



COUNTY OF SANTA CLARA

BASIC AND SUPPLEMENTAL LONG-TERM DISABILITY PLAN

BENEFIT BOOKLET

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Effective July 1, 2005

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**SANTA CLARA COUNTY
LONG-TERM DISABILITY (LTD) BENEFIT PLAN**

The **LONG-TERM DISABILITY (LTD) PLAN** offered by Santa Clara County is comprised of two parts. The Plan is to financially aid Participants in the event of Disability that lasts longer than sixty (60) days. The Plan does not replace other disability benefit sources that are available to Participants, such as Social Security, Workers' Compensation, State Disability Insurance or Public Employees Retirement System (P.E.R.S.).

This booklet is separated into two sections. Each section details the eligibility, waiting periods, benefits available and all terms of each Part of the LTD Plan. Please refer to the applicable sections for complete plan details.

PART ONE of the LTD Plan has a maximum benefit period of 24 months for Sickness and 60 months for Accidental Injury. This Part became effective on August 6, 1979 and has been amended and restated to read as set forth herein, effective for Disabilities commencing on and after January 6, 1992. The payment of benefits for any Disability commencing prior to January 6, 1992 shall be governed by the terms of the Plan as in effect when such Disability commenced.

PART TWO of the LTD Plan is coverage after all LTD Plan benefits under Part One are exhausted and is for disabilities commencing on or after June 1, 1995. This Part of the LTD Plan is underwritten by Highmark Life Insurance Company. The information for Part Two of the LTD Plan is the Group Insurance Certificate.

LONG-TERM DISABILITY PLAN PART ONE

ARTICLE I

1.01 Amount of Benefits

MAXIMUM BENEFIT

Plan Based On 2/3rds Of Base Salary

This Benefit pays 66 2/3% of bi-weekly Regular Base Wages. If applicable, this maximum is reduced by the other benefit sources described in Section 1.03.

Fixed Benefit Option

If you do not elect the benefit level at 66 2/3% of your bi-weekly Regular Base Wages, this benefit may be elected at any of the following benefit levels shown below provided the benefit elected does not exceed 66 2/3% of the employee's bi-weekly Regular Base Wages.

<u>Bi-Weekly Benefit Amt.</u>	<u>Bi-Weekly Covered Salary</u>	<u>Bi-Weekly Cost (\$.81 with SDI)</u>	<u>Bi-Weekly Cost (\$90 w/out SDI)</u>
\$700	\$1,050	\$8.45	\$10.87
\$800	\$1,200	\$9.66	\$12.42
\$900	\$1,350	\$10.87	\$13.97
\$1,000	\$1,500	\$12.08	\$15.53
\$1,100	\$1,650	\$13.28	\$17.08
\$1,200	\$1,800	\$14.49	\$18.63
\$1,300	\$1,950	\$15.70	\$20.18
\$1,500	\$2,250	\$18.11	\$23.29
\$1,800	\$2,700	\$21.74	\$27.95
\$2,000	\$3,000	\$24.15	\$31.05

MINIMUM BENEFITS ALL PLANS

Effective January 6, 1992 the bi-weekly minimum benefit amount for all Plans is \$100.00. If the Plan benefit is reduced by the other benefit sources described in Section 1.03, to less than one hundred dollars (\$100.00) bi-weekly, the Plan will still pay the one hundred dollars (\$100.00) bi-weekly minimum amount. This benefit is payable on new disabilities and continuing disabilities which commenced prior to the amendment date. However, benefits are not retroactive prior to January 6, 1992.

MAXIMUM BENEFIT PERIOD

For Sickness - Benefit is limited to a maximum of 24 months

Accidental Injury - Benefit is limited to a maximum of 60 months

Refer to Section 1.04 - B, Termination of Benefits for additional details.

AFTER ALL BASIC PLAN BENEFITS ARE EXHAUSTED, SEE PART TWO SUPPLEMENTAL LTD PLAN.

1.02 Benefits For Less Than a Bi-Weekly Period

For each day of any period of disability for which benefits are paid and which is less than a full bi-weekly period, the amount of benefit payable shall be one-fourteenth (1/14) of the amount of the Bi-Weekly Benefit.

1.03 Reductions Because of Other Benefits Payable

The Disability benefit as described previously under the heading "Amount of Benefits" shall be reduced by the amount of any benefits (expressed in comparable bi-weekly terms) which the Plan Administrator determines are available to the Participant for the same period of Disability as is payable hereunder, whether or not such benefits are applied for, and whether or not such benefits are contingent upon disability, from the following:

- 1) primary and dependent Disability benefits (as a result of such Disability) or old age retirement benefits under the Federal Social Security Act as now or hereafter in effect; provided, however that after the initial deduction for such benefits, the bi-weekly benefit shall not be further reduced by the amount of any increase in benefits as may thereafter become effective during a period for which Disability benefits are payable and which is due to a cost-of-living adjustment pursuant to Section 230, Title 11 of the Act;
- 2) disability benefits under a state Disability fund or a Company plan established in lieu thereof, or the County's Short-Term Disability Benefit Plan, Public Employees Retirement System (P.E.R.S.), or any other County-sponsored Retirement and/or Disability Plan;
- 3) benefits paid pursuant to any state or federal workers' compensation or Disability law or other law of similar purpose; such benefits shall include, but shall not be limited to temporary Disability and permanent Disability payments (whether total or partial), vocational rehabilitation payments and any amounts awarded or allocated for future medical expenses any amount awarded or paid in a lump sum, whether voluntarily or by operation of law, shall be deducted from the Plan benefit payable commencing from the date of the award of settlement and continuing for as many future months as is necessary to equal the amount of such lump sum;
- 4) benefits under any plan, fund or other arrangement, by whatever name called, providing Disability benefits pursuant to any compulsory benefit act or law or any government;

- 5) benefits under any Employer sponsored program which provides for a periodic Disability benefit or a lump sum Disability payout (only the portion of these benefits attributable to contributions made by the Employer will be integrated with the Plan benefits); and
- 6) amounts received or awarded because the Participant was injured by a third party (see Section 1.05), less any unreimbursed medical expenses awarded by a court and less reasonable expenses of collecting such amounts, including attorneys' fees.

If the Participant either chooses not to apply for, elects to defer or fails to request any of the above benefits, for which he or she may be eligible, the Claims Administrator will reduce such benefits on the basis that the Participant had received the benefit on the earliest date of eligibility.

If, however, a Participant does apply for and/or requests any of the above benefits for which he may be eligible and can provide the Claims Administrator with written evidence of these applications and/or requests, the Claims Administrator shall have the option of having the Participant sign a promise to repay the Plan the appropriate integrable amount of the "other benefits" payable. If the Participant signs the promise to repay, the Claims Administrator will pay the Participant the full Plan benefits while the Participant is waiting for other benefits payments. Otherwise, benefits will be reduced as provided above.

1.04 Commencement and Termination of Benefits

A) Commencement of Benefits

Long-Term Disability benefits shall be payable as of the first day following sixty (60) days of continuous Disability.

B) Termination of Benefit

Disability benefits, once approved, shall be payable bi-weekly so long as eligibility for Long-Term Disability benefits continues. Eligibility for Long-Term Disability benefits shall terminate upon the earliest of any of the following events or dates:

- 1) the death of the Participant;
 - 2) the cessation of the Participant's Disability as determined by the Plan Administrator;
 - 3) the Participant's failure to cooperate in an independent medical examination within thirty (30) days following a written request by the Plan Administrator;
 - 4) the Participant's failure to provide, within thirty (30) days following request, information reasonably requested in writing by the Plan Administrator for the purpose of determining whether he or she is entitled to benefits under the Plan;
 - 5) the date on which the Participant ceases to be under the regular and continuous care and treatment of a licensed Physician, unless such regular and continuous care and treatment is not medically indicated (given the nature of the Disability), or the Participant refuses to follow or rejects the treatment plan recommended by the attending Physician, unless such treatment plan is disputed in good faith and on the advice of another Physician.
- 6(a) for a disability which arises out of, relates to, is caused by, or results from a sickness, eligibility shall terminate after 26 months of Continuous Disability.
- 6(b) for a disability which arises out of, relates to, is caused by, or results from an accidental injury, and the disability begins within 30 days from the date of the accident, eligibility shall terminate after 26

months of Continuous Disability if:

- i) a determination is made by the Social Security Administration that the condition for which the participant is claiming benefits is not or is no longer disabling within the meaning of the Federal Social Security Act as now or hereafter in effect; or
 - ii) a determination is made by the Plan Administrator that the condition for which the Participant is claiming benefits does not meet or no longer meets all of the required medical criteria ("listing of impairments") as set forth in the Social Security regulations pertaining to Disability claims under Title II of the Social Security Act; or
 - iii) after an additional 36 months of Continuous Disability if i) or ii) above do not apply.
- (c) Notwithstanding 6(a) and (b) above, in no event will disability benefits be paid for a period in excess of 60 months from the commencement date of benefits.

1.05 Acts of Third Parties

In the event that the Participant is injured through the acts or omissions of another person or organization, benefits shall be provided only on condition that the participant agrees in writing to the following:

- a) to reimburse the Plan for the full amount of payments made under the terms of this Plan, immediately upon receipt of the portion of the proceeds of any settlement of, or judgment in, an action at law, arbitration, claim or other proceeding to determine said Participant's right of recovery arising out of said injury, which are designated as reimbursement for past or future loss of Regular Base Wages (Note: in the absence of any specific allocation in the judgment or settlement, the total award, less the Participant's reasonable attorney's fees, shall be assumed to be reimbursement for loss of past or future Regular Base Wages); said Participant shall execute and deliver instrument and papers and do whatever is necessary to secure the rights of the Plan to reimbursement out of such proceeds; said Participant shall do nothing to prejudice such rights;
- b) to provide the Claims Administrator with a lien on the proceeds described above, to the extent of the full amount of payments made under the terms of this Plan; said lien may be filed with the person or organization whose act or omission injured the Participant, with his or hers (its) agents, or may be filed with the Court, and
- c) provide the Claims Administrator with a credit against payments to be made in the future under this Plan, said credit to be equal to the proceeds above described, less any amount paid to the Plan by way of reimbursement.

ARTICLE II

PLAN COST

2.01 PARTICIPANT CONTRIBUTIONS

The bi-weekly cost to you for the Plan Based on Salary is:

- 1. If *covered* by the State Disability Insurance Plan \$.81 per \$100.00 of your bi-weekly salary.
- 2. If *not covered* by the State Disability Insurance Plan \$1.04 per \$100.00 of your bi-weekly salary.

Benefit Based on 66 2/3% of Base Salary

This benefit pays 66 2/3% of bi-weekly Regular Base wages.

EXAMPLE OF BENEFITS AND BIWEEKLY COST

1. For Employees covered by the State Disability Insurance Plan.

<u>If your bi-weekly salary is</u>	<u>Your bi-weekly benefit will be</u>	<u>Your bi-weekly contribution will be</u>
\$1,050.00	\$700.00	\$8.45
1,500.00	1,000.00	9.66
2,250.00	1,500.00	15.75
3,000.00 or over	2,000.00	21.00

2. For Employees not covered by the State Disability Insurance Plan.

<u>If your bi-weekly salary is</u>	<u>Your bi-weekly benefit will be</u>	<u>Your bi-weekly contribution will be</u>
\$1,050.00	\$700.00	\$9.45
1,500.00	1,000.00	13.50
2,250.00	1,500.00	20.25
3,000.00 or over	2,000.00	27.00

ARTICLE III

ELIGIBILITY FOR BENEFITS

3.01 Elimination Period

A Participant who sustains a Disability shall, subject to the provisions of the Plan, become eligible to receive the benefit described in Section 1.01 only after such Disability has lasted continuously for sixty (60) days.

3.02 Disability Defined

“Disability” shall mean any physical or mental condition arising from an illness or injury, which renders a Participant incapable of performing work. During the first twenty-four (24) months of a Disability Benefit period, a Participant must be unable to perform the work of his regular occupation or any reasonably related occupation.

After twenty-four (24) months of a Disability Benefit period, a Participant must be unable to perform the work of any occupation for which he is or becomes reasonably qualified by training, education or experience.

3.03 Limitations and Exclusions

A. A Participant shall not be entitled to a Long-Term Disability benefit payment if his or her Disability arises out of, relates to, is caused by or results from:

- 1) an intentionally self-inflicted injury of any kind, while sane or insane;
- 2) an illness or injury to which a contributing cause was the commission or attempted

commission of a felony, or the engagement in an illegal occupation;

- 3) an illness or injury due to war or any act of war, declared or undeclared, insurrection, rebellion or participation in a riot;
- 4) an illness or injury for which the Participant was or is not under the regular and continuous care and treatment of a medical doctor or doctor of osteopathy, unless such regular and continuous care and treatment are not medically indicated given the nature of Disability;

B. Long-Term Disability benefits shall be payable only if the Participant's Disability commences while he or she is a Plan Participant.

3.04 Successive Periods of Disability

After Plan benefits have become payable, successive periods of Disability separated by less than six (6) consecutive months of continuous active work on a Full-Time basis shall be considered one (1) period of Disability, unless the subsequent Disability is due to an illness or injury found by the Claims Administrator to be entirely unrelated to the cause of the previous Disability and commences after the return to active work with the County on a Full-Time basis.

ARTICLE IV

PARTICIPATION

4.01 Eligibility for Participation

If you are a classified or unclassified employee receiving a paycheck from the County and holding a code in provisional, probationary or permanent status, and are making a contribution to this Plan through payroll deduction, you are eligible for coverage under this Plan.

4.02 Commencement of Coverage

If an eligible Employee was employed prior to the Effective Date of the Plan, and was also participating in the Santa Clara County Long Term Income Protection Plan prior to the effective date of this Plan, he or she will automatically be covered by this Plan on the Plan effective date, unless such Employee elects, in writing, to withdraw from the Plan.

If an eligible Employee is employed on or after the Effective Date of the Plan, he or she will be covered as of the first date following the pay period for which the first payroll deduction is made provided that such Employee completes and signs the Enrollment Card and thereby elects to make contributions in accordance with Section 2.01. Example: If the first payroll deduction was taken from your paycheck for the period December 23, 1991 through January 5, 1992, your effective date would be January 6, 1992.

If an Employee was not enrolled in the Santa Clara County Long Term Income Protection Plan on the effective date of this Plan or initially rejected Plan coverage or withdrew from the Plan, or did not enroll within 60 days from the date he or she was first eligible and subsequently desires to be covered under this Plan, he or she will be required to provide acceptable proof of insurability, in accordance with procedures established by the Plan Administrator, before coverage will commence. If the evidence received is satisfactory, you will be advised by the Plan Administrator the date your coverage will become effective.

If the Employee was not working full-time on the day or during the period he or she would ordinarily become covered by the Plan, coverage will not become effective until such Employee has returned to Full-Time work.

4.03 Cessation of Participation

An Employee may voluntarily cease to participate in the Plan as of the last day of any payroll period by giving advance written notice to the Benefits Office, in accordance with the procedures established by the Plan Administrator.

Participation shall automatically cease upon the earliest of the following dates:

- A. on the date of termination of employment by termination of Employer-Employee relationship; or
- B. on the last day of the month in which the Participant begins a County approved medical or non-medical leave of absence; or
- C. on the date a Participant is placed on layoff status; or
- D. on the date a Participant ceases to be an eligible Employee; or
- E. on the date of termination of the Plan.

ARTICLE V

DEFINITIONS

General

Wherever the following terms are used in this Plan, they shall have the meanings specified below, unless the context clearly indicates to the contrary.

5.01 Claims Administrator

The words "Claims Administrator" shall mean United Administrative Services.

5.02 Disability

The word "Disability" shall mean a disability as described in Section 3.02.

5.03 Effective Date

The words "Effective Date of the Plan" shall mean August 6, 1979.

5.04 Employee

The word "Employee" shall mean a person who, on or after the Effective Date, is a classified or unclassified individual who performs a service for the Employer on a regular basis.

5.05 Employer

The word "Employer" shall mean Santa Clara County.

5.06 Participant

The word "Participant" shall mean an Employee who satisfies the eligibility requirements of Section 4.01 and who elects to participate in the Plan.

5.07 Physician

The word "Physician" shall mean a medical doctor, a doctor of osteopathy, or any other licensed practitioner operating within the scope of his license and under the laws of the jurisdiction in which he operates.

5.08 Plan

The word "Plan" shall mean the Santa Clara County Basic Long-Term Disability Benefit Plan.

5.09 Plan Administrator

The words "Plan Administrator" shall mean Santa Clara County.

5.10 Definition of "Regular Base Wages"

"Regular Base Wages" for the purposes of benefit computation and contribution determination, shall mean the product of the Employee's hourly rate of pay (excluding shift differential pay, call back pay, overtime, etc.) times the number regularly scheduled hours in a payroll period.

The term "regularly scheduled hours in a payroll period", as used above, means the number of such hours without regard to any temporary, mandatory reduction in work hours imposed by the County. For the purposes of benefit computation, "Regular Base Wages" shall be deemed to be that amount in effect on the date immediately prior to the date of the commencement of the period of Disability.

5.11 Sickness

"Sickness" means illness or disease. It includes pregnancy and resulting childbirth, in addition to complications of pregnancy.

5.12 Accidental Injury

"Accidental Injury" means physical harm which is the result of a specific unexpected incident caused by an outside force. The physical harm must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound. Disabilities due to an accidental injury must start within 30 days from the date of the accident, and the accidental injury must have been incurred while the participant was covered under the Plan.

ARTICLE VI

PAYMENT OF BENEFITS

6.01 Application for Benefits

1. Obtain a claim form by contacting the Claims Administrator's Office: United Administrative Services, telephone number (408) 288-4400
2. Fill out and sign the "Claim Statement of Employee". Write or print clearly. Be sure all information is correct. Be especially careful with your Social Security Number, addresses and dates.
3. Give the form to your doctor for completion of the "Attending Physician Statement".
4. Mail the claim form to:

United Administrative Services
P.O. Box 5057
San Jose, California 95150-5057

Early filing will speed your payment. Please direct any questions regarding your claim to the Claims Administrator's Office:

United Administrative Services
P.O. Box 5057
San Jose, California 95150-5057
Telephone Number: (408) 288-4400

Except for good cause, written notice of claim must be given to the Claims Administrator within ninety (90) days after the first (1st) day of a Disability.

Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity shall a claim be accepted more than twelve (12) months after commencement of Disability. A claim may be submitted by a representative of the Participant if the Participant is not reasonably able to do so.

The Claims Administrator shall have the right to:

- (a) require continued proof of Disability, at the Participant's expense, during the pendency of a claim;
- (b) require written authorization for medical records and other information needed to document properly the Participant's file;
- (c) require information with respect to the Participant's age, address, marital status, dependents, employment record and medical history;
- (d) require any other information reasonably relevant to a determination of whether such Participant is eligible to receive Plan benefits; and
- (e) personally contact and interview the Participant, the Participant's Physician, Employer or any other persons who can provide relevant information regarding the Participant's Disability. The Participant's failure to cooperate with the Claims Administrator in a reasonable investigation or processing of a claim will result in benefits being denied, suspended or terminated.

6.02 Medical Examinations

The Claims Administrator may require that a Participant applying for Plan benefits submit to an examination by one or more Physicians or vocational specialists designated by the Claims Administrator. Reexaminations of a Participant receiving Plan benefits may be required by the Claims Administrator from time to time for the purpose of determining whether a Disability continues to exist. The fees of such Physician or vocational specialist and the expenses of such examination shall be paid by the Plan.

6.03 Non-Alienation of Benefits

The interest and property rights of any person in the Plan or in any payment to be made under the Plan shall not be subject to option nor be assignable either by voluntary or involuntary assignment or by operation of law, including (without limitation) bankruptcy, garnishment, attachment or other creditor's process, and any act in violation of this Section 6.03 shall be void.

6.04 Payments Are Made

Upon receipt of all the necessary information and determination of the Participant's eligibility for Plan benefits, the Claims Administrator will calculate the amount of the benefit payment and forward the initial check directly to the participant's residence. Subsequent benefit checks will be issued bi-weekly by the Claims Administrator, provided the claim is still approved and is complete in all respects at that time.

6.05 Payments to Representative

In the event that a guardian, conservator, committee or other legal representative has been duly appointed for a Participant who is entitled to any payment under the Plan, any such payment due may be made, in good faith, to the legal representative making claim therefor, and any such payment so made shall be in complete discharge of the liabilities of the Plan therefor and the obligations of the Plan Administrator and the Claims Administrator.

ARTICLE VII

APPEALS

7.01 Claims Appeal Procedure

The claimant and/or his or her representative may appeal a denied claim or a claim deemed to have been denied and may do the following:

- a. Request from the Claims Administrator a review of the eligibility status for any claim denied in whole.
- b. Request from the Claims Administrator a review of any benefit payments. Such requests must include Participant's name and Social Security Number.
- c. File a request for review in writing, stating in clear and concise terms the reason or reasons for the disagreement with the handling of his/her claim.

The request for review should be directed to the Claims Administrator within twenty (20) days after the claim payment date or the date of the notification of denial of benefits. A copy of your appeal will be filed with the Plan Administrator's office, Personnel Department.

Your request will be submitted to the appeals panel. You are entitled to a hearing before the panel if you should so request. You may bring a representative of your choice to the hearing. Information regarding your claim will be kept confidential except for the purposes allowed by law.

The appeals panel will review the denial and the Plan Administrator will provide the claimant with a written response within sixty (60) days of the date the Plan Administrator receives the written request for review. If because of extenuating circumstances the Plan Administrator is unable to complete the review process within sixty (60) days, the Plan Administrator shall notify the claimant of the delay within the sixty (60) day period and shall provide a final written response to the request for review within one hundred twenty (120) days of the date the Claims Administrator received the written request for review. If no notice of denial or notification of extenuating circumstances requiring a delay is provided as herein described, the claimant may appeal the claim as though the claim had been denied.

The Plan Administrator's written response to the claimant shall, if the denial is upheld, cite the specific Plan provision(s) upon which the denial is based.

**LONG TERM DISABILITY SUPPLEMENTAL PLAN
GROUP INSURANCE CERTIFICATE**

HIGHMARK LIFE INSURANCE COMPANY

P.O. BOX 1840, HARTFORD, CONNECTICUT 06 144-1840
1-800-443-3221

Highmark Life Insurance Company certifies that you will be insured under the Group Policy described below during the time, in the manner, and for the amount provided in the Group Policy.

Timothy Foley

PRESIDENT

GROUP POLICY NUMBER	908736-A
NAME OF POLICYHOLDER	County of Santa Clara
TYPE OF COVERAGE	Long Term Disability Insurance — Part Two
GROUP POLICY EFFECTIVE DATE	June 1, 1995
GROUP POLICY DELIVERED IN	California and governed by the laws of that state.

IMPORTANT: PLEASE READ THIS

A Group Policy has been issued to the Policyholder. Your coverage under that Group Policy is shown in this Certificate. If your coverage is changed by an amendment to the Group Policy, we will provide the Policyholder with a revised Certificate or other notice to be given to you.

PLEASE READ THIS CERTIFICATE OF INSURANCE CAREFULLY. This Certificate Of Insurance has a Table of Contents to help you find specific provisions. "You" and "your" refer to the insured Member. "We", "us", and "our" refer to **Highmark Life Insurance Company**. Other defined terms are printed with an initial capital letter.

OUTLINE OF YOUR LONG TERM DISABILITY INSURANCE

THIS OUTLINE IS INTENDED FOR USE WITH THIS CERTIFICATE AND CANNOT BE USED SEPARATELY AS A DESCRIPTION OF YOUR COVERAGE. OTHER PROVISIONS ARE FOUND IN THIS CERTIFICATE. PLEASE READ THIS CERTIFICATE CAREFULLY.

TYPE OF INSURANCE - Long Term Disability Insurance provides you with income protection if you become Disabled from a covered sickness, accidental bodily injury, or pregnancy.

LONG TERM DISABILITY INSURANCE (LTD) BENEFITS - The purpose of this Insurance is to provide you with an LTD Benefit while you are Disabled. The amount of your LTD Benefit is shown in Part 3C.

Your Elimination Period is shown in Part 3A.

Your Maximum Benefit Period is determined by your age when you become Disabled. See Part 3B.

DISABILITY - Disability is defined in Part 5.

EXCLUSIONS AND LIMITATIONS - Your Insurance is subject to the Exclusions and Limitations shown in Part 4.

BECOMING INSURED - Parts 1 and 9 explain when you become insured and when Insurance ends. The Policyholder determines the amount of your contribution toward the cost of your Insurance if your Insurance is Contributory.

Part 1. BECOMING INSURED

To become insured you must meet each of the requirements of A through E plus the Active Work requirement.

A. DEFINITION OF MEMBER

You must be a Member. You are a **MEMBER** if you are all of the following:

1. An active employee of the Employer, other than a temporary or seasonal employee or a full-time member of the armed forces of any country.
2. Regularly scheduled to work at least 40 hours during each bi-weekly pay period.
3. A citizen or resident of the United States or Canada.

B. ELIGIBILITY FOR INSURANCE

You must be eligible for Insurance. You are eligible for Insurance on the effective date of the Group Policy if you are a Member on that date. Otherwise, you will become eligible for Insurance on the date you become a Member.

C. APPLICATION FOR INSURANCE

Your Insurance is Contributory. You must apply for Insurance and agree to make the required contributions to the Employer by signing a completed enrollment card.

D. EVIDENCE OF INSURABILITY

Your Insurance is Contributory; you must provide us with satisfactory Evidence Of Insurability to become insured if either of the following applies:

1. You apply for Insurance more than 60 days after you are first eligible for Insurance.
2. You apply for any increase in you Maximum LTD Benefit.

The Employer will notify you if Evidence Of Insurability is required.

E. EFFECTIVE DATE OF INSURANCE

Your Insurance will become effective on the appropriate following date, if you meet the Active Work requirement on that date:

1. The effective date of the Group Policy, if you apply on or before that date and Evidence Of Insurability is not required for you to become insured.
2. The date you apply for Insurance, if you apply within 60 days after the date you become eligible for Insurance and Evidence Of Insurability is not required for you to become insured.
3. The date we approve your Evidence Of Insurability, if Evidence Of Insurability is required for you to become insured.

F. ACTIVE WORK REQUIREMENT

You must meet an Active Work requirement to become insured.

You automatically meet the Active Work requirement on the date your Insurance is scheduled to become effective unless you were Disabled on the day before that date. If you were Disabled on the day before the scheduled effective date of your Insurance, the effective date of your Insurance will be delayed until the first day after you complete one full day of Active Work as a Member.

For purposes of this Active Work requirement, you are Disabled if you are currently unable, as a result of your sickness, accidental bodily injury, or pregnancy, to perform the substantial and material duties of your own occupation.

ACTIVE WORK and **ACTIVELY AT WORK** mean performing the usual duties of your job at the Employer's usual place of business.

This Active Work requirement also applies to any increase in your Insurance.

Part 2. LONG TERM DISABILITY INSURING CLAUSE

Subject to all the terms of the Group Policy, we will pay the LTD Benefit described in Part 3 upon receipt of satisfactory written proof that you have become Disabled while insured under the Group Policy.

Part 3. SCHEDULE OF LONG TERM DISABILITY INSURANCE

You must read each section to understand when LTD Benefits are payable and how LTD Benefits are calculated.

A. ELIMINATION PERIOD

ELIMINATION PERIOD means the length of time you must be continuously Disabled before LTD Benefits become payable.

Your Elimination Period for each period of Disability due to accidental bodily injury is 62 months.

Your Elimination Period for each period of Disability due to sickness or pregnancy is 26 months.

Your Elimination Period begins on the date you become Disabled. No LTD Benefits are ever payable for the Elimination Period.

Temporary Recovery during the Elimination Period:

For purposes of serving the Elimination Period, all separate periods of Disability from the same cause or causes will be added together and treated as one period of continuous Disability. However, you must serve the full Elimination Period within a total period equal to 35 days for each 30 days of the Elimination Period.

For purposes of this provision, a period of Temporary Recovery means any time when we do not consider you Disabled as defined in Part 5.

B. MAXIMUM BENEFIT PERIOD

MAXIMUM BENEFIT PERIOD means the longest period of time for which LTD Benefits are payable for any one period of continuous Disability, whether from one or more causes.

Your Maximum Benefit Period is equal to the period shown below or the period which lasts until your Normal Retirement Age under the 1983 amendments to the federal Social Security Act, whichever is longer.

Your Maximum Benefit Period is determined as follows:

Your Age When Disability Begins	Your Maximum Benefit Period
58 or younger	To age 65
59	To age 65 or 5 years, whichever is longer
60	5 years
61	4 years
62	3 years 6 months
63	3 years
64	2 years 6 months
65.	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69 or older	1 year

Your Normal Retirement Age under the 1983 amendments to the federal Social Security Act is determined by the year of your birth, as follows:

Year of Birth	Normal Retirement Age
Before 1938	Age 65
1938	Age 65 and 2 months
1939	Age 65 and 4 months
1940	Age 65 and 6 months
1941	Age 65 and 8 months
1942	Age 65 and 10 months
1943 through 1954	Age 66
1955	Age 66 and 2 months
1956	Age 66 and 4 months
1957	Age 66 and 6 months
1958	Age 66 and 8 months
1959	Age 66 and 10 months
After 1959	Age 67

Your Maximum Benefit Period begins at the end of the Elimination Period. During the Maximum Benefit Period, LTD Benefits are paid at the end of each monthly period for which you qualify for LTD Benefits. LTD Benefits will stop at your death or at any time during the Maximum Benefit Period when you no longer qualify for LTD Benefits. LTD Benefits will stop at the end of the Maximum Benefit Period even if you are still Disabled.

Temporary Recovery during the Maximum Benefit Period:

For purposes of continuing LTD Benefits during the Maximum Benefit Period, any two periods of Disability from the same cause or causes will be added together and treated as one period of continuous Disability if they are separated by a period of Temporary Recovery of less than 180 days. Thus, a new Elimination Period will not be required, the Predisability Earnings used to compute your LTD Benefit will not change, and the Maximum Benefit Period will be the balance of the Maximum Benefit Period Temporary Recovery.

No LTD Benefits will be payable under this provision after benefits become payable to you under any other group long term disability insurance policy. This rule prevents double coverage if you become insured under another policy while you are working during a period of Temporary Recovery.

For purposes of this provision, a period of Temporary Recovery means any time when we do not consider you Disabled as defined in Part 5.

C. AMOUNT OF LTD BENEFIT

Your monthly **LTD BENEFIT** equals your Maximum LTD Benefit reduced by your Income From Other Sources.

Your Maximum LTD Benefit depends on whether you are insured under Benefits Based on 66 2/3% of Base Salary as described below.

Your **MAXIMUM LTD BENEFIT** equals A, where:

A = 66 2/3% of bi-weekly Pre-disability bi-weekly regular base wages

Your monthly LTD Benefit during a period of Disability will be determined by your Maximum LTD Benefit in effect on your last day of Active Work before you become Disabled:

The MINIMUM LTD BENEFIT is \$100 per month.

Pre-disability Earnings are defined in Part 6.

Income From Other Sources is defined in Part 7.

Part 4. EXCLUSIONS AND LIMITATIONS

A. RISKS NOT COVERED

1. **WAR:** You are not covered for a disability caused or contributed to by war or any act of war.

WAR means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.

2. **INTENTIONALLY SELF-INFLICTED INJURY:** You are not covered for a disability caused or contributed to by an intentionally self-inflicted injury.

B. LIMITATIONS

1. **REGULAR CARE OF A PHYSICIAN:** No LTD Benefits will be paid for any period of Disability when you are not under the regular care of a Physician. This limitation will not apply if you remain Disabled and further care of a Physician is determined to be medically unnecessary.

PHYSICIAN means a licensed medical professional, other than yourself, diagnosing and treating you within the scope of the license.

2. **MENTAL DISORDER:** Payment of LTD Benefits is limited to 24 months for each period of Disability caused or contributed to by a Mental Disorder. However, if you are a resident patient in a Hospital at the end of the 24 months, this limitation will not apply while you remain continuously confined.

MENTAL DISORDER means a mental, emotional, or behavioral disorder.

HOSPITAL means a legally operated hospital providing full-time medical care and treatment under the direction of a full-time staff of licensed physicians (M.D. or D.O.). Rest homes, nursing homes, convalescent homes, homes for the aged, and facilities primarily affording custodial, educational, or rehabilitative care are not Hospitals.

3. **WORK EARNINGS:** No LTD Benefits will be paid for any period when your work earnings exceed 60% of your Indexed Pre-disability Earnings.

Part 5. DEFINITION OF DISABILITY

You will be considered **DISABLED** during the Elimination Period if you are Totally Disabled as defined below, and you are not working at all.

You will be considered Disabled during the Maximum Benefit Period if you are either Totally Disabled or Residually Disabled, as defined below:

TOTALLY DISABLED: You must be Totally Disabled from all occupations. You are Totally Disabled from all occupations if you are currently unable, as a result of your sickness, accidental bodily injury, or pregnancy, to perform the substantial and material duties of any occupation for which you are reasonably fitted by education, training, and experience, and you are not working at all.

RESIDUALLY DISABLED: You are Residually Disabled during the Maximum Benefit Period if you are currently unable, as a result of your sickness, accidental bodily injury, or pregnancy, to perform the substantial and material duties of any occupation for which you are reasonably fitted by education, training, and experience and you are working in your own occupation or another occupation or specialty and your work earnings do not exceed 60 % of your Indexed Predisability Earnings.

The Return To Work Provision in Part 8A explains the effect your work earnings will have on the amount of your LTD Benefit. No LTD Benefits will be paid for any period when your earnings from work in your own occupation or another specialty or occupation exceed 60% of your Indexed Predisability Earnings.

You will not be considered Disabled solely because of the loss or restriction of your license to engage in your own occupation.

INDEXED PREDISABILITY EARNINGS used for purposes of the income protection guarantee in the definition of Disability means an amount determined as follows:

Until you have been Disabled for one year, your Indexed Predisability Earnings will equal your Predisability Earnings on your last full day of Active Work before you became Disabled. Thereafter, we will increase the amount of your Indexed Predisability Earnings on each anniversary of the date you became Disabled. Increases are compounded, and there is no limit on the number of increases. The amount of each increase to the amount of Indexed Predisability Earnings in effect during the prior year of Disability will equal A or B, whichever is less, where:

A = 10% of your Indexed Predisability Earnings during the prior year of Disability

B = The rate of increase in Consumer Price Index (CPI-W) during the prior calendar year multiplied by your Indexed Predisability Earnings during the prior year of Disability.

There will never be a decrease in your Indexed Predisability Earnings, even if there is a drop in the Consumer Price Index (CPI-W).

CPI-W means the Consumer Price Index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. If the index is discontinued or changed, we may use another nationally published index which is comparable to the CPI-W.

Part 6. DEFINITION OF PREDISABILITY EARNINGS

PREDISABILITY EARNINGS means your monthly rate of earnings from the Employer including commissions and tax deferred contributions you make to a qualified plan sponsored by the Employer, but excluding bonuses, overtime pay, and any other extra compensation. The following rules apply to the computation of your monthly rate of earnings:

Commissions: Your monthly rate of earnings on any date includes the average monthly commissions paid to you by the Employer during the prior calendar year (or during the period you were a Member, if you were not a Member throughout the prior calendar year).

Weekly Pay: Weekly earnings are multiplied by 4.333 to find your monthly rate of earnings.

Hourly Pay: Your hourly pay rate is multiplied by the number of hours you are regularly scheduled to work each month (but not more than 40 hours per week) to find your monthly rate of earnings. If you do not have regular work hours, your monthly rate of earnings on any date will be based on the average number of hours you worked during the prior calendar year (or during the period you were a Member, if you were not a Member throughout the prior calendar year), but not more than 40 hours per week.

Part 7. DEFINITION OF INCOME FROM OTHER SOURCES

Income From Other Sources is used to reduce your LTD Benefit and is explained in the following definition, exceptions, and rules.

A. DEFINITION OF INCOME FROM OTHER SOURCES

INCOME FROM OTHER SOURCES means:

1. Any sick pay or other salary continuation (other than vacation pay) paid to you by the Employer which, when added to the amount of your Maximum LTD Benefit, exceeds 100% of your Predisability Earnings.

2. The amount determined from the Return To Work Provision in Part 8A, if you work while you are Disabled. Part 8A explains the effect your work earnings will have on the amount of your LTD Benefit.
3. Any amount you receive or are eligible to receive as a result of your disability under any workers' compensation law or similar law, including amounts for partial or total disability, whether permanent, temporary, or vocational.
4. Any amount you, your spouse, or your children receive or are eligible to receive because of your disability or retirement under the Federal Social Security Act, the Canada Pension Plan, the Quebec Pension Plan, or any similar plan or act. Early retirement benefits payable prior to normal retirement age under the plan or act will not be used to reduce the amount of your LTD Benefit unless they are actually received.

Benefits your spouse or children receive or are eligible to receive because of your disability will be considered Income From Other Sources regardless of marital status, custody, or place of residence.

5. The amount you receive or are eligible to receive because of your disability under any group insurance coverage, other than group credit insurance or group mortgage disability insurance.
6. The amount you receive or are eligible to receive because of your disability under any state unemployment compensation disability benefit law or state disability income benefit law.
7. The following amounts from any disability or retirement plan under which you are covered as a result of your employment with the Employer (including but not limited to a public employee retirement system, a state teacher retirement system, or any plan arranged and maintained by a union or employee association for the benefit of its members):
 - a. Any disability benefits you receive or are eligible to receive because of your disability.
 - b. Any retirement benefits you receive or are eligible to receive because of your retirement.

If the disability or retirement plan has two or more payment options, we will reduce your LTD Benefit by the amount of the plan option which provides, or comes closest to providing, a monthly income to you for life with no survivors benefit. This will be true even if you select a different option.

8. Any amount received by compromise, settlement, or other method as a result of a claim for any of the above.

B. EXCEPTIONS TO INCOME FROM OTHER SOURCES

The following will not be used to reduce the amount of your LTD Benefit:

1. Any cost of living increase in any Income From Other Sources, provided that the increase becomes effective while you are Disabled and while you are eligible to receive the Income From Other Sources. (This exception does not apply to any increase in your earnings from any work.)
2. Any amount received as reimbursement for hospital, medical, or surgical expense.

3. Any amount which represents reasonable attorney's fees incurred in connection with the claim for Income From Other Sources.
4. Benefits from any individual disability insurance policy.
5. Any amount you receive from the following types of retirement plans: A defined contribution (money purchase) retirement plan, a profit sharing plan, a thrift or savings plan, a deferred compensation plan, a 401(k) plan, an Individual Retirement Account (IRA), a Tax Sheltered Annuity (TSA), a stock ownership plan, a Keogh (HR-10) Plan, or a retirement plan under a Professional Service Corporation with respect to principals or shareholders.
6. Any benefits under the Federal Social Security Act received by, or on behalf of, your dependent child age 18 or over.

C. RULES FOR INCOME FROM OTHER SOURCES

1. Monthly Equivalents

Each month your LTD Benefit will be reduced by the Income From Other Sources for the same monthly period, even if you actually receive the Income From Other Sources in another month.

If you receive any Income From Other Sources periodically other than monthly, we will determine the monthly equivalent and use that amount to reduce your LTD Benefit.

If you receive any Income From Other Sources in a lump sum, we will prorate the lump sum over the period of time for which the lump sum was paid and use that amount to reduce your LTD Benefit. If no period of time is stated, we will determine the maximum period of time to which the lump sum is fairly attributable and prorate the lump sum over that period of time.

Each month we will determine the amount of your LTD Benefit using the Income From Other Sources for the same monthly period, even if you actually receive the Income From Other Sources in another month.

2. Your Duty To Pursue Income From Other Sources

You must pursue Income From Other Sources for which you may be eligible. We may ask for written documentation of your pursuit of Income From Other Sources. You must provide it within 60 days after we mail you our request. Otherwise, we may reduce your LTD Benefits by the amount we estimate you would be eligible to receive upon proper pursuit of the Income From Other Sources.

3. Income From Other Sources Which Is Pending

If you are actively pursuing a claim for Income From Other Sources, we will not deduct that Income From Other Sources until it becomes payable. You must notify us of the amount of the Income From Other Sources when it is received. You must repay us for any resulting overpayment of your claim.

4. Overpayment Of Claim

We will notify you of the amount of any overpayment of your claim under any group disability insurance policy issued by us. You must immediately repay us the amount of

the overpayment. You will not receive any LTD Benefits until we have been repaid in full. In the meantime, any LTD Benefits becoming payable, including the Minimum LTD Benefit, will be applied to reduce the amount of the overpayment. We may charge you interest at the legal rate for any overpayment which is not repaid within 30 days after we first mail you notice of the amount of the overpayment.

Part 8. OTHER BENEFITS AND PROVISIONS

A. RETURN TO WORK PROVISION

This provision is designed to give you an incentive to work to the extent of your ability while you are Disabled.

If you work while you are Disabled, the amount of your LTD Benefit will only be reduced as follows:

50% Return To Work Benefit:

The Income From Other Sources used to reduce the amount of your LTD Benefit will include one-half the amount of your earnings from work you perform while you are disabled, but only if your work earnings exceed 20% of your Indexed Predisability Earnings.

B. SURVIVORS BENEFIT

If you die while LTD Benefits are payable to you, we will pay a lump sum Survivors Benefit. The following rules will apply:

1. The Survivors Benefit will equal three times the amount of your Maximum LTD Benefit.
2. Any Survivors Benefit payable will first be applied to reduce the amount of any outstanding overpayment of your claim for LTD Benefits.
3. The Survivors Benefit will be paid to your surviving spouse. If you are not survived by a spouse, the Survivors Benefit will be paid in equal shares to your surviving children. If you are not survived by a spouse or any children, the Survivors Benefit will be paid to your estate.

C. WAIVER OF PREMIUM

Your Long Term Disability Insurance in effect when you become Disabled will be continued without payment of premiums while LTD Benefits are payable.

If a period of continuous Disability is extended by a new cause while LTD Benefits are payable, LTD Benefits will continue while you remain Disabled (subject to the terms of the Group Policy), but not beyond the end of the original Maximum Benefit Period.

D. BENEFITS AFTER INSURANCE ENDS OR IS CHANGED

Your right to receive LTD Benefits for a period of continuous Disability which begins while you are insured under the Group Policy will not be affected by:

1. The termination of the Group Policy after the date you become disabled.
2. The termination of your Insurance while the Group Policy remains in force.
3. The termination of this Insurance for your classification of employees of the Employer.
4. Any amendment to the Group Policy approved after the date you become disabled.

Part 9. WHEN INSURANCE ENDS

Your Insurance will end automatically on the earliest of the following dates:

1. The date you cease to be a Member as defined in Part IA.
2. The date you become a full-time member of the armed forces of any country.
3. The date the Group Policy terminates or is amended to terminate coverage for your classification of employees.
4. The last day of the last period for which you make the required premium contribution for your Insurance.

Note: Your Insurance may be continued while you are scheduled to be away from work for any period of 30 days or more under the terms of your employment.

Part 10. BECOMING INSURED AGAIN AFTER INSURANCE ENDS

You may become insured again under the Group Policy after your Insurance ends. The general rule is that you may become insured again on the same basis as a new Member, as provided in Part 1. However, the following special rules apply to becoming insured again under the Group Policy after your Insurance ends:

1. If your Insurance ends because you fail to make the required pre contribution for Contributory Insurance, you must submit Evidence Of Insurability satisfactory to us before becoming insured again unless you qualify for reinstatement of your Insurance under rule 2.
2. If your Contributory Insurance ends during a period of family or medical leave mandated by the federal Family and Medical Leave Act of 1993 or by applicable state law and you return to Active Work for the Employer immediately after the end of that period of family or medical leave, then:
 - a. You will not be required to satisfy the eligibility waiting period to become insured again;
 - b. You will not be required to provide satisfactory Evidence Of Insurability to become insured again for a Maximum LTD Benefit up to the amount in effect when you Insurance ended; and
 - c. Your Insurance will not be subject to a new Preexisting Condition exclusion or limitation.
3. If your Insurance ends because you cease to be a Member or because you cease to be Actively At Work for the Employer on your regular work days, you will not be required to satisfy the eligibility waiting period Shown in Part 1B again if you qualify as a Member and return to Active Work for the Employer within 90 days after your Insurance ends.
4. If your Insurance ends because you become a full-time member of the armed forces of the United

States, you will not be required to satisfy the eligibility waiting period shown in Part 1B again if you qualify as a Member and return to Active Work for the Employer within 90 days after you leave active military service.

5. If you are immediately eligible for Insurance under rule 3 or 4 and you apply for Insurance within 31 days after you become eligible, you will not be required to provide satisfactory Evidence Of Insurability to become insured again for a Maximum LTD Benefit up to the amount in effect when your Insurance ended.

Your Insurance will become effective again on the date determined from Part 1, and will not be retroactive to the date your Insurance ended. Your Insurance will be subject to the Preexisting Condition exclusion or limitation in Part 4, if any, as follows:

1. If you become insured again more than 90 days after your Insurance ends, the Preexisting Condition provision will apply to any condition which is a Preexisting Condition on the date you become insured again, except as provided in item 2.
2. If you become insured again immediately after a period of family or medical leave mandated by the federal Family and Medical Leave Act of 1993 or by applicable state law or if you become insured again within 90 days after your Insurance ends, the Preexisting Condition provision will apply to any condition which was a Preexisting Condition at the start of the prior period of Insurance. For this purpose only, the two periods of Insurance will be treated as one period of continuous Insurance and the period when you were not insured will be ignored. (The same principles will apply if your Insurance ends two or more times and each time you become insured again within 90 days. The three or more periods of Insurance will be added together for purposes of the Preexisting Condition exclusion or limitations.

Note: After LTD Benefits for a period of Disability end, your Insurance will continue without any interruption if you are a Member and immediately return to Active Work for the Employer. This Part 10 will not apply since your Insurance continues while you are receiving LTD Benefits.

Part 11. CLAIMS PROVISIONS AND PROCEDURES FOR LTD BENEFITS

A. PAYMENT OF BENEFITS; TIME OF PAYMENT

LTD Benefits will be paid to you. Any LTD Benefit remaining unpaid at your death will be paid to the person or persons receiving the Survivors Benefit or to your estate.

All benefits payable under the Group Policy will be paid within 60 days after we receive satisfactory written proof of loss in connection with the claim for benefits. All accrued LTD Benefits payable under the Group Policy will be paid not less frequently than monthly during the continuance of the period for which benefits are payable. Any benefits remaining unpaid at the end of that period will be paid as soon as possible after the receipt of satisfactory written proof of loss in connection with the claim for benefits.

B. TIME LIMITS FOR FILING A CLAIM

You must claim LTD Benefits within 120 days after the end of the Elimination Period or as soon thereafter as reasonably possible and, in any case, within one year after the end of that 120 day period. Claims not filed within these time limits will be denied and no LTD Benefit will be paid. These limits will not apply during any period when you lacked the legal capacity to file a claim.

C. FILING A CLAIM

All claims for LTD Benefits should be submitted on our forms. You should obtain claim forms from the Employer or the Plan Administrator.

You may also request claim forms from us. If we fail to provide you with claim forms within 15 days of your request, you may submit your claim in a letter stating the occurrence, character, and extent of the event for which the claim is made.

D. PROOF OF LOSS

No LTD Benefits will be paid unless you provide us with satisfactory written proof of loss at your expense. If your claim is approved, no LTD Benefits will be continued beyond the end of the period for which you have provided us with satisfactory written proof of loss at your expense.

You must submit the following documents at your expense:

1. A completed claim statement signed by you.
2. A completed claim statement signed by the Employer.
3. A completed claim statement signed by your treating Physician.
4. Your written authorization for us to obtain the records and information (including tax returns) needed to determine your eligibility for LTD Benefits.
5. Such other documents as we may reasonably require, including copies of your tax returns.

We will require you to submit additional documentation of your claim at your expense at reasonable intervals while you are receiving LTD Benefits.

E. INVESTIGATION OF YOUR CLAIM

We have the right at any time to conduct an investigation of your claim.

F. INDEPENDENT RE-EXAMINATION

We have the right to have you examined at our expense at reasonable intervals while you are claiming LTD Benefits. Any such examinations will be conducted by one or more Physicians or vocational specialists of our choice.

We have the right to defer or suspend payment of LTD Benefits if you fail to attend an examination or fail to cooperate with the person conducting the examination. In such a case LTD Benefits may be resumed, provided that the required examination occurs within a reasonable time and LTD Benefits are otherwise payable.

G. NOTICE OF DECISION ON CLAIM

You will receive a written decision on your claim within a reasonable period of time after we receive your claim.

If we deny all or any part of your claim, you will receive a written notice of denial containing:

1. The reasons for the denial.
2. Reference to the provisions of the Group Policy on which the denial is based.

3. A description of any additional information or documentation you must submit to obtain benefits and an explanation of why such information or documentation is required.
4. Notice of your right to a review of the denial.
5. A description of the review procedure.

If you do not receive a written decision on your claim within 60 days after your claim is received, you will have an immediate right to request a review under the review procedure, as if your claim had been denied.

H. REVIEW PROCEDURE

You have a right to a review of any denial by us of all or any part of your claim. To obtain a review, you should send a written request for review to us within 60 days after you receive notice of the denial. No special form is required.

As a part of your request for review, you may submit issues and comments in writing and provide additional documentation in support of your claim. You may review pertinent documents related to your request for review.

We will review your claim promptly after receiving your request for review. You will receive written notice of our decision within 60 days after your request for review is received, or within 120 days if special circumstances require an extension. The written decision you receive will include the reasons for the decision and reference to the provisions of the Group Policy on which the decision is based.

You may authorize another person to act for you under this review procedure.

Part 12. TIME LIMITS ON LEGAL ACTIONS

No action at law or in equity may be brought to recover under the Group Policy until 60 days after written proof of loss has been provided to us.

Part 13. INCONTESTABLE CLAUSES

A. INCONTESTABLE CLAUSE FOR YOUR INSURANCE

Any statement you make to obtain Insurance is a representation and not a warranty. No misrepresentation by you will be used to reduce or deny your claim or to deny the validity of your Insurance unless all of the following are true:

1. Your insurance would not have been approved if we had known the truth.
2. Your misrepresentation is contained in a written instrument signed by you.
3. You have been given a copy of the written instrument containing your misrepresentation.

After your Insurance has been in effect for two years, we will not use a misrepresentation by you to reduce or deny your claim or to deny the validity of your Insurance, unless it was a fraudulent misrepresentation made with actual intent to deceive.

B. INCONTESTABLE CLAUSE FOR GROUP POLICY

Any statement made by the Employer to obtain the Group Policy is a representation and not a warranty. No misrepresentation by the Employer will be used to deny a claim or to deny the validity of the Group Policy unless all of the following are true:

1. The Group Policy would not have been issued by us if we had known the truth.
2. The misrepresentation is contained in a written instrument signed by the Employer.
3. A copy of the written instrument has been given to the Employer.

The validity of the Group Policy will not be contested after it has been in effect for two years, except for non-payment of premiums or a fraudulent misrepresentation made with actual intent to deceive.

Part 14. ALLOCATION OF AUTHORITY

Except for those functions which the Group Policy specifically reserves to the Employer, we have the full and exclusive authority to administer claims and to interpret the Group Policy and resolve all questions arising in the administration, interpretation, and application of the Group Policy.

Our authority includes, but is not limited to, the following:

1. The right to resolve all matters when a review has been requested.
2. The right to establish and enforce rules and procedures for the administration of the Group Policy and any claim under it.
3. The right to determine (a) your eligibility for Insurance, (b) your entitlement to benefits, and (c) the amount of the benefits payable to you.

Part 15. ASSIGNMENT NOT PERMITTED

Your Certificate is not assignable. The Insurance provided and benefits payable are not assignable.

Part 16. GENERAL DEFINITIONS

EMPLOYER means County of Santa Clara.

GROUP POLICY means our group policy number 908736-A issued to the Employer.

LONG TERM DISABILITY INSURANCE means your disability insurance under the Group Policy.

INSURANCE means your Long Term Disability Insurance under the Group Policy.

LTD BENEFIT means the monthly Long Term Disability Insurance benefit payable to you according to the terms of the Group Policy.

Providing **EVIDENCE OF INSURABILITY**, if required, means you must do all of the following:

1. Complete and sign our health and medical history form.
2. Sign our form authorizing us to obtain information about your health and other insurance coverage.
3. Provide any additional information about your insurability reasonably required by us and undergo a physical examination and testing, if required by us.

All required information must be provided to us at your expense.

CONTRIBUTORY Insurance means you pay all or a part of the cost of your Insurance. If your Insurance is Contributory, the Employer determines the amount of your contribution toward the cost of your Insurance.

NONCONTRIBUTORY Insurance means the Employer pays the entire cost of your Insurance.

REQUIRED CALIFORNIA NOTICE

To Our California Policyholders and Certificate Holders:

We are here to serve you....

As our policyholder or certificate holder, your satisfaction is very important to us. Should you have a valid claim, we fully expect to provide a fair settlement in a timely fashion. In the event you need to contact someone about this policy for any reason, please contact your agent. If you have additional questions, you may contact Highmark Life Insurance Company at the following address and toll-free telephone number:

**Highmark Life Insurance Company
P.O. Box 1840
Hartford, Connecticut 06144-1840
Telephone number: 1-800-443-3221**

If you are not satisfied...

Should you feel you are not being treated fairly and you have been unable to contact or obtain satisfaction from us or the agent, we want you to know you may contact the California Department of Insurance with your complaint and seek assistance from the governmental agency that regulates insurance.

To contact the Department, write or call:

**Consumer Affairs Division
California Department of Insurance
300 South Spring Street
Los Angeles, CA 90013**

Telephone number: 1-800-927-HELP

California Life and Health Insurance Guarantee Association Act Summary Document and Disclaimer

Residents of California who purchase life and health insurance and annuities should know that the insurance companies licensed in this state to write these types of insurance are members of the California Life and Health Insurance Guarantee Association ("CLHIGA"). The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guarantee Association will assess its other member insurance companies for the money to pay the claim of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided through the Association is not unlimited, as noted in the box below, and is not a substitute for consumers' care in selecting insurers.

The California Life and Health Insurance Guarantee Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. *However, insurance companies and their agents are prohibited by law from using the existence of the Guarantee Association to induce you to purchase any kind of insurance policy.*

Policyholders with additional questions should first contact their insurer or agent or may then contact:

Executive Director
California Life and Health Insurance
Guarantee Association
P.O. Box 70069
Los Angeles, CA 90070

OR

Allegra Willison, Staff Counsel
California Department of Insurance
45 Fremont Street, 24th Floor
San Francisco, CA 94105

The state law that provides for safety-net coverage is called the California Life and Health Guarantee Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Association.

COVERAGE

Generally, individuals will be protected by the California Life and Health Insurance Guarantee Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guarantee Association if:

- Their insurer was not authorized to do business in this state when it issued the policy or contract;
- Their policy was issued by a health care service plan (HMO, Blue Cross, Blue Shield), a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society;
- They are eligible for protection under the laws of another state. This may occur when the insolvent insurer was incorporated in another state whose guarantee association protects insurers who live outside that state.

The Guarantee Association also does not provide coverage for:

- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which guarantee rights to group contract holders, not individuals;
- Employer and association plans, to the extent they are self-funded or uninsured;
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance unless an assumption certificate was issued;
- Interest rate yields that exceed an average rate;
- Any portion of a contract that provides dividends or experience rating credits.

LIMITS ON AMOUNT OF COVERAGE

The Act limits the Association to pay benefits as follows:

LIFE AND ANNUITY BENEFITS

- 80% of what the insurance company would owe under a life policy or annuity contract up to
- \$100,000 in cash surrender values,
- \$100,000 in present value of annuities, or
- \$250,000 in life insurance death benefits.
- A maximum of \$250,000 for any one insured life no matter how many policies and contracts there were with the same company, even if the policies provided different types of coverages.

United Administrative Services
1120 South Bascom Avenue
San Jose, CA 95128
Phone: (408) 288-4400

Insured By:

HIGHMARK
LIFE INSURANCE COMPANY