TRINITY HEALTH

SHORT-TERM DISABILITY PLAN

Holy Cross Hospital

Summary Plan Description

July 1, 2007

Branch No. 905

INTRODUCTION

Short-term Disability is a partial wage replacement plan designed to assist employees financially in the event that illness or injury prevents them from working. **The Plan does not provide benefits for occupational illness or injury.**

The Trinity Health Short-term Disability Plan, herein referred to as the “Plan”, is provided to eligible employees of Trinity Health at no cost to them. Detailed information about eligibility for coverage, what benefits are payable, how to file a claim, and other features of this Plan are contained in this summary plan description (SPD). Please retain a copy of this summary for your reference.

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OVERVIEW OF PLAN

Trinity Health “Trinity” is both the Plan Sponsor and appointed Administrator for this Plan. “We”, “us” and “our”, as used in this summary, also refers to Trinity Health.

As Plan Administrator, Trinity controls and manages the operation and administration of the Plan which includes the authority to modify, amend, suspend or terminate, in whole or in part, any of the provisions of this Plan at any time, for any reason. We have discretionary authority to determine your eligibility for benefits and to interpret and enforce the terms and provisions of the Plan.

As the Plan Sponsor, Trinity has assigned a Claims Administrator, Unum, to provide certain administrative claims handling services. Unum may or may not issue disability claim payments on our behalf. Regardless, benefits are paid out of the Plan’s general assets fund and are self-insured. Neither Unum, including any of its affiliates or related insuring entities, nor Trinity Health insures that any claims for covered individuals will be paid. If the Plan should terminate, there are no specific assets set aside which will be used for any purpose other than for payment of claims incurred prior to the date of such termination.

If you do not understand any of the terms or provisions contained in this SPD, please contact your local benefit representative or the System Benefits Administration Department at Trinity Health. Contact information can be found on the Plan Administration Information page within this summary.

PLAN ADMINISTRATION INFORMATION

Name of Plan:
Trinity Health Short-term Disability Plan

Type of Plan: Welfare
Plan Number: 581

Name and Address of Employer:
Trinity Health

34605 Twelve Mile Road
Farmington Hills, MI 48331

Employer Identification Number:
35-1443425

Plan Funding: Benefits are paid from the general assets of the employer

Plan Year: The year ends on each June 30

Contact Information:

Plan Administrator:
Trinity Health
System Benefits Administration
34605 Twelve Mile Road
Farmington Hills, MI 48331
(248) 489-6736

Claims Administrator:
UNUM
2211 Congress Street
Portland, ME 04122
Call Center – (800) 858-6843
Fax – (800) 447-2498

Agent for Service of Legal Process: The law requires someone to be named for whom court papers may be given officially if a court dispute does arise. Process may be served upon the Plan Administrator as identified above.

Department of Labor:
SPD
Office of Reporting and Disclosure
Pension & Welfare Benefit Programs
U.S. Department of Labor
Washington, D.C. 20216

PLAN OUTLINE

Description of Eligible Classes

All active Full-time employees who are regularly scheduled and who meet the minimum hours requirement.

“You” and “your”, as used in this summary, refer to an eligible employee as described above.

Minimum Hours Requirement

Seventy-two (72) budgeted hours per pay period

Waiting Period

Coverage will begin the 1st of the month following 30 days of active employment.

Rehire

If your employment ends and you are rehired by us within 12 months, any prior service while in an eligible group, will apply toward the waiting period. All other Plan provisions apply.

Elimination Period

Thirty (30) calendar days

Amount of Coverage

60% of basic weekly earnings

Definition of Basic Weekly Earnings

The amount of regular weekly salary or wages paid by your employer, not including commissions, bonuses, overtime, incentive pay or any other extra compensation. Your regular earnings are based on budgeted hours and not actual hours worked.

Maximum Benefit Period

**Four (4) months from the benefit begin date

Contributions

The cost of this coverage is paid entirely by your employer.

****Coverage under the Plan is not a guarantee of continued employment.**

ELIGIBILITY

When are you eligible for coverage?

If you are in an eligible group, as defined in the Plan Outline, the date you are eligible for coverage is the later of:

- the Plan effective date; or
- the day after you complete your **waiting period**

What if you are absent from work on the date your coverage would normally begin*?*

If you are absent from work due to **injury or illness**, your coverage will begin on the date you return to **active employment**.

When will changes to your coverage take effect*?*

Once your coverage begins, any increased or additional coverage will take effect immediately as long as you are in **active employment**. If you are not in active employment due to **injury or illness**, any increased or additional coverage will begin on the date you return to active employment.

When does your coverage end*?*

Your coverage under the Plan ends on the earliest of:

- the date your **employer** discontinues the Plan;
- the date you are no longer in an eligible group; as defined in the Plan Outline;
- the date your eligible group is no longer covered;
- the last day you are in **active employment** prior to separation or retirement;
- the date of your death

BENEFIT PROVISIONS

When are you considered disabled?

You are **disabled** when Unum determines that due to your **illness or injury:**

- you are unable to perform the **material and substantial duties** of your **regular occupation**; and
- you are not working in any occupation, and
- you are under the **regular care** and treatment of a licensed **physician**, who is practicing within the scope of his/her license during the entire period of **disability**.

How long must you be disabled before you are eligible to receive benefits?

You must be continuously **disabled** through your **elimination period** in order to be eligible for benefits. A new **elimination period** will be applied for each disability.

What happens if you return to work and become disabled again?

If you are **disabled**, return to work, and become **disabled** again due to the same or a related cause, the second **disability** will be considered a continuation of the first claim, as long as you had returned to work for <u>less than 14 consecutive days</u>. You will not have to complete another **elimination period**.

If your second **disability** is unrelated to the first, or if you have returned to work for <u>more than 14 consecutive days</u>, the second period of **disability** will be considered a separate claim and a new **elimination period** must be satisfied before benefits will become payable.

When will you begin to receive payments?

Unum will approve payment of a **weekly benefit** after the end of the **elimination period**, when you and your physician provide proof that you are **disabled** and under appropriate treatment and care of a **physician**. Please refer to the “Claim Application Process” section for details on how to file a claim.

To whom will payments be made?

All benefits are payable to you.

What conditions must be met for benefit payments to continue?

Once the claim is approved, benefits will be paid weekly or in accordance with your normal payroll schedule, during any period that you remain **disabled** under the terms of the Plan. Unum has the right to request proof of continuing disability. You will have 14 days from the date of the request to comply. In the absence of such proof, Unum may elect to suspend benefits until such proof is received.

How much will your weekly benefit amount be?

The following process will be used to calculate your payment:

1. Multiply your **weekly earnings** by the amount of coverage shown in the Plan Outline; this amount is your **gross disability payment**.

2. Subtract from your **gross disability payment** any **deductible sources of income**. The amount figured is your **net weekly benefit**.

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

How much is your weekly benefit if you are disabled and working?

If you are unable to return to a normal work schedule, but the condition allows for a reduced work schedule as part of a rehabilitation program, you will continue to receive a **weekly benefit.**

If you are **disabled** and your weekly **disability earnings** are from 20% through 80% of your **weekly earnings**, you will receive payments based on the percentage of income you are losing due to your **disability.** The following process will be used to figure your payment:

1. Subtract your **disability earnings** from your **weekly earnings**.

2. Divide the answer in item 1 by your **weekly earnings**. This is your percentage of lost earnings.

3. Multiply your weekly benefit amount as calculated above by the answer in item 2. The amount figured is your weekly payment.

Unum may request proof of your **disability earnings** each week and will adjust your **weekly benefit** amount based upon those earnings.

Unum will determine the appropriate financial records necessary to substantiate your income.

What are Deductible Sources of Income?

The following **deductible sources of income** will be subtracted from your **gross disability payment**:

- Any amount provided under federal maritime law;
- Any amount you are entitled to, under any group insurance plan of your **employer**, that provides **disability** income benefits;
- Any benefits you are entitled to receive under the provisions of any retirement or pension plan, excluding lump sum distributions, regardless of whether your **employer** sponsored or maintained the plan.
- Any benefits you are entitled to receive under No Fault Insurance award or through Third Party Subrogation.
- Any benefits you or your dependents are eligible to receive because of your **disability** or age under the United States Social Security Act or similar plan or act. If benefits from these programs are denied for any reason (except your non-insured status), you will be required to appeal the denial to the full extent permitted. You will continue to be considered eligible to receive these benefits until all appeal processes are exhausted.
- Any benefits you are eligible to receive under any plan or provision providing periodic payments for disability, or providing benefits for loss of time or income, to which your **employer**, union, trade, or professional organization directly or indirectly sponsored or contributed;
- Any benefits payable under any state compulsory benefit act or law.

Only **deductible sources of income** that are payable as a result of the same **disability** will be subtracted from the weekly payment.

You must notify Unum promptly when you receive payments that are **deductible sources of income**. Overpayments that result from your failure to notify us must be repaid to the Plan.

What if you receive a lump sum payment from these other income sources?

Unum will prorate lump sum income benefits (excluding distributions from any retirement or pension plan) on a weekly basis over the time period for which the sum is given. If no time period is given, the lump sum amount will be prorated over your expected lifetime, as determined by Unum.

How long will you receive payments?

We will stop sending you payments and your benefits will end on the earliest of:

- the end of the Plan's **maximum benefit period**;
- the date your **disability earnings** exceed the amount allowable under the Plan;
- the date it is determined that you are no longer **disabled** under the terms of the Plan;
- the date you fail to submit proof of continuing **disability**;
- the date that you are able to work in your regular occupation on a part-time basis but you choose not to. (Part-time basis means the ability to work and earn between 20% to 80% of your weekly earnings, as identified by your physician)
- the date of your death

You must notify your Human Resource Department and Unum immediately when you return to work in any capacity.

What happens if your claim is overpaid?

Unum, as the Claim Administrator, or Trinity Health has the right (on behalf of the Plan) to recover any overpayments due to:

- claim processing errors
- your receipt of **deductible sources of income**.
- fraud

Once an overpayment has been identified, you will be required to reimburse the Plan in an amount equal to the improper payment. Unum, or in some cases Trinity Health, will determine the method by which the repayment is to be made. It may be possible to reduce or eliminate future payments instead of requiring repayment.

If our initial attempts to recover money are unsuccessful, we will have the amount of the improper payment withheld from your wages or other compensation to the extent consistent with applicable law.

If all corrective efforts prove unsuccessful, or are otherwise unavailable, Trinity Health, consistent with its business practices, will treat the debt as it would any other business indebtedness.

FRAUD WARNING: If you, with intent to defraud or knowing that you are facilitating a fraud against us, submit an application or file a claim containing a false or deceptive statement, we will assert all legal and equitable rights against you and pursue all legal and equitable remedies we have against you.

EXCLUSIONS AND LIMITATIONS

What disabilities aren't covered?

Benefits will not be paid for any **disabilities** caused by, contributed to by or resulting from:

- an occupational illness or injury;
- intentionally self-inflicted injuries or attempted suicide, while sane or insane;
- active participation in a riot;
- loss of a professional license, occupational license or certification
- commission of a crime for which you have been convicted under state or federal law;
- your attempt to commit or commission of a crime under state or federal law;
- war or act of war, unless you are a United States expatriate or on temporary assignment in a war area on **employer** business, or while you are in the military service of any country which is at war;
- cosmetic surgery, except surgery made necessary by accidental injury incurred while covered under the Plan;
- a vague or indefinable condition (such as "tiredness" or "pain"), for which your physician cannot provide a medical diagnosis;
- any injuries sustained while you are on a personal leave of absence, excluding jury duty and vacations (see "Active Employment" in the Definitions section)

SUBROGATION

Subrogation means that the Plan has the same rights as you to recover benefits for time you have lost from work for which another person, organization, or plan is legally liable. To the extent that the Plan provides benefits in that situation, the Plan is subrogated to the amount of benefits provided.

When benefits have been rendered by the Plan and responsibility for payment is with another plan or person, the Plan has the right to recover the cash value of the benefits. You shall cooperate in those efforts.

You or your representative will execute and deliver to the Plan any instruments and documents and undertake all actions necessary to enable the Plan to exercise the right of subrogation.

If a suit brought by the Plan on your behalf results in a monetary award in excess of the benefits provided by the Plan, the Plan shall have the right to recover its legal fees and expenses out of the excess.

At its election, the Plan shall have a lien, or the right to recover, any sums you receive from a person, organization, or plan, including reimbursement, settlement, judgment**,** or compromise, for benefits which have been provided by the Plan.

You shall not compromise or settle a claim or take any action that would prejudice the rights and interest of the Plan Sponsor pursuant to this section without the prior written consent of the Plan.

Please refer to the Benefit Provisions section under “What happens if you are overpaid?” to clarify further your responsibility for repayment and our methods for recovery.

PLAN TERMINATION, MODIFICATION OR AMENDMENT

Trinity Health reserves the right to terminate, modify or amend the Plan at any time (with respect to Employees and/or Retirees). Upon termination, modification or amendment, the right of covered individuals to benefits is limited to claims incurred and filed prior to the date of termination, modification or amendment. Any termination, modification or amendment that could affect covered individuals of the Plan will be communicated to the covered individuals.

CLAIM APPLICATION PROCESS

When do you notify your employer of a claim?

You must advise your Human Resource Department of a Medical Leave of Absence if you expect to be absent from work for more than three consecutive days. You are required to do this within seven business days so that a claim decision can be made in a timely manner. Whenever practical, the process should begin in advance of requesting benefits.

What is the process for filing a claim?

Upon notification of an impending Short-term Disability claim, your Benefits Representative will do the following:

1. Complete the **employer**'s section of the claim application and forward to the Disability Benefits Specialist at Unum, who in turn will begin processing your application for benefits.

2. Provide you with the employee section and medical documentation section of the claim application for completion.

   Your attending physician should be provided with the form and notified that a representative from Unum will be contacting him or her for medical information. If you do not receive the application form within 15 days of your request, you may send written proof of claim to Unum without waiting for the form.

Your Short-term Disability claim must be filed with Unum within 30 days after the date your disability begins.

The assigned Unum Disability Specialist will review the **employer** statement and contact you by telephone within three days of receipt of the notice. The Specialist will answer your questions regarding the claim application process, as well as gather additional information about your claim including your attending physician's name and telephone number. If you are required to submit the employee section of the claim application, as determined by the Disability Benefits Specialist, you must provide the information promptly to avoid any delays in processing your claim. Alternatively, you may follow any claims filing procedures approved by Unum. You will be separately advised of any such alternate procedure.

Your attending physician will be contacted directly by the Disability Benefits Specialist, and instructed to provide medical documentation and related information as written proof of your claim. The physician should send the completed medical information section of the application form directly to Unum.

Written proof of your claim must be sent to the Unum no later than 90 days after your elimination period.

If it is not possible to give proof within 90 days, it must be given no later than one year after the time proof is otherwise required except in the absence of legal capacity.

What information is needed as proof of your claim?

Your proof of claim, provided at your expense, must show:

- that you are under the **regular care** of a **physician**;
- the date your **disability** began;
- the cause of your **disability**;
- the extent of your **disability**, including restrictions and limitations preventing you from performing your regular occupation; and
- the name and address of any hospital, institution or other source where you received treatment, including all attending physicians' names and addresses.
- the appropriate documentation of your **weekly earnings**;

In some cases, you may be required to give Unum authorization to obtain additional medical evidence in support of your claim. Such evidence may consist of records from your physician, narrative reports, x-rays and any other medical records, as well as evidence that you are under the appropriate care and treatment of a physician. You may also need to provide non-medical information as part of your proof of claim or proof of your continuing disability.

If your physician cannot substantiate your disability by objective findings, Unum may require that an independent physician examine you. If you fail to comply with such a request, the result may be an interruption in or suspension of benefits. Benefits may also be suspended if the results of the independent examination determine that you are not **disabled** under the definition of the Plan.

DISABILITY CLAIM DETERMINATIONS

Unum, 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 an extension is necessary due to matters beyond the control of the Plan. In this scenario, you will be notified of the circumstances requiring the extension of time and the date by which a decision is expected. 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 from receipt of the notice to provide the specified information. If you deliver the requested information within the time specified, the Unum will give you the claim determination 30 days from their receipt of that information. If you fail to deliver the requested information within the time specified, Unum may make a determination on your claim without that information.

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

- state the specific reason(s)for 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 your right to obtain information about those procedures and the right to sue in federal court; 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.

CLAIM APPEAL PROCESS

You have 180 days from your receipt of a notice of an adverse benefit determination to file an appeal.

Written requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Unum determines 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). Unum 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 from receipt of the notice 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 provided that information. If you fail to

deliver the requested information within the time specified, Unum 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. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. 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 regard will be given to the initial determination. The review will be conducted by Unum 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, Unum 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, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

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

- the specific reason(s) for the appeal determination;
- 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);
- a statement describing your right to bring a civil suit under federal law;
- a 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
- a statement that "You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

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 complete before you begin any legal action regarding your claim. In no event can you start any legal action regarding your claim more than three years from the time proof of claim is required, unless other timeframes apply under federal law.

YOUR RIGHTS UNDER ERISA

As a participant in this Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive information about the Plan and its benefits.

You may:

- examine, without charge, at the Plan Administrator's office, and at other specified locations, all plan documents, including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

- obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for such copies.

- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary report.

Prudent action by Plan Fiduciaries.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the disability Plan. The people who operate the Plan, who are called "fiduciaries", have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your **employer**, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce your rights.

If your claim for benefits is denied or ignored, in whole or in part, you have the right to receive written explanation as to why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and you do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent due to circumstances beyond the Administrator's control. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court, after filing the appeal process outlined below. If it should happen that the Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit

in a federal court. The court will decide who should pay these costs and fees. If you lose the suit, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

Assistance with your questions.

You are entitled to receive assistance with your questions. If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

You may obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration at (800) 988-7542.

Discretionary Acts

In exercising our discretionary powers under the Plan, we, as the Plan Administrator, will have the broadest discretion permissible under ERISA and any other applicable laws, and our decisions will constitute final review by the Plan of your claim by the Plan. Benefits under the Plan will be paid only if we decide in our discretion that the applicant is entitled to them. We also have discretion to determine eligibility for benefits and to interpret the terms and conditions of the Plan.

DEFINITIONS

Many terms used in this booklet have special meanings. A list of these terms and their meanings follow:

Active employment:

"Active" status requires that you:

- are working for your **employer** (at your usual place of business or at a location that your **employer**'s business requires you to travel) and paid regular earnings; and
- are performing the material and substantial duties of your regular occupation; and
- are working at least the minimum number of hours as described under the Minimum Hours Requirement in the Plan Outline. (You are still considered actively employed during any approved vacation)

Basic Weekly Earnings: As defined in the Plan Outline.

Complications of pregnancy: Abnormal conditions or a concurrent disease significantly affecting the usual medical management during the pregnancy, during the delivery, or after the delivery.

Deductible Sources of Income: 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 payment.

Disability / Disabled: You are completely unable to perform any and every material and substantial duty of your regular occupation due to your illness or injury. Furthermore, you are not considered disabled or under a disability unless you are under the regular care and treatment of a licensed physician, who is practicing within the scope of his/her license during the entire period of disability.

Disability Benefits: The money that is paid as a weekly benefit when your claim for disability benefits has been approved.

Disability Earnings: The earnings that you receive while you are disabled and working.

Elimination Period: A period of continuous disability that must be satisfied before you are eligible to receive Short-term Disability benefits. Your specific elimination period is defined in the Plan Outline and begins on the first day of disability.

Employer: Trinity Health including any division, subsidiary, or affiliated company named in the Plan.

Fiduciary: The person or entity for which the duty or responsibility is imposed on is called the fiduciary.

Gross Disability Payment: The disability benefit amount before deductible sources of income and disability earnings are subtracted.

Hospital or Institution: An accredited facility licensed to provide care and treatment for the condition causing your disability.

Illness: Any sickness, disease or other medical conditions including pregnancy.

Injury: A bodily injury that is the direct result of an accident and not related to any other cause. The disability resulting from the injury must begin while you are covered under the Plan.

Law / Plan / Act: The original enactment of any law, plan, or act and all amendments.

Layoff or Leave or Absence: A temporary absence from active employment for a period of time that has been agreed to in advance and in writing by us.

Limited: Inability to perform at normal capacity at your regular occupation.

Material and Substantial Duties: Duties that are normally required for the performance of your regular occupation and cannot be reasonably modified or omitted. (Even if you are required to work on average more than 40 hours per week, we will consider you able to perform your duties if you are working or have the capacity to work 40 hours per week)

Maximum Capacity: The greatest extent of work you are able to perform in your regular occupation that is reasonably available based on your restrictions and limitations.

Maximum Benefit Period: The longest period of time the Plan will make payments to you for any one period of disability.

Net Weekly Benefit: The disability benefit amount after any reduction for other income benefits and earnings (subject to the maximum benefit).

Occupational Illness or Injury: A sickness or injury that was caused by or aggravated by any employment for pay or profit.

Payable Claim: A claim for which the Plan is liable.

Physician: A person performing tasks that are within the limits of his or her medical license

Regular Care:

1. You personally visit a physician as frequently as is medically required, according to standard medical practice, to effectively manage and treat your disabling condition(s); and

2. You are receiving the most appropriate treatment and care, which conforms to generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s).

Regular Occupation: 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.

Waiting Period: The continuous period of time that you must be in active employment in an eligible group before you are eligible for coverage under the Plan. Your specific waiting period is defined in the Plan Outline.

Weekly Benefit: The total benefit amount an employee is eligible for under the Plan subject to the maximum benefit.

Weekly Earnings: The gross weekly income you earned just prior to your disability as defined in the Plan.

Weekly Payment: Your payment after any sources of income and weekly disability earnings has been subtracted from your gross disability payment.