Zurich American Life Insurance Company of New York

Short 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* Short 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.

Elimination Period:
For *sickness* or *accident*: 14 days
Benefits begin the day after the *elimination period* is completed.

Weekly Benefit: 60% of *your covered* w*eekly earnings* less *deductible sources of income.*

Maximum Weekly Benefit: $1,500

Minimum Weekly Benefit: $25

Maximum Weekly Benefit Period: 24 weeks

Maternity Duration: Natural: 6 weeks Cesarean Section: 8 weeks

***Your* benefit may be reduced by *deductible sources of income* and *disability earnings*. Some disabilities may not be covered.**

Limited and Excluded Conditions and Disabilities:

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

If *you* are receiving or are eligible to receive benefits for a disability under a prior disability plan that was sponsored by *your Policyholder* or *you* were terminated before the effective date of this *Plan*, then no benefits will be payable for the disability under this *Policy*.

Zurich American Life Insurance Company of New York

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Policy Number: CNYEX01112

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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 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.

Elimination Period:
For *sickness* or *accident*: 14 days
Benefits begin the day after the *elimination period* is completed.

Weekly Benefit: 66.67% of *your covered* w*eekly earnings* less *deductible sources of income.*

Maximum Weekly Benefit: $1,500

Minimum Weekly Benefit: $25

Maximum Weekly Benefit Period: 24 weeks

Maternity Duration: Natural: 6 weeks Cesarean Section: 8 weeks

***Your* benefit may be reduced by *deductible sources of income* and *disability earnings*. Some disabilities may not be covered.**

Limited and Excluded Conditions and Disabilities:

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

If *you* are receiving or are eligible to receive benefits for a disability under a prior disability plan that was sponsored by *your Policyholder* or *you* were terminated before the effective date of this *Plan*, then no benefits will be payable for the disability under this *Policy*.

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Policy Number: CNYEX01112

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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.

Elimination Period:
For *sickness* or *accident*: 14 days
Benefits begin the day after the *elimination period* is completed.

Weekly Benefit: 60% of *your covered* w*eekly earnings* less *deductible sources of income.*

Maximum Weekly Benefit: $1,500

Minimum Weekly Benefit: $25

Maximum Weekly Benefit Period: 11 weeks

Maternity Duration: Natural: 6 weeks Cesarean Section: 8 weeks

***Your* benefit may be reduced by *deductible sources of income* and *disability earnings*. Some disabilities may not be covered.**

Limited and Excluded Conditions and Disabilities:

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

If *you* are receiving or are eligible to receive benefits for a disability under a prior disability plan that was sponsored by *your Policyholder* or *you* were terminated before the effective date of this *Plan*, then no benefits will be payable for the disability under this *Policy*.

Zurich American Life Insurance Company of New York

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Policy Number: CNYEX01112

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

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:
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.

Elimination Period:
For *sickness* or *accident*: 14 days
Benefits begin the day after the *elimination period* is completed.

Weekly Benefit: 66.67% of *your covered* w*eekly earnings* less *deductible sources of income.*

Maximum Weekly Benefit: $1,500

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***Your* benefit may be reduced by *deductible sources of income* and *disability earnings*. Some disabilities may not be covered.**

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

If *you* are receiving or are eligible to receive benefits for a disability under a prior disability plan that was sponsored by *your Policyholder* or *you* were terminated before the effective date of this *Plan*, then no benefits will be payable for the disability under this *Policy*.

Zurich American Life Insurance Company of New York

Certificate of Coverage

Short Term Disability Income Insurance Plan

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

Zurich American Life Insurance Company of New York is pleased to welcome *you* to the Short 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 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, endorsements, 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.

Table Of Contents

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 Short 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 the *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:

- y*ou* must be in *active employment*; and
- y*ou* 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 a new benefit 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

Effective Date For Benefit Changes Due To A Change In Covered Weekly Earnings
If *you* are in *active employment*, a change in *your weekly benefit* due to a change in *your covered weekly 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*, a change in *your weekly benefit* 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 weekly 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.

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:

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

Reinstatement Of Coverage

If *your* short 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.

What Happens To My Coverage 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*.

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.

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* to 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 its own behalf. Under no circumstances will the *Policyholder* be deemed *our* agent.

Assignment

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

SHORT TERM DISABILITY INCOME INSURANCE BENEFITS
Section 2

The *Plan* provides *you* with a source of *income* if *you* should become disabled and are unable to work, or *you* are *partially disabled* and working reduced hours, because of a *sickness* or *injury* while covered under this *Plan*. If *you* meet the requirements described below, and *your* claim is approved, *your disability benefits* will be payable after the *elimination period*, if any, is over. The *elimination period* is the amount of time *you* must be disabled before benefits start.

Your short term disability benefits will be payable for as long as *your disability benefit* eligibility continues, but not beyond the end of the maximum weekly benefit period. The *elimination period* and the maximum weekly benefit period are shown in the Benefits Schedule.

Short term disability coverage will pay a *weekly benefit to you.*

How Do We Define A Short Term Disability?

You are considered to be disabled if *you* meet all of the following requirements:

- y*ou* must be covered by this *Plan* at the time *you* become disabled;
- y*ou* must be under the *regular care* of a *physician* for *your sickness* or *injury*;
- y*ou* must satisfy the *elimination period* if any; and
- y*ou* must meet the definition of disability below:

You are disabled when *we* determine that due solely to *your sickness* or *injury*:

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

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

You must be under the *regular care* of a *physician* in order to be considered disabled. This means that *you* must have been seen and treated in person by a *physician* for the *sickness,* or *injury* that caused the disability no more than 31 days after the start of 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*. No benefit is payable for or during the *elimination* period. *You* must be under the care of a *physician* during the *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 14 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*.

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* remain disabled. The *benefit payable* is the weekly benefit shown in the Benefits Schedule. The *weekly benefit* is based on *your covered weekly earnings.*

You will begin to receive *benefits* when *we* approve *your* claim, providing the *elimination period* has been satisfied and *you* are disabled as defined in the *Plan*. *We* will send *you* a *benefit* for any period for which *we* are liable, but not beyond the *maximum weekly benefit period* shown in the Benefits Schedule. No benefit is payable during the *elimination* period.

When You Are Disabled For Less Than One Week

After the *elimination period*, if *you* are disabled for less than one week, *we* will send *you* 1/7th of *your weekly benefit* for each day of disability.

What Are Your Covered Weekly Earnings?

"Covered Weekly Earnings" means weekly 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 weekly 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 weekly earnings* by the weekly benefits percentage shown in the Benefits Schedule.
2) The *maximum weekly benefit* is listed in *your* Benefits Schedule.
3) Compare the answer from Item 1) with the maximum *weekly 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 weekly benefit*. The *weekly benefit* will be recalculated when *you* receive any new *deductible sources of income*.

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

Maximum Weekly 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*.

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

For the maximum number of weeks disability benefits are payable:

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

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

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

    - During the weeks of payable benefits, while working, *your weekly benefit* will not be reduced by *your disability earnings* as long as *disability earnings* plus the *gross disability benefit* does not exceed 100% of *weekly covered earnings.*

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

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

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

When Will Your Weekly Benefits End If Working While Disabled?

During the weeks of disability *benefits*, if *your weekly disability earnings* exceed 80% of *your covered weekly earnings*, *we* will stop *your* benefits and *your* claim will end.

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

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

Disability earnings means the earnings which *you* receive while *you* are disabled and working.

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 Weekly 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 covered weekly 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 week to week, *we* may average *your disability earnings* over the most recent 3 weeks 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 3 weeks exceed 80% of *covered weekly earnings*. *We* will not pay *you* a benefit for any week during which *disability earnings* exceed 80% of covered *weekly earnings*.

We will not pay *you* for any week during which *disability earnings* exceed the above amounts. The *minimum weekly 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 weekly benefit* is calculated and may reduce *your weekly 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 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*.

2. 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.

3. 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.

4. 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.

5. The amount of loss of time benefits that *you* receive or are entitled to receive under any *salary continuation or accumulated sick leave*.

6. 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.

    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 Short Term Disability Plan;
- The Episcopal Church Lay Employees' Retirement Plan (Lay DB);
- retirement benefits from a former employer; or
- auto liability insurance policies.

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

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

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

The *minimum weekly benefit* will not be paid in any week when *disability earnings* exceed 80% of *your* covered *weekly 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 weekly 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 weekly 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 weekly 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 weekly 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 week *you* remain disabled up to the *maximum benefit period. Your maximum benefit period* is described in the Benefits Schedule.

When Will Benefits Stop?

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

- the end of the *maximum weekly benefit period*;
- the date *you* are no longer disabled under the terms of the *Plan*;
- when *you* are able to work in *your regular occupation* on a part-time basis, or increase *your* hours, or increase the number or type of duties *you* perform in *your* own job but *you* choose not to;
- *if you* are working and *your* weekly *disability earnings* exceed 80% of *your covered weekly earnings*,
- 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 weekly 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 regular occupation*;
- refuse a transitional work arrangement or other modified work arrangement which may be for *your regular occupation* 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 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 from:

- war or act of war (whether declared or undeclared);
- participation in a felony, riot or insurrection;
- suicide, attempted suicide or intentionally self-inflicted *injury;* or
- for which benefits are provided under any state or federal Workers' Compensation, employer's liability or occupational disease *law.*

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 14 days 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 14 days 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 short term disability insurance plan, *you* will not be eligible for benefits under this *Plan*.

CLAIM INFORMATION
Section 3

Short 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 20 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 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* weekly 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 restricting *your* ability to work; 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 weekly 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

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 the Certificate requests 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 4

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*.

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*.

Complication of Pregnancy means a condition requiring *hospital* stays, when pregnancy is not terminated, whose diagnosis is distinct from pregnancy but adversely affected or caused by pregnancy. *Complication of pregnancy* includes, but is not limited to, non-elective Cesarean section; termination of ectopic pregnancy; spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible; acute nephritis or nephrosis; cardiac decompensation; missed abortion; and similar medical and surgical conditions of comparable severity. It does not include false labor; occasional spotting; morning *sickness*; doctor prescribed rest; hyperemesis gravidarum; pre-eclampsia; or any other condition associated with the management of a difficult pregnancy not consisting of a nosologically distinct *complication of pregnancy*.

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

Covered Weekly Earnings means weekly 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 weekly earnings just prior to the date of disability.

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 Classes 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 are 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 continuous 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 e*mployer* as a regular workday for *full-time member*s 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.

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 l*ayoff* 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 hours 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,and *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 *members* 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.

Part-Time Basis means the ability to work and earn 20% or more of *your indexed weekly 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;
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; 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.

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 weekly earnings*.
- *your indexed weekly earnings* multiplied by the *weekly benefit* percentage or if less,
- the amount of the *maximum weekly 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 short 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 weekly 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 include 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 weekly 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.

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

We, **Us, Our, and the 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*.