member receiving the care will be eligible as a deduction under this provision. An immediate relative is a spouse, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild.

Your current monthly earnings after the deduction of your family care credit will be used to determine your monthly income loss. In no event will you be eligible to receive a monthly benefit under the policy if your current monthly earnings, before the deduction of the family care credit exceed 80% of your (Indexed) pre-disability earnings.

Any work as part of a rehabilitation program must be approved, in writing, by us.

## **Work Place Modification**

We will reimburse your employer for the expense of reasonable modifications to your work place to accommodate your disability and enable you to return to work as an active full-time employee, provided any such modifications are approved in writing by us prior to implementing the modifications. To qualify for this benefit:

1. Your disability must be covered by the policy; and
2. The employer must agree to make modifications to the work-place to reasonably accommodate your return to work and the performance of the essential duties of your job.

Benefits paid for such work-place modification shall not exceed the amount shown in Section 3. of the Schedule of Benefits for the maximum monthly benefit or equal to your pre-disability earnings multiplied by your benefit percentage which ever is the less.

We have the right, at our expense, to have you examined or evaluated by a physician, other health care professional, a vocational expert or rehabilitation specialist of our choice so that we may evaluate the appropriateness of any proposed modification.

The employer's cost for approved modifications will be reimbursed after:

1. The proposed modifications made on your behalf are complete;
2. We have been provided written proof of the expenses incurred to provide such modification prior to expenses being incurred; and
3. You have returned to work as an active full-time employee.

This work-place modification benefit will not be payable if:

1. the employer does not incur any cost in making the modification; or
2. we have not given written approval of the modification prior to expenses being incurred; or
3. you become self-employed, or return to work for another employer.

Work-place modification means change in your work environment, or in the way a job is performed, to allow you to perform, while disabled, the essential duties of your job. Such work-place modification shall meet the federal standards under the Americans with Disabilities Act of 1991, as amended.

Payment of this benefit will not reduce or deny any benefit you are eligible to receive under the terms of the policy.



## SURVIVOR INCOME BENEFIT

If you die while benefits are payable under the policy, and on the date you die you have been continuously disabled, we will pay a survivor benefit to:

1. your surviving beneficiary;
2. your surviving spouse;
3. your surviving child(ren), in equal shares, if there is no surviving spouse; or
4. your estate, if there is not a surviving spouse or child.

No survivor benefit shall be paid if you are not survived by any person listed in 1. through 4. above.

If a minor child is entitled to benefits, we may, at our option, make benefit payments to the person caring for and supporting the child.

The benefit is one payment of an amount that is three times the lesser of:

1. your pre-disability earnings multiplied by the benefit percentage shown in Section 2. of the Schedule of Benefits; or
2. the maximum monthly benefit shown in Section 3. of the Schedule of Benefits.

The survivor benefit shall first be applied to reduce any overpayment of your claim.

The following terms apply to this section:

1. "spouse" means your wife or husband who:
  - a. is mentally competent; and
  - b. was not legally separated from you at the time of your death; and
2. "child" means your unmarried natural, step or adopted son or daughter under age 25 who is dependent on you for financial support.

## PRE-EXISTING CONDITIONS LIMITATIONS

### Definitions

The following definitions apply to this section:

**Medical care:** care received when: (1) a physician is consulted or medical advice is given; or (2) treatment is recommended, prescribed by, or received from a physician.

**Treatment:** includes but is not limited to: (1) medical examinations, tests, attendance or observation; and (2) use of drugs, medicines, medical services, supplies or equipment.

**Pre-existing Condition:** any accidental bodily injury, sickness, mental illness, pregnancy, or episode of substance abuse; or any manifestations, symptoms, findings, or aggravations related to or resulting from such accidental bodily injury, sickness, mental illness, pregnancy, or substance abuse for which you received medical care during the number of months shown in Section 6. a. of the Schedule of Benefits, that ends the day before your effective date of coverage; or the effective date of a change in coverage.

## **Waiting Period**

No benefit will be payable under the policy for any disability that is due to, contributed to by, or results from a pre-existing condition, unless such disability begins after the number of months shown in Section 6. b. of the Schedule of Benefits during which you have been continuously insured under the policy.

## **EXCLUSIONS**

The policy does not cover, and no benefits shall be paid for any disability:

1. unless you are under the regular care of a physician;
2. caused or contributed to by war or act of war (declared or not);
3. caused by your commission of or attempt to commit a felony, or to which a contributing cause was you being engaged in an illegal occupation; 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;
4. caused or contributed to by an intentionally self-inflicted injury;
5. for which you are receiving or are eligible to receive benefits under a prior disability plan that: (a) was sponsored by the employer; and (b) was terminated before the effective date of the policy;
6. caused or contributed to by any surgery or other procedure which: (a) is not medically necessary; or (b) does not promote the proper function of your body or prevent or treat an illness or injury; or (c) is directed at improving your appearance, unless such surgery or procedure is necessary to correct a deformity resulting from a congenital abnormality or a disfiguring illness or injury;
7. occurring as a result of participating in any sporting event for pay or prize money;
8. occurring while held, detained or imprisoned in a local, state or federal penal or correctional institution or while in the custody of law-enforcement officials. Persons on work release are not considered to be held, detained or imprisoned if they are otherwise eligible members.

## **TERMINATION PROVISIONS**

### **When Coverage Ends**

Except as stated below, you will cease to be covered on the earliest to occur of the following dates:

1. the date the policy terminates;
2. the date the policy no longer insures your class;
3. the date premium payment is due but not paid by the employer;
4. the last day of the period for which you make any required premium contribution, if you fail to make any further required contribution;
5. the date you cease to be an active full-time employee in an eligible class including:

- a. temporary layoff;
  - b. leave of absence; or
  - c. a general work stoppage (including a strike or lockout).
6. the date you enter into military service, other than for duty of less than 30 days;

## **Continuation of Coverage**

1. If you are disabled and you cease to be an active full-time employee, your insurance will be continued:
- a. during the elimination period while you remain disabled by the same disability; and
  - b. after the elimination period for as long as you are entitled to benefits under the policy.

No premium will be due for you beginning on the first day of the calendar month following the end of the elimination period and for as long as benefits are payable.

If you are entitled to benefits while disabled and the policy terminates, benefits:

- a. will continue as long as you remain disabled by the same disability; but
- b. will not be provided beyond the date we would have ceased to pay benefits had the insurance remained in force.

Termination for any reason of the policy will have no effect on our liability under this subsection.

2. If you are temporarily laid off or granted a leave of absence, the employer may continue your insurance for the number of months shown in Section 7. of the Schedule of Benefits following the month coverage would have terminated subject to the following:
- a. you are not disabled; and
  - b. we receive written advance notice of an approved leave of absence which includes the beginning and ending dates of the leave or is documented as a leave for military purposes; and
  - c. the required premium must be paid; and
  - d. your benefit level, or the amount of earnings upon which your benefits may be based, will be that in effect on the day before said leave or layoff commenced; and
  - e. such continuation will cease immediately if one of the following events should occur:
    - (1) the leave terminates prior to the agreed upon date;
    - (2) the lay-off becomes permanent;
    - (3) the termination of the group insurance policy;
    - (4) non-payment of premium when due by the policyholder or you; or
    - (5) the group insurance policy no longer insures your class.

## GENERAL PROVISIONS

### Misstatements

If material facts about you were not stated correctly:

1. your premium may be adjusted; and
  2. the true facts will be used to determine if, and for what amount, coverage should have been in force.
- No statement made by you relating to your insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during your lifetime. In order to be used, the statement must be in writing and signed by you.

### Notice of Claim

You must give us written notice of a claim within 30 days after disability starts. If notice cannot be given within that time, it must be given as soon as possible. Such notice must include your name, your address and the group insurance policy number.

When we receive a notice of claim, you will be sent forms for providing us with proof of loss. We will send these forms within 15 days after receiving a notice of claim. If we do not send the forms within 15 days, you may submit any other written proof which fully describes the nature and extent of your claim.

### Proof of Loss

Proof of loss may include but is not limited to the following:

1. documentation of:
  - a. the date your disability began;
  - b. the cause of your disability;
  - c. the prognosis of your disability;
  - d. your earnings or income, including but not limited to copies of your filed and signed federal and state tax returns; and
  - e. evidence that you are under the regular care of a physician;
2. any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
3. the names and addresses of all:
  - a. physicians and practitioners of healing arts you have seen or consulted;
  - b. hospitals or other medical facilities in which you have been seen or treated; and
  - c. pharmacies which have filled your prescriptions within the past three years;
4. your signed authorization for us to obtain and release:
  - a. medical, employment and financial information; and
  - b. any other information we may reasonably require;

5. your signed statement identifying all other income benefits; and
6. proof that you and your dependents have applied for all other income benefits which are available. You will not be required to claim any retirement benefits which you may only get on a reduced basis.

All proof submitted must be satisfactory to us within 90 days after the start of the period for which we owe payment. If proof is not given by the time it is due, it will not affect the claim if:

1. it was not possible to give proof within the required time; and
2. proof is given as soon as possible; but
3. not later than 1 year after it is due, unless you are not legally competent.

We may request proof of loss throughout your disability. In such cases, we must receive the proof within 30 days of the request.

To assist us in determining if you are disabled, or to determine if you meet any other term or condition of the policy, we have the right to require you to: (1) meet and interview with our representative; and (2) be examined by a doctor, vocational expert, functional expert, or other medical or vocational professional or our choice. Any such interview, meeting or examination will be at our expense and as reasonably required by us.

We reserve the right to determine if your proof of loss is satisfactory. Unless we determine you have a valid reason for refusal, we may deny, suspend or terminate your benefits if you refuse to be examined, met or interviewed.

## **Application for Social Security Benefits**

You will be required to apply for Social Security disability benefits when the duration of your disability meets the minimum duration required to apply for such benefits. You must apply within 45 days from the date of our request. If the Social Security Administration denies your eligibility for benefits, you will be required:

1. to follow the process established by the Social Security Administration to reconsider the denial; and
2. if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.

We do not estimate Social Security Benefit offsets if the disabled employee fully cooperates with the Social Security application and appeals process and signs both the release of information form and a reimbursement agreement.

We reserve the right to reduce your monthly benefit by estimating the Social Security disability benefits you or your spouse and children may be eligible to receive.

When we determine that you or your dependent child may be eligible for benefits, we may estimate the amount of these benefits. We may reduce your monthly benefit by the estimated amount.

Your monthly benefit will not be reduced by estimated Social Security disability benefits if:

1. You apply for Social Security disability benefits and pursue all required appeals in accordance with the Social Security provision; and
2. You have signed a form authorizing the Social Security Administration to release information about awards directly to us; and
3. You have signed and returned our reimbursement agreement, which confirms that you agree to repay all overpayments.

If we have reduced your monthly benefit by an estimated amount and you or your dependent are later awarded Social Security disability benefits, we will adjust your monthly benefit when: (a) we receive proof of the amount awarded, and determine if it was higher or lower than our estimate; or (b) your application for Social Security disability benefits has been denied, we will

adjust your monthly benefit when you provide us proof of final denial from which you cannot appeal from an Administrative Law Judge of the Office of Hearing and Appeals.

If your Social Security benefits were lower than we estimated, and we owe you a refund, we will make such refund in a lump sum. If your Social Security benefits were higher than we estimated, and if your monthly benefit has been overpaid, you must make a lump sum refund to us equal to all overpayments, in accordance with subsection "Recovery of the Overpayments".

## **Direct Payment of Benefits**

All payments are payable to you. Any remaining benefit payments owed at your death may be paid to your estate.

## **Claim Processing Procedure**

Following receipt of a correctly filed disability claim we will advise you of our decision within 45 days of receiving the claim. A correctly filed claim includes receipt of the employer, covered employee and attending physicians statement. We determine that the 45-day period begins the date we are in receipt of all completed statements. Any benefits paid under the policy shall fully discharge us from all further liability, to the extent of benefits paid. If benefits are payable under the policy, payment of such benefits shall be made directly to you.

In the event of an incomplete claim or circumstances beyond our control, we will advise you that a 30-day extension is necessary. An incomplete claim is a correctly filed claim that requires additional information such as additional clinical documentation. A second 30-day extension may also be required under some circumstances. In the event an extension is required, we will notify you in writing of the reasons for the extension.

If the claim is denied, you will receive a written notice from us with: (1) the specific reasons for the denial; (2) the specific references to the policy provisions on which the denial is based; (3) a description of additional material or information which may be necessary for you to perfect your claim and an explanation of why such material or information is necessary; and (4) an explanation of how you may have the claim reviewed by us if you do not agree with the denial or partial denial.

## **Claim Review Procedure**

If you do not agree with the denial of your claim, we will review our decision in accordance with the following procedure:

1. You must file a written appeal and mail it to:

The EPIC Life Insurance Company  
Attention: Life & Disability Department  
P.O. Box 8430  
Madison, Wisconsin 53708-8430

You must state the specific reasons why you do not agree with the denial. We cannot accept telephone requests for review.

2. Upon request, and at no charge, you may obtain reasonable access to, and copies of, all documents, records and information relevant to your claim for benefits.
3. Our review will take into account all comments, documents, records and other information submitted that relates to the claim. This would include comments, documents and records and other information that either were not submitted previously or were not considered in the initial benefit decision. The review on appeal will be a "fresh" look at the claim without deference to the denial decision. It will be conducted by a person or committee not involved in the denial decision and who is not a subordinate of, or the members of which are not subordinates of EPIC's supervisory or managerial employee involved in the denial decision.

If your denial was based in whole or in part on a medical judgement, we will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved

with the denial decision, nor be a subordinate of the health care professional who was involved. If we have obtained or will obtain medical or vocational experts in connection with the claim, they will be identified upon your request, regardless of whether we rely on their advice in making any benefit determinations.

4. Within 45 days after we receive your written request for review, we will send you a written decision which will contain the specific reasons for our decision and identify the specific policy provisions on which the decision is based.
5. In some situations, we may need additional time to make a decision. In that case, before the 45-day period has expired, we will send you a written notice that more time is necessary. Then we have up to an additional 45 days after the first 45-day period has expired (a total of 90 days from the date we received your request for review) to provide you with our decision.

## **Limitation on Lawsuits and Legal Proceedings**

Legal action cannot be taken against us:

1. sooner than 60 days after due proof of loss has been furnished; or
2. three years after the time written proof of loss is required to be furnished according to the terms of the policy.

## **Recovery of Overpayments**

An overpayment occurs when it is determined that the total amount we have paid in benefits is more than the amount that was due to you under the policy. This includes, but is not limited to, overpayments resulting from:

1. retroactive awards of other income benefits;
2. failure to report, or late notification to us of other income benefits or earned income;
3. misstatement; or
4. an error we may make.

We have the right to recover from you any amount that is an overpayment of benefits under the policy. You must refund to us the overpaid amount. We may also, without forfeiting our right to collect an overpayment through any means legally available to us, recover all or any portion of an overpayment by reducing or withholding future benefit payments, including the minimum monthly benefit.

## **Subrogation**

If you:

1. suffer a disability because of the act or omission of a third party;
2. become entitled to and is paid benefits under the policy in compensation for lost wages; and
3. do not initiate legal action for the recovery of such benefits from the third party in a reasonable period of time,

then we will be subrogated to any rights you may have against the third party and may, at our option, bring legal action to recover any payments made by it in connection with the disability. Such right may be exercised only if the you have been, or will be, fully compensated for the lost wages.

## **Fraud**

Insurance fraud occurs when you and/or your employer, with the intent to injure, defraud or deceive us, provides us with false information or files a claim for benefits that contains any false, incomplete or misleading information. It is a crime if you and/or your employer commit insurance fraud. We will use all means available to us to detect, investigate, deter and prosecute those who commit insurance fraud. We will pursue all available legal remedies if you and/or your employer perpetrates insurance fraud.

## **Interpretation of Terms and Conditions**

We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the policy.

## **Waiver and Change**

Only the president of EPIC can execute a waiver or make a change to the policy. No agent, broker or other person may waive or change any term, condition, exclusion, limitation, or other provision of the policy in any way or extend the time for any premium payment. At our option, EPIC may unilaterally change any term, condition, exclusion, limitation or other provision of the policy if we send written notice to the policyholder at least 30 days in advance of that change. Any change to the policy shall be made by endorsement which is signed by the president of EPIC. Each endorsement shall be binding on the policyholder, each of its covered employees, and EPIC. No error by EPIC, the policyholder, or any covered employee shall invalidate coverage otherwise validly in force, continue or reissue coverage validly terminated, or cause coverage to be issued which otherwise would not be issued by EPIC. Upon our discovery of any error, an equitable adjustment of coverage, payment of benefits, and/or premium shall be made by EPIC at its sole option.



**THE EPIC LIFE INSURANCE COMPANY**

**AMENDED BENEFITS ENDORSEMENT FOR**

**LONG TERM DISABILITY CERTIFICATE**

In consideration of the premium charged for the Group Policy under which EPIC issued the Certificate to which this endorsement is attached, that Certificate and the Group Policy is amended as follows.

**In Section “DEFINITIONS” the following definition is added:**

**Adverse Benefit Determination:** any denial, reduction, or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit.

**In Section “GENERAL PROVISIONS” subsection “Claim Processing Procedure” and “Claim Review Procedure” are deleted and replaced with the following:**

**Claim Processing Procedure**

Following receipt of a written proof of loss, we will advise you of our decision within a reasonable period of time, but no later than 45 days after receiving proof of loss.

This period may be extended by an additional 30 days, if we determine the extension is necessary. Before the end of the initial 45-day period, we will send notification of the extension to indicate the circumstances requiring the extension and the date by which we expect to make a decision.

The review period may be extended for another 30 days, if before the end of the first 30-day extension, we determine a second extension is necessary. Before the end of the first 30-day extension, we will send notification of the additional extension to indicate the circumstances requiring the extension and the date by which we expect to make a decision.

If the reason for the extension is because we do not have enough information to decide the claim, then the notice of extension will describe the required information and you will have at least 45 days from the date the notice is received to provide the specified information. We will make a decision on the earlier of the date on which you respond or the expiration of the time allowed for submission of the requested information.

Any benefits paid under the policy shall fully discharge us from all further liability, to the extent of benefits paid. If benefits are payable under the policy, payment of such benefits shall be made directly to you.

If the claim is denied, you will receive a written notice of denial with: (1) the specific reasons for the denial; (2) the specific references to the policy provisions on which the denial is based; (3) a description of additional material or information which may be necessary for you to perfect the claim and an explanation of why such material or information is necessary; (4) a description of our review procedures and the time limits applicable to such procedures, including a statement of the claimant’s right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on review, if applicable, including a description of any applicable contractual limitations period, and the calendar date on which the contractual limitations period expires, for the claim that applies to a claimant’s right to bring such an action; (5) an explanation of the basis for disagreeing with any disability determination made by: (a) your treating physician, (b) any medical or vocational expert whose advice was obtained on behalf of EPIC in evaluating the claim, or (c) the Social Security Administration, as applicable; and (6) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all, documents, records, and other information relevant to the claimant’s claim for benefits..

If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the policy to the claimant’s medical circumstances, or a statement that such explanation will be provided free of charge upon request.

31664-088-1801

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For use with 29995WI-088-1612, E12072WI-0708, E12072IA-0708, E12072IN-0708, E12072KS-0708, E12072KY-0703, E12072MN-0708, E12072ND-0708, E12072OH-0708, E12072OK-0708, E12072PA-0708, E12072SD-0708, E12072WV-0708 and E12106WI-1107

The notice will also disclose if any internal plan rule, protocol, or similar criterion was relied upon to deny the claim. A copy of the rule, protocol, or other similar criterion will be provided, free of charge, to you upon request. Alternatively, if no such internal rules, protocol, or similar criterion exist, then the notice will include a statement indicating that none exist. Lastly, the notice will be provided in a culturally and linguistically appropriate manner.

If you want to appeal the denial, such an appeal must be made in accordance with subsection “Claim Review Procedures” below.

## **Claim Review Procedures**

If you do not agree with the denial of a claim, we will review our decision in accordance with the following procedure:

1. You must file a written appeal to EPIC within 180 days following receipt of a benefit denial notification. Such written appeal should be mailed to:

The EPIC Life Insurance Company  
Attention: Claims Department  
P.O. Box 8430  
Madison, Wisconsin 53708-8430

You must state the specific reasons why you do not agree with the denial. We cannot accept telephone requests for review.

2. Upon request, and at no charge, you may obtain reasonable access to, and copies of, all documents, records, and information relevant to your claim for benefits.
3. Our review will take into account all comments, documents, records, and other information submitted that relates to the claim. This would include comments, documents and records, and other information that either were not submitted previously or were not considered in the initial benefit decision.

The review on appeal will be a fresh look at the claim without deference to the denial decision. It will be conducted by a person or committee not involved in the denial decision and who is not a subordinate of the EPIC employee involved in the initial denial decision.

If your benefit denial was based in whole or in part on a medical judgment, we will consult with a health care professional with training and experience in the relevant medical field. This health care professional engaged for purposes of consultation shall be an individual who is neither an individual who was consulted in connection with the initial denial decision that is subject of the appeal, nor the subordinate of any such individual. If we have obtained or will obtain medical or vocational experts in connection with the claim, they will be identified upon your request, regardless of whether we rely on their advice in making any benefit determinations.

4. We will provide you, free of charge, with a copy of any new or additional evidence considered, relied upon, or generated in connection with the review of your claim. We will provide this information as soon as possible and sufficiently in advance of the date on which a notice of adverse benefit determination on review is required to be provided in order to provide a reasonable opportunity to respond.
5. We will provide you, free of charge, with a copy of any new or additional rationale considered or relied upon in connection with the review of the claim. We will provide this information as soon as possible and sufficiently in advance of the date on which a notice of adverse benefit determination on review is required to be provided in order to provide a reasonable opportunity to respond.
6. Within 45 days after we receive your written request for review, we will send you a written decision. If the initial denial decision is upheld, then the written notice will contain:
  - a. The specific reasons for our denial decision;

- b. A reference to the specific policy provisions on which the denial decision is based;
  - c. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and
  - d. A statement of the claimant's right to bring a civil action under ERISA section 502(a), if applicable, including a description of any applicable contractual limitations period, and the calendar date on which the contractual limitations period expires, for the claim that applies to a claimant's right to bring such an action.
  - e. An explanation of the basis for disagreeing with any disability determination made by the: (1) claimant's treating physician, (2) any medical or vocational expert whose advice was obtained on behalf of EPIC in evaluating the claim, or (3) the Social Security Administration, if applicable.
  - f. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Policy to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request. The notice will also disclose if any internal plan rule, protocol, or similar criterion was relied upon to deny the claim. A copy of the rule, protocol, or other similar criterion will be provided, free of charge, to you upon request. Alternatively, if no such internal rules, protocol, or similar criterion exist, then the notice will include a statement indicating that none exist.
  - g. The notice will be provided in a culturally and linguistically appropriate manner.
7. In some situations, we may need additional time to make a decision. In that case, before the initial 45-day period has expired, we will send you a written notice that more time is necessary, the reasons for the extension, and the date by which we expect to render a decision. In no event shall such extension exceed a period of 45 days from the end of the initial 45-day period (a total of 90 days from the date we received your request for review) to provide you with our decision.

**In Section "GENERAL PROVISIONS" the following subsection is added:**

**Authorized Representatives**

You may designate an authorized representative to act on your behalf in pursuing a benefit claim or appeal. The authorization must be made in writing to EPIC on a form approved by us. An assignment of benefits does not constitute a designation of an authorized representative.

This endorsement shall be effective beginning with the date for which the appropriate premium shall have been paid to and accepted by EPIC. It shall continue in force under the same provisions as govern the Policy.

All other terms, provisions and conditions of the entire Policy remain unchanged except as stated above.

IN WITNESS WHEREOF, The EPIC Life Insurance Company has executed this endorsement.

**THE EPIC LIFE INSURANCE COMPANY**



**Michael F. Hamerlik, President**

**THE EPIC LIFE INSURANCE COMPANY**  
**AMENDED BENEFITS ENDORSEMENT FOR**  
**LONG TERM DISABILITY CERTIFICATE**

In consideration of the premium charged for the Group Policy under which EPIC issued the Certificate to which this endorsement is attached, that Certificate and the Group Policy is amended as follows.

The following language will be added:

**KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS**  
**PROBLEMS WITH YOUR INSURANCE?** – If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

EPIC Specialty Benefits  
The EPIC Life Insurance Company  
Customer Service  
1717 West Broadway  
P.O. Box 8430  
Madison, Wisconsin 53708-8430  
Toll Free: 1-800-520-5750

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can file a complaint electronically with the **OFFICE OF THE COMMISSIONER OF INSURANCE** at its website at <http://oci.wi.gov/>, or by contacting:

Office of the Commissioner of Insurance  
Complaints Department  
P.O. Box 7873  
Madison, WI 53707-7873  
1-800-236-8517  
608-266-0103

This endorsement shall be effective beginning with the date for which the appropriate premium shall have been paid to and accepted by EPIC. It shall continue in force under the same provisions as govern the Policy.

All other terms, provisions and conditions of the entire Policy remain unchanged except as stated above.

IN WITNESS WHEREOF, The EPIC Life Insurance Company has executed this endorsement.

**THE EPIC LIFE INSURANCE COMPANY**



**Michael F. Hamerlik, President**