Zurich American Life Insurance Company of New York
Long Term Disability Income Insurance Plan
Benefits Schedule

This Benefits Schedule (hereinafter "Schedule") is a summary of some of the features and benefits of *your Policyholder's* Long Term Disability Plan. It is not a contract. *You* are not necessarily entitled to insurance because *you* received this Schedule. *You* are only entitled to insurance if *you* are eligible in accordance with the terms of the Certificate, *you* have met *your Policyholder's* eligibility requirements and premium has been paid. For a complete description of the terms, conditions, exclusions and limitations of the *Policyholder's Plan,* refer to *your* Certificate. In the event of a discrepancy between this Schedule and the Certificate, the Certificate will govern.

IMPORTANT: THIS SCHEDULE SHOULD BE ATTACHED TO YOUR CERTIFICATE. THIS SCHEDULE REPLACES ANY PRIOR SCHEDULES ISSUED TO YOU WITH RESPECT TO THE COVERAGES DESCRIBED IN THE CERTIFICATE.

Policyholder:	The Episcopal Church Clergy & Employees' Benefit Trust
Policy Number:	CNYEX01112
Policy Effective Date:	January 1, 2020
Plan Year:	January 1, 2020 through December 31, 2020 and each following January 1st.

Eligible Class: All persons in the following class are eligible for *member* coverage:

Class 1A: All *active members* normally scheduled to work a minimum of 20 compensated hours per week. Excludes temporary and seasonal *members,* and, if elected by *your employer,* all clergy.

Minimum Hours Requirement For Active Employment:
Members must be normally scheduled to work a minimum of 20 compensated hours per week.

Service Waiting Period: None.

Who Pays For The Coverage:
Your employer pays the cost of *your* coverage.

Premium Waiver:
If *you* become disabled, no premium payments are required for *your* coverage while *you* are receiving benefits under this *Plan*, provided the premium was paid during the *elimination period*.

Elimination Period:

Benefits start after the first 180 days of an approved disability.
Benefits begin the day after the *elimination period* is completed.

Accumulation Period:	30 days

Monthly Benefit

Monthly Benefit Percentage: 40% of *covered monthly earnings* to the maximum monthly benefit less *deductible sources of income.*

***Your* benefit may be reduced by *deductible sources of income* and *disability earnings*. Some disabilities may not be covered or may have limited coverage under this *Plan*.**

The Maximum Monthly Benefit Is:	$5,000 per month
The Minimum Monthly Benefit Is:	Greater of $100 or 10% of *your gross disability benefit*. ***You* are not eligible for the *minimum monthly benefit* during periods of overpayment until the overpayment has been recovered by *us* or offset by *your monthly benefit*.**

Limited Benefits For Mental Disorders:

Disabilities resulting from mental disorders will be paid in accordance with any benefit limitation described in the Certificate.

Additional Benefits and Features:

Benefit:	**Benefit Amount:**
Survivor Benefit	A lump sum benefit equal to 3 months of *your gross disability benefit.*

Rehabilitation Program Benefit

Ten percent of *your gross disability benefit* to a maximum of $500 per month for 24 months. Refer to the Certificate for program details.

In addition, *we* will provide a *monthly benefit* to *you* for 3 months following the date *your* disability ends if *we* determine *you* are no longer disabled while:

- *you* are participating in the *rehabilitation program*; and
- *you* are not able to find employment.

Maximum Benefit Duration Table

The table below shows the maximum duration for which benefits may be paid. All other limitations of the *Policy* will apply.

Age At Disability	Maximum Benefit Period
Less than age 60	To Social Security Normal Retirement Age or to age 65 but not less than 5 years
Age 60	60 months
Age 61	48 months
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 or older	12 months
Year of Birth	**Social Security Normal Retirement Age**
1937 or before	65 years
1938	65 years 2 months
1939	65 years 4 months
1940	65 years 6 months
1941	65 years 8 months
1942	65 years 10 months
1943-1954	66 years
1955	66 years 2 months
1956	66 years 4 months
1957	66 years 6 months
1958	66 years 8 months
1959	66 years 10 months
1960 and after	67 years

Limited And Excluded Conditions And Disabilities:

Total Benefit: The total benefit payable to *you* on a monthly basis (including all benefits provided under this *Plan*) will not exceed 100% of *your covered monthly earnings* unless otherwise stated in the Certificate under specific conditions.

Your Plan does not cover disabilities related to all *sickness*, *illness* or disease. Refer to *your* Certificate for a complete list of exclusions and limitations.

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Policy Effective Date:	January 1, 2020
Plan Year:	January 1, 2020 through December 31, 2020 and each following January 1st.

Eligible Class: All persons in the following class are eligible for *member* coverage:

Class 1B: All *active members* normally scheduled to work a minimum of 20 compensated hours per week. Excludes temporary and seasonal *members,* and, if elected by *your employer,* all clergy.

Minimum Hours Requirement For Active Employment:
Members must be normally scheduled to work a minimum of 20 compensated hours per week.

Service Waiting Period: None.

Who Pays For The Coverage:
Your employer pays the cost of *your* coverage.

Premium Waiver:
If *you* become disabled, no premium payments are required for *your* coverage while *you* are receiving benefits under this *Plan*, provided the premium was paid during the *elimination period*.

Elimination Period:

Benefits start after the first 180 days of an approved disability.
Benefits begin the day after the *elimination period* is completed.

Accumulation Period:	30 days

Monthly Benefit

Monthly Benefit Percentage: 60% of *covered monthly earnings* to the maximum monthly benefit less *deductible sources of income.*

***Your* benefit may be reduced by *deductible sources of income* and *disability earnings*. Some disabilities may not be covered or may have limited coverage under this *plan*.**

The Maximum Monthly Benefit Is:	$7,500 per month
The Minimum Monthly Benefit Is:	Greater of $100 or 10% of *your gross disability benefit*. ***You* are not eligible for the *minimum monthly benefit* during periods of overpayment until the overpayment has been recovered by *us* or offset by *your monthly benefit*.**

Limited Benefits For Mental Disorders:

Disabilities resulting from mental disorders will be paid in accordance with any benefit limitation described in the Certificate.

Additional Benefits and Features:

Benefit:	**Benefit Amount:**
Survivor Benefit	A lump sum benefit equal to 3 months of *your gross disability benefit.*

Rehabilitation Program Benefit

Ten percent of *your gross disability benefit* to a maximum of $500 per month for 24 months. Refer to the Certificate for program details.

In addition, *we* will provide a *monthly benefit* to *you* for 3 months following the date *your* disability ends if *we* determine *you* are no longer disabled while:

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1939	65 years 4 months
1940	65 years 6 months
1941	65 years 8 months
1942	65 years 10 months
1943-1954	66 years
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1959	66 years 10 months
1960 and after	67 years

Limited And Excluded Conditions And Disabilities:

Total Benefit: The total benefit payable to *you* on a monthly basis (including all benefits provided under this *Plan*) will not exceed 100% of *your covered monthly earnings* unless otherwise stated in the Certificate under specific conditions.

Your Plan does not cover disabilities related to all *sickness*, *illness* or disease. Refer to *your* Certificate for a complete list of exclusions and limitations.

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Eligible Class: All persons in the following class are eligible for *member* coverage:

Class 1C: All *active members* normally scheduled to work a minimum of 20 compensated hours per week. Excludes temporary and seasonal *members,* and, if elected by *your employer,* all clergy.

Minimum Hours Requirement For Active Employment:
Members must be normally scheduled to work a minimum of 20 compensated hours per week.

Service Waiting Period: None.

Who Pays For The Coverage:
Your employer pays the cost of *your* coverage.

Premium Waiver:
If *you* become disabled, no premium payments are required for *your* coverage while *you* are receiving benefits under this *Plan*, provided the premium was paid during the *elimination period*.

Elimination Period:

Benefits start after the first 180 days of an approved disability.
Benefits begin the day after the *elimination period* is completed.

Accumulation Period:	30 days

Monthly Benefit

Monthly Benefit Percentage: 66.67% of *covered monthly earnings* to the maximum monthly benefit less *deductible sources of income.*

***Your* benefit may be reduced by *deductible sources of income* and *disability earnings*. Some disabilities may not be covered or may have limited coverage under this *plan*.**

The Maximum Monthly Benefit Is:	$7,500 per month
The Minimum Monthly Benefit Is:	Greater of $100 or 10% of *your gross disability benefit*. ***You* are not eligible for the *minimum monthly benefit* during periods of overpayment until the overpayment has been recovered by *us* or offset by *your monthly benefit*.**

Limited Benefits For Mental Disorders:

Disabilities resulting from mental disorders will be paid in accordance with any benefit limitation described in the Certificate.

Additional Benefits and Features:

Benefit:	**Benefit Amount:**
Survivor Benefit	A lump sum benefit equal to 3 months of *your gross disability benefit.*

Rehabilitation Program Benefit

Ten percent of *your gross disability benefit* to a maximum of $500 per month for 24 months. Refer to the Certificate for program details.

In addition, *we* will provide a *monthly benefit* to *you* for 3 months following the date *your* disability ends if *we* determine *you* are no longer disabled while:

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Your Plan does not cover disabilities related to all *sickness*, *illness* or disease. Refer to *your* Certificate for a complete list of exclusions and limitations.

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Plan Year:	January 1, 2020 through December 31, 2020 and each following January 1st.

Eligible Class: All persons in the following class are eligible for *member* coverage:

Class 2A: All *active members* normally scheduled to work a minimum of 20 compensated hours per week. Excludes temporary and seasonal *members,* and, if elected by *your employer,* all clergy.

Minimum Hours Requirement For Active Employment:
Members must be normally scheduled to work a minimum of 20 compensated hours per week.

Service Waiting Period: None.

Who Pays For The Coverage:
Your employer pays the cost of *your* coverage.

Premium Waiver:
If *you* become disabled, no premium payments are required for *your* coverage while *you* are receiving benefits under this *Plan*, provided the premium was paid during the *elimination period*.

Elimination Period:

Benefits start after the first 90 days of an approved disability.
Benefits begin the day after the *elimination period* is completed.

Accumulation Period:	30 days

Monthly Benefit

Monthly Benefit Percentage: 40% of *covered monthly earnings* to the maximum monthly benefit less *deductible sources of income.*

***Your* benefit may be reduced by *deductible sources of income* and *disability earnings*. Some disabilities may not be covered or may have limited coverage under this *plan*.**

The Maximum Monthly Benefit Is:	$5,000 per month
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Class 2B: All *active members* normally scheduled to work a minimum of 20 compensated hours per week. Excludes temporary and seasonal *members,* and, if elected by *your employer,* all clergy.

Minimum Hours Requirement For Active Employment:
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Service Waiting Period: None.

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Monthly Benefit Percentage: 60% of *covered monthly earnings* to the maximum monthly benefit less *deductible sources of income.*

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Minimum Hours Requirement For Active Employment:
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Service Waiting Period: None.

Who Pays For The Coverage:
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Premium Waiver:
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Elimination Period:

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Accumulation Period:	30 days

Monthly Benefit

Monthly Benefit Percentage: 66.67% of *covered monthly earnings* to the maximum monthly benefit less *deductible sources of income.*

***Your* benefit may be reduced by *deductible sources of income* and *disability earnings*. Some disabilities may not be covered or may have limited coverage under this *plan*.**

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Rehabilitation Program Benefit

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Your Plan does not cover disabilities related to all *sickness*, *illness* or disease. Refer to *your* Certificate for a complete list of exclusions and limitations.

Zurich American Life Insurance Company of New York

Certificate of Coverage

Long Term Disability Income Insurance Plan

Policyholder: The Episcopal Church Clergy & Employees' Benefit Trust
Policy Number: CNYEX01112
Classes: 1A, 1B, 1C, 2A, 2B & 2C

Zurich American Life Insurance Company of New York is pleased to welcome *you* to the Long Term Disability Income Insurance Plan (the "*Plan"*). This is *your* Certificate of Coverage, hereinafter "Certificate," as long as *you* are eligible for coverage, and *you* meet the requirements for becoming insured*. You* will want to read this Certificate carefully and keep it in a safe place. This Certificate may be delivered electronically when agreed to by the *Policyholder* and *us*.

This *Plan* provides financial protection for *you* by paying a benefit for a portion of *your income* if *you* become disabled due to a *sickness* or *injury* while covered under this *Plan*. The amount *you* receive is calculated based on the amount *you* earned before *your* disability began. In some cases, *you* can receive disability payments even if *you* work while *you* are disabled.

Throughout this document the words *"we", "our", "us",* and "the Company" means Zurich American Life Insurance Company of New York. The words *"you"* and *"your"* mean the insured *member* of the *employer* which has elected to insure *you* under this *Plan*. Some terms and provisions are written as required by insurance *law*. Important terms are defined in the "Glossary" Section of the Certificate. Defined terms appear in italic print. If *you* should have any questions about the content or provisions, please consult *us* electronically through *our* website or at the toll-free number provided below. *We* will assist *you* in any way to help *you* understand *your* benefits.

The benefits described in this Certificate are subject in every way to the entire Group Insurance Policy. The Group Insurance Policy (*"Policy"*) includes this Certificate, the Benefits Schedule(s), and any riders or amendments issued with the *Policy*. The *Policyholder's* application and any application or *evidence of insurability* completed by *you* when applying for coverage or an increase in coverage, are also considered part of the *Policy*.

Your coverage may be cancelled or changed in whole or in part under the terms and provisions of the *Policy*. The *Policy* is delivered in and is governed by the *laws* of the State of New York. When making a benefit determination under the *Policy*, *we* have authority to determine *your* eligibility for benefits and to interpret the terms and provisions of the *Policy*. Such determinations are subject to appeal as described in this Certificate. Nothing in the Policy will invalidate or impair any rights or benefits of the *Insured* as stated in this Certificate or granted by the State of New York.

For purposes of effective dates and ending dates under the Group Insurance Policy, all days begin at 12:01 a.m. and end at 12:00 midnight at the *Policyholder's* address.

Zurich American Life Insurance Company of New York is located at:

150 Greenwich Street
Four World Trade Center, 54th Floor
New York, New York 10007-2366

Our toll-free number is: 800-206-8826.
Outside the United States: 719-268-2416.
Our website address is: www.zurichna.com.

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SPECIAL NOTICES

Section 1

Zurich American Life Insurance Company of New York

Toll Free Number:	800-206-8826
Claim Information Toll Free Number:	800-206-8826
Outside the United States:	719-268-2416

No benefits are covered under this Certificate in the absence of payment of current premiums subject to the *grace period* and the "Premium" Section of the Group Insurance Policy. Unless specifically provided for in any applicable termination or continuation of coverage provision, described in this Certificate or under the terms of the Group Insurance Policy, this *Plan* does not pay benefits for a disability incurred before coverage starts under this *Plan*. This *Plan* will not pay any benefits for any losses, claims or expenses that start after coverage ends.

Benefits may be modified during the term of this *Plan* as specifically provided under the terms of the Group Insurance Policy or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply to any losses incurred that start on or after the effective date of the *Plan* modification. There are no vested rights to receive any benefits described in the Group Insurance Policy or in this Certificate beyond the date of termination or renewal including if the loss or disability starts on or after the effective date of the *Plan* modification, but prior to *your* receipt of amended *Plan* documents. Nothing is incorporated by reference, unless a copy is endorsed upon or attached to the *Policy*.

The rights of the *Policyholder*, *Insured* or beneficiary under this *Policy* will not be affected by any provision other than one in the *Policy* or the riders, endorsements or amendments signed by the *Policyholder* and *us* or in the copy of the *Policyholder's* application attached to the *Policy* or in the individual statements, if any, submitted.

Fraud Notice

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

GENERAL PROVISIONS

Your Long Term Disability Income Insurance Plan (the *"Plan"*)

This *Plan* provides *you* with a source of *income* if *you* should become disabled and unable to work because of a *sickness* or *injury* while covered under this *Plan*.

What Is The Certificate?

This Certificate of Coverage ("Certificate") is a written document prepared by Zurich American Life Insurance Company of New York. The *Policyholder* will provide *you* with a Certificate. It tells *you* important information about *your Plan* such as:

- the coverage to which *you* may be entitled;
- claim processing and administrative procedures;
- to whom *we* will make a payment; and
- the limitations, exclusions and requirements that apply within the *Plan*.

The Certificate may include attachments such as amendments, endorsements and riders, which describe additional provisions about *your Plan*. Please read the entire document carefully to fully understand *your Plan*.

Eligibility

Who Is Eligible For Coverage?

To be eligible for coverage under this *Plan*, the following requirements must be met:

- *you* must be in *active employment;* and
- *you* must be in an *eligible class.*

Determining Your Eligible Class

Your employer determines the criteria that are used to define the *eligible class(es)* for insurance coverage under this *Plan*. *Your employer* determines if *you* are in an *eligible class*.

Such criteria are based solely upon the conditions related to *your* employment and established by the *Policyholder*. These conditions include geographic situs, earnings, compensation methods, hours, and occupational duties.

We will rely upon the representation of the *employer* as to *your* eligibility for coverage under this *Plan* and as to any fact concerning such eligibility.

The criteria describing *eligible classes* of *members* are listed on the Benefits Schedule attached to this Certificate. Refer to the Benefits Schedule or contact *your employer* to determine if *you* are in an *eligible class*.

When Are You Eligible For Coverage?

If *you* are working for *your employer* in an *eligible class*, the date *you* are eligible for coverage is the *Plan* effective date.

New Hires

If *you* are in an *eligible class* on the date of hire, *your eligibility date* is the date *you* are hired. If *you* enter an *eligible class* after *your* date of hire, *your eligibility date* is the date *you* enter the *eligible class*.

Effective Date Of Coverage

When Does Your Coverage Begin?

If *you* have met all *your* eligibility requirements and *you* are in *active employment*, *your* coverage takes effect at 12:01 a.m. on the date *you* are eligible for coverage.

What If You Are Absent From Work On The Date Your Coverage Would Normally Begin?

If *you* are absent from work due to *injury*, *sickness*, a *mental disorder*, temporary *layoff* or *leave of absence*, on the date *your* insurance would otherwise become effective, *your* coverage, increase in coverage or new benefits will be deferred until the date *you* return to *active employment*.

Enrollment

How Do You Enroll For Coverage?

You will be provided with *Plan* design information when *you* first become eligible. If *you* are not required to contribute towards the cost of coverage, *you* are not required to request coverage or complete an enrollment form. *Your* enrollment will be handled by *your employer*.

After Coverage Begins

When Will Changes To Your Coverage Take Effect?

Effective Date For Benefit Changes Due To A Change In Covered Monthly Earnings
If *you* are in *active employment* or if *you* are on a covered *layoff or leave of absence,* a change in *your covered monthly benefit* due to a change in *your covered monthly earnings* will be effective on the date of the change. If *you* are not in *active employment* due to *injury* or *sickness,* any increased or additional coverage will begin on the date *you* return to *active employment*.

Effective Date For Benefit Changes Due To A Change In Insurance Class
If *you* are in *active employment* or if *you* are on a covered *layoff or leave of absence,* a change in *your covered monthly earnings* due to a change in *your* insurance class will be effective on the date of the change. If *you* are not in *active employment* due to *injury* or *sickness,* any increased or additional coverage will begin on the date *you* return to *active employment*.

Effective Date For Benefit Changes By Policy Amendment
A change in *your covered monthly benefit* due to a change in the *Policy* by an amendment elected by the *Policyholder*, will be effective on the effective date of the amendment, if *you* are in *active employment.* If *you* are not in *active employment* on the date a change would otherwise be effective, any increased or additional coverage will begin on the date *you* return to *active employment*. A change in *your* benefit payable because of a change made by the Company will normally be effective on the *Policy* anniversary date, or as otherwise determined by state or federal *law,* or by *us.* However, if *you* are not in *active employment* on the date a benefit payable change would otherwise be effective, the benefit payable change will not be in force until *you* return to *active employment*.

How Do You Pay For Your Coverage?

We will bill *your employer* for the premium and any amount *you* owe. *Your employer* will pay the premium on *your* behalf.

Premium Waiver

Once *you* have satisfied the *elimination period*, *your* premium and contributions, if any, will be waived for any period *you* are eligible to receive disability benefits under the *Plan*.

When Coverage Ends

When Does Your Coverage End?

Your coverage under this *Plan* ends on the earliest of:

- the date the *Policy* or a *Plan* is cancelled;
- the date *you* are no longer in an *eligible class;*
- the date *you* are no longer eligible for coverage;
- the date *your eligible class* is no longer covered;
- the last day *you* are in *active employment* except as provided under the covered *layoff* or *leave of absence* provision;
- *your* employment stops for any reason, including job elimination, or being placed on severance. This will be the date *you* stop *active employment;*
- the date on which *you* retire; or
- the date on which *you* begin active duty in the armed forces of any country.

What Happens If The Policy Or The Plan Is Cancelled While You Are Disabled?

Cancellation of the *Policy* during a period of disability will not affect a *payable claim* for that disability.

When Will Your Coverage Continue If You Are Temporarily Not Working?

If premium payments continue to be made on *your* behalf, *we* may deem *your* employment to continue for purposes of remaining eligible for coverage under this *Plan* as described below.

If *you* are not in *active employment* due to *sickness* or *injury*, or other authorized leave as agreed to by *your employer* and *us*, *your* coverage may continue until the earlier of:

- up to a maximum of 12 weeks from the start of *your* absence; or
- until stopped by *your employer*.

Reinstatement Of Coverage

If *your* long term disability coverage ends, *you* may apply to reinstate coverage subject to the rules described in the "When Does Your Coverage Begin?" Section. If *we* approve *your* request, *we* will notify *you* of *your* reinstatement date. If *you* return to work within 12 months *we* will not apply a new *pre-existing condition* exclusion.

What Happens To My Coverage Under This Policy While I Am On A Family And Medical Leave Of Absence Or A Military Leave Of Absence?

Coverage may be continued until the end of the later of:

- the leave period required by the federal Family and Medical Leave of Absence Act of 1993 and any amendments; or
- the leave period required by applicable national, state or local *law*, or any similar *law*, *plan* or *act*.

If the *employer*'s policy does not provide for continuation of *your* coverage during a family and medical *leave of absence*, *your* coverage will be reinstated when *you* return to *active employment*.

If *you* return to work within 12 months *we* will not apply a new *pre-existing conditions* exclusion.

Misstatements Made In Application For Coverage

We consider any material statements made by *you* in a signed application for coverage or an *evidence of insurability* form, or that *your employer* makes in the application, reinstatement or renewal process, a representation and not a warranty. If any of the written statements *you* or *your employer* make are not complete and true at the time they are made, *we* may:

- make an equitable adjustment in premiums or benefits;
- reduce or deny any claim; or
- contest *your* coverage from *your* original effective date or the date of any increase in coverage as described below in the Incontestability provision.

If *we* use a statement to reduce, deny, or contest a claim, or contest *your* coverage, a copy of that statement will be furnished to *you* or, in the event of *your* death or incapacity, to *your eligible survivor* or personal representative. *We* will use only statements made by the *employer* in the application process and statements made by *you* in a signed application as a basis for doing this.

Our failure to implement or insist upon compliance with any provision of this *Policy* at any given time or times shall not constitute a waiver of *our* right to implement or insist upon compliance with that provision at any other time or times. This applies whether or not the circumstances are the same.

Incontestability

During the first two years that *your* coverage is in force, *we* may use any statement *you* have made in contesting the validity of that coverage. This also applies to any increase in *your* coverage for the two years that follow the effective date of that increase if *evidence of insurability* was required in order for the increase to take effect.

Once coverage, including an increase in coverage has been continuously in effect for two years, the validity of *your* insurance may not be contested by *us* unless *your* statement was in writing on a form signed by *you* and was fraudulently made in order to obtain that coverage or increase.

Does The Coverage Under A Plan Replace Or Affect Any Workers' Compensation Or State Disability Insurance?

The coverage under a *Plan* does not replace or affect the requirements for coverage by Workers' Compensation or state disability insurance. However, any Workers' Compensation benefits are considered a *deductible source of incom*e.

Recovery Of Overpayments

If payments are made in amounts greater than the benefits that *you* are entitled to receive, *we* have the right to recover any overpayments. Refer to the "Claim Information" Section for the process *we* use to recover overpayments.

How Will We Handle Insurance Fraud?

We shall have the right and promise to use all means available to *us* to detect, investigate, deter and prosecute those who commit insurance fraud. *We* shall have the right to pursue all legal remedies if *you* and/or *your employer* perpetrate insurance fraud.

Insurance fraud occurs when *you* or *your Policyholder* knowingly and with intent to defraud or deceive *us*, provide *us* with false information or file a claim for benefits that contains any false, incomplete or misleading information, or conceals for the purpose of misleading, information concerning any material fact.

It is a crime if *you* or the *Policyholder* commit insurance fraud and may subject such person to criminal and civil penalties. Such penalties include, but are not limited to fines, denial or termination of insurance benefits, recovery of any amounts paid, civil damages, criminal prosecution and penalties.

Does The Policyholder Act As Our Agent?

No. For purposes of the *Policy*, the *Policyholder* acts on their own behalf. Under no circumstances will the *Policyholder* be deemed *our* agent.

Assignment

No assignment of benefits is permitted for the *Plan.*

LONG TERM DISABILITY INCOME INSURANCE BENEFITS

How Do We Define A Long Term Disability?

During the *elimination period*, and for the first 24 months benefits are payable*, you* are disabled when *we* determine that as a result of *sickness* or *injury*:

- *you* are unable to perform the *material and substantial duties* of *your regular occupation* due to *your sickness* or *injury*;
- *you* are under the *regular care* of a *physician*; and
- *you* have a 20% or more loss in *your covered monthly earnings* due to the same *sickness* or *injury*.

After monthly payments have been payable for 24 months, *you* are disabled when *we* determine that due to the same *sickness* or *injury*:

- *you* are unable to perform the duties of any *gainful occupation* for which you are reasonably fitted by education, training or experience;
- *you* are under the *regular care* of a *physician*; and
- *you* have a 20% or more loss in *your covered monthly earnings* due to the same *sickness* or *injury.*

"Loss of Earnings" means *your covered monthly earnings,* less *your* earnings in the month for which a benefit is claimed. The loss of earnings must be due to a *sickness* or *injury* that caused the disability.

We will assess *your* ability to work and the extent to which *you* are able to work by considering the facts and opinions from *your physicians,* and *physicians* and medical practitioners or vocational experts of *our* choice.

We may require *you* to be examined by a *physician*, other medical practitioner, and/or vocational expert of *our* choice. *We* will pay for this examination. *We* can require an examination as often as it is reasonable to do so. *We* may also require *you* to be interviewed by *our* authorized representative. Refusal to be examined or interviewed may result in denial or termination of *your* claim.

How Long Must You Be Disabled Before You Are Eligible To Receive Benefits?

You must be continuously disabled through *your elimination period*. The days that *you* are not disabled will not count toward *your elimination period*. *We* will treat *your* disability as continuous if *your* disability stops for 30 days, or less, during the *elimination period*. No benefit is payable for or during the *elimination period*.

Your elimination period is described in the Benefits Schedule.

Can You Satisfy Your Elimination Period If You Are Working?

If *you* are working while *you* are disabled, as defined under this *Plan*, the days *you* are disabled will count toward *your elimination period*.

Accumulation Period

In addition, if *you* return to work while satisfying *your elimination period*, and are no longer disabled, *you* must satisfy *your elimination period* within the accumulation period. *You* do not need to be continuously disabled through *your elimination period* if *you* are satisfying *your elimination period* under this provision.

If *you* do not satisfy the *elimination period* within the accumulation period, a new period of disability will begin.

Your accumulation period is described in the Benefits Schedule.

When Will You Begin To Receive Benefits?

You will begin to receive *benefits* within 30 days of *our* receipt of proof of loss if *we* approve *your* claim, providing the *elimination period* has been satisfied and *you* are disabled. We will send *you* a *monthly benefit* for any period for which *we* are liable but not beyond the *maximum monthly benefit period* shown in the Benefits Schedule.

What Are Your Covered Monthly Earnings?

"Covered Monthly Earnings" means monthly gross Total Assessable Compensation, as defined under The Church Pension Fund Clergy Pension Plan (Clergy Pension Plan), but excluding one-time payments such as overtime and bonuses and income received from sources other than the *employer.* Earnings will be based on the annualized monthly earnings just prior to the date of disability.

How Is Your Benefit Determined?

We will follow this process to calculate *your* benefit amount:

1) Multiply *your covered monthly earnings* by the *monthly benefits* percentage shown in the Benefits Schedule.
2) The *maximum monthly benefit* is listed in *your* Benefits Schedule.
3) Compare the answer from item 1) with the *maximum monthly benefit*. The lesser of these two amounts is *your gross disability benefit***.**
4) Subtract from *your gross disability benefit* any *deductible sources of income*.

The amount figured in item 4) is *your monthly benefit*. The *monthly benefit* will be recalculated when *your income* changes or *you* receive any new *deductible sources of income*.

After the *elimination period*, if *you* are disabled for less than one month, *we* will send *you* 1/30th of *your* benefit for each day of disability.

Monthly Benefit means *your* benefit amount as calculated above after any *deductible sources of income* have been subtracted from *your gross disability benefit*.

Maximum Monthly Benefit means the maximum benefit amount for which *you* are insured under this *Plan* as shown in the Benefits Schedule.

Gross Disability Benefit means the benefit amount before *we* subtract *deductible sources of income* and *disability earnings,* if any.

Deductible Sources of Income means other *income* from deductible sources listed in the *Plan* that *you* receive or are entitled to receive while *you* are disabled. This *income* will be subtracted from *your gross disability benefit*.

Disability Earnings are the earnings *you* receive for work performed while *you* are disabled and working. *Disability earnings* include only those earnings from work performed for the *employer* or from another employer for which *you* become employed after *your* disability began.

How Is Your Benefit Determined If You Are Disabled And Working?

If *you* have a *partial* or *residual disability*, *you* may continue to work or return to work and still be eligible

collect *your monthly benefit*. *Your monthly benefit* may be reduced if while benefits are payable, if *you* earn *income* from the *employer*, or another employer for which *you* become employed after *your* disability began.

For the first 12 months of payable benefits:

1. If *you* are disabled and return to work, *we* will not reduce *your monthly benefit* for *disability earnings* if:

    - *your* monthly *disability earnings,* if any, are less than 20% of *your indexed monthly earnings* due to the same *sickness* or *injury*; and
    - *you* have satisfied the *elimination period*.

2. If *you* are disabled and *your* monthly *disability earnings* are 20% or more of *your indexed monthly earnings,* due to the same *sickness* or *injury*, *we* will calculate *your monthly benefit* as follows:

    - During the first 12 months of payable benefits, while working, *your monthly benefit* will not be reduced by *your disability earnings* as long as *disability earnings* plus the *gross disability benefit* does not exceed 100% of *indexed monthly earnings.*

        1) Add *your* monthly *disability earnings* to *your gross disability benefit*.
        2) Compare the answer in item 1) to *your indexed monthly earnings*.

    If the answer from item 1) is less than or equal to 100%of *your indexed monthly earnings, we* will not further reduce *your monthly benefit*.

    If the answer from item 1) is more than 100% of *your indexed monthly earnings*, *we* will subtract the amount over 100% from *your monthly benefit*.

After benefits have been payable for 12 months, while working, the amount of *your monthly benefit* will change, and *we* will consider a portion of *your disability earnings* to be a *deductible source of income.*

Fifty percent of *your disability earnings* will be added to *your* other *deductible sources of income*, if any. The sum will be deducted from *your gross disability benefit.* This amount will be *your monthly benefit*.

We may require *you* to send proof of *your disability earnings* on a monthly basis. *We* will re-calculate *your* benefit each month and adjust *your monthly benefit* based on *your* monthly *disability earnings*.

As part of *your* proof of *disability earnings*, *we* can require that *you* send *us* appropriate financial records, including copies of *your* IRS federal income tax return, W-2's and 1099's, which *we* believe are necessary to substantiate *your income*.

After the *elimination period*, if *you* are disabled for less than one month, *we* will send *you* 1/30th of *your monthly benefit* for each day of disability.

When Will Your Monthly Benefits End If Working While Disabled?

If *your monthly disability earnings* exceed 80% of *your indexed monthly earnings*, *we* will stop *your* benefits and *your* claim will end.

Disability earnings means the earnings which *you* receive while *you* are disabled and working, plus the earnings *you* could receive if *you* were working to *your* greatest extent possible. This would be, based on *your* restrictions and limitation:

- during the first 24 months of disability benefits, the greatest extent of work *you* are able to do in *your regular occupation*, that is reasonably available.
- beyond 24 months of disability payments, the greatest extent of work *you* are able to do in any occupation, that is reasonably available, for which *you* are reasonably fitted by education, training or experience.

Salary continuance paid to supplement *your disability earnings* will not be considered payment for work performed.

We will review *your* status from time to time. *We* will require satisfactory proof of earnings and continued disability. No disability benefits will be paid, and insurance will end if *we* determine *you* are able to work under a transitional work arrangement or other modified work arrangement and *you* refuse to do so without *good cause*.

What Will We Use For Covered Monthly Earnings If You Become Disabled During A Covered Layoff Or Leave Of Absence?

If *you* become disabled while *you* are on a covered *layoff* or *leave of absence*, *we* will use *your* monthly earnings from *your employer* in effect just prior to the date *your layoff* or *leave of absence* begins.

How Can We Protect You If Your Disability Earnings Fluctuate?

If *your disability earnings* routinely fluctuate widely from month to month, *we* may average *your disability earnings* over the most recent three months to determine if *your* claim should continue.

If *we* average *your disability earnings*, *we* will not terminate *your* claim unless the average of *your disability earnings* from the last three months exceed 80% of *indexed monthly earnings*. *We* will not pay *you* a benefit for any month during which *disability earnings* exceed 80% of *indexed monthly earnings*.

We will not pay for any month during which *disability earnings* exceed the above amounts. The minimum monthly benefit will not be paid when *disability earnings* exceed the above amounts.

What Are “Deductible Sources Of Income" And How Do They Affect My Benefits?

Deductible sources of income are other *income* benefits *you* may be entitled to receive because of *your* disability or retirement. These benefits are taken into consideration when *your monthly benefit* is calculated and may reduce *your monthly benefit.*

We will subtract from *your gross disability benefit* the following *deductible sources of income*:

1. The amount that *you* receive or are entitled to receive under:
    - a Workers' Compensation *law; or*
    - an occupational disease *law.*
2. The amount that *you* receive or are entitled to receive as disability *income* benefits under any:
    - state compulsory benefit act or *law;*
    - other group insurance plan; or
    - governmental retirement system as a result of *your* job with *your employer*.
3. The gross amount that you receive or are entitled to receive as disability benefits because of *your* disability under:
    - the United States Social Security Act;
    - the Canada Pension Plan;

- the Quebec Pension Plan; or
- the Railroad Retirement Act.

4. The gross amount that *you* receive as retirement payments or the amount receive as retirement payments because *you* are receiving retirement payments under:

    - the United States Social Security Act;
    - the Canada Pension Plan;
    - the Quebec Pension Plan; or
    - the Railroad Retirement Act.

    This does not include benefits for any month before *you* reach normal retirement age, as defined under the Social Security Act, unless *you* choose to receive these benefits.

5. The amount that *you*:

    - receive as disability benefits under *your employer*'s *retirement plan*;
    - voluntarily elect to receive as retirement benefits under *your employer*'s *retirement plan*; or
    - receive as retirement benefits when *you* reach the later of age 62 or *normal retirement age*, as defined in *your employer*'s *retirement plan*.

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

    Retirement benefits will be those benefits that are paid based on *your employer*'s contribution to the *retirement plan*. *Disability benefits* which reduce the retirement benefit under the *Plan* will also be considered as a retirement benefit.

    Regardless of how the retirement funds from the *retirement plan* are distributed, *we* will consider *your* and *your employer*'s contributions to be distributed simultaneously throughout *your* lifetime.

    Amounts received do not include amounts rolled over or transferred to any eligible *retirement plan*. *We* will use the definition of eligible *retirement plan* as defined in Section 402 of the Internal Revenue code including any future amendments that affect the definition.

6. One hundred percent of the amount *you* receive under Title 46, United States Code Section 688 (The Jones Act).

7. One hundred percent of the amount *you* receive under the maritime doctrine of maintenance, wages and cure. This includes only the "wages" part of such benefits.
8. The amount of loss of time benefits that *you* receive or are entitled to receive under any *salary continuation* or *accumulated sick leave*.

9. The amount *you* receive or are entitled to receive under any unemployment *income act or law* due to the end of employment with *your employer* or payable by insured and uninsured plans or as a result of *your* membership or association in any group, union or other organization.

10. Fifty percent of *your disability earnings*.

11. Paid family leave.

With the exception of retirement payments, or amounts that *you* receive from a partnership, proprietorship or any similar draws, *we* will only subtract *deductible sources of income* which are payable as a result of the same disability.

We will not reduce *your* payment by *your* Social Security retirement *income* if *your* disability begins after age 65 and *you* were already receiving Social Security retirement payments.

What Are Not Deductible Sources Of Income?

We will not subtract from *your gross disability benefit income you* receive from, but not limited to, the following:

- 401(k) plans;
- profit sharing plans;
- thrift plans;
- tax sheltered annuities;
- stock ownership plans;
- non-qualified plans of deferred compensation;
- military pension and disability income plans;
- individual retirement accounts (IRA);
- individual disability income plans;
- 457 deferred compensation plans;
- 403(b) tax sheltered annuity plans;
- The Church Pension Fund Clergy Pension Plan;
- The Episcopal Church Lay Employees' Retirement Plan (Lay DB);
- The Church Pension Fund Clergy Long-Term Disability Plan;
- retirement benefits from a former employer; or
- auto liability insurance policies.

What If Subtracting Deductible Sources Of Income Results In A Zero Benefit (Minimum Monthly Benefit)?

If *your monthly benefit* is reduced to zero due to subtracting *deductible sources of income*, *you* will receive a minimum monthly benefit. *Your* minimum monthly benefit is listed on the Benefits Schedule.

We may apply *your* minimum monthly benefit toward any outstanding overpayment.

The minimum monthly benefit will not be paid in any month when *disability earnings* exceed 80% of *your indexed monthly earnings*. This includes when *we* average *your disability earnings* as described above.

What Happens When You Receive A Cost Of Living Increase From Deductible Sources Of Income?

Once *we* have subtracted a *deductible source of income* from *your gross disability benefit*, *we* will not further reduce *your monthly benefit* due to a cost of living increase from that source.

What If We Determine You May Qualify For Deductible Income Benefits?

When *we* determine that *you* may qualify for benefits in the" Deductible Sources of Income" Section, *we* will estimate *your* entitlement to these benefits. *We* can reduce *your monthly benefit* by the estimated amounts if such benefits:

- have not been awarded or received; and

- have not been denied; or
- have been denied, and the denial is being appealed, if appeal rights are provided.

Your monthly benefit may **NOT** be reduced by the estimated amount if you:

- apply for the disability benefits in the "Deductible Sources of Income" Section, and appeal *your* denial to all administrative levels *we* feel are necessary; and
- sign *our* Reimbursement Agreement form. This form states that *you* promise to pay *us* any overpayment caused by an award.

If *your* benefit has been reduced by an estimated amount, *your* benefit will be adjusted when *we* receive proof:

- of the amount awarded; or
- those benefits have been denied and all appeals *we* feel are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to *you*.

What Happens If You Receive A Lump Sum Payment?

If *you* receive a lump sum payment from any *deductible source of income*, the lump sum will be pro-rated on a monthly basis over the time period for which the sum was given. If no time period is stated, *we* will use a reasonable one.

What Is The Maximum Benefit Period?

You will receive a benefit for each month *you* remain disabled up to the *maximum benefit period.* Benefits will end when you have reached the *maximum benefit period*.

Your maximum benefit period is based on *your* age when the disability occurred. Refer to the Benefits Schedule for specific *maximum benefit period* durations.

When Will Benefits Stop?

Your claim will end and benefits will stop on the earliest of the following:

- the end of the *maximum benefit period;*
- the date *you* are no longer disabled under the terms of the *Plan*;
- during the first 24 months of benefits, when *you* are able to work in *your regular occupation* on a part-time basis, but *you* choose not to; or after 24 months of benefits, when *you* are able to work in any *gainful occupation* on a part-time basis, but *you* choose not to;
- if *you* are working and *your* monthly *disability earnings* exceed 80% of *your indexed monthly earnings*, the date *your* earnings exceed 80%;
- the date *you* fail to submit proof of continuing disability;
- if *you* are incarcerated;
- the date *you* die; or
- the date *your employer* offers *you* another or modified job position, which *physicians* agree *you* are able to perform, at a pay rate that exceeds 80% of *your indexed monthly earnings.*

Disability Benefits Will Not Be Paid For Any Period Of Disability During Which You:

- are not following a plan of *appropriate care* for *your* disability, or complications of *your* disability, this includes effective treatment for alcoholism or drug abuse, if alcoholism or drug abuse is the cause (or part of the cause of *your* disability);

- are not receiving *appropriate care*;
- refuse to be examined by an independent *physician* or a licensed certified health care practitioner as requested by *us* when provided at *our* expense;
- refuse modification to *your* worksite or a job process designed to suit identified medical limitations;
- refuse adaptive equipment or devices that would allow *you* to perform *your own job*;
- refuse a transitional work arrangement or other modified work arrangement which may be for *your own job* or any reasonable occupation;
- *you* fail to cooperate with *us* in the administration of the claim. Such cooperation includes, but is not limited to providing any information or documents needed to determine whether benefits are payable or the actual *benefit amount* due; or
- the date *you* refuse to interview with *our* representative about *your* disability.

Benefit Extension – Total Disability

Your coverage will be extended 31 days if *your* insurance coverage is terminated due to termination of employment, termination of eligibility or termination of the *Policy*, while *you* are *totally disabled* due to a *hospital confinement* commencing or surgery performed during the 31 days following such termination of coverage. *We* will not pay benefits beyond the limited pay period as indicated above, or the *maximum benefit period*, whichever occurs first.

What Disabilities Have A Limited Pay Period Under Your Plan?

We will pay disability benefits on a limited basis for a disability caused by, or contributed to by, any one or more of the following conditions:

- Disabilities, which as determined by *us*, due in whole or in part to mental disorders have a limited pay period during *your* lifetime.
- Disabilities which as determined by *us*, due in whole or in part to alcohol abuse, drug abuse or dependency have a limited pay period during *your* lifetime.

The lifetime cumulative *maximum benefit period* for all disabilities caused by, or contributed to by mental disorders; alcohol abuse and drug abuse or dependency; is 24 months during *your* lifetime.

Only 24 months of benefits will be paid for any combination of such disabilities even if the disabilities:

- are not continuous; and/or
- are not related.

Benefit Extension
We will continue *your* benefits beyond the *maximum benefit period* if *you* meet one or both of these conditions:

1. If *you* are *confined* to a *hospita*l or *institution* at the end of the 24-month period, *we* will continue *your* benefits during *your confinement*. If *you* are still disabled when *you* are discharged, *we* will continue *your* benefits for a recovery period of up to 180 days.
   If *you* become *re-confined* at any time during the recovery period and remain *confined* for at least 14 days in a row, *we* will continue *your* benefits during that additional *confinement* and for one additional recovery period up to 180 more days.

2. In addition to item 1), if, after the 24-month period for which *you* have received benefits, *you* continue to be disabled and subsequently become *confined* to a *hospital* or *institution* for at least 14days in a row, *we* will continue benefits during the length of the *re-confinement*.

We will not pay beyond the limited pay period as indicated above, or the *maximum benefit period,* whichever occurs first. *We* will not apply any period of *confinement* to *your* lifetime cumulative maximum.

Exceptions
We will not apply the mental disorder limitation to dementia if it is a result of:

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

What Disabilities Are Not Covered Under Your Plan?

Your Plan does not cover any disabilities caused by, contributed to by, or resulting from an *illness*, *accident,* treatment, or medical condition arising out of:

- war or act of war (whether declared or undeclared);
- participation in a felony, riot or insurrection;
- suicide, attempted suicide or intentionally self-inflicted *injury;*
- aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline; or
- any loss sustained or contracted in consequence of the *Insured's* being intoxicated or under the influence of any narcotic unless administered on the advice of a *physician.*

What Is A Pre-Existing Condition?

You have a *pre-existing condition* if both 1 and 2 are true:

1. a physical or mental condition for which medical advice was given or treatment was recommended or received from a *physician,* within three months just prior to *your* effective date of coverage under the *Policy,* and

2. the disability begins in the first 12 months after *your* effective date of coverage.

The pre-existing condition benefit waiting period will run concurrently with the required *service waiting period*, if any.

For *insureds* age 65 or older, the *pre-existing condition* limitation is six months following the effective date of the *Insured's* coverage.

What If You Are Not In Active Employment When Your Employer Changes Insurance Carriers To Us? (Continuity of Coverage)

When the *Plan* becomes effective, *we* will provide coverage for *you* if:

- *you* are not in *active employment* because of a *sickness* or *injury*; and
- *you w*ere covered by the prior policy.

Your coverage is subject to payment of premium. *Your monthly benefit* will be limited to the amount that would have been paid by the prior carrier. *We* will reduce *your monthly benefit* by any amount for which *your* prior carrier is liable.

Replacement Coverage Of Your Employer's Prior Plan (Continuity of Coverage)

All eligible *members* of the same class or classes insured under the *prior plan* are eligible for coverage under this *Plan* without *evidence of insurability* or restrictions as to *preexisting conditions*, except as described below.

Application Of The Pre-Existing Condition

If the *employer*'s *prior plan* did not have a *pre-existing condition* exclusion or limitation, then a *pre-existing condition* will not be excluded or limited under this *Plan*.

Special rules apply to *pre-existing conditions*, if this *Plan* replaces *your employer*'s *prior plan* and the *prior plan* applied a *pre-existing* condition limitation.

We will not pay benefits under *our Plan* until the *pre-existing condition* waiting period is satisfied.

You may be eligible for a *monthly benefit* if *your* disability results from a *pre-existing condition* if, *you* were:

- in *active employment* and insured under the *Plan* on its effective date; and
- insured by the prior policy at the time of change or *you* qualify with *credible coverage* from a previous plan.

In order to receive a *monthly benefit you* must satisfy the shorter of the *pre-existing condition* provision under

1. our *Plan*; or
2. the prior carrier's plan, if benefits would have been paid had that policy remained in force.

If *you* satisfy item 1), we will determine *your* benefits according to *our Plan* provisions.

If *you* only satisfy item 2), *we* will administer *your* claim according to *our Plan* provisions. However, *your monthly benefit* will be the lesser of:

- the *monthly benefit* that would have been payable under the terms of the *prior plan* if it had remained in force.
- the *monthly benefit* under *our Plan*.

Your benefits will end on the earlier of the following dates:

- the end of the *maximum benefit period* under the *Plan*; or
- the date benefits would have ended under the *prior plan* if it had remained in force.

If the change from *your employer's prior plan* to this *Plan* of coverage would result in an increase in *your* amount of benefits, the benefits for *your* disability that is due to a pre-existing *sickness* or *injury* will not increase. Instead, the benefits are limited to the amount *you* had on the day before the *Plan* change.

What Happens If You Return To Work Full Time With Your Employer And Your Disability Occurs Again? (Recurrent Disability)

If *you* have a *recurrent disability*, as determined by *us*, *we* will treat *your* disability as part of *your* prior claim and *you* will not have to complete another benefit *elimination period* if:

- *you* were continuously insured under the *Plan* for the period between the end of *your* prior claim and *your recurrent disability*; and
- *your recurrent disability* occurs within six months from the end of *your* prior claim.

Your recurrent disability will be subject to the same terms of the *Plan* as *your* prior claim and will be treated as a continuation of that disability.

Any disability, which occurs after six months from the date *your* prior claim ended, will be treated as a new claim. The new claim will be subject to all of the *Policy* provisions, including the *elimination period*.

If *you* become covered under any other group long term disability insurance plan, *you* will not be eligible for benefits under this disability *Plan*.

ADDITIONAL LONG TERM DISABILITY BENEFITS AND PROGRAMS

SECTION 3

Rehabilitation Program

A Program To Help You Return To Work.
We have a vocational *rehabilitation program* available to assist *you* in returning to work. *We* will determine whether *you* are eligible for this program. In order to be eligible for rehabilitation services, *you* must be medically able to engage in a return to work program.

Your claim file will be reviewed by one of our rehabilitation professionals to determine if a *rehabilitation program* might help *you* return to *gainful employment*. As *your* file is reviewed, medical and vocational information will be analyzed to determine an appropriate return to work program. *We* will make the final determination of *your* eligibility for participation in the program. *We* will provide you with a written rehabilitation plan developed specifically for *you*.

The *rehabilitation program* may include some of the following services and benefits:

- coordination with *your employer* to assist you to return to work;
- adaptive equipment or job accommodations to allow *you* to work;
- vocational evaluation to determine how *your* disability may impact *your* employment options;
- job placement services;
- resume preparation;
- job seeking skills training; or
- education and retraining expenses for a new occupation.

Additional Benefits While You Participate In Our Rehabilitation Program

We will pay an additional benefit of 10% of *your gross disability benefit* to a maximum benefit of $500 per month for 24 months. This benefit is not subject to *Policy* provisions which would otherwise increase or reduce the benefit amount such as *deductible sources of income*. However, the *maximum benefit* and *maximum benefit period* will apply. In addition, *we* will continue benefits for *you* for three months following the date *your* disability ends if *we* determine *you* are no longer disabled while:

- *you* are participating in *our rehabilitation program*; and
- *you* are not able to find employment.

This benefit payment may be paid in a lump sum.

When Will The Rehabilitation Program Benefits End?

Benefits for the *rehabilitation program* will end on the earliest of the following dates:

- the date *we* determine that *you* are no longer eligible to participate in *our rehabilitation program*s; or
- any other date on which benefits would stop in accordance with this *Plan*.

Worksite Modification Benefit

How Can We Help Your Employer Identify And Provide Worksite Modification?

A worksite modification might be what is needed to allow *you* to perform the *material and substantial duties* of *your regular occupation* with *your employer*. One of *our* designated professionals will assist *you* and *your employer* to identify a modification *we* agree is likely to help *you* remain at work or return to work. This agreement will be in writing and must be signed by *you, your employer,* and *us*. When this occurs, *we* will assist *your employer* with the cost of the modification, up to the greater of:

- $1,000; or
- the equivalent of two months of *your monthly benefit*. This benefit is available to *you* on a one-time only basis.

Plan Conversion Option

What Insurance Is Available If You End Employment (Conversion)

If *you* end employment with *your employer, your* coverage under this *Plan* will end. *You* may be eligible to purchase insurance under *our* group conversion policy. To be eligible, *you* must have been insured under *your employer's* group *Plan* for at least 12 consecutive months. *We* will consider the amount of time *you* were insured under *our Plan* and the plan it replaced, if any.

You must apply for insurance under the conversion policy and pay the first quarterly premium within 31 days after the date *your* employment ends. *We* will determine the coverage *you* will have under the conversion policy. The conversion policy may not be the same coverage *we* offered *you* under *your employer's* Group Plan.

Contact the *Policyholder* for more information regarding *your* Long Term Disability conversion options.

Survivor Benefit

When *we* receive proof that *you* have died, while disabled under the *Plan*, *we* will pay *your eligible survivor* a lump sum benefit equal to three months of *your gross disability benefit* if, on the date of *your* death:

- *your* disability had continued for 180 days; and
- you were receiving or were entitled to receive payments under this *Plan*.

However, *we* will first apply the survivor benefit to any overpayment that may exist on *your* claim.

If *you* have no *eligible survivors*, payment will be made to *your* estate, unless there is none.

CLAIM INFORMATION

SECTION 4

Long Term Disability Income Insurance Plan

Reporting Of Claims

You or *your* authorized representative are required to submit a claim to *us* in writing by mail or fax.

The claim form is available from *your employer*, or *you* can request a claim form from *us.* If *you* do not receive the form from *us* within 15 days of *your* request, send *us* written proof of claim without waiting for the form. *You* or *your* authorized representative shall be deemed to have complied with the requirements of the *Policy* as to proof of loss upon submitting within the time fixed in the *Policy* for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

Follow the procedure below to report a disability claim to *us. You* may submit *your* initial claim electronically through *our* website at www.zurichna.com. Follow the instructions on the website and submit all requested documents and information.

When Do You Notify Us Of A Claim?

We encourage *you* to notify *us* of *your* disability claim as soon as possible, so that a claim decision will be made in a timely manner. Written notice of a claim should be sent to *us* within 90 days after the date *your* disability begins. Failure to furnish such proof within such time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof within such time, provided such proof was furnished as soon as reasonably possible.

When Do I File A Claim?

You must send *us* written proof of *your* claim for disability benefits. This must be done on a claim form provided by *us*. Written proof of for loss of time must be furnished to us within 90 days after the disability began or the elimination period ended.

Failure to furnish such proof within such time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof within such time, provided such proof was furnished as soon as reasonably possible.

In the case of claim for any other loss, written proof of such loss must be furnished to the insurer within 120 days after the date of such loss.

Failure to give notice within the time prescribed does not invalidate or reduce any claim if it is shown that it was not reasonably possible to give the notice within that time, and notice was given as soon as was reasonably possible.

Subsequent written proof of the continuance of *your* disability must be furnished to *us* at such intervals *we* may reasonably require.

You must notify *us* immediately when *you* return to work in any capacity.

How Do You File A Claim?

You and the *employer* must fill out *your* own sections of the claim form. *You* must then give *your* claim form to *your* attending *physician* for *your* disability. *Your physician* should fill out his or her section of the form and send it directly to *us*.

What Information Is Needed As Proof Of Your Claim?

Your proof of claim must be provided at *your* expense. It must include the following information:

1. that *you* are under the *regular care* of a licensed *physician*;
2. appropriate documentation of *your monthly covered income*;
3. appropriate documentation regarding the hours *you* are working, if any, for the *employer*;
4. the date *your* disability began;
5. the cause of *your* disability;
6. the extent of *your* disability, including restrictions and limitations preventing *you* from performing *your regular occupation* or any gainful occupation; and
7. the name and address of any inpatient or outpatient facility, *hospital*, or *institution* where *you* received treatment, including all attending *physicians*.

We may request that *you* provide *us* with proof of continuing disability indicating that *you* are under the *regular care* of a *physician*. This proof shall be in writing and satisfactory to *us*.

You will be required to give *us* authorization to obtain additional medical information from *your* medical providers. *You* may also be required to provide *us* with non-medical information such as copies of *your* IRS Federal Income Tax return, W-2's and 1099's, as part of *your* proof of continuing disability.

This proof must be provided at *your* own expense and must be received within 30 days of a request by *us*. *We* will deny *your* claim or stop sending *you* payments if the appropriate information is not submitted.

Benefit Payment

Benefits will be paid to *you*.

Your initial disability income benefit will be paid within 60 days of *our* receipt of *your* claim and satisfactory proof of loss. Thereafter, the benefit will be paid monthly during the continuance of the period for which *we* are liable. Any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.

All other benefits payable under the *Policy* will be payable to *you* within 60 days or less where satisfactory proof of loss is received by *us.*

Any benefits payable after *your* death will be paid to *your eligible survivor* or *your* estate.

What Happens If We Overpay Your Claim?

We have the right to recover any overpayments for amounts paid greater than the benefits that *you* are entitled to receive. This includes but is not limited to *our* error, *your* receipt of *deductible sources of income* or fraud. *We* will not recover more money than the amount *we* paid *you*.

We have the right to do any one or all of the following:

- require *you* to return the overpayment on request;
- stop payment of benefits until the overpayment is recovered;
- take any legal action needed to recover the overpayment; and
- place a lien, if not prohibited by *law,* in the amount of the overpayment on the proceeds of any other *income*, whether on a periodic or lump sum basis.

If the overpayment occurred as a result of *your* receipt of *deductible sources of income,* during the period for which *you* have received a benefit under this *Plan*, *we* will exclude from the amount to be recovered, any advocate or legal fees incurred by *you* to obtain such *deductible sources of income,* provided *you* return the overpayment to *us* within 30 days of *our* written request. If *you* do not return the overpayment to *us* within 30 days, such fees will not be excluded. *You* will remain responsible for repayment of the total overpaid amount.

Unpaid Premium Due

Any unpaid premium due for *your* coverage under this *Policy* may be recovered by *us* by offsetting against amounts otherwise payable to *you* under this *Policy*, or by other legally permitted means.

When Will We Require You To Obtain Physical Examinations And Evaluations?

We will have the right and opportunity to have a *physician*, dentist, vocational expert or other medical or vocational professional of *our* choice examine *you* when *you* request benefits for new and ongoing claims under this *Plan*. Multiple exams, evaluations and functional capacity exams may be required during *your* disability for an ongoing claim. This will be done at all reasonable times while a claim for benefits is pending or under review. This will be done at *our* expense at no cost to *you*.

We also have the right and opportunity to make an autopsy in case of death where it is not prohibited by *law.*

What Are The Time Limits For Legal Proceedings?

You can start legal action regarding *your* claim 60 days after proof of claim has been given to *us* and up to two years from the time proof of claim is required, unless otherwise provided under federal *law.*

CLAIM PROCEDURES AND APPEAL INFORMATION

SECTION 5

How To File A Claim

If *you* wish to file a claim for benefits, *you* should follow the claim procedures described in *your* Certificate. To complete *your* claim filing, *we* must receive the claim information from *you* (or *your* authorized representative), *your* attending *physician*, and *your employer*. If *you* or *your* authorized representative has any questions about what to do, *you* or *your* authorized representative should contact *us* directly.

Claims Procedures

We will give *you* notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if *we* determine that such an extension is necessary due to matters beyond the control of the *Plan* and *we* notify *you* of the circumstances requiring the extension of time and the date by which *we* expect to render a decision. If such an extension is necessary due to *your* failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and *you* will be afforded at least 45 days within which to provide the specified information. If *you* deliver the requested information within the time specified, any 30-day extension period will begin after *you* have provided that information. If *you* fail to deliver the requested information within the time specified, *we* may decide *your* claim without that information.

If *your* claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the *Plan* will:

- state the specific reason(s) for the determination;
- reference specific *Plan* provision(s) on which the determination is based;
- describe additional material or information necessary to complete the claim and why such information is necessary;
- describe *Plan* procedures and time limits for appealing the determination; and
- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Appeal Procedures

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made no later than 45 days following receipt of the written request for review. If *we* determine that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). *We* will notify *you* in writing if an additional 45-day extension is needed.

If an extension is necessary due to *your* failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and *you* will be afforded at least 45 days to provide the specified information. If *you* deliver the requested information within the time specified, the 45-day extension of the appeal period will begin after *you* have provided that information. If *you* fail to deliver the requested information within the time specified, *we* may decide *your* appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of *your* appeal. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by *us* and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, *we* will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of *your* claim, *we* will provide *you* with the names of each such expert, regardless of whether the advice was relied upon.

A notice that *your* request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;
- a reference to the specific *Plan* provision(s) on which the determination is based;
- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
- the statement that *you* are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and
- the statement that "*you* or *your Plan* may have other voluntary alternative dispute resolution options, such as mediation."

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before *you* begin any legal action regarding *your* claim.

Other Rights

The Company, for itself and as claims fiduciary for the *Plan,* is entitled to legal and equitable relief to enforce its right to recover any benefit overpayments caused by *your* receipt of *deductible sources of income* from a third party. This right of recovery is enforceable even if the amount *you* receive from the third party is less than the actual loss suffered by *you* but will not exceed the benefits paid *you* under the *Policy*. The Company and the *Plan* have an equitable lien over such sources of income until any *benefit overpayments* have been recovered in full.

Delegation Of Authority

Zurich American Life Insurance Company of New York may delegate its discretionary authority to make benefit determinations under the Plan to its affiliates. We may act directly or through our employees and agents or further delegate our authority through contracts, letters or other documentation or procedures to other affiliates, persons or entities. Benefit determinations include determining eligibility for benefits and the amount of any benefits, resolving factual disputes, and interpreting and enforcing the provisions of the *Plan.* All benefit determinations must be reasonable and based on the terms of the *Plan* and the facts and circumstances of each claim.

GLOSSARY

SECTION 5

General definitions used throughout this Certificate include:

Active Employment means *you* are working for *your employer* for earnings that are paid regularly and that *you* are performing the *material and substantial duties* of *your regular occupation. You* must be regularly working at least the minimum number of hours as described under *eligible class(es)* in each *Plan*.

Your work site must be:

- *your employer's* usual place of business;
- an alternative work site at the direction of *your employer*, other than *your* home unless clear specific expectations and duties are documented;
- a location to which *your* job requires *you* to travel; or
- at a location to which *your employer's* business requires *you* to relocate.

Normal vacation is considered *active employment*.

If *your* employment status is being continued under a severance or termination agreement, *you* will not be considered in *active employment*.

Temporary and seasonal workers are excluded from coverage.

Administrator means the person(s) or organization(s) that are designated by the *Policyholder* to perform certain functions on behalf of the *Policyholder*.

References to the *Policyholder* mean the *administrator* when the *administrator* is acting on behalf of the *Policyholder*.

References to the Company and Zurich American Life Insurance Company of New York mean the *administrator* when the *administrator* is acting on *our* behalf as specified in an agreement between the *administrator* and *us*.

Another Occupation means the *Insured* is totally unable to perform each and every duty of his or her *regular occupation;* is unable to perform any other *gainful occupation* for which he or she is reasonably suited by reason of education, training, and experience and is not engaged in any occupation for remuneration or profit, unless participating in the Rehabilitation Program.

Appropriate Care means the determination of an accurate and medically supported diagnosis of the *Insured's* disability, or ongoing medical treatment and care of the *Insured's* disability by a *physician* that conforms to generally accepted medical standards, including frequency of treatment and care.

Benefit Amount; Benefit Payable means the disability income payable to *you* according to the terms of the *Policy*.

Confined or Confinement means a *hospital* stay of at least 8 hours per day.

Covered Monthly Earnings means monthly gross Total Assessable Compensation, as defined under The Church Pension Fund Clergy Pension Plan (Clergy Pension Plan), but excluding one-time payments such as overtime and bonuses and income received from sources other than the *employer.*

Earnings will be based on the annualized monthly earnings just prior to the date of disability.

Credible Coverage means *you* will be credited the time *you* were previously covered under a previous group disability insurance plan or policy or *employer*-provided disability benefit arrangement, if the previous coverage was continuous to a date not more than 60 days prior to the effective date of the new coverage under this *Plan.* The credit shall apply to the extent that the previous coverage or level of benefits was substantially similar to the new coverage or level of benefits under this *Plan.*

Deductible Sources of Income means *income* from the deductible sources listed in the *Plan* that *you* receive or are entitled to receive while *you* are disabled. This income will be subtracted from *your gross disability benefit*.

Disability Benefit when used with the term *retirement plan*, means money which:

- is payable under a *retirement plan* due to a disability, as defined in the *Plan*, and
- does not reduce the amount of money, which would have been paid as retirement benefits which would have been paid as retirement benefits under the *Plan* if the disability had not occurred. If the payment does cause a reduction, it will be considered a retirement benefit as defined in this Certificate.

Disability Earnings are the earnings *you* receive for work performed while *you* are disabled and working. *Disability earnings* include only those earnings from work performed for the *employer* or from another employer for which *you* become employed after *your* disability began.

Salary continuation paid to supplement *your disability earnings* will not be considered payment for work performed.

Eligible Class(es) means the classes of *members* that *your employer* has selected as being eligible to receive coverage under a *Plan*. *Your employer* alone determines the criteria that is used to define the *eligible class(es)* for insurance coverage under this *Plan*. *Your employer* alone also sets the criteria and determines if *you* are in an *eligible class* to receive coverage under this *Plan*. *We* will rely on the representation(s) of the *employer* as to *your* eligibility for coverage under this *Plan* and as to any fact concerning such eligibility.

Eligible Survivor means *your* s*pouse*, if living, otherwise *your* children under age 25 equally.

Eligibility Date means the date *you* become eligible for insurance.

Elimination Period means a period of continuo*us* disability that must be satisfied before *you* are eligible to receive benefits from this *Plan*.

Employer means the organizations associated with The Episcopal Church that the *Policyholder* has requested in writing to have included under the *Policy*, and *we* have approved such request.

Evidence of Insurability means a statement of *your* medical history which *we* will use to determine if *you* are approved for coverage, or an increase in coverage.

Full-Time means the number of hours set by the *employer* as a regular workday for *full-time members* in the *Insured's eligible class*.

Gainful Occupation means *any occupation* for which *you* are or become reasonably fitted by training, education, or experience.

Good Cause means a medical reason preventing *your* participation in the *Rehabilitation Program* or in a transitional work arrangement. Satisfactory proof of *good cause* must be provided to *us*.

Grace Period means the period of time following the premium due date during which premium payment may be made.

Gross Disability Benefit means the total benefit amount for which a *member* is insured under this *Plan* before *we* subtract *deductible sources of income* and *disability earnings* subject to the *maximum benefit.*

Home Office means 150 Greenwich Street, Four World Trade Center, 54th Floor, New York, New York 10007-2366.

Hospital or Institution means an accredited short-term, acute, general hospital or facility licensed to provide care and treatment for the condition causing *your* disability which:

(1) is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment, and care of injured or sick persons;
(2) has organized departments of medicine and major surgery;
(3) has a requirement that every patient must be under the care of a physician or dentist;
(4) provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
(5) if located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in Section 1861(k) of United States Public Law 89-97 (42 USCA 1395x(k));
(6) is duly licensed by the agency responsible for licensing such hospitals; and
(7) is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilatory care.

Income means *income you* earn, while disabled and working, from *your employer* or any other employer. However, any *income* earned by working for another employer will be considered *income* only to the extent that it exceeds the amount of *income you* were earning from such employer immediately before *you* became disabled.

Indexed Monthly Earnings means for the first year *you* are disabled *your indexed monthly earnings* will be equal to *your monthly covered earnings*. After *you* have been disabled for one year, *your indexed monthly earnings* means *your covered monthly earnings* adjusted on each anniversary of benefit payments, after a 12-month period of disability by the lesser of 1% or the current annual percentage increase in the Consumer Price Index. *Your indexed monthly earnings* may increase or remain the same, but will never decrease.

The U.S. Department of Labor publishes the consumer price Index (CPI-W). *We* reserve the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-W. Indexing is only used as a factor in the determination of the percentage of lost earnings while *you* are disabled and working in the determination of any *gainful occupation*.

Injury means bodily injury that is a direct result of an *accident* and independent of all other causes. The *injury* must occur, and the disability must begin while *you* are covered under this *Plan*. Exception: any disability that occurs more than 60 days after the *injury* will be considered a *sickness* for the purpose of determining benefits under this *Policy*.

Insured means any person covered under this *Plan* for whom premium has been paid.

Law, Plan or **Act** means the original enactment of the *law, plan* or *act* and all amendments.

Layoff or **Leave of Absence** means *you* are temporarily absent from *active employment* for a period of time that has been agreed to in advance in writing by *your employer. Your* normal vacation time or any period of disability is not considered a temporary *layoff* or *leave of absence.*

Material and Substantial Duties means duties that:

- are normally required for the performance of *your regular occupation*; and
- cannot be reasonably omitted or modified, except that if *you* are required to work an average in excess of 40 hours per week, *we* will consider *you* able to perform that requirement if *you* are working or have the capacity to work 40 h*our*s per week.

Maximum Benefit Period means the longest period of time *we* will make payments to *you* for any one period of disability

Member means a person who is in *active employment* with the *employer.* It includes the officers, managers, *members* and retired *members* of the *employer* and of subsidiary or affiliated corporations of a corporate *employer*, and the *members*, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the *employer* and such affiliated corporations, proprietorships or partnerships is under common control. *Member* shall exclude in any case, part-time *members*, temporary *members* and *members* who work for the *employer* less than the number of hours per week indicated in the Benefits Schedule. This term does not include *member*s who normally work less than 20 hours a week for the *employer*.

Mental Disorders means a psychiatric or psychological condition classified in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM) published by the American Psychiatric Association, most current as of the start of a disability. Such disorders include, but are not limited to; psychotic, emotional or behavioral disorders, schizophrenia, depression, bipolar illness, or disorders relating from stress or to substance abuse or dependency. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of the disability. These conditions are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other methods of treatment as standardly accepted in the practice of medicine.

Monthly Benefit means *your* benefit amount after any *deductible sources of income* and *disability earnings* have been subtracted from *your gross disability benefit***.**

Part-Time Basis means the ability to work and earn 20% or more of *your indexed monthly earnings*.

Payable Claim means a claim for which *we* are liable under the terms of the *Policy*.

Physician means a person performing tasks that are within the limits of his or her medical license; and

- a person who is licensed to practice medicine, and prescribe and administer drugs and medicines, or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction; or
- a practitioner of the healing arts acting within the scope of their New York State license.

We will not recognize *you* or a person related to *you* as a *physician* for a claim that *you* send to *us*. This includes but not limited to *your spouse*, children, parents, siblings, brothers-in-law, sisters-in-law, or stepchildren.

Plan means a line of coverage under the *Policy* such as Short Term Disability, Long Term Disability, Life Insurance or Accidental Death and Dismemberment.

Policy means the group insurance contract between the *Policyholder* and Zurich American Life Insurance Company of New York.

Policyholder means The Episcopal Church Clergy & Employees' Benefit Trust.

Prior Plan means the plan of insurance providing similar benefits sponsored by the *employer* in effect directly prior to the *Policy* effective date.

Reasonable Accommodation means modifications or adjustments to a job, an employment practice or the work environment that makes it possible for a disabled person to perform the material duties of their occupation without causing undue hardship to any *employer*. It must meet federal standards of *reasonable accommodation* as detailed in the Americans with Disabilities Act of 1991 and any later amendments.

Reasonable Occupation means any gainful activity for which *you* are, or may reasonably become fitted by education, training, or experience; and which results in, or can be expected to result in an *income* of more than:

- 80% of *your indexed monthly earnings*.
- *your indexed monthly earnings* multiplied by the *monthly benefit* percentage or if less,
- the amount of the *maximum monthly benefit*.

Recurrent Disability means a disability, which is:

- caused by a worsening in *your* condition; and
- due to the same cause(s) as *your* prior disability for which *we* made a long term disability payment or *you* satisfied *your elimination period*.

Regular Care means:

- *you* personally visit a *physician* as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat *your* disabling condition(s); and
- *you* are receiving the most appropriate treatment and care, which conform with generally accepted, medical standards, for *your* disabling condition(s) by a *physician* whose specialty or experience is the most appropriate for *your* disabling conditions(s) according to generally accepted medical standards.

Regular Occupation means the occupation *you* are routinely performing when *your* disability begins. *We* will look at *your* occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific *employer* or at a specific location.

Rehabilitation Program means a program, approved by *us*, designed to assist *you* to return to work.

Retirement Plan means a defined contribution plan or defined benefit plan. These are plans, which provide retirement benefits to *members* and are not funded entirely by *member* contributions. *Retirement plan* includes but is not limited to any plan that is part of any federal, state, county, municipal or association retirement system.

Salary Continuation or Accumulated Sick Leave means continued payments to *you* by *your employer* of all or part of *your monthly earnings*, after *you* become disabled as defined by the *Policy*. This continued payment must be part of an established plan maintained by *your employer* for the benefit of all *members* covered under the *Policy*. *Salary continuation* or *accumulated sick leave* does not included compensation paid to *you* by *your employer* for work *you* actually perform after *your* disability begins. Compensation for work *you* actually perform after *your* disability begins is considered *disability earnings*, and would be taken into account in calculating *your monthly benefit.*

Sickness means an *illness*, disease or disabling pregnancy. The *sickness* must begin while *you* are covered under this *Plan*.

Spouse means the *Insured's* lawful *spouse.* This includes a marriage between same-sex partners legally performed in New York and other jurisdictions. It does not include a *spouse* who is legally separated. A marriage that is otherwise valid shall be valid regardless of whether the parties to the marriage are of the same or different sex.

We, **Us**, **Our and Company** means Zurich American Life Insurance Company of New York.

You, **Your** means an insured *member* who is eligible for *our* coverage under this *Plan.*